Public Document Pack

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday 15th March 2016**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Appointment of Chairman**

   To appoint a Chairman following changes in the membership of the Cheshire East Health and Wellbeing Board

2. **Apologies for Absence**

   To receive any apologies for absence

3. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

4. **Minutes of Previous meeting** (Pages 1 - 8)

   To approve the minutes of the meeting held on 26 January 2016

For requests for further information
Contact: Julie North
Tel: 01270 686460
E-Mail: julie.north@cheshireeast.gov.uk with any apologies

5. **Public Speaking Time/Open Session**

In accordance with Procedure Rules Nos.11 and 35 a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the body in question. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers. Members of the public are not required to give notice to use this facility. However, as a matter of courtesy, a period of 24 hours' notice is encouraged.

Members of the public wishing to ask a question at the meeting should provide at least three clear working days' notice in writing and should include the question with that notice. This will enable an informed answer to be given.

6. **Better Care Fund 2016/17** (Pages 9 - 40)

To receive an update on the proposals for the implementation and delivery of the Cheshire East Better Care Fund in 2016/17

7. **Safeguarding Adults Board Annual Report** (Pages 41 - 70)

To receive a presentation on the Local Safeguarding Adults Board Annual Report 2014-15

8. **Caring for Carers: A Joint Strategy for Carers of All Aged in Cheshire East 2016 - 2018** (Pages 71 - 110)

To consider a report on the Joint Strategy for Carers of All Aged in Cheshire East 2016-2018

9. **Caring Together Update** (Pages 111 - 114)

To consider a report on the Caring Together programme

10. **NHS England Sustainability and Transformation Planning Update**

To receive an oral update on the NHS England Sustainability and Transformation planning

11. **Transforming Care Update** (Pages 115 - 242)

To receive an update on the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities

12. **Supporting the Mental Health of Children and Young People** (Pages 243 - 262)

To consider reports on Supporting the Mental Health of Children and Young People

13. **Health Protection Forum** (Pages 263 - 268)

To consider a report on the establishment of a Health Protection Forum as a sub-group of the Health and Wellbeing Board, to be chaired by the Director of Public Health

This page is intentionally left blank

Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 26th January, 2016 at Committee Suite 1, 2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members:
Councillor David Brown – Cheshire East Council (in place of Cllr M Jones)
Councillor Rachel Bailey – Cheshire East Council
Councillor Janet Clowes – Cheshire East Council
Simon Whitehouse – Southern Cheshire Clinical Commissioning Group
Jerry Hawker – Eastern Cheshire Clinical Commissioning Group
Dr Paul Bowen – Eastern Cheshire Clinical Commissioning Group (GP Lead)
Kate Sibthorp – Healthwatch
Tracy Bullock – Mid-Cheshire Hospitals NHS FT (Independent NHS Rep)
Kath O'Dwyer – Director of Children's Services, Cheshire East Council
Brenda Smith – Director of Adult Social Care and Independent Living, Cheshire East Council

Non-voting Members:
Dr Heather Grimbaldeston – Cheshire East Council
Tina Long – NHS England

Observers:
Councillor Stewart Gardiner – Cheshire East Council
Councillor Sam Corcoran – Cheshire East Council

Cheshire East Council officers/others in attendance:
Guy Kilminster – Head of Health Improvement, CE Council
Karen Carsberg – Strategic Housing Manager
Gill Betton – Children's Improvement and Development Manager, CE Council
James Morley – Scrutiny Officer

Councillor in attendance:
Councillor Jos Saunders, Chairman of the Health and Adult Social Care Overview and Scrutiny Committee

44 **APPOINTMENT OF CHAIRMAN FOR THE MEETING**

RESOLVED

That Councillor David Brown be appointed as Chairman for the first part of the meeting and Councillor J Clowes take the Chair thereafter.

(Councillor D Brown in the chair)

45 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Michael Jones, Dr Andrew Wilson and Mike Suarez.

46 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a non-pecuniary interest by virtue of his wife being a GP and a Director of South Cheshire GPs Alliance Ltd.

47 **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes be approved as a correct record.

48 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present wishing to use public speaking time.

49 **NHS PLANNING GUIDANCE 2016/17 - 2020/21**

The Board was asked to consider the most appropriate transformation footprints for the local health system.

The NHS Planning Guidance for 2016/17 – 2020/21 had been published just before Christmas and was attached as Appendix 1 to the report. There was a focus on place-based planning and the requirement to prepare five year local health system Sustainability and Transformation Plans (STPs). These would need to be based upon an agreed 'transformation footprint' that had to be notified to NHS England by 29th January 2016. One year operational plans were also required.

There were a number of options for system leaders to consider in terms of the transformation footprints as set out in the report.

In considering the options, the Board had regard to the need for a rural, Cheshire-based footprint commensurate with the need for sufficient economies of scale to attract significant investment. It was acknowledged that this would not prevent valuable partnerships from being formed with neighbouring areas as and when appropriate.

Concern was expressed at the short amount of time allowed for consideration of the matter before responding to NHS England.

RESOLVED

That the Board considers the most appropriate transformation footprint for the local health system(s) to be a Cheshire and Warrington-based footprint and NHS England be advised accordingly.

(At this point, Councillor Brown vacated the chair and left the meeting.)

(Councillor J Clowes in the chair)

50 **KEY WORKER ACCOMMODATION**

The Board considered a proposal to commission a Borough-wide survey into potential demand for key worker housing which would allow Strategic Housing to contribute to Spatial Planning's emerging planning guidance.

Initial contact with partner agencies employing key workers had proven very positive. Strategic Housing now sought to gather evidence of potential affordable housing need for key workers within Cheshire East through primary qualitative research by conducting an online key worker affordable housing needs survey.

RESOLVED

That the Board supports Strategic Housing's conducting of a survey within the Borough with partner agencies to gain valuable intelligence into potential key workers' affordable housing needs, which will in turn supplement the Cheshire East Council Local Plan and inform the development of a Supplementary Planning Document.

51 **ENSURING AND IMPROVING QUALITY AND CHOICE IN RESIDENTIAL AND NURSING HOME PROVISION.**

This item was withdrawn.

52 **BETTER CARE FUND DRAFT PLAN 2016/17**

The Board considered a briefing paper which provided an update on the emerging guidance for Better Care Fund in 2016/17 and beyond.

On 8th January 2016, the policy paper 'Better Care Fund: how it will work in 2016 to 2017' was published. The paper set out the policy framework for the implementation of the Better Care Fund in 2016/17. The strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Fund had been taken on board and the planning and assurance process had been streamlined and simplified, including the removal of the £1billion payment for performance framework.

The key messages arising from the policy guidance were set out in the briefing paper.

RESOLVED

That the contents of the briefing paper be noted.

53 **THE SUSTAINABLE COMMUNITY STRATEGY AND THE HEALTH AND WELL BEING BOARD STRATEGY REFRESH**

The Board considered a proposal to merge the Health and Wellbeing Strategy and the Sustainable Community Strategy.

It had become apparent that there was work currently in hand to refresh both the Health and Wellbeing Strategy and the Sustainable Community Strategy. This offered an opportunity to consider bringing the two together to form the key strategic focus for the future. The Council's Management Group Board and Cabinet (informally) were supportive of this approach and the Health and Wellbeing Board's views were now sought to determine the next steps.

A combined Strategy could provide a means of establishing a more effective golden thread through the Authority and its partners signed up to by the Leaders' Board and the Health and Wellbeing Board. In addition the recently published NHS Planning Guidance 2016/17 – 2020/21 had introduced the requirement to draft 'Local health system sustainability and transformation plans'. There needed to be consideration given as to how these related to the Sustainable Community and Health and Wellbeing Strategies.

RESOLVED

That the proposal to merge the Health and Wellbeing Strategy and the Sustainable Community Strategy be supported.

54 **CHILDREN AND YOUNG PEOPLE'S IMPROVEMENT PLAN UPDATE**

The Board considered an update report on developments with the children and young people's improvement plan. The improvement plan had been developed to address the areas of improvement identified by Ofsted and would need to align closely with the Health and Wellbeing Strategy.

The Board had previously endorsed a proposal for it to become the accountable body to monitor, scrutinise and challenge progress against the improvement plan.

In endorsing the draft improvement plan in November, the Board had felt that there needed to be clarity around the governance arrangements. The amended governance information was attached at Appendix 1 to the report. This had been included in the final improvement plan submitted to Ofsted and the DfE ahead of the deadline; a summary of the plan, developed for professionals, was attached at Appendix 2.

On 16th December 2015 Cheshire East Council had received a letter from Sam Gyimah, MP, confirming that the improvement notice, issued to Cheshire East on 12th September 2013, had now been lifted. A copy of the letter was attached at Appendix 3 to the report. The Improvement Board that was the accountable body for the previous improvement plan had now been disbanded and responsibility had passed to the Health and Wellbeing Board. The Board would receive regular updates on progress against the improvement plan.

In affirming its commitment to become the accountable body for the improvement plan, the Health and Wellbeing Board had identified the need to improve the knowledge and understanding of Board Members in relation to the areas of the improvement plan. An outline development plan was attached at Appendix 4 to the report for endorsement by members.

RESOLVED

That the Health and Wellbeing Board

1. notes the contents of the report, including the revised governance model at Appendix 1, the summary improvement plan for professionals at Appendix 2 and the letter from the Minister lifting the improvement notice at Appendix 3; and

2. agrees the development plan for the Board as set out at Appendix 4.

55 **BUILDING COMMUNITY CAPACITY**

The Board considered the need to focus upon building community capacity as one of its priorities.

Details of a course on 'Leadership for Empowered and Healthy Communities' were circulated at the meeting. The course was aimed at leaders in health and social care who wanted to think radically about the challenges and opportunities in a community-based approach.

Reference was also made to a document circulated to Board members last September called 'Developing the Power of Strong, Inclusive Communities' which had been produced by Think Local Act Personal in collaboration with Public Health England and which sought to provide a framework to enable Health and Wellbeing Boards make the development of strong and inclusive communities integral to their work.

It was suggested that a one day conference be arranged to discuss these matters further.

RESOLVED

That

1. the Director of Adult Social Care and Independent Living seek interest among relevant Cheshire East officers regarding attending the course on 'Leadership for Empowered and Healthy Communities'; and

2. the Corporate Manager for Health Improvement work with partners to arrange a one day workshop for the Board to consider the issues around building community capacity and the formation of a strategy.

56 **MEMORANDUM OF UNDERSTANDING WITH SCRUTINY AND HEALTHWATCH**

The Board considered a report providing a brief overview of the relationship between Overview and Scrutiny, the Health and Wellbeing Board and Healthwatch, together with a Memorandum of Understanding that had been proposed to support the work of the bodies.

The purpose of the Memorandum of Understanding was to provide a guidance to the bodies as to how they should work together, to ensure their activities were complementary and contributed towards achieving the strategic health and care outcomes of the Borough. The Memorandum of Understanding could help to develop relationships between the bodies that allowed each to focus on particular issues, producing better quality work and enabling the bodies as a whole to achieve more.

RESOLVED

That a Word version of the draft Memorandum of Understanding be circulated to Board members for comments on the Memorandum and how it might be implemented.

57 **CARE ACT UPDATE**

This item was deferred and would be considered at the next informal meeting. In the meantime, members were asked to feed back their comments to the Director of Adult Social Care and Independent Living.

58 **NEXT MEETING**

RESOLVED

That an informal meeting of the Board be held on 1st March 2016 from 2.00 pm to 5.00 pm to consider the following items:

1. Better Care Fund Plan 2016-2017
2. Care Act Update Paper
3. Ensuring and Improving Quality and Choice in Residential and Nursing Home Provision.

The meeting commenced at 2.00 pm and concluded at 4.28 pm

Councillor J Clowes (in the chair)

This page is intentionally left blank

Cheshire East Council

Health & Wellbeing Board

Date of Meeting: **15/3/16**

Report of: **Brenda Smith**

Subject/Title: **Better Care Fund 2016/17**

Portfolio Holder: **Cllr Janet Clowes (Adults and Integration)**

1. Report Summary

1.1 The purpose of this report is to provide Health & Wellbeing Board with an update on the proposals for the implementation and delivery of the Cheshire East Better Care Fund (BCF) in 2016/17.

1.2

2. Recommendations

2.1 It is recommended that Health & Wellbeing Board:

a. Advises how sign-off of the final return on 25th April be undertaken in the absence of HWB meetings between 15th March and 31st May 2016;

b. Approves the continuation of the 2015/16 arrangements via two s75 Partnership Agreements from 1st April 2016 until 31st March 2017, and for these arrangements to continue post April 2017 so long as there is a national requirement to operate the BCF as a s75 pooled budget agreement;

c. Acknowledges that the continuation of the two s75 arrangements is proposed to reflect the local integrated care system programmes (Caring Together being led by Eastern Cheshire CCG and Connecting Care being led by South Cheshire CCG);

d. Approves BCF Governance Group, which links to Caring Together and Connecting Care transformation programmes through its membership, to be the lead group to develop and agree returns prior to HWB sign-off.

Reasons for Recommendations

3.1 The BCF plans and allocations have been developed on the Cheshire East Health and Wellbeing Board basis, as required. In 2015/16, the pooled budget for Cheshire East was £23.9m,and consisted of Local Authority Capital funding of £1.8m, South Cheshire CCG funding of £10.5m and Eastern

Cheshire CCG Funding of £11.6m. This was the minimum required pool nationally.

3.2 In 2016/17, the minimum required pool is £24,236,470 and consists of Disabled Facilities Grant funding of £1,637,470, South Cheshire CCG funding of £10.705m and Eastern Cheshire CCG funding of £11.894m.

3.3 Due to a combination of factors, including the national direction of travel and improvements in trusting meaningful working relationships, there is an appetite across SCCCG and CEC to have a 2016/17 pooled budget that goes beyond the minimum required. Plans in SCCCG are to invest their ringfenced budget in out of hospital NHS-commissioned services.

3.4 ECCCG is not proposing going beyond the minimum required due to significant financial pressures. Plans in ECCCG are to retain the maximum ringfenced amount as part of a risk share agreement.

3.5 The proposed areas of work to bring under the pooled budget for 2016/17 in the SCCCG area, in addition to those already in for 2015/16, are:

- Staffing of integrated teams
- Carers (including young carers)
- Cheshire Care Record
- Mental health reablement
- Community equipment service

3.6 The initial Cheshire East BCF plan for 2016/17 was submitted to NHS England on 2nd March 2016. A second submission is due on 21st March 2016 followed by a final complete return, to be signed off by HWB, on 25th April 2016. HWB is asked to advise how they would like this sign-off to be undertaken.

3.7 The BCF Governance Group, which links into Caring Together and Connecting Care transformation programmes through its membership, is leading on the development of the plans.

3.8 Full approval by NHS England of the plans for 2016/17 is based on the following conditions:

- A s75 pooled budget agreement is used as the mechanism to deliver the approved BCF plan.
- Health and Wellbeing Boards jointly agree plans for how money will be spent, with plans signed off by the local authority and Clinical Commissioning Groups
- That a proportion of the area's allocation is invested in NHS-commissioned out of hospital services, or retained pending release as part of a local risk sharing agreement
- Social care services are maintained
- Agreement for the delivery of 7-day working across health and social care
- Improved data sharing between health and social care based on the NHS number

- Joint approaches to assessment and care planning, and that where integrated packages of care are funded, that there is an accountable professional
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans
- Agreement on a local action plan to reduce delayed transfers of care

3.6 It is a statutory requirement for a s75 pooled budget, partnership agreement to have been in place to support the delivery of the BCF from 1st April 2015, and for this to be continued into 2016/17. The pooled budget arrangement is fundamental to the smooth delivery and implementation of the BCF plan, in particular ensuring that the level of both financial and non financial risk that partners could be exposed to is managed appropriately.

3.7 In 2015/16, the Cheshire East Health and Wellbeing Board endorsed progressing with two separate s75 pooled budget agreements locally, to support the delivery of the Better Care Fund plan and to be aligned with the respective health integration programmes Caring Together (Eastern Cheshire Clinical Commissioning Group) and Connecting Care (South Cheshire Clinical Commissioning Group). Cheshire East Council would enter into a pooled budget arrangement with Eastern Cheshire Clinical Commissioning Group (CCG) and a separate s75 arrangement with South Cheshire Clinical Commissioning Group. It is proposed that this arrangement continues into 2016/17. It is a statutory requirement for a s75 pooled budget, partnership agreement to have been in place to support the delivery of the BCF from 1st April 2015, and for this to be continued into 2016/17 The Cheshire East Better Care Fund plan has been developed with health partners and is aligned with local health and social care transformation programmes.

3.8 The BCF s75 agreements for 2015/16 have been reviewed for 2016/17 by the BCF Governance Group and respective partners are now considering the revised s75 agreements.

3.9 The governance arrangements supporting the s75 Better Care Fund pooled budget arrangement are fundamental to the smooth delivery of the expected changes and ensuring the level of risk both financial and non-financial the council, partner organisations and providers are exposed to. The s75 pooled budget partnership agreement provides an overview of the current governance arrangements.

3.10 Policy Guidance regarding the BCF for 2016/17 describes the need for areas to develop Sustainability and Transformation Plans to 2020 by June 2016. These plans will need to describe how fully integrated health and social care systems will be achieved by 2020. Partners recognise that the BCF s75 pooled budget is a vehicle by which this can be achieved. However a significant rate of pace and change will be required to get from the minimum required to a fully integrated system. Areas that do go beyond the minimum requirements in 2016/17 are expected to have more autonomy in choosing the method by which their integrated system is achieved and in managing this integration process.

4. Other Options Considered

4.1 The requirement to have a s75 agreement and BCF is mandatory.

4.2 The option to maintain a minimum pool has not been recommended as it does not demonstrate progress in the direction of a fully integrated Health and Social Care system by 2020 as required nationally.

4.3 The option to increase the pool across the HWB area was considered but was not agreed by ECCCG.

5. Background

5.1 The BCF is a nationally driven initiative being overseen by the Department of Health and is a key part of Public Sector Reform supporting the integration of Health and Social Care. The BCF enters its second year in 2016/17 with a national pooling of £3.9billion (an increase from £3.8 billion in 2015/16) from a variety of existing funding sources within the health and social care system and will be utilised to further develop closer integration across health and social care. The BCF is a pooled budget held between Local Authorities and Clinical Commissioning Groups (CCG's) via a legal section 75 (s75) partnership agreement.

6. Wards Affected and Local Ward Members

6.1 All wards.

7. Implications of Recommendation

7.1 Policy Implications

7.1.1 Health and Social Care integration is a key element of public sector reform. The Better Care Fund develops these joint initiatives further during 2016/17.

7.1.2 Elements of the Better Care Fund funding are linked to the implementation of the Social Care Act, in particular carers, safeguarding boards and maintaining eligibility criteria.

7.2 Legal Implications

7.2.1 S141 of the Care Act 2014 provides for the Better Care Fund Pooled Funds to be held under and governed by an overarching s75 National Health Service Act 2006 Partnership Agreement.

7.2.2 Pursuant to Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (the "Regulations"), NHS bodies and local authorities can enter into partnership arrangements for the exercise of specified functions. The regulations define the nature of the partnership arrangements. They provide for the establishment of a fund made up of contributions from the partners out

of which payments may be made towards expenditure incurred in the exercise of their functions; for the exercise by NHS bodies of local authority functions and for the exercise by local authorities of NHS functions; and require the partners to set out the terms of the arrangements in writing. The specific objectives for implementing Section 75 Agreements are:

- To facilitate a co-ordinated network of health and social care services, allowing flexibility to fill any gaps in provision;
- To ensure the best use of resources by reducing duplication (across organisations) and achieving greater economies of scale; and
- To enable service providers to be more responsive to the needs and views of users, without distortion by separate funding streams for different service inputs.

7.2.3 In 2015/2016 Cheshire East Council entered into two separate s75 agreements, one with each CCG operating within the Cheshire East Borough footprint. In accordance with those agreements (and the statutory requirement to hold BCF pooled funds under a s75 agreement), during January 2016 a review was commenced into the continuation of the agreements for a further period of one year.

7.2.4 As set out in paragraph 3.4, Policy Guidance regarding the BCF for 2016/17 describes the need for areas to develop Sustainability and Transformation Plans to 2020 by June 2016, which plans will need to describe how fully integrated health and social care systems will be achieved by 2020. Partners have recognised that the BCF s75 pooled budget is a vehicle by which this can be achieved and are considering amendments to the agreements which reflect this ambition both in terms of going beyond the minimum financial requirements in 2016/17 and of committing to designing and articulating how integration is to be achieved and managed.

7.2.5 During 2015/16 the governance of the BCF pooled fund arrangements has been developed and the BCF Governance Group now makes decisions, which has been taken into account within the amendments to the agreements.

7.3 Financial Implications

7.3.1 In 2016/17, the minimum required pool is £24,236,470 and consists of Local Authority Capital funding of £1,637,470, South Cheshire CCG funding of £10.705m and Eastern Cheshire CCG funding of £11.894m.

7.3.2 The local health and social care economy will work together to deliver better care arrangements for its population, seeking to keep individuals within the community, avoiding hospital/residential nursing care.

7.3.3 Following the agreement to operate two section 75 agreements within the Cheshire East area, the respective Clinical Commissioning Groups and Council are responsible for producing the pooled budget's accounts and audit in respect of those elements of the budget which they receive directly

from government. This arrangement reduces the number of transactions across organisations and provides the opportunity for the pooled budgets to be aligned to the local health and social care transformation programmes. The organisations host the budget in line with the agreed plans of all partners and the funding would be used explicitly for the agreed areas of spending identified in the plan. The Council takes responsibility for the collation and consolidation of standardised financial and reporting information for the Cheshire East Health and Wellbeing board.

7.3.4 The risk sharing arrangements for over and underspends is directly linked to each scheme specification and the lead commissioning organisation will be responsible for the budget management of the pooled fund allocated to the each individual scheme. The risks of overspends for the schemes included in the BCF plan are currently limited to the funding contribution. A variation schedule has been included in the partnership agreement to provide the lead commissioner with the escalation process to raise issues and concerns.

7.4 Human Resources Implications

7.4.1 None

7.5 Equality Implications

7.5.1 The recommendations will most likely benefit over 65's and people living in disadvantaged areas more than other parts of the population.

7.6 Rural Community Implications

7.6.1 None.

7.7 Public Health Implications

7.7.1 The recommendations will have a positive impact on populations experiencing the greatest inequities in health and social care, e.g. those aged 65 years and above, and those with lower incomes / living in disadvantaged areas.

8 Risk Management

8.1 The Better Care Fund plan includes a risk register and each lead commissioner is responsible for maintaining a risk register. The risk register is monitored by the BCF Governance Group

8.2 These risks are being managed, and will continue to be managed, as part of the delivery of the Better Care Fund plan.

9 Background Papers

9.1 The background papers relating to this report can be inspected by contacting:

Name: Caroline Baines
Designation: Strategic Commissioning Manager
Tel No: 01270 686248
Email: caroline.baines@cheshireeast.gov.uk

This page is intentionally left blank

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

• NHS Planning Guidance for 2016-17 released – 22 December 2015
• BCF Allocations published following release of CCG allocations – 09 February 2016
• Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
• BCF Planning Return template, released – 24 February 2016
• First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
o BCF planning return template (this template)
All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)
• First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
• Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March
• Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:
o High level narrative plan
o Updated BCF planning return template
• Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016
• BCF plans finalised and signed off by Health and Wellbeing Boards in April, and submitted 2pm on 29 April 2016
This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

The details of each sheet within the template are outlined below.

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.
The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please **enter the following information:**
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one if being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)
This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**
- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the “Technical Definitions” and the “Supplementary Technical Definitions” at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (E6) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

Incomplete Template

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10		Yes
completed by:	C13		Yes
e-mail:	C15		Yes
contact number:	C17		Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19		Yes

Sheet Completed:	Yes

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37		Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37		Yes
Total value of funding held as contingency as part of lcoal risk share to ensure value to the NHS	F47		Yes

Sheet Completed:	Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25		Yes
Gross Contribution: £000's	C16 : C25		No
Comments (if required)	E16 : E25		N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42		Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54		Yes
Gross Contribution: £000's	C45 : C54		Yes
Comments (if required)	E45 : E54		N/A
Funding Sources Narrative	B61		N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70		Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71		Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72		Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73		Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70		No
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	D71		Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72		No
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73		No

Sheet Completed:	No

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B66		Yes
Scheme Type (see table below for descriptions)	C17 : C66		Yes
Please specify if 'Scheme Type' is 'other'	D17 : D66		Yes
Area of Spend	E17 : E66		No
Please specify if 'Area of Spend' is 'other'	F17 : F66		No
Commissioner	G17 : G66		Yes
if Joint % NHS	H17 : H66		Yes
if Joint % LA	I17 : I66		Yes
Provider	J17 : J66		No
Source of Funding	K17 : K66		No
2016/17 (£000's)	L17 : L66		No
New or Existing Scheme	M17 : M66		Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N67		No

Sheet Completed:	No

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43		Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45		Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45		Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45		Yes

5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	Yes
5.1 - Cost of NEA	E54	Yes
5.1 - Comments (if required)	F54	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	Yes
5.2 - Comments (if required)	I68	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	Yes
5.3 - Comments (if required)	I81	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	Yes
5.4 - Comments (if required)	Q93	N/A
5.5 - Local Performance Metric	C105	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	Yes
5.5 - Comments (if required)	G105	N/A
5.6 - Local defined patient experience metric	C117	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	Yes
5.6 - Comments (if required)	G117	N/A

Sheet Completed:	Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14		Yes
2) Maintain provision of social care services (not spending)	C15		Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16		Yes
4) Better data sharing between health and social care, based on the NHS number	C17		Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	C18		Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19		Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20		Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21		Yes
1) Plans to be jointly agreed, Comments	D14		Yes
2) Maintain provision of social care services (not spending), Comments	D15		Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16		Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17		Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments	D18		Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19		Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20		Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21		Yes

Sheet Completed:	Yes

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

Health and Well Being Board	**Cheshire East**
completed by:	Caroline Baines
E-Mail:	caroline.baines@cheshireeast.gov.uk
Contact Number:	01270 686248
Who has signed off the report on behalf of the Health and Well Being Board:	This return has not been agreed by HWB

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Summary and confirmations	3
3. HWB Funding Sources	9
4. HWB Expenditure Plan	7
5. HWB Metrics	34
6. National Conditions	16

Template for BCF submission 1: due on 02 March 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one if being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£1,637,470
Total Minimum CCG Contribution	£22,598,516
Total Additional CCG Contribution	£172,000
Total BCF pooled budget for 2016-17	**£24,407,986**

Specific funding requirements for 2016-17	**Select a response to the questions in column B**
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	No - in development
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	No - in development
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	No - in development

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure
Acute	£0
Mental Health	£0
Community Health	£15,675,238
Continuing Care	£0
Primary Care	£0
Social Care	£7,615,232
Other	£1,010,735
Total	**£24,301,205**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£7,340,000	This is subject to refresh and update as we get a

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	£0
Community Health	£15,675,238
Continuing Care	£0
Primary Care	£0
Social Care	£3,321,762
Other	£0
Total	**£18,997,000**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£6,421,857
Total value of NHS commissioned out of hospital services spend from minimum pool	£18,997,000
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£3,393,596
Balance (+/-)	**£15,968,739**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	10,546	10,541	11,211	10,360	42,657
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	10,546	10,541	11,211	10,360	42,657
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	599.2

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	85%

5.4 Delayed Transfers of Care

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16	Q4 (Jan 17 - Mar 17
		1002.8	900.9	1146.7	1148.3

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
Injuries due to falls, persons 65+	2159.4

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
People who feel supported managing long term conditions (GP Survey)	65

6. National Conditions

National Conditions For The Better Care Fund 2016-17	**Please Select (Yes, No or No - plan in place)**
1) Plans to be jointly agreed	No - in development
2) Maintain provision of social care services (not spending)	No - in development
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development
4) Better data sharing between health and social care, based on the NHS number	No - in development
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development
7) Agreement to invest in NHS commissioned out-of-hospital services	No - in development
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development

Template for BCF submission 1: due on 02 March 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Cheshire East	£1,637,470	DFG allocation
Cheshire East		Additional pooling from proposed service areas - community equipment scheme
Cheshire East		Additional pooling from proposed service areas - carers
Cheshire East		Additional pooling from proposed service areas - mental health reablement
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£1,637,470**	

CCG Minimum Contribution	Gross Contribution
NHS Eastern Cheshire CCG	£11,893,596
NHS South Cheshire CCG	£10,704,921
Total Minimum CCG Contribution	**£22,598,516**

Are any additional CCG Contributions being made? If yes please detail below;	Yes

Additional CCG Contribution	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS South Cheshire CCG	£172,000	
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£172,000**	

Total BCF pooled budget for 2016-17	**£24,407,986**

Funding Contributions Narrative
Eastern Cheshire CCG plans to retain its maximum ringfence as part of a rish share agreement whilst South Cheshire CCG does not plan to retain any. Figures still being worked up regarding additional pooling value from Cheshire East Council. Expenditure plan is inciomplete and requires further updates and refining to separate out scheme lines particularly for integrated teams and intermediate care provision.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	**Select a response to the questions in column B**	**Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.**
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	No - in development	
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	No - in development	Provisional figures using the care act ready reckoner suggest CE allocation amount that would need to be under BCF (largely for carers but likely to need to include independent mental health advocacy) would be £834,000
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development	
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	No - in development	

Template for BCF submission 1: due on 02 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Cheshire East

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

	Expenditure												
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Supporting empowerment	Other	Self-care and self-management as w	Other	Will be across providers and commu	Local Authority			NHS Community Provider	<Please Select>	£215,000	Existing	£215,000
Universal access to low level support	Other	Early intervention and prevention to c	Other	Multisectoral	Local Authority			Charity/Voluntary Sector		£552,000	Existing	£552,000
Assistive technology - telecare	Assistive Technologies		Social Care		Local Authority			Local Authority		£494,826	Existing	£494,826
Assistive technology - learning disability pilot	Assistive Technologies		Social Care		Local Authority			Local Authority		£248,174	Existing	£248,174
Early discharge schemes	Personalised support/ care at home		Social Care		Local Authority			Charity/Voluntary Sector		£258,000	Existing	£228,000
Disabled facilities grant	Personalised support/ care at home		Social Care		Local Authority			Private Sector		£1,637,470	Existing	£990,000
Carers breaks	Support for carers		Social Care		Local Authority			Charity/Voluntary Sector		£424,180	Existing	£424,180
Carers assessment	Support for carers		Social Care		Local Authority			Local Authority		£318,820	Existing	£318,820
Dementia reablement	Reablement services		Social Care		Local Authority			Local Authority		£837,000	Existing	£837,000
Programme enablers	Other	Staffing to support delivery of BCF in	Other	Local authority and acute care	Local Authority			Local Authority		£243,735	Existing	£243,735
Community equipment scheme	Personalised support/ care at home		Social Care		Local Authority			Local Authority	Additional CCG Contribution	£275,000	New	
Carers spend (other)	Support for carers				Local Authority						New	
STAIRRS (Eastern Cheshire)	Intermediate care services		Social Care		CCG			Local Authority	Local Authority Social Services	£3,321,762	Existing	£3,321,762
STAIRRS (Eastern Cheshire)	Intermediate care services		Community Health		CCG			NHS Acute Provider	CCG Minimum Contribution	£12,085,238	Existing	£10,315,238
Integrated community teams (Eastern Cheshire)	Integrated care teams		Community Health		CCG			NHS Acute Provider	CCG Minimum Contribution	£3,029,000	Existing	£1,350,000
Integrated community teams (Eastern Cheshire)	Integrated care teams		Social Care		CCG			Local Authority	Local Authority Social Services		Existing	
Community Based Co-ordinated Care (South Cheshire)	Integrated care teams		Community Health		CCG			NHS Acute Provider	CCG Minimum Contribution	£561,000	Existing	£561,000
Community Based Co-ordinated Care (South Cheshire)	Integrated care teams		Social Care		CCG			Local Authority	Local Authority Social Services		Existing	

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 1: due on 02 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board: Cheshire East

Data Submission Period: 2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Cheshire East	% Cheshire East resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan***
NHS Eastern Cheshire CCG	98.3%	50.6%	4,755	4,580	4,872	4,500	4,892	4,712	4,721	4,547	19,040	18,340
NHS North Derbyshire CCG	0.4%	0.3%	8,498	30	8,206	29	8,543	31	8,243	29	33,490	120
NHS North Staffordshire CCG	1.1%	0.6%	5,205	57	5,262	57	5,282	57	5,148	56	20,977	227
NHS Shropshire CCG	0.1%	0.0%	8,342	9	8,070	9	8,545	9	8,043	8	33,000	35
NHS South Cheshire CCG	98.6%	45.3%	5,562	5,486	5,640	5,563	6,087	6,004	5,406	5,332	22,695	22,384
NHS Stockport CCG	1.6%	1.3%	9,917	162	9,897	162	10,541	173	9,896	162	40,251	659
NHS Trafford CCG	0.2%	0.1%	6,324	11	6,324	11	6,324	11	6,324	11	25,296	42
NHS Vale Royal CCG	0.7%	0.2%	2,916	19	2,854	19	3,034	20	2,792	18	11,596	76
NHS Warrington CCG	0.7%	0.4%	6,319	46	6,388	47	6,388	47	6,248	46	25,343	186
NHS West Cheshire CCG	2.0%	1.3%	7,238	146	7,186	144	7,379	149	7,417	149	29,200	588
Totals		**100%**	**65,076**	**10,546**	**64,479**	**10,541**	**66,995**	**11,211**	**64,238**	**10,360**	**260,788**	**42,657**

Are you planning on any additional quarterly reductions?	No						
If yes, please complete HWB Quarterly Additional Reduction Figures							
HWB Quarterly Additional Reduction Figure							
HWB NEA Plan (after reduction)							
HWB Quarterly Plan Reduction %							

Are you putting in place a local risk sharing agreement on NEA?	Yes
BCF reverse funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£8,421,857
Cost of NEA as used during 15/16 ****	£1,490
Cost of NEA for 16/17 ****	£1,490

Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.

Additional NEA reduction delivered through the BCF	£0					£0
HWB Plan Reduction %	0.00%					

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	614.3	548.6	697.4	599.2	Final submitted numerator for planned 15/16 was 500 not 450. This is still our forecast. Plan not agreed by partners. Will probably need
	Numerator	493	450	500	505	
	Denominator	80,257	82,320	82,320	84,281	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	83.3%	90.0%	84.1%	84.8%	Final submitted numerator for planned 15/16 was 276 not 270. This is still our forecast. Plan is not agreed by partners and will probably
	Numerator	225	270	276	306	
	Denominator	270	300	328	361	

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	922.8	781.2	774.3	880.7	1002.7	897.2	1149.3	1148.7	1002.8	900.9	1146.7	1148.3	Q3 15/16 is actual not forecast. Our data suggests that there is an anomaly with the data
	Numerator	2,762	2,295	2,334	2,658	3,023	2,705	3,465	3481	3039	2730	3475	3497	
	Denominator	301,480	301,480	301,480	303,041	301,480	301,480	301,480	303,041	303,041	303,041	303,041	304,527	

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Injuries due to falls, persons 65+	Metric Value	2213.2	2159.4	Not agreed by partners. Will probably need refresh in future submission.
	Numerator	1822.0	1800.0	
	Denominator	82320.0	84281.0	

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
People who feel supported managing long term conditions (GP Survey)	Metric Value	64.3	65.0	Not agreed by partners. Will probably need refresh in future submission.
	Numerator	2011.0	2047.0	
	Denominator	3128.0	3150.0	

Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.1 HWB NEA Activity

Cheshire East Data Source Used - 15/16	MAR				
	Q1	Q2	Q3	Q4	Total
Cheshire East 14/15 Baseline (outturn)	10,226	10,142	10,985	10,303	41,656
Cheshire East 15/16 Plan	9,868	9,787	10,600	9,853	40,108
Cheshire East 15/16 Actual	10,105	10,644			20,749

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. Actual Q3 and Q4 data is not available at the point of this template being released.

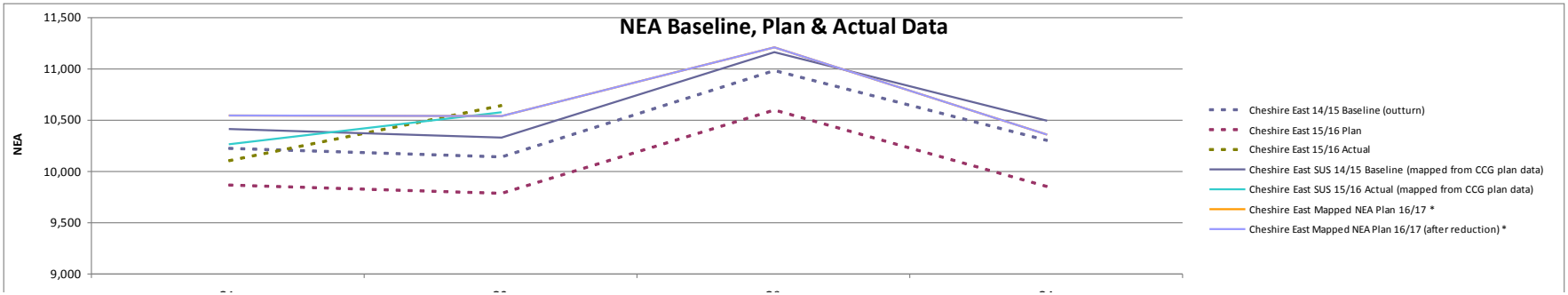
Cheshire East SUS 14/15 Baseline (mapped from CCG plan data)	**10,414**	**10,331**	**11,164**	**10,495**	**42,404**
Cheshire East SUS 15/16 Actual (mapped from CCG plan data)	10,266	10,578			20,844
Cheshire East SUS 15/16 FOT (mapped from CCG plan data)					42,193

SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Cheshire East Mapped NEA Plan 16/17 *	**10,546**	**10,541**	**11,211**	**10,360**	**42,657**
Cheshire East Mapped NEA Plan 16/17 (after reduction) *	**10,546**	**10,541**	**11,211**	**10,360**	**42,657**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

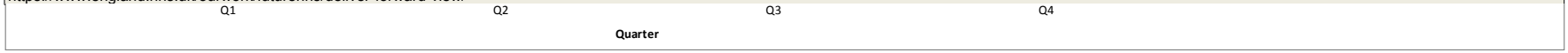
2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the “Technical Definitions” and the “Supplementary Technical Definitions” at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/



Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

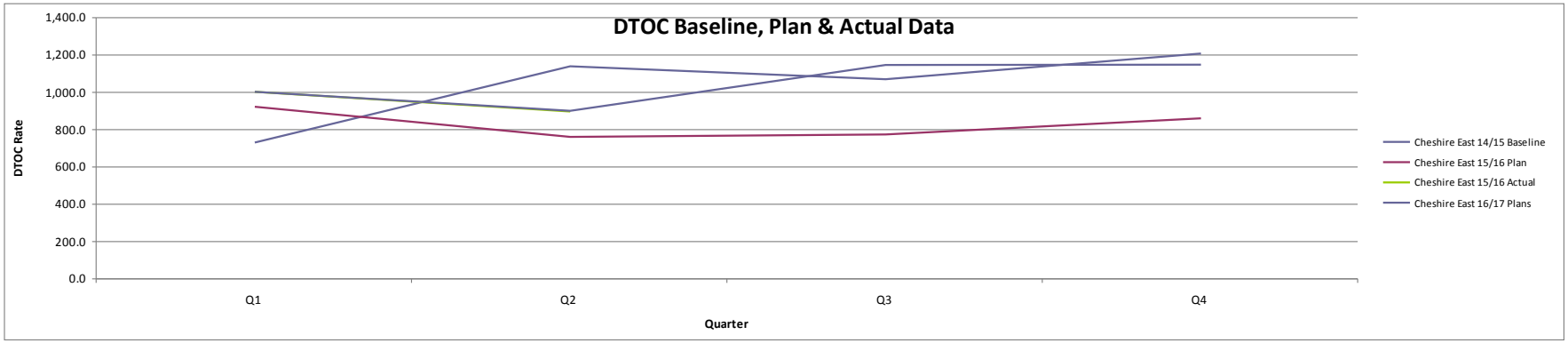
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4	Total
Cheshire East 14/15 Baseline	731.0	1,139.6	1,070.2	1,208.0	4,148.9
Cheshire East 15/16 Plan	922.6	761.2	774.3	860.7	3,318.8
Cheshire East 15/16 Actual	1,002.7	897.2			1,900.0

Delayed Transfers Of Care numerator data for baseline and actual performance has been sourced from the monthly DTOC return found here http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/. Actual Q3 and Q4 data is not available at the point of this template being released.

Cheshire East 16/17 Plans	**1,002.8**	**900.9**	**1,146.7**	**1,148.3**	**4,198.8**



Template for BCF submission 1: due on 02 March 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	No - in development	Plans will be jointly agreed and papers to HWB are scheduled.
2) Maintain provision of social care services (not spending)	No - in development	To be agreed
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development	Likely to be achieved as a result of work initiated in 15/16
4) Better data sharing between health and social care, based on the NHS number	No - in development	Likely to be achieved as a result of work initiated in 15/16
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development	To be delivered through integrated teams - currently partly in place.
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development	Consensus required across the Pioneer geography
7) Agreement to invest in NHS commissioned out-of-hospital services	No - in development	Awaiting technical guidance
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development	Awaiting technical guidance

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	94.0%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.0%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%

E08000002	Bury	00V	NHS Bury CCG	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.3%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	2.0%	1.3%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.4%	53.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%

E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%

E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.7%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.9%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%

E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.0%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.0%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%

E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.7%	1.6%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.1%	96.4%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.6%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	85.0%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%

E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.9%	0.8%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%

E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	91.9%	14.5%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%

E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	9.1%	7.6%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by Health and Social Care Information Centre (HSCIC)

Cheshire East Safeguarding Adults Board – Annual Report 14/15

Contents

Cheshire East Local Adult Safeguarding Board Outcomes

Stopping Adult Abuse - Everyones Business"

See it. Hear it. Report it!

Cheshire East Adult Social Care

0300 123 5010

(8.30am -5pm)

0300 123 5022

(out of hours)

Cheshire Police

101 – non emergency

999 - emergency

STOP ADULT ABUSE
everyone's business

Developed by service users and carers of Cheshire East as part of the Service User Reference Group: a sub-group to the Cheshire East Safeguarding Adults Board

Foreword

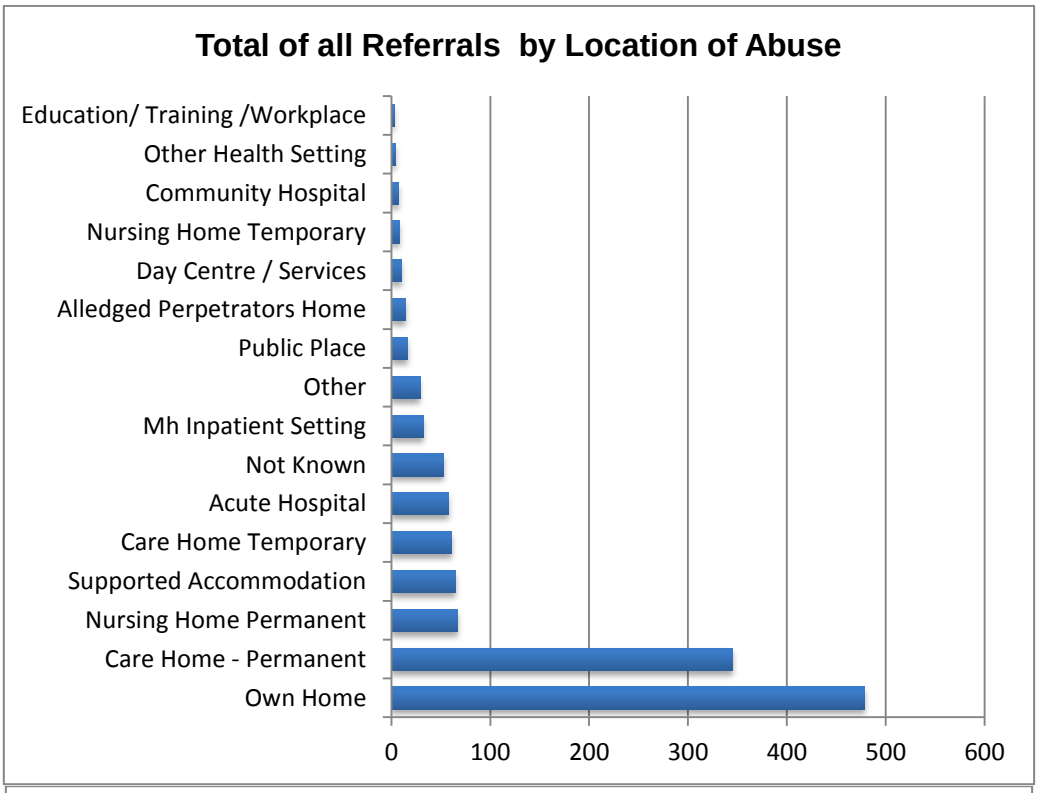
I have been delighted to fulfil the role of Interim Independent Chair during 2014/15. This has been a busy year for the board in preparing for the implementation of the Care Act 2014. For the first time, adult safeguarding boards will be a legal requirement from 1st April 2015, with a range of statutory duties that are aimed at ensuring that key partners work together effectively to improve safeguarding, wellbeing and independence. During 2014/15, CESAB has carried out a full review of its constitution to ensure that it is able to fulfil its new statutory duties. This has included reviewing the membership and the purpose of the board as well as working closely with our service user reference group to ensure that the work of the board "makes safeguarding personal". The Care Act requires the board to produce a Strategic Plan that sets out our goals and priorities in consultation with the public. During the latter part of 2014/15 we have therefore carried out a public consultation exercise and have developed our priorities for going forward into 2015/16 based on the issues people raised with us. Protecting & safeguarding people at risk of abuse or neglect is an important job, and we have taken steps to start working more closely with other partners. As well as building on our close relationship with the Children's Safeguarding board and Cheshire East Domestic Abuse Partner-ship (CEDAP) we have met with the Community Safety Partnership and Health & Wellbeing Board to ensure that we work together more effectively on those cross cutting issues that affect us all. During my time as Interim Chair, I have been impressed with the commitment and hard work of all of the partner agencies, and in particular the commitment to listen to people who have had experience of safeguarding processes and to learn from those experiences. I have no doubt that the board will continue to build on its current strengths to meet the challenges ahead.

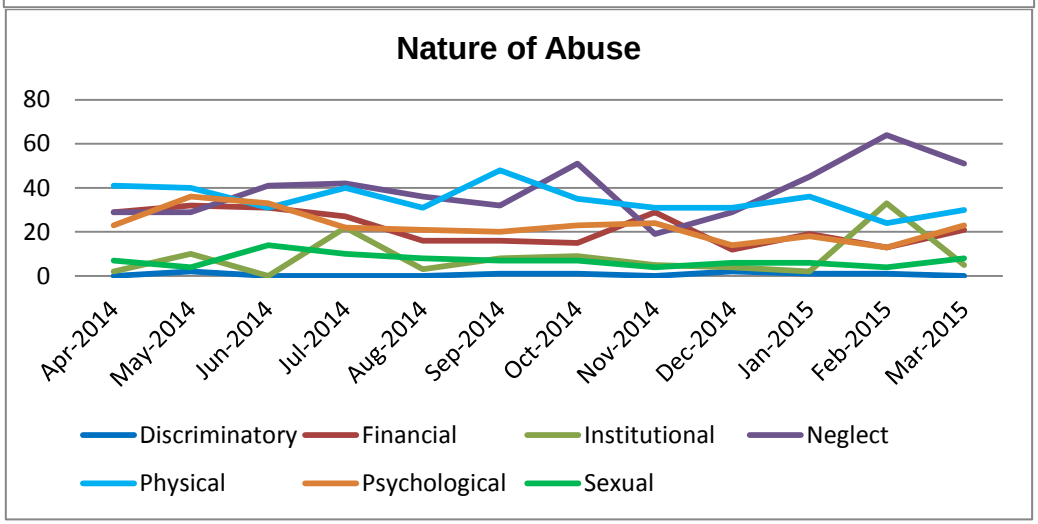
Kathy McAteer

CESAB Independent Chair 2014/15

Local context

Cheshire East has a population of 372,100 people, 11,700 of which are aged 65 or over. There is an estimated 3,300 residents over the age of 90. The number of residents over the age of 65 is expected to increase substantially by 26% by 2021. The risk of people being susceptible to abuse is high. This is illustrated by the charts below highlighting adult safeguarding activity in the borough during 14/15:





Cheshire East Safeguarding Adults Board

The Cheshire East Safeguarding Adults Board (CESAB) is the strategic body that oversees multi-agency working to assure that adults at risk from abuse and neglect are safeguarded effectively.

The Board is committed to ensuring that all agencies working in Cheshire East and the wider community work together to minimise and reduce the risk of abuse and neglect to adults at risk.

This report summarises CESAB's activities that has taken place between April 2014 and March 2015. It highlights the commitment to multi-agency working; the robust performance management and quality assurance mechanisms in place and the achievements of the CESAB.

Safeguarding adults maintained a high profile during 2014-15 locally, regionally and nationally both in terms of Government initiatives and in the media. Multi-agency working to prevent abuse and safeguard adults at risk has continued to be scrutinised.

2014-15 saw a number of new guidance notes and reports being produced to aid organisations to work more effectively together to prevent abuse and neglect. The Care Bill received Royal Assent in May 2014, becoming the Care Act 2014. In preparation for the Care Act 2014 and Making Safeguarding Personal (national guidance that promotes putting service users in control of the safeguarding process), CESAB established clarity with its partners during 14/15 about the board's purpose, remit and function. Membership, roles and responsibilities – including common understanding of terms, were also reviewed and a reformed CESAB Constitution document was produced.

Vision and Principles

The strategic objectives and work of the Board is based on the following vision:

People in Cheshire East have the right to live a life free from harm, where communities:

- *have a culture that does not tolerate abuse*
- *work together to prevent abuse*
- *know what to do when abuse happens*

Principles

The work of the Board is underpinned by the following principles:

- **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent.
  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

- **Prevention** – It is better to take action before harm occurs.
  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
  "I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed."

- **Protection** – Support and representation for those in greatest need.
  "I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able."

- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me."

- **Accountability** – Accountability and transparency in delivering safeguarding.
  "I understand the role of everyone involved in my life."

Service User Engagement

CESAB believe that effective safeguarding of people in Cheshire East requires participation and engagement from across agencies, volunteers, communities and users and their families.

At the heart of all CESAB's work during 204/15 was the views and experiences of the people who are directly affected by the work overseen by the Board through:

- Following the standards for participation developed by the user group ensuring that the voice of users and the impact of activity was considered in all aspects of its business
- Service Users were involved directly in evaluating multi-agency practice through the Performance and Quality group and the national Safeguarding Outcomes Measure Pilot Study

Business 2014/15

CESAB met on 6 occasions in 2014/2015 – five Business Meetings and an Annual Review session. During this period CESAB was chaired by an independent person and operated with the following nine standing sub-groups. However, a new board structure will be introduced from April 2015.

SERVICE USER REFERENCE As stated, it is a priority of the Board to include service users, carers and the public in the work it's doing to keep people safe. This group determines the way that Adult Social Services and partners work with its service users, carers & the public. Information and advice from our service users helps to improve the Safeguarding Adults process and policy development.

MCA/ DOLS GROUP This group was formed in Spring 2014 and ran for a 12 month period before the new structure was introduced. Its purpose was to oversee the governance arrangements of Mental Capacity Act and Deprivation of Liberty Safeguard legislation across Cheshire East; quality assuring Local Authority implementation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, on behalf of Cheshire East Safeguarding Adults Board.

PREVENTION & PUBLIC AWARENESS Ensures that awareness of adult safeguarding is promoted across the borough and that mindful consideration is given to all communities within the borough including minority groups. One of the responsibilities of the group is to develop and review information for public and professionals regarding safeguarding adult issues.

PROTECTION This sub group carries out the development of policies, procedures and protocols for adult safeguarding. Its function is to ensure that all policies and procedures are both appropriate and operable. The group promotes effective working relationships between partner organisations and professional groups and facilitates a shared understanding and agreement about operational practices through policy development.

INFORMATION INTELLIGENCE QUALITY AND AUDIT As the board is responsible for ensuring that national policy and guidance is being adhered to locally, this subgroup develops a local mechanism of audit and quality assurance to ensure that a consistent approach is maintained across all partner organisations.

TRAINING & LEARNING DEVELOPMENT ensures that development needs of staff and partners working with vulnerable adults have been agreed and that there is a broad range of training initiatives in place. The group ensures that both single and multi-agency training is delivered to a consistently high standard in all areas and that a process exists for evaluating its effectiveness.

E-SAFFETY as society increasingly uses social networking and other developing media to communicate, it is critical that safeguarding protocols and practices keep pace with the raft

of communication methods in use. This group advises both the LSCB and LSAB on of potential safeguarding risks linked with technology and how this can be addressed.

CASE REVIEW GROUP The overall purpose of this sub-group is to ensure when a Safeguarding Adults Review (SAR) is required that the panel and process is robust and clear.

SAFER WORKING this joint Children's and Adults Safeguarding Boards sub-group ensures that all agencies working or in contact with Vulnerable adults and children operate recruitment, supervision, management and working practices to safeguard vulnerable adults and children

It is important to note however, that the constitution review work undertaken during 2014/15 will see the board working to a reformed structure during 15/16. This includes the establishment of a new set of sub-groups plus a Business Management Group to deliver on the board's strategic vision and work plan.

Statements from key partners

The following statements have been provided by some of the key agencies represented on the CESAB. The reports cover adult safeguarding issues from each organisation's perspective and identify key priorities for 2015/2016

Adult Safeguarding in 2014-15 **Cheshire East Council**
Cheshire East continued to act as the Lead Agency for receiving and investigating all safeguarding referrals in line with the No Secrets Guidance. During 2014/15 a total of 1251 safeguarding referrals were received by the 10 Adult Teams listed on PARIS. Thirty percent were either substantiated or partially substantiated. Most of the referrals were received from hospital staff and the top 3 types of abuse were Neglect, (468) Physical (418) and Psychological.(270). Although the Total number of referrals has remained the same, the types of abuse have changed. In 2013/14 the top type of abuse was Physical rather than Neglect. The Council continued to operate a Threshold Policy and Providers were required to submit Care Concern Data to report low level concerns. During 2014 a total of 1541 care concerns were received. This type of intelligence is used by Commissioners to inform Quality and Contractual standards in Provider settings. In March 2015 a total of 195 staff attended training to introduce Making Safeguarding Personal. Moreover, in March, workshops were held to promote the interface between Domestic Abuse and Safeguarding. Mental Capacity Awareness Sessions were delivered to 202 staff and Mental Capacity Master Classes were attended by 47 staff. Over the past 12 months Cheshire East has moved Adult Safeguarding Activity back into Operational Teams. The rationale for moving the functions away from a Specialist Safeguarding Unit to the Front line teams was to ensure that Safeguarding is Everyone's business, to encourage Front Line Practitioners to take responsibility for decision making and to maintain consistent practice standards. The changes have also allowed more distinctions between the role of the Adult Safeguarding Board and the Councils activity. In preparation for the Care Act, new policies and procedures have been produced to cover statutory

requirements. Additional policies have been introduced to address Large Scale Investigations, Persons in Positions of Trust and Sexual Exploitation.
An Audit Tool and Practice Standards have been introduced to measure compliance and to demonstrate the culture shift from a Process driven service to a Person Centred/Outcome focussed approach. Liquid Logic will assist Practitioners with their recording, when it is available later in the year.
Quarterly Multi Agency Practitioner Forums have been re-launched to focus on discussing case studies, inviting guest speakers and building professional relationships across partner agencies.
This year also saw the launch of the Domestic Abuse Hub, which acts as a ONE STOP shop to enable all referrals and concerns to be received at one central point of access.
Monthly Safeguarding Governance Meetings are chaired by the Director of Adult Social Care, to ensure that Safeguarding is embedded in each part of the Directorate. Senior Managers participate in both the main Safeguarding Board and the Sub Groups.

How your organisation has captured the Voice of Service Users:

- The Service User Reference Group have designed information packs and guidance suitable for both adults at risk as well as staff. Cheshire East have embraced their views about being valued, respected, included and informed and will ensure that the wishes and feelings of adults at risk are heard at the beginning, middle and end of the Safeguarding Process.
- The drama Company AFTA THOUGHT introduced the principles of Personalisation to Practitioners and used real case studies to aid their delivery and bring the Principles of Making Safeguarding Personal to life.

Key Issues/ Risks:

- Advocacy: The Care Act has increased the demand for advocates to ensure that adults are properly supported in decision making. One of the key risks is that there may not be enough advocates to meet the demand in a timely way.
- Reporting mechanisms: Care Providers will be required to report low level incidents in a different way via Key Performance Indicators. It is important that this shift is managed in a safe way.

Key areas of focus for 2015-16 for safeguarding adults at risk:

The key areas of focus for the next year are to

- Embed the new Statutory requirements and embed new policies and procedures
- Raise awareness about new areas of work, including Human Trafficking, Sexual Exploitation, Self-Neglect and the Persons In Positions of Trust Policy
- Training to ensure staff have the skills in models of interventions for example Restorative Justice, Conflict Resolution, and Mediation.
- New electronic recording systems will be introduced during this financial year and staff will require additional training to ensure accuracy and consistency
- Websites will be refreshed to raise awareness about what and how to report abuse.

Adult Safeguarding in 2014-15
Cheshire Constabulary

Within Cheshire Police safeguarding adults is the responsibility of every member of staff. Staff take calls from anyone who has concerns that an adult may be or is at risk. This information is then assessed to decide what should happen next and which department and what action should be taken. This may be;

- visits to check on people's welfare and make sure they are safe
- engaging with relatives

- referral to other agencies depending on the nature of the concern

If we think a criminal offence has been committed we speak to adult social care and take part in a Strategy Discussion to decide what action should be taken. When we do this we take into account what the adult at risk wants to happen unless that person does not have capacity. We keep contact with the adult at risk and other professionals while we are investigating so that everyone knows what is happening and why. The victim can choose how and when this is done.

Where we have completed criminal investigations sometimes the victim has been unable to attend our specialist suite so that their evidence can be recorded on video. Getting the victim's statement in this way means that they may not have to give that evidence in a court as the video can be used instead. To protect those who can't attend and make sure they have the same access to justice we have made use of mobile video equipment on several occasions sometimes at hospital and sometimes in nursing/care homes. We have made good use of Section 44 of the Mental Capacity Act 2005 over the last 12 months and carried out a number of investigations in relation to this offence most recently having cautioned two individuals using this offence. This means they can no longer work with vulnerable people.

In the last 12 months we have delivered training to all staff about the Care Act 2015, Adults at Risk, and roles and responsibilities of staff. We were fortunate to have support in this training from the Adult Safeguarding Lead for Mid Cheshire Hospital. We have revised our Force Policy to reflect the changes from the new Care Act. We have supported multi-agency training events about Capacity and Deprivation of Liberty particularly to health and social workers. We have given presentations at Practitioners Workshops to improve understanding of the police role in respect of Adults at Risk and our processes for professional referral. We are active members of two Board sub groups, the Training sub group and the Protection sub group.

How your organisation has captured the Voice of Service Users:

Whenever the police have contact with an adult who is thought to be at risk a form is completed with details about the person, what that adult or an advocate has to say, how they feel, what they want to happen, and consider any immediate concerns or risk. This form is then assessed by a specialist department to decide whether any further action should be taken and if necessary passed to other agencies.

The police also work to what is called the Victim Code of Practice. This means that where there is a criminal investigation the victim is told about any important steps in the investigation and at a time, place and frequency that the victim wants. These updates are personalised to the wishes and needs of the victim.

Key Issues/ Risks:

There has been a change to the referral process from social care to the police..

The Force is also going through a restructuring process which includes review of areas of responsibility. An additional dedicated Adult at Risk officer has been introduced at the North part of Cheshire East meaning there are now 2 FTE staff.

There is a risk resulting from both the process change and the restructure that staff do not fully understand their role/responsibilities affecting initial response. This will not be affected where there is a clear need for immediate or emergency action. The changes are and will be monitored to make sure that the police response is timely and effective, and that the correct process is followed including initial response where a joint agency approach is needed. In addition the 100% increase in dedicated officers will provide the support and expertise colleagues may need.

Key areas of focus for 2015-16 for safeguarding adults at risk:

Embedding of the process change resulting from the revised referral process

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Adult Safeguarding in 2014-15 **South and East Cheshire Clinical Commissioning Groups**
• Adult Safeguarding Policies have been completely reviewed and refreshed to reflect The Care Act and Making Safeguarding Personal in line with the new guidance • Bespoke training for CCG staff on Adult Safeguarding was undertaken to support findings from an internal audit • From a commissioning perspective, the NHS Safeguarding Commissioning standards document is now a nationally recognised document that supports the NHS Standard Contract in commissioning services, the framework embeds the NHS 6C's, Safeguarding Adult Principles, Section 11 and the supports the requirement from CQC's new Safeguarding statement • The CCG showcased through their first Seminar to over 120 delegates, the dedicated work relating to MCA/DoLS from a multi-agency partner perspective, keynote speakers from Central government, police and law all provided their dedicated time. • Clear processes have been implemented to the reporting of Adult Safeguarding within the CCG's • A flow chart has been developed within health and is available to all professionals in primary care, and the CCG. • There is also a dedicated website for Safeguarding on both CCG websites, all information is the same to ensure consistency, initial website information from the communications team suggest that the safeguarding site is in the top ten of views • Funding for 12 months has been sourced to create a MCA/DoLS practitioner post to support the work of Adult Safeguarding, the dedicated post will cover the Cheshire East footprint and drive the key work necessary to deliver on outcomes relating to MCA/DoLS • Quarterly Safeguarding Assurance meetings continue to provide a robust forum for holding out main providers to account on their safeguarding arrangements internally • The Designated Nurse is Chair of the Learning & Development Sub-Group to the SAB, and has been instrumental in scoping and developing the members of the group to ensure the right people are at the table for decision making
How your organisation has captured the Voice of Service Users:
• Public engagement events-Healthvoice meetings every six weeks [membership consists of public retired members with health and social care background] • CCG has public members as part of a reader's panel to review CCG policies and information documents. • The Caring Together team engage directly with public members on a quarterly basis. • There are also CCG formal Complaints, Serious Untoward Incidents review meetings and the whistleblowing policy for the CCG supports all staff in raising any concerns they may have
Key Issues/ Risks:
• MIAA internal audit – highlighted succession planning/risk register/contract monitoring & scope of the roles off the designated nurses as areas of risk • MCA/DoLS Practitioner post funding for 1 year – business case to support a permanent post for the CCG for the vast volume of work that is necessary for the post
Key areas of focus for 2015-16 for safeguarding adults at risk:
• Development of a robust risk register for Adult Safeguarding within the CCG's to measure risks at a corporate level, and ensure the Governing body undertake ownership to reduce the risk • MCA/DoLS Practitioner to raise the profile and support other MCA Leads in primary and secondary care to ensure the best outcomes for our most at risk adults

- Work to raise awareness on the growing concerns relating to Trafficking and Modern Slavery – signs to look for – how to report
- Revise the CCG E-Learning Academy training

Adult Safeguarding in 2014-15
NHS England

NHS England North (Cheshire & Merseyside)
Key Developments over past 12 months

- Support given to GP practices with regard to CQC Outcome 7: Safeguarding people who use services from abuse.
- Additional resource given to LA to ensure increased capacity for S11 training. The funding enabled increased awareness training of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Additional funding enabled social workers to access the Deprivation of Liberty Safeguards Best Interests Assessors Training, supporting the LA to ensure that DOLS applications are completed in a timely reducing the risk of individual being unlawfully deprived of their liberty and breaching their human rights.
- Supporting the delivery of Care and Treatment reviews as part of the response to the Winterbourne View Concordat and the renewed focus and national ambition to discharge patients with a learning disability from an inpatient facility to a community setting if clinically safe to do so.

How your organisation has captured the Voice of Service Users:

NHS England routinely seeks the voice of service users via NHS Voices National Patient engagement team

At a local level NHS England North (Cheshire & Merseyside) captures feedback from service users in the form of patient stories. This feedback is provided from:

- Complaints
- North West Self advocate forum/groups and local LD Partnership boards in respect of learning disability services.

Key Issues/ Risks:

NHS England Key issues/Risks

- Gaining whole system safeguarding assurance from all health service provision
- Acceptability and completion of Safeguarding assurance audit tool for primary care services. I.e. GP, dental and pharmacy practices.

Key areas of focus for 2015-16 for safeguarding adults at risk:

The key priorities for NHS England during 2015/16 are:

- Child Sexual Exploitation – commissioning standards for services who provide long term support; working with partner agencies to prevent CSE
- MCA/DOLs – continued work regarding skills and knowledge of frontline staff; work with Coroner regarding GP knowledge of MCA/DOLs
- Female Genital Mutilation – Implementation of mandatory reporting across GP Practices
- Lampard Enquiry – implementing recommendations from Lampard Enquiry relating to Saville
- PREVENT – continue to work with partner agencies regarding radicalisation and PREVENT agenda

- Looked After Children – implementation of new statutory guidance and support for transition work

Adult Safeguarding in 2014-15	**Cheshire Centre for Independent Living**

Adult Safeguarding is embedded in all services delivered across Cheshire Centre for Independent Living (CCIL). All staff complete annual Safeguarding training and have access to a Safeguarding Officer at all times. CCIL has a referral pathway, process and procedure for any concern raised by a staff member about an adult.

During the period 2014-2015, CCIL made 2 referrals to Cheshire East Adult Social Care.

The Chief Executive Officer is a member of the LSAB and Chairs the Service User Reference Group to meet the Board Strategic Objective:- to listen to people who have been subject to abuse or neglect, and to seek assurance that people are able to be supported in the way that they want, are empowered to make decisions, and can achieve the best outcomes

How your organisation has captured the Voice of Service Users:

Cheshire Centre for Independent Living is a user led organisation, run and controlled by disabled people for disabled people, that by its very nature is driven by the needs and aspirations of people with care and support needs.

Cheshire Centre for Independent Living captures the voice of service users in a variety of formats:

- Regular consultation events
- Quarterly review of service
- Peer Support Groups
- Attendance by service users at AGM
- Steering Groups

CCIL uses a number of communication formats to capture the voice of service users:

- PECS
- Widget
- Large Print
- Newsletter
- Case Recording
- Telephone
- Text
- Email
- Braille (upon request)
- Alternative language (upon request)

Key areas of focus for 2015-16 for safeguarding adults at risk:
CCIL's key areas of focus for 2015-2016 are: • Ensure all staff complete annual safeguarding training • Ensure Adult Safeguarding remains embedded within all service delivery across the organisation • Ensure the voice of disabled adults is heard and listened to with regard to Safeguarding

Cheshire East Strategic Housing & Registered Housing Providers

Adult Safeguarding in 2014-15 **Housing**
During 2014/15 Cheshire East Strategic Housing Services and Partner Registered Providers have developed a network of safeguarding lead officers in order to: • Disseminate information • Share good practice • Ensure that we are all have the required policies and procedures in place Cheshire East Housing and Registered Provider staff have received safeguarding training and one indicated that they now have a rolling programme in place to promote safeguarding annually with staff. Another Registered Provider is delivering enhanced Adult Safeguarding training to customer facing staff to ensure that staff are fully equipped to identify and report suspected abuse. Registered Providers have raised awareness of safeguarding through their own publications to ensure that tenants know how to report suspected abuse and the new Safeguarding Newsletter is circulated to the network. The Registered Providers who responded indicated that they have reviewed and have Policy and procedures are in place. Both Strategic Housing and Registered Providers have assisted with the provision of alternative accommodation following Safeguarding reviews.
How your organisation has captured the Voice of Service Users:
Whilst reviewing existing policies Registered Providers have consulted customers and the board in the production of these documents. Information has been provided and advice to some of the most vulnerable residents, including those people living within our Sheltered Housing and Extra Care schemes
Key Issues/ Risks:
Registered Providers have highlighted the following risks/issues:

Ensure we continue to work in partnership with our Safeguarding Board and relevant teams to safeguard children and adults at risk.

We work with a broad range of people who live in our properties or who access our services We are alive to the safeguarding risks that this presents and deploy robust management strategies to ensure that these risks are effectively managed

Strategic Housing need to ensure that all Registered Providers have Safeguarding policies and procedures in place. The majority operate across a number of authorities and therefore we cannot ensure that their policies/procedures align with Cheshire East.

Key areas of focus for 2015-16 for safeguarding adults at risk:

There is a variety of activity being undertaken within the housing sector which includes the following:

Strategic Housing will continue to be actively engaged in the safeguarding adults agenda contributing towards to the work of the Safeguarding Adults Board and the Task and Finish Groups. We will continue to network with the Local Registered Providers, disseminating information and ensuring that policies and procedures are in place and reviewed on a regular basis.

Registered Providers will:

Work with Cheshire East and LSB to work jointly for the benefit of victims and their families. Ensure that key messages and areas for improvement/change are communicated internally and externally. Ensuring all our staff understand the six principles in full and adequate training is carried out with key officers.

Other areas of work include setting up Corporate Safeguarding groups, rolling out Professional Boundaries training to staff in Independent Living Teams. Strengthening Safeguarding internal reporting arrangements.

Both Strategic housing and Registered Providers will continue to raise awareness of Safeguarding issues with both tenants and residents.

CHESHIRE FIRE & RESCUE SERVICE

Adult Safeguarding in 2014-15
Cheshire Fire & Rescue

Cheshire Fire & Rescue Service delivers prevention, protection and emergency response services to the communities of Warrington, Halton, Cheshire East and Cheshire West & Chester in fulfilment of statutory requirements stated in the Fire & Rescue Services Act.

In doing so the Service contributes to safeguarding vulnerable adults through its attendance at emergency incidents, prevention activity such as Home (Fire) Safety Assessments and in its enforcement activity in residential care premises.

The Service plays an active role in partnership working in the area of adult safeguarding so as to maintain organisational awareness and deal effectively with those situations where adults at risk may be in need of

assistance and support.

The Service continues to be a member of the Board structures in all four local authority areas it serves.

Progress report for 2014 – 2015

- The Service has had a safeguarding adults at risk policy and procedure document since 2011, it was reviewed in 2012/13 with front-line staff receiving refresher training throughout 2014/15. A 2015 policy review is programmed.
- In 2014 the Service commissioned an external training provider to deliver adult safeguarding Train The Trainer skills to key Prevention managers who then rolled out a bespoke staff training programme. This programme of training has further up-skilled the Service's in-house training capacity as well as front-line awareness on recognising and reporting adult abuse and neglect.
- The Service continues to utilise LSABs to promulgate fire risk awareness amongst those agencies and professionals offering services to those who may be at heightened risk from fire.
- As a member of the Board the Service will look to continuously develop the fire risk awareness of professionals and the wider community so that risk from fire is fully integrated with the well being of any adult at risk.

How your organisation has captured the Voice of Service Users:

As the Service is not a provider of health or care services per se we focus on receiving service user experiences through our annual consultation process and specific customer satisfaction surveys for our emergency response, prevention & protection activities.

In addition we have formal procedures for receiving and handling compliments and complaints.

Key Issues/ Risks:

A key issue for the Service relates to maintaining fire risk awareness amongst professionals and/or volunteers providing care and assistance to those meeting adult at risk criteria. We therefore remain committed to continually strengthening our collaboration with other agencies so that fire risk is not only a key consideration for all those that are in receipt of care services or assisted living arrangements but particularly for those that require a more concerted multi-agency approach.

Key areas of focus for 2015-16 for safeguarding adults at risk:

In 2015-16 Cheshire Fire & Rescue Service will be looking to use its position within LSABs and on the Pan-Cheshire Mental Health Strategic Board to raise awareness of the links between mental health, alcohol, smoking and increased likelihood of falling victim to fire. It is anticipated that this could lead to further collaboration between agencies so as to reduce the likelihood of those meeting adult at risk criteria dying in a fire in a domestic dwelling, residential care home or other environment that provides for the health, safety and well-being of the adult at risk.

The Service is commencing development of an internal Dementia Friends training programme. The training itself is programmed to be delivered later in 2015/16 and will assist our staff in engaging with and supporting those with dementia who may also meet adult at risk criteria.

North West Ambulance Service NHS
NHS Trust

Adult Safeguarding in 2014-15
North West Ambulance Service

The Trust has a legal duty to protect patients, staff and the public from harm. This includes harm from others as well as avoidable harm to patients. The Clinical Safety and Safeguarding Team have worked hard during the year to identify patients at risk and have focussed the following work streams to ensure patients and the public receive appropriate care and protection when required.

The implementation of the new Care Act 2014 provides a legal framework for the assessment and protection of adults including those at risk with an emphasis on the 'wellbeing' of the patient. This may account in part for the notable rise in safeguarding adult activity over the year which includes concern for the welfare of vulnerable adults requiring assessment. Likewise safeguarding children activity steadily increases across the trust particularly within the Paramedic Emergency Service but at a slower rate than for adults.

A number of high profile national investigations have resulted in an update to safeguarding procedures and training to ensure that adults and children who are at risk or victims of exploitation and radicalisation are also safeguarded.

Achievements

- **CQC pilot standards**

The Trust took part in the CQC pilot assessments of Ambulance Service NHS Trusts. The result is that a number of standards have been developed for Ambulance Services and good assurance was received in relation to safeguarding arrangements.

- **Engagement with Safeguarding Boards**

The Trust has a named contact for each of the 46 Safeguarding Boards across the North West. This strengthens working together and information sharing relationships and is reflected in the increased number of Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. Staff also access multi-agency training and share learning and expertise with their peers.

- **Frequent caller Project and vulnerable people.**

The safeguarding and frequent caller teams are regularly identifying and sharing information to enable a joined up approach to ensure vulnerable people are afforded the assessment and care they require in accordance with their wishes. When appropriate they are protected from harm or abuse and a significant amount of valuable patient data is now shared to ensure the best outcomes for these patients. This also includes sharing concerns in relation to nursing and Care Homes.

- **Update of the safeguarding Vulnerable Persons Policy and Procedures**

A significant amount of work has been done to update the Policy and associated procedures. These now include the principles of adult safeguarding and pathways are included for victims of Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) and the radicalisation of vulnerable people (PREVENT).

- **PREVENT awareness and training**

Over 75% of all NWAS staff have received WRAP 3 training which is the 'Workshop to Raise Awareness of PREVENT- part of the government's anti-terrorism strategy. WRAP is included within mandatory training for all staff and compliance with this national requirement continues to increase monthly.

Adult Safeguarding

Figure 1 Adult Safeguarding Referrals by area

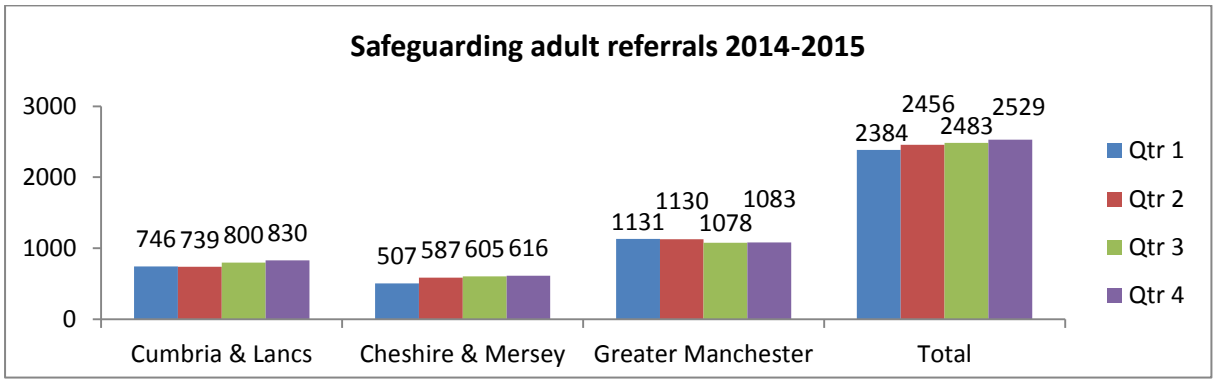


Figure 1 shows the number of safeguarding adult referrals across Q1 to Q4 2014-2015. Referral rates across all sectors continue to increase year on year by as much as approximately 50% in each area. The referrals include adults at risk and adults requiring an assessment. All referral information is shared using the Trust's web-based system (ERISS) to ensure security and ease of access to referral data.

Proposed development 2015- 2016

- **Safeguarding alerts**

The Electronic Information Sharing System (ERISS) is a bespoke web-based system used by the Trust for sharing safeguarding referral information with Children's and Adult Social Care. This system has the functionality to place warning flags to alert the attending crew about child or adult protection issues. The application will be piloted over the forthcoming year. The current position of staff raising alerts with the Trust Safeguarding Team remains in place.

- **Domestic Abuse**

The Trust is continuing to develop processes in relation to Domestic Abuse. Following the success of the pilot last year a referral form for domestic abuse will be developed with provision for enhanced information sharing which links to the national guidance (NICE).

- **Sexual exploitation, Slavery and Trafficking**

The Trust Safeguarding Team is in the process of developing links with all the CSE Teams in the North West to enable efficient and timely information sharing in relation to CSE. This is over and above the current safeguarding procedures already in place. There is also a process to capture data relating to FGM which has been communicated to all staff and this will be monitored during the year.

The Trust is working with partners to help tackle issues relating to Slavery and Trafficking of children and adults. This work is in the initial scoping phase and any identified actions will be added to the Safeguarding Work Plan for the year and progress monitored.

Annual Assurance Statements for Cheshire East SAB 14/15

All partners completed an assurance document as part of ensuring that the SAB can be satisfied that agencies are working together to safeguard the citizens of Cheshire East and improved outcomes during 2014/15. The information gathered from these statements will be used to support any national or regional benchmarking of safeguarding activity and to identify where additional work needs to be undertaken during 2015/16. Intelligence about partner organisations will help to ensure that CESAB is better prepared and able to plan ahead to meet future changes and challenges. Partner's statements were written against the Care Act's 6 Key Principles of Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability in relation to Safeguarding Adults

Using best practice examples, each of the organisations listed above were able to give at least two examples of systems/practices in place which show clearly how their organisation is assured that they are meeting each standard.

Examples of statements given:

"*Patient's feedback on their experiences is used to develop the way we work*"

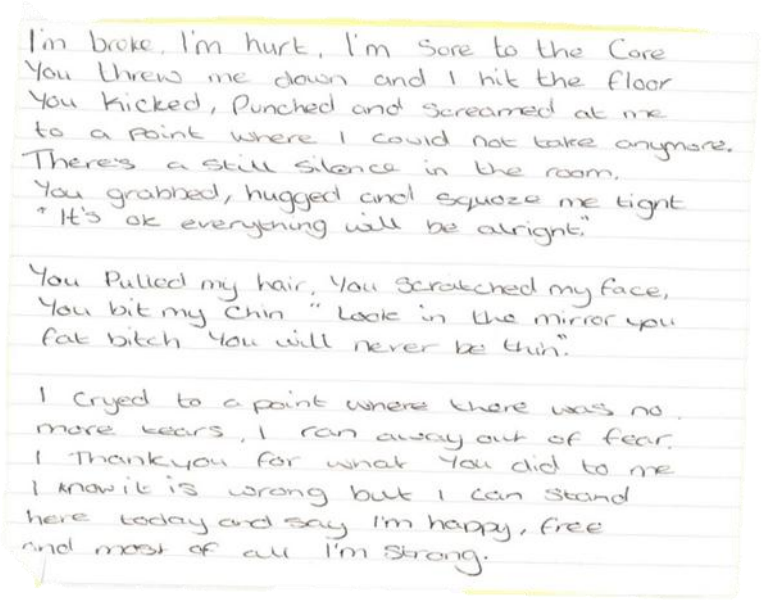
"The training programmes have led to services being offered in a way which prevents abuse occurring in the first place"

"*We are more able to quickly identify where abuse has occurred*"

"Safeguarding activity is person centred, not process led"

"Our database records all safeguarding activity and can identify rationales, emerging themes etc."

cheshire east
domestic abuse
partnership



I'm broke, I'm hurt, I'm sore to the Core
You threw me down and I hit the floor
You kicked, Punched and screamed at me
to a point where I could not take anymore.
There's a still silence in the room,
You grabbed, hugged and squeeze me tight
"It's ok everything will be alright."

You Pulled my hair, You Scratched my face,
You bit my Chin "Look in the mirror you
fat bitch You will never be thin".

I Cryed to a point where there was no
more tears, I ran away out of fear.
I Thank you for what You did to me
I know it is wrong but I can stand
here today and say I'm happy, free
and most of all I'm Strong.

Domestic abuse continues to be a significant safeguarding issue for adults at risk in Cheshire East with multiple and often long lasting impacts on safety, health, wellbeing and achievement. As domestic abuse is often linked to substance misuse and mental ill health cases can involve a degree of complexity and interrelated harm which makes safeguarding and co-ordination both challenging and vital across a range of agencies and Boards.

Cheshire East Domestic Abuse Partnership (CEDAP) highlights the work it has undertaken over 2014/15 in the embedded report

CEDAP LSAdultsB Report 2014-15.docx

How have we made a difference?

In 2014/15 the Cheshire East Safeguarding Adults Board has undertaken detailed preparatory work for the implementation of the Care Act 2014. This included reviewing the role, responsibilities, membership and infrastructure of the Board. The vision and principles of the board were established; along with the formation of the structure of the board and its governance arrangements. The Board also defined its powers and duties; i.e. the set of rules by which the Board will operate.

The key functions of CESAB in 2014/15 can be grouped into seven broad areas:

- Strategic planning
- Producing multi-agency policies, procedures, protocols and guidance
- Quality Assurance regarding the responsibilities of agencies including commissioners, partners, the Board itself and through learning from Safeguarding Adults Reviews
- Ensuring participation and involvement by people who use services and carers as key stakeholders (both in their own safeguarding and in the work of the Board)
- Active promotion of safeguarding including awareness raising and publicity
- Oversight of learning and workforce development
- Partnership working and managing key stakeholder relationships

To perform these functions 2014/15 saw the -

- Establishment of an effective mechanism to involve people who use services in the work of the Board
- Public consultation exercises to aid the development of the Strategic Plan
- Introduction of a CESAB Social media presence via the establishment of Facebook and Twitter pages
- Reorganisation of the Board's administrative arrangements i.e. Review of: the frequency of meetings, work plan, format of agendas and papers.
- Public awareness campaigns – linking with White ribbon Day, Action against Elder Abuse and Dignity in Care Day
- Focussed work on Financial Abuse – including the development of a financial Abuse Toolkit for frontline staff

- Development of a risk matrix for the work of the Board

- Implementation of the Board internal standards and how Board effectiveness is assessed – e.g. annual Board appraisal and the development of an Assurance Framework

- Review of Cross-cutting issues:

CESAB, LSCB, the Community Safety Partnership and the Health & Wellbeing Boards designed a Cross Cutting Issues management arrangement. Each cross cutting issue has been allocated to one of the Boards as the lead board, with the expectation that links are made with other boards to take forward joint work. The cross cutting group agreed that Chairs and Lead officers should meet twice a year to ensure that issues are being captured, investigated and assurances provided. The respective boards will lead on the following issues:

Shared priority area	**Strategic governance lead**
Domestic Abuse	**Community Safety Partnership**
Terrorism and Prevent	**Community Safety Partnership**
Reducing Offending	**Community Safety Partnership**
Anti-social Behaviour	**Community Safety Partnership**
Organised crime	**Community Safety Partnership**
Hate Crime	**Community Safety Partnership**
Sexual exploitation	**Local Safeguarding Children Board**
Trafficking and Modern Slavery	**Cheshire East Safeguarding Adults Board**
'Mate crime'	**Cheshire East Safeguarding Adults Board**
Substance misuse	**Health &Well Being Board**
Mental Health	**Health &Well Being Board**

Once each Board has written their local strategy for their lead issue, a review will take place in 2015/16 to ensure these strategies are all aligned.

What next? 2015/16 & beyond –

2014/15 was an incredibly positive year for CESAB. With the revised Constitution and three year strategy now in place, the board are looking forward to the work of 2015/16 with the implementation of the Care Act and the Board's statutory status.

The Board's three year objectives for 2015/16–2017/18 are set out in CESAB's Strategy Document, aligned with the various work streams of the Board, each year, when the Business Plan is agreed for the next 12 months, it will include various elements of these three year objectives. This will help to focus on longer term goals that need to be worked towards over a lengthier period of time.

Some of CESAB's priorities and key actions for the upcoming year are listed below and they are embedded in the CESAB Business Plan for 2015/16:

- Ensure that a 'making safeguarding personal' approach to adult safeguarding is embedded in practice in Cheshire East. The "Making Safeguarding Personal" initiative is a national initiative that couples the Care Act 2014. It sets out to develop person-centred responses to safeguarding circumstances. It encourages local authorities and their partners to develop a range of responses they can offer to people who have experienced harm and abuse, so that they are empowered and their outcomes are improved.

- Ensure that people involved in safeguarding have the appropriate skills and knowledge to deliver a personalised approach

- Introduce a regular adult safeguarding newsletter to promote CESAB's work and inform the public and the wider health and social care sector about adult safeguarding issues

- Launch an independent CESAB Website that has been designed and developed by local service users

- Ensure people have access to information and advice about protecting themselves, and what to do if they are being harmed or abused.

- A key role of the Board is to seek ways to continually improve standards of practice and outcomes for people within the safeguarding adults procedures. One way in which the CESAB achieves this is through its performance, audit and quality assurance processes. A new partner audit has been developed and will be issued in 2015/16. A public consultation is also planned along with other means to improve the ways of capturing service users experiences and perceptions of the adult safeguarding process in Cheshire East.

- Make sure all staff is aware about the Mental Capacity Act and the use of Independent Mental Capacity Advocates role in safeguarding work.

- Ensure all partners have plans to check that people who use services are treated with dignity and respect.

- Continue to embed safeguarding in commissioning, contracting and grant arrangements

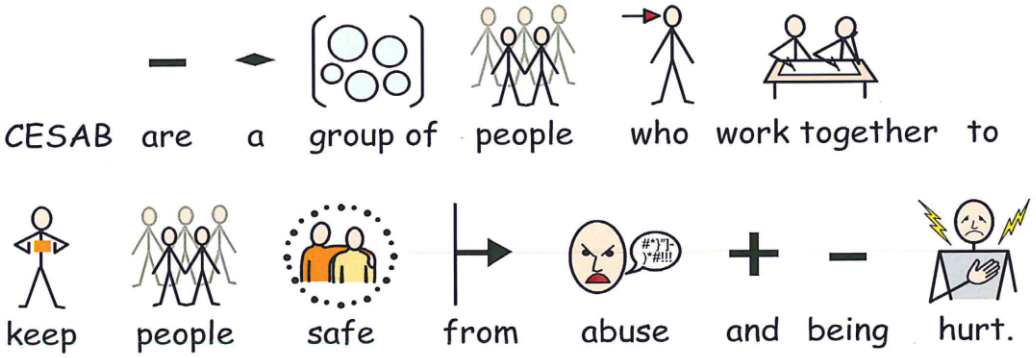
The Board Business Plan 2015/16 and Strategy Document is available on the Cheshire East Safeguarding Adults Board website

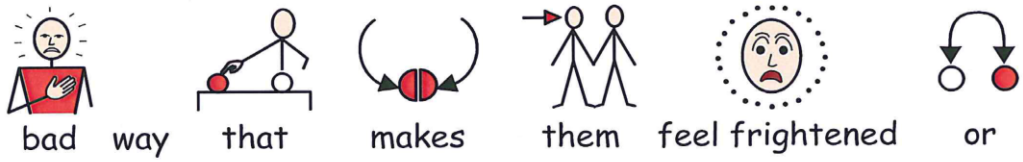
Easy Read ***Appendix 1***

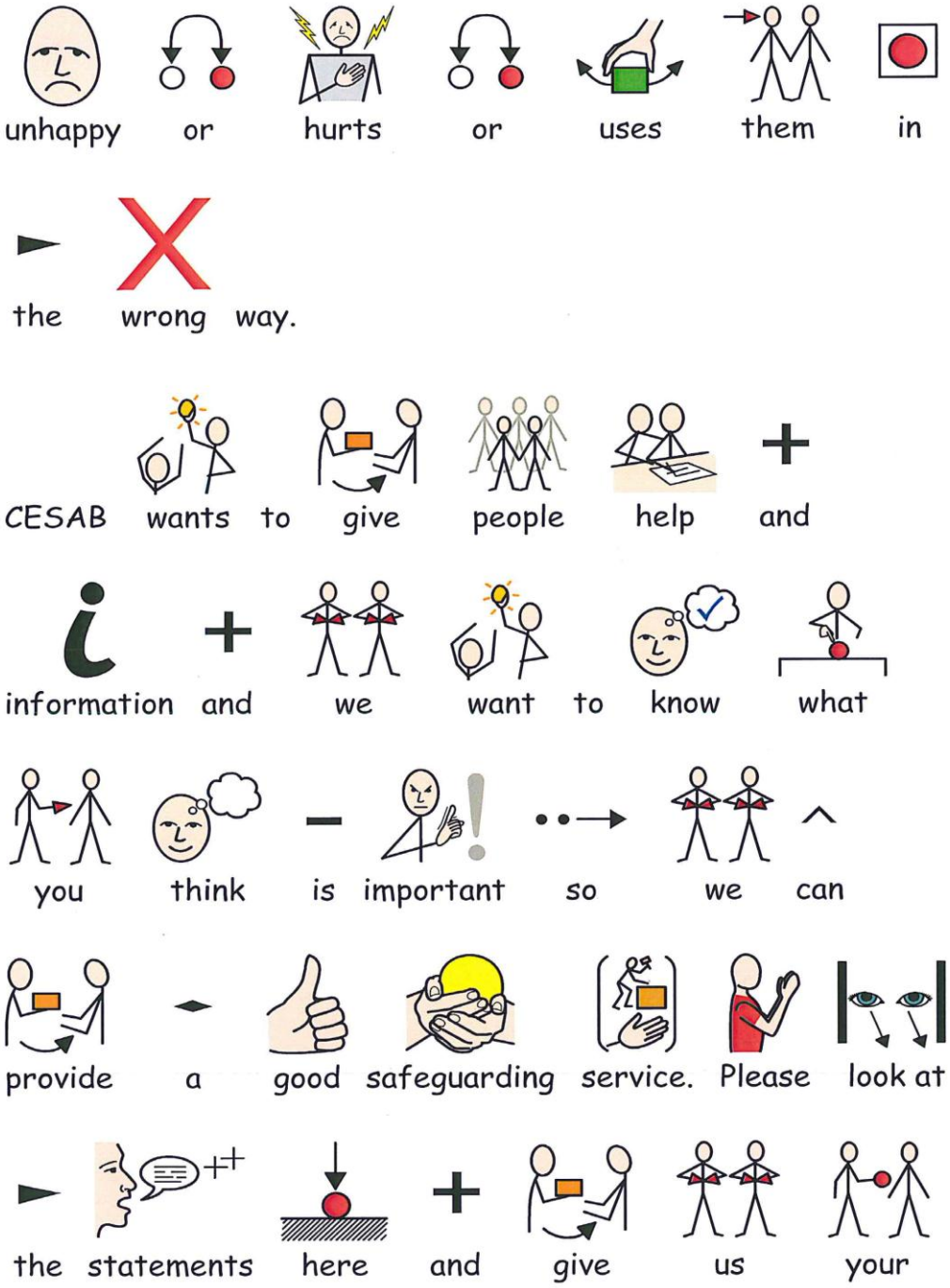
What is the Cheshire East Safeguarding Adults Board and what do they do to keep me safe?

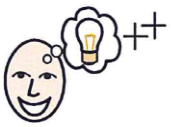
Information designed by the Service user Sub-Group

(CESAB)

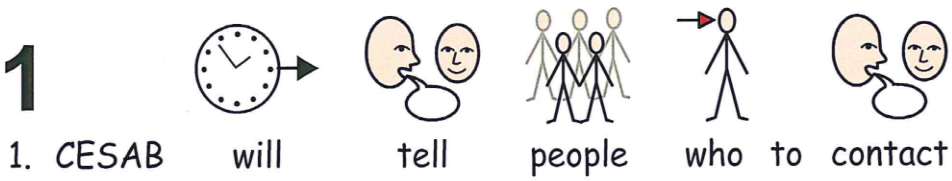





unhappy or hurts or uses them in
the wrong way.
CESAB wants to give people help and
information and we want to know what
you think is important so we can
provide a good safeguarding service. Please look at
the statements here and give us your

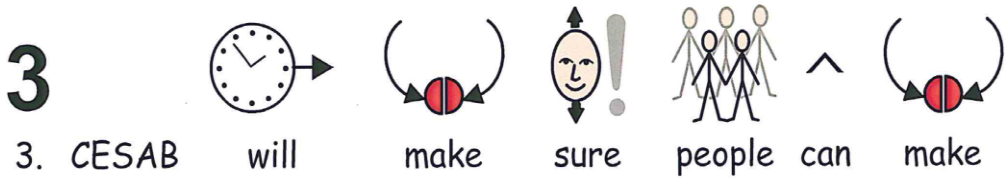


opinions,

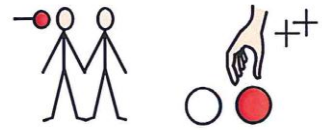


1. CESAB will tell people who to contact about abuse if they are worried.

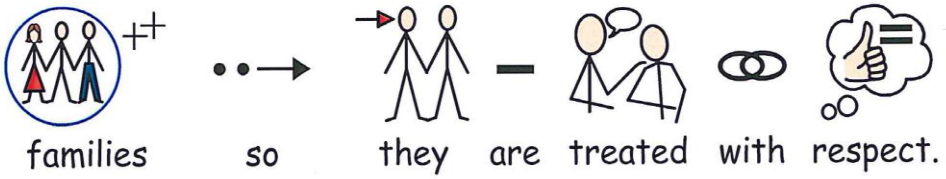
2. CESAB will provide information by talking to people, providing leaflets and online.

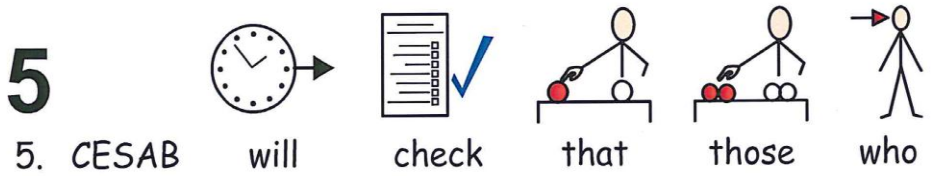


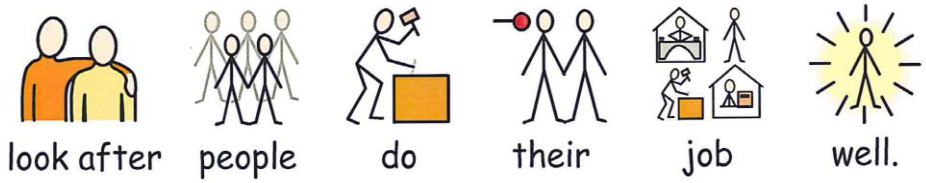
3. CESAB will make sure people can make

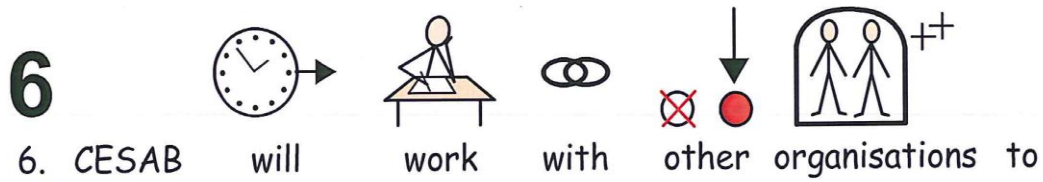

their own decisions.

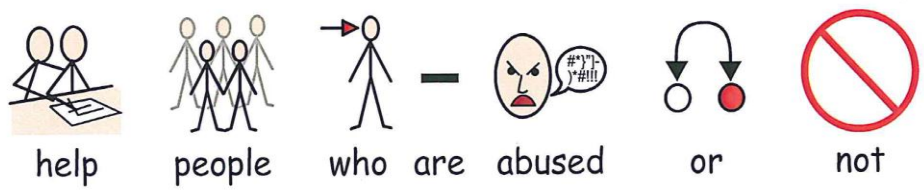

4
4. CESAB will listen to people and their


families so they are treated with respect.


5
5. CESAB will check that those who

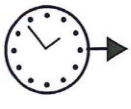

look after people do their job well.

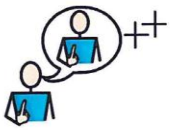

6
6. CESAB will work with other organisations to


help people who are abused or not

looked after.

7



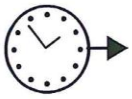
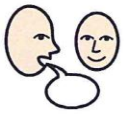


7. CESAB will provide advocates (people who




can support you) if you need help.

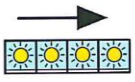
8


8. CESAB will tell people what we

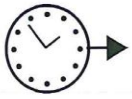


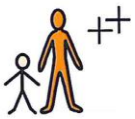




learn to make lives better in the future.

9

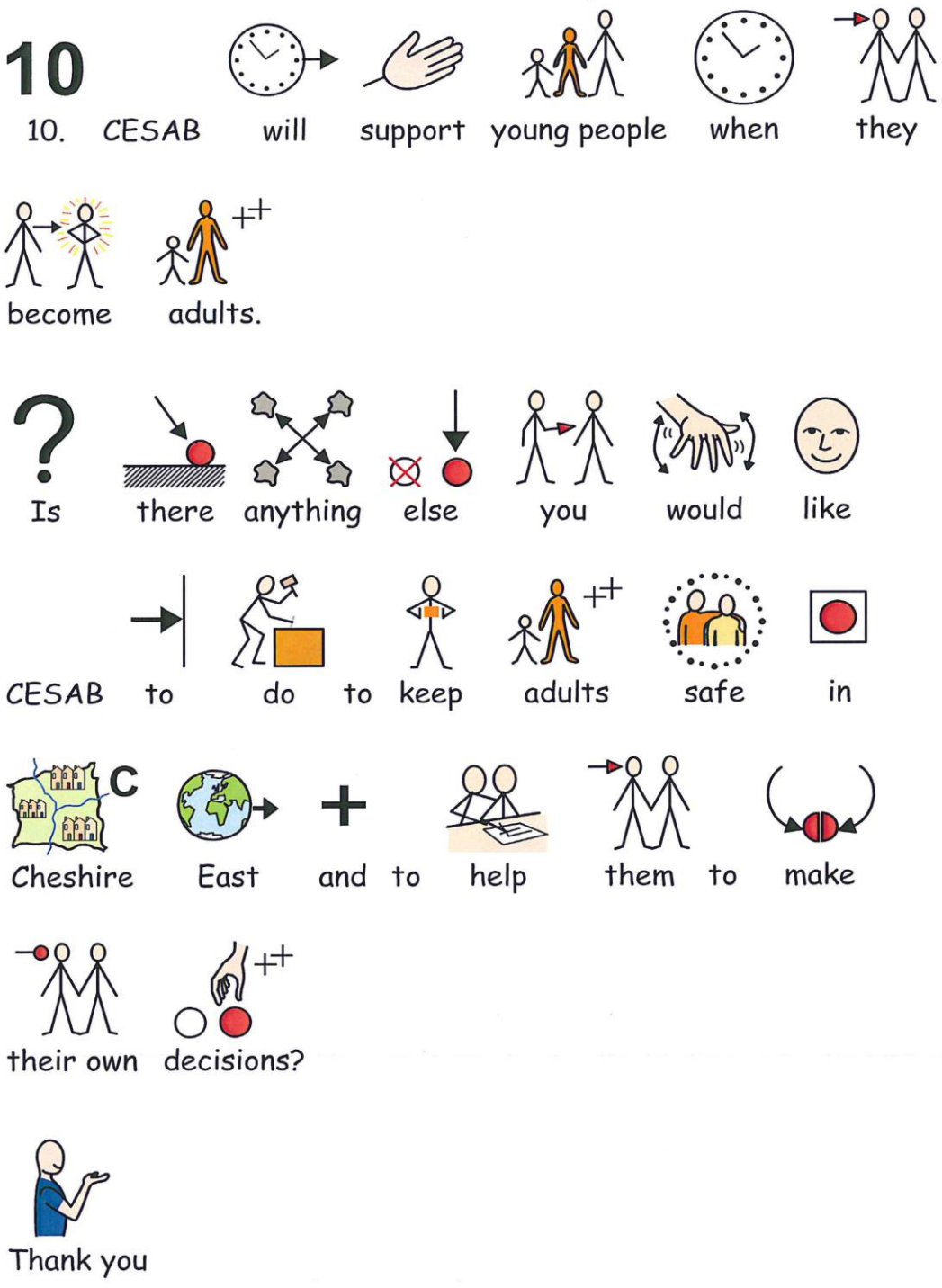


9. CSAB will check that adults feel as




safe as they want to.



email – lsab@cheshireeast.gov.uk

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15 March 2016
Report of: Jacki Wilkes, Associate Director of Commissioning ECCG
Subject/Title: Caring for Carers: A Joint Strategy for Carers of All Aged in Cheshire East 2016 - 2018

1 Report Summary

1.1 Cheshire East Council (ECCCG) has worked in partnership with carers, Eastern Cheshire Clinical Commissioning Group and South Cheshire Clinical Commissioning Group to develop a new two year strategy for carers.

1.2 An evaluation of the previous strategy (2011-2015) shows that some progress has been made to improve the health and well-being of carers in Cheshire East.

1.3 A number of engagement events have been held over the past two years to understand the stated needs of carers and review opportunities to meet those needs.

1.4 The publication of the 2014 Care Act outlines specific changes to the offer of support for carers and the impact of these changes have been assessed and included in the strategy.

1.5 There are five priority areas outlined in the new strategy (informed by carers) and a delivery plan with details of actions, timescales and clear lines of both organisational and individual officer accountabilities is included for each area.

1.6 An outcomes framework, with measures of success has been developed alongside the implementation plan and will be used to monitor progress. This will report to the Health and Well Being Board via the Joint Commissioning Leadership Team.

1.7 An innovative approach to measurement of success is proposed in partnership with carers. This two year strategy will be monitored through traditional approaches such as surveys, activity, registers, Carers Reference group etc. It will also adopt an innovative approach to measurement of success through carers, representing a wide range of circumstances, sharing their stories. This will demonstrate how the strategy will improve their quality of life by regularly feeding back on the impact of the strategy during the implementation phase.

2 Recommendations

The Cheshire East Health and Well Being Board is asked to:

Agree the strategy for 2016-18 in that it aligns to the Caring Together, and Connecting Care vision and transformation agenda and as such is a key priority for Cheshire East Council, South Cheshire and Eastern Cheshire Clinical Commissioning Groups.

Note that the Strategy has been endorsed by Eastern Cheshire CCG but is yet to be endorsed by South Cheshire CCG. Approve the proposal to manage the implementation action plan and resource requirements via the partnership Executive Teams.

Endorse the proposal to monitor progress of delivering this strategy via the Joint Commissioning Leadership Team and report as required to the Health and Well Being Board.

3 Reasons for Recommendations

3.1. Health and Well Being Board partners have committed to '*ensure the health and wellbeing of carers to enable them to carry out their caring role'* This strategy describes how that will be achieved.

3.2. In order to begin work on this strategy, decisions will need to be made in a timely way. The executive teams meet regularly and can make decisions which may be required to keep plans on target.

3.3. Governance arrangements are required to ensure plans progress well and issues are identified and escalated where required.

4 Impact on Health and Wellbeing Strategy Priorities

4.1. The mission statement 'Valuing Carers and Supporting their Health and well-being in Cheshire East' was developed in response to feedback received during the engagement events. Specifically the strategy aims to:

- Recognise and value carers as partners with expert knowledge, experience and understanding
- Capture the experience and ideas of carers to improve and develop service
- Help carers to realise and release their potential including access to work and educational opportunities
- Support a life outside of caring
- Support carers to stay out of financial hardship

- Keep people in caring roles safe from harm
- Improve the health and well-being of those in a caring role
- Identifying and supporting young carers to ensure thy learn, develop and thrive

5 Background and Options

5.1 The 2014 Care Act places a duty of care on health and social care to work in partnership to identify and support people in a caring role, and empowerment of carers in Eastern Cheshire is central to the Caring Together programme.

5.2 According to the most recent census data there are 12,453 people in Cheshire East caring for 20 hours per week or more, with a further 27,481 caring between 1 and 19 hours per week. Altogether that is almost 11% of the population of Cheshire East.

5.3 In Cheshire East the number of people caring for 50 hours or over has increased by nearly a third since 2001 to 8,014, with over 42% of them aged 65 or over.

5.4 In a recent survey on the impact of caring on the carer 1 in 8 respondents (12.7%) said that they do not do anything they value or enjoy with their time, with over a third of respondents said that sometimes they can't look after themselves well enough. In addition 14.9% of respondents said that they had little social contact with people and felt socially isolated.

5.5 In Cheshire East, 1,236 of the Carers who were caring for 20 hours or more per week (10%) reported that they were in bad or very bad health.

5.6 By 2037 Carers UK calculates that the number of carers in the UK will increase by 40%, which would equates to an estimated 56,000 carers in Cheshire East.

5.7 Following feedback from ECCCG Governing Body, representatives from the CCGs and Council, working with the carers reference group have 're-profiled' the priority areas giving the strategy a clearer focus with Carers advising on what needs to happen to deliver a tangible difference.

5.8 Eastern Cheshire Clinical Commissioning Group (ECCCG) Governing Body received proposals for a Joint Commissioning Strategy at its April 2015 meeting but required further information on; benefits to carers, measurements of success, process for needs assessment with assurance that adequate capacity is available and clear arrangements for delivery.

5.9 Further engagement has taken place and priority areas re-profiled with assessment of need and respite now clearly identified as work streams.

5.10 The proposal presented here brings together the key strands of work described above which relate to carers of all ages, in a new strategy for 2016 - 18.
The five emerging priorities are:

- Respite and carer breaks
- Realising carer potential
- Information service
- Assessment of carer needs and crisis support
- Engagement and co-production

5.11 Each of these priorities will be supported by an outcomes framework to monitor and review progress, and measure success.

5.12 An implementation action plan has been developed which describes in relevant detail the timeline to achieve the outcomes required.

5.13 A new project manager post, funded from the three commissioning partners, has been established to drive through the delivery plan and promote effective engagement with people of all ages in caring roles. The post holder will have access to a small pooled budget for engagement.

Table 1: Financial plan from ECCCG to support carers

ECCG Contribution	Cost
33.3% funding for carers post	£14,964
33.3% contribution to engagement budget	£2,000
Carer Breaks	£226,000
Total for ECCCG	**£242,964**
CEC Contribution	Cost
CEC Early Intervention and Prevention Services to Carers	£372,489
CEC Generic services	£1,157,000
Carers Respite bed based services	£1,946,387.04
Carer Breaks	£426,000

-

Carers also receive support through the provision of services to the cared for.

6 Access to Information

For further information relating to this report contact:

Name	Jacki Wilkes
Designation	Associate Director of Commissioning
Telephone	01625 663473
Email	jackiwilkes@nhs.net

This page is intentionally left blank

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

'Caring for Carers' ..... A Joint Strategy for Carers of All Ages in Cheshire East

2016 – 2018

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Contents

Foreword

Around 3 in 5 people will be carers at some point in their lives, taking this role on at any age, from very young children caring for parents or siblings, to adults caring for parents, partners or children as well as older people looking after family members.

Carers offer a vital contribution to their families and communities providing unpaid support for someone who is ill, frail or disabled. Hidden carers often spend more than 20 hours a week looking after loved ones. Without help and support, they can find themselves struggling and isolated with what can be very physical and emotional demands, trying to balance work and home life, and potentially risking their own health and wellbeing as a result. Supporting carers to enable them to meet their own needs is a key focus for health and social care partners

For us to have an effective Carers Strategy in Cheshire East, it has been really important to develop this plan with carers of all ages, reflecting the views and needs of local people. We have been gathering the views of carers of all ages over a number of years through workshops, focus groups, regular meetings and in depth life stories. The importance of supporting carers is a key feature of the Care Act 2014, raising the profile of carers, giving them an equal status to their family member who is being cared for. Through the engagement events we have heard some very inspiring stories of local carers of all ages. Carers often ask for very little but when they need help, it is crucial that it is quickly available and easily accessible. We need to know that we are commissioning and providing the right services to help carers continue this valuable role

Health and social care will take this opportunity to work in partnership with carers, wherever they are, to recognise, respect and respond to their needs. The important message for us, and one which we have heard repeatedly when listening to those in caring roles is this; carers want to be respected, valued and supported, they want help when they need it, sometimes that means quickly, and they want to only have to tell their story once. Carers of all ages want to know what support is available and how they can access that support, enabling them to make decisions that are right for them as individual's and for the people they love and care for. It is important that we work in partnership with carers and provide a support structure.

This then, is a strategy for young carers as well as adults. We have set out a vision that Cheshire East must be a great place to be young; we want this to be the experience for every young person regardless of their circumstances. Young Carers are too often part of an invisible population, working hard to balance the care for a loved one, their education, running a household and their own lives as young people - often putting their own needs last.

We have the greatest respect for all Young Carers and they should be immensely proud of all that they do. We also feel extremely protective of them and want to ensure Cheshire East is a caring community, one that readily identifies children and young people who are carers, one which provides support and advice services at the right time to meet their needs and one that continues to listen to the voice of children in the design, delivery and review of services.

We are all confident that through the combined effort of all services including both adult and children's social care, our schools, health providers and others the

partnership approach, outlined in this joint strategy, we can improve outcomes for all carers and their families.

This strategy sets out how we will work with carers we know are there and those we need to find, to deliver better outcomes for them over the next two years.

Cllr. Janet Clowes, Adult Social Care Portfolio Holder and Chair of the Cheshire East Health and Wellbeing Board

Councillor Rachel Bailey, Portfolio Holder Safeguarding Children and Adults

Brenda Smith, Director of Adult Social Care and Independent Living Cheshire East Council

Kath O'Dwyer, Deputy Chief Executive and Director of Children's Services

Jacki Wilkes, Associate Director of Commissioning NHS Eastern Cheshire Clinical Commissioning Group and Carers Lead for Cheshire East

Fiona Field, Director NHS South Cheshire Clinical Commissioning Group

Introduction

This strategy is Health and Social Care's response to the stated needs of carers. It focuses on the needs of children and adults and addresses the complexity and diversity of the carer's situations. In keeping with the Government definition and for the purposes of this strategy a carer is somebody who:

'…provides support or who looks after a family member, partner or friend who needs help because of their age, physical or mental illness, or disability. They can be any age, young or old. This would not usually include someone paid or employed to carry out that role, or someone who is a volunteer.'

Anyone can become a carer in response to a very broad range of circumstances. Caring relationships can be complex, and family members may provide different types of care for each other in order to live independently in the community.

For Young Carers the impact of caring at a young age can be both positive and negative but should not be allowed to impact on a child or young person so much that they cannot 'be a child first'. The vision of those involved in developing this strategy is to identify and significantly reduce the numbers of young people undertaking inappropriate and harmful caring roles in Cheshire East and to support young people and their families and ensure services work together to ensure a more effective, joined up approach.

12,453 people in Cheshire East have identified themselves as caring for 20 hours per week or more, with a further 27,481 caring between 1 and 19 hours per week. Altogether that is almost 11% of the population of Cheshire East. The number of people caring for 50 hours or over has increased by nearly a third since 2001 to 8,014, with over 42% of them aged 65 or over. 1,236 of the carers who were caring for 20 hours or more per week (10%) reported that they were in bad or very bad health.

There is no current figure for the true number of young carers in the borough. Young carers are only known to agencies when they or their families identify themselves and therefore there are many who remain 'hidden'.

By 2037 Carers UK calculates that the number of carers in the UK will increase by 40%, which would mean nearly 56,000 carers in Cheshire East.
We believe since the Census in 2011 the numbers of carers in Cheshire East has risen and there will be people of all ages taking on caring responsibilities daily that we are not aware of; 'hidden' from main stream services not recognising or choosing not to declare their caring role.

Our Ambition

'Valuing Carers and Supporting their Health and Wellbeing in Cheshire East'

The success of this strategy will be measured in accordance with carers experience and reflected in the extent to which the following 'I' statements are achieved.

As Health and Social Care partners we will *'take account of an individual's wishes and situation'* in all services and support we offer to carers. Thereby, embracing and building on work already started on the local governments Think Local Act Personal (TLAP) initiative. The TLAP principles refer to choice and control, enabling people to live full and independent lives.

National Context

The **Care Act 2014** refers mostly to adult carers, people aged 18 and over, who are caring for another adult. The Act places on local authorities a responsibility to assess the Carers need for support. This assessment will consider the impact of caring, as well as the things carers want to achieve in their own life. It must also consider other important issues, such as whether carers are able or willing to carry on caring, if they work or want to work, and whether they want to study or do more socially.

The Act explains how a Local Authority should carry out a Young Carers' needs assessment where there is 'likely need' for support post-18 and when it is of 'significant benefit', this is especially important during the 'transition' period from childhood to adulthood services. Guidance is also provided to assist professionals when they are working with a family to consider the whole family circumstances when assessing an adult's need for care, for example, making sure the position of a young carer within a family is not overlooked.

The Act details a duty to provide independent advocacy to represent and support carers as individuals - if needed to facilitate their involvement in assessments and preparing support plans. This includes advocacy support for carers, carers of children at transition age and young carers at transition age. Carers have the right to request that the local authority meets some or all of their eligible needs by giving them a direct payment so that they can control how this support is provided.

The **Children and Families Act** 2014 provides guidance on young carers, (aged 18 and under) and Parent Carers; adults who care for their disabled children.

An assessment can take place if it appears a young carer may have need for additional support, or if an assessment is requested. Young carers' needs assessments must have regard to the extent to which the young carer is participating in or wishes to participate in education, training or recreation, and the extent to which the young carer wishes to work. All young carers under the age of 18 have a right to an assessment of their need, no matter who they care for, what type of care they provide, or how often they provide it. There is no longer a requirement to provide a "substantial" amount of care.

Many young carers remain hidden for a host of reasons, including family loyalty, stigma, bullying, not knowing where to go for support. Some do not come forward because they and their families are frightened of outside interference and being taken away. Many do not even tell their teachers or friends.

Caring can have a dramatic effect on their lives. Young carers' health can be compromised due to lack of sleep, excessive household chores and physical care. Almost a third of young carers' have serious educational problems with many failing to attain any GCSEs at all.

Respite

It is important that carers are offered a chance to have occasional breaks from your caring role.
You may be able to access more support to help you look after yourself and carry on caring which may include carer respite. A financial assessment can be undertaken to assess what financial support is available.

The Council is committed to providing a choice of respite services and individual bed based services local to you:

Local provision – respite is now available in 15 care homes throughout Cheshire East.

The Council has now signed new contracts with the independent sector to provide 21 respite care beds, 19 of these are pre bookable and two are reserved for carer emergency.
If you have been assessed as requiring carer respite and are planning a short break, a night out or a holiday it is easy to book a bed by calling our dedicated booking line or by emailing:
Email: ce.contracts@cheshireeast.gov.uk
Phone: 01270 686 428

Safeguarding Carers

We know that the situations carers face can sometimes create unbearable stresses and strains, and sometimes result in safeguarding issues. It is important that carers understand what abuse is and recognise types of abuse. The main aim of safeguarding is to ensure that the user and carer is kept safe and secure, and involvement from the Council, health or other organisations must be supportive, offering practical assistance for carers where required.

Organisations must work in partnership with others to identify and respond to any young carers who are suffering, or likely to suffer, significant harm and to protect them from this harm. All professionals working with families are required to be extra vigilant, especially in relation to 'Hidden Carers' http://www.cheshireeastlscb.org.uk

http://www.cheshireeast.gov.uk/care-and-support/vulnerable-adults/adult-safeguarding-board.aspx

The Care Act also embeds the Principles of Making Safeguarding Personal. Adults at risk and carers should feel that their views and wishes are taken into account at all times, and be included and involved at all stages of the Safeguarding Process. People who are unable to make their wishes known or lack mental capacity will be supported by Advocacy services.

The National Strategy for Young Carers says that: ***'Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive and to enjoy positive childhoods'.***

Being a young carer can have detrimental effects on young people, including problems at school, health problems, emotional difficulties, isolation, lack of time for leisure, feeling different, pressure from keeping family problems a secret, problems with transition to adulthood, lack of recognition and feeling they are not being listened to.

Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. The tasks undertaken can vary according to the nature of the illness or disability, the level and frequency of need for care and the structure of the family as a whole.

Some young carers may undertake high levels of care, whereas for others it may be frequent low levels of care. Either can impact heavily on a child or young person.

The term does not apply to the everyday and occasional help around the home that may often be expected of or given by children in families and is part of community and family cohesion.

A young carer becomes vulnerable when:

- the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child,
- there is an impact on his or her emotional or physical wellbeing or
- there is an impact on his or her educational achievement and life chances.

Young carers often may not think of themselves as carers and are not recognised as such by other people like friends, teachers, doctors and other family members

The Care Act includes a duty to carry out a Young Carers' needs assessment where there is 'likely need' for support post-18 and when it is of 'significant benefit'.

Parent Carers

Under the Children Act 1989, it is expected that an assessment of a child 'In need' will take account of the needs of other family members. However, parent carers also have a right to their own assessment and services under the Children and Families Act 2014.Under the Act the Council must assess a parent carer if:

- they appear to have a need or if the parent requests an assessment. This will include whether that parent has needs for support and, if so, what those needs are, and whether it is appropriate for the parent to provide care for their disabled child in the light of their own needs for support.

- there are concerns about the well-being of the parent carer which may impact on the welfare of the disabled child and any other child the parent is responsible for.

Local Context - Strategic Vision for Cheshire East

Cheshire East Health and Social Care come together as a partnership through the local Health and Well Being Board. The Board looks at the joint needs of the population and agree strategic plans. This is then delivered through two transformation programmes; in South Cheshire his is called 'Connecting Care' and in Eastern Cheshire it is 'Caring Together', all of which prioritises the need to identify carers and provide support.

The overarching principle aims are the same for each programme;

- shifting the focus of care from hospital to home,
- working with individuals to support self-care,
- independence and choice,
- integrate services where people have needs which span health and social care.

Together the three organisations want to Empower carers and ensure support systems are in place to help carers to live their own life as well as recognising the carer as the expert in providing care and support for another person.

The partners also recognise that children and young people have very specific needs and have reflected this through the Children and Young People's 3 year Plan.

The outcomes within the Children and young people's plan have been shaped by the views and insights of children, young people and their families and are that:

1. Children and young people will be **actively involved in decisions** that affect their lives and communities
2. Children and young people **feel and are safe**
3. Children and young people experience **good emotional and mental health and wellbeing**
4. Children and young people are **healthy and make positive choices**
5. Children and young people **leave school with the best skills and qualifications they can achieve** and the **life skills they need to thrive** into adulthood
6. Children, young people and adults with additional needs **have better life chances**

In planning how support will be delivered to carers in Cheshire East, it will be necessary to review existing services and ensure that they are aligned to the

priorities identified within this strategy. Where gaps exist we will work with the market to develop new models of support and the services that carers need.

Where are we now?

Strategic Priorities for 2016-18

This strategy identifies five priorities based on the feedback we have received through our engagement with carers and the changes in legislation following the Care Act 2014 and the Children and Families Act 2014 implementation

The overarching priorities for the next 2 years are

- Respite and carer breaks
- Realising carer potential
- Information service
- Assessment of carer needs and crisis support
- Engagement and co-production

For each priority area a work programme has been identified within a two year delivery plan which will be regularly monitored and updated, and which is summarised on a plan on a page'

There are a range of resources available to support carers and meet their individual needs. Establishing a value for money approach means exploring suitable solutions which are appropriate, adequate and meet the needs of carers both non-eligible or eligible for funded support.

It is vital that Health and Social Care partners take an active role in identifying carers and providing them with the support to access services. Services commissioned by either Clinical Commissioning Group or Cheshire East Council are free at the point of delivery to carers. A charge may be applied by the individual commissioned organisation for activities which the carer may participate in such as trips, meals out with other carers and other types of activity that the carer may interested in attending.

Equality and Diversity

We recognise the full diversity of carers across Cheshire East, and aim to ensure that community support and services for all carers are fully accessible. This includes taking due regard of carers who themselves may be disabled, from different ethnic and cultural backgrounds, gay, bisexual or transgender and recognises that diversity of carers covers more than this. It includes for example, health of carers, diversity of the people cared for, income and finance and the impact of caring for more than 50 hours per week. The Equality Act 2010 has the potential to reduce the strain on some carers, particularly when fitting caring responsibilities around education and employment, as carers have greater protection from discrimination as a result of their caring responsibilities.

Cheshire East Council Impact Assessment

In the first year following its implementation Cheshire East Council are **establishing a baseline** against which future targets can be set. An Annual review of targets will need to take account of the anticipated need and annual financial allocations.

Carers Engagement in Cheshire East

In 2012 and 2014, Cheshire East Council carried out the National Carers Survey for carers in their area. For this, a random sample of all the carers who have received an assessment in the past year are contacted and asked to answer questions on their experience of information, services and support in East Cheshire.

Year	Sample size	Total responses
2012	1131	440
2014	982	471

The results from the 2012 survey showed us that:

- 71% of carers were satisfied with the support or services that they and the person they cared for had received from social services in the previous 12 months
- 91% of carers felt that they had some measure of control over their daily life
- 79% of carers who were looking for information found it easy to find.

This shows that while support and information is working well for some, there is still work to be done to ensure that all carers receive the support that they need.

This strategy has been informed by information gained from the 2014 National Carers Survey, about Adult carers in Cheshire East who have had an assessment.

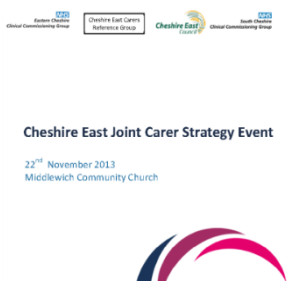
Profile of Adult carers who were surveyed in 2014:

- 46.4% of carers are aged 65 or over and looking after someone aged 65 or over.
- 63.3% of respondents were providing 50 hours or more care per week. Half (50.6%) were providing more than 100 hours of care per week.
- around two-thirds carried out personal care for the person they care for, and just over half provided physical help.
- over half (54.1%) of respondents were carrying out more than eight of the eleven caring tasks listed in the questionnaire.
- more than a third (36.4%) had been providing care for the person for more than ten years and around a fifth (20.6%) had been providing care for more than twenty years.
- some carers are providing care whilst also dealing with their own health problems. Just over half (51.2%) had one or more health conditions.

The impact of caring on those who were surveyed in 2014:

- 1 in 8 respondents (12.7%) said that they do not do anything they value or enjoy with their time.
- carers providing the higher intensities of care in terms of hours per week, particularly those providing 50 or more hours care per week, appear to be more likely to report that they do not do anything they value or enjoy than those providing care of less than 20 hours per week.
- 11.4% said that they felt they had no control over their daily life. Those who provided care of 50 or more hours per week were far more likely to respond that they felt they had no control over their daily life.
- over a third of respondents (37.7%) said that sometimes they can't look after themselves well enough or even to the extent that they feel they were neglecting themselves (12.9%). This is an increase from the last survey in 2012/13, up from 30.2% and 8.1% respectively.
- there also appears to be a greater likelihood amongst carers aged under 65 to report that they feel they are neglecting themselves. There was also an increasing likelihood of respondents saying that they felt they were neglecting themselves with increasing hours of care provided per week.
- 14.9% of respondents said that they had little social contact with people and felt socially isolated. There were a higher proportion of carers who provided 50 or more hours of care per week (22.1%) that said that they felt socially isolated compared to those who provided less hours of care.

Carer Engagement Events



In November 2013 a Cheshire East Joint Strategy event was held to enable carers and professionals from health, social care and the voluntary and community sector to work together to identify what needed to be added to any new carers' strategy, and to look at how best to work together to deliver what matters for carers in Cheshire East. A report of that event is available and the views from that event have informed this new carers' strategy.

South Cheshire CCG link: http://www.southcheshireccg.nhs.uk/publication

Eastern Cheshire CCG link:
https://www.easterncheshireccg.nhs.uk/Links/resources.htm

In January 2015, a series of follow-up events were held across Cheshire east, where the 90 carers who attended had the opportunity to tell the Council and local NHS Clinical Commissioning Groups how they can improve the support they offer.

The main messages to come out of this were:

- Carers have/retain control
- Reducing stigma/increasing awareness,
- Understanding and compassion
- Communication
- Personalisation
- Forward planning

These have informed the 2016-18 priorities.

Consultation

Throughout 2014/2015 there have been a number of consultations about the changes in the Health and Social Care policy where the views of service users and carers have been sought all of which have helped shape this strategy.

What do our Children and Young People tell us?

The voice of children and young people is central to all that we do; to understand what is important to our young carers a consultation and participation activity was undertaken with children and young people across the borough. Our young carers told us that they want to:

- Feel involved and supported by well promoted, accessible services with well skilled and knowledgeable professionals.
- Have something to do/places to go that are relevant, appropriate to need, of benefit to them and distract from negative behaviour and building partnership between education young carers projects and youth service.
- Engage through accessible/cool/up to date methods.
- Know that agencies are joining up to understand and address need.
- Cheshire East Young Carers have told us that they also can feel proud, more self-confident, closer to the people they care for and valued by their family but they feel more should be done to find other young people in caring roles.
- Be supported as individuals and as families in order to make sure caring is not impacting negatively on their wellbeing.

Bringing the strategy to life: Hearing and responding to our own Cheshire East carer's stories

In developing our plans we asked people in a variety of caring roles to share their experiences of being an informal carer in order to make this strategy relevant, wide ranging and fit for purpose.

Introducing…

Carer 1

I am 44 years old and live with my partner of 13 years. I have two sons, one who is 19 and has just left home to start a 4 year degree at University and my younger son who is 8 and attends a small local mainstream primary school and I would like to share our story.

I had to give up my job because I could not access appropriate childcare to care for him due to his complex needs.

I completed an "Independent Supporter" course when he started school and started as a volunteer for the Parent Partnership services, now known as Cheshire East Information and Advice Support (CEIAS). They must have thought I was alright because now I work for them in a paid position part time, flexible term time hours. I love my job, supporting parents and empowering them to get the best for their children.

I care for my younger son. I am obviously biased, but he is the most inspirational little boy I have ever had the pleasure in caring for. He spreads a smile wherever he goes, never lets his disabilities hold him back and always makes the most of every opportunity and loves life. He has not been diagnosed with a specific condition. He has global development delay, which for him means that he needs some kind of support twenty-four hours a day. He cannot as yet communicate verbally and requires a familiar adult who knows him well to assist. This is so that he can be understood and he is safe at all times. He needs adult support with all his daily living skills and is cared for by me and my partner on a daily basis. We have a couple of close friends who we allow care for him occasionally. He has an amazing teaching assistant at school that we would not be without.

Experiences as a Carer:
It was at the birth of my second son that my caring story began. It started with a harrowing birth and several distressing weeks with him in hospital. I felt as though I went through a grieving process before I started to move on and embrace my role as not just a mum but a mum of a child with additional needs and a carer.

The experience has changed all our lives, including our extended family. He has always been able to access the services that he needs. The majority of our experiences have been positive in regards to the care he has received. Although I do feel that at times role of the parent carer is not always recognised, especially when the additional need is not visible.

My experience has been shaped by my own previous knowledge, supportive family and friends and determination that I can and will cope. My concerns are; what happens if I cannot cope? Can I get support before I reach that point? Am I going to be told that his needs are not being met because I need support? What about the parent carers who don't have support?

What would make a difference?

- an initial point of contact either at birth/hospital or when the carer's journey starts – to support/advise/signpost.
- patient/hospital passports/one page profiles and help and support in filling these out. Therefore, carers are not having to go over and over/repeat information when they come into contact with professionals.
- carers assessment – clear information about who will do what, timelines, and flowcharts. Not to have to be at breaking point before support is offered – ***Prevention***
- to have our child looked after in the same way we would look after them it is important a choice is available on the type of respite offered.
- information for parent carers. Early Intervention – relevant Agencies, support groups, benefits. Cheshire and Warrington Carers play a vital role in Cheshire East.
- short breaks that are accessible to children and young people with complex additional needs.
- meaningful engagement – not walking away until the carer is happy. To be listened to and given choices as other parents would be with their children. Important to explore how professionals can be trained when dealing with carers so that there is empathy/sympathy when delivering diagnosis and ongoing medical issues.
- make use of other parents who can support other parent cares who need help e.g. signpost.

Carer 2

I am a young carer and live with my Mother and three Brothers. My mother has suffered with ongoing mental problems since I was born but after her mental health deteriorated; I was made aware of her bipolar and severe depression diagnosis when I was eight. Although I have been my Mothers part time carer since then, it is only as I have got older have I had to deal with more adult responsibilities. Once I was informed that my Mum suffered with various mental health illnesses I had a lot of questions, that to this day, I feel are left unanswered and the absence of understanding often leads to feelings of confusion. This ultimately contributes to emotional tension in the household.

Mums condition has not been too restricting on my life as she is reasonably self-sufficient. In the past, I have confided in friends and explained my Mother's condition but I refrain from telling them about how I feel as they are not in a position to improve things. My Mother has good days and bad days. Whilst my Mum is going through a depressive period she finds it difficult to sympathise with others and doesn't understand how I feel. On the good days we watch our favourite boxset or film and generally do normal family things. When she has an episode I do what I can to help, however, there are times where she has had to be admitted to a psychiatric unit to receive treatment. As a symptom of this, she gets short-term memory loss, which for a six week period, complicates things at home.

I often get frustrated at the situation my family and I are in. When I was optimistic about my Mothers condition until around the age of ten, I was under the assumption that her mental health would improve and she would become happy. I now know that is not the case, there is no miracle cure for mental illness, you just have to accept the difficult times and embrace the good times. Although I am perplexed by the way Mum can be optimistic one day and suicidal the next I have learned to accept it as it is out of my control.

It can be challenging to go to school whilst Mum combats severe suicidal feelings but as I have aged I have been able to decipher whether my Mum is just extremely depressed or she is in fact likely to attempt suicide or self-harm. From this inference, I am then able to inform people who can intervene.

School:

When I was younger, teachers used to help me at school by talking to me about my home life but they were never able to offer me an outlet to express my emotions, I

was apprehensive about asking for help as at that point I was unsure whether I qualified as a carer. I instead joined a carers group when I was around nine years old but due to logistical issues, I was unable to attend for long.

It was another three to four years until I joined a Young Carers Group. I owe the strength and positive attitude I now possess to this support group. They inspired a great change within me and encouraged me to explore the things I am passionate about today (namely literary analysis & mental health awareness). When I leave school I would like to join the Police force and ultimately become a Detective Constable Inspector. In the meantime, I am enquiring into whether I can join The Young Volunteer Police Force when I turn 16.

The Outward Bound Trust

In April 2015, I was lucky enough to go on a five day residential to the Outward Bound Trust (www.outwardbound.org.uk) with, as I was put in a group with younger members I had to engage my leadership skills and ensure that the most vulnerable kids were okay. My instructor saw potential in me and as a result, I was offered the chance to attend a nineteen day scholarship course with The Outward Bound Trust. In order to secure a place, I acquired a part-time job at a local pub - so far I have managed to raise £400 to cover the scholarship. The recognition of my potential ignited my desire to succeed and self-improve.

The Future

Although I do worry about what my Mother will do when my Brothers and I leave school and I am concerned about doing my exams whilst dealing with my Mum when she has to endure an episode, I know I will take it in my stride and cope with it. I'm now able to picture my ideal future, a future only accessible if I work hard at school.

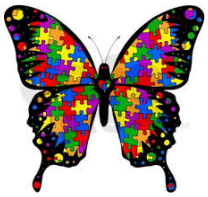
Prior to the residential course I lacked a sense of direction; I willingly accepted the constraints of being a carer I *thought* I had to endure. I now realise that I do not have to let my current situation withhold me from being successful in the future.

What would make a difference?

I feel that a good way to find hidden carers within Cheshire is to have informative and inviting leaflets handed out to **everyone** at registration at school. It is important to hand the leaflets out to everyone so the Young Carer that requires support does not have to face the stigma attached to caring for someone. I used to doubt whether I was a carer as I assumed that you only qualified as a carer if you were so involved that it took over your life, it turns out that although there are different levels of care, you are a carer all the same. This information would have been useful to me in the early stages of becoming a carer.

Therefore, it would be ideal to hold an assembly at schools about young carers to educate all children about the realities of caring for someone. Even if a child is not directly affected by the topic of caring, it is vital that they know how to behave if a Young Carer confides in them so they can offer them an avenue of support which would combat the feelings of isolation a Young Carer may experience.

- counsellors for young carers as soon as they are on the radar.
- Children should be educated on their parents/siblings condition.
- We need to manage people's expectations – the people they are caring for may never get better. If it's a lifelong condition, carer should be aware of this.
- Assist young carers with homework and extra help during exam time to take the pressure off.
- Educate young carers on the transition period when they are leaving home and what services will help to take their place to some degree.
- Mental Health professionals talking to children as well as their parent to help children understand the condition and how their parent is feeling.
- Help from school with homework and allow time to do it.



Carer 3

I am a single parent with two children, 8 and 12. My son suffers from high functioning Asperger's, ADHD and he has pathological demand avoidances. He also suffers from sensory processing disorder. My son feels safe in his bedroom where it is quiet and no interaction. He has struggled in the past being in mainstream school. Often he would run away and pretend to be ill to avoid going. He has friends and wants friends but doesn't always understand friendships. He struggles following rules and will change rules to suit him.

When it comes to holidays, we would go to the same place every year. We used to be able to go out of term time where the situation would suit my son as it would be quiet and not a lot of people around.

My daughter is fantastic with him, but occasionally she can get upset with his behaviour so I explain it is not him acting this way it is his autism.
In my sons early years he developed very quickly. He was reading by two years old and walking and talking very early on. I noticed he was extremely clingy and would not interact, play and share very well with other children. It got to the point whereby he was excluded from a nursery and I had to work as a child minder in order to look after him.

By the age of 6, I insisted on seeing the Head of the school as I was constantly being called into speak to my son's teacher regarding his behaviour. The Head Teacher recommended bringing in the school nurse. It was then that she recommended I was referred to CAHMS. We were put in touch with an ADAHD specialist who carried out a classroom observation. It was picked up that he was showing signs of Autism Spectrum Disorder mainly High Functioning Aspergers.

Space 4Autism became involved when I had been given a leaflet with a list of places for support from CAHMS in 2009. They were able to help me with information and some respite. They also asked me to become involved when the BBC got in touch with them as part of doing an Autism Awareness Week, in particular looking at waiting times for diagnosis.

My son has now reached high school age and was put into mainstream education, despite me raising concerns that this would not suit him at all and that he needs to be in a special school. Sure enough he was bullied and his behaviour deteriorated. One of the psychologists at CAHMS supported me when I started having issues with getting my son to school. He told the school that the added pressure of me trying to get my son to school was resulting in his behaviour escalating and becoming violent towards myself, and so this shouldn't be forced upon me to get my son to school. After which my son's behaviour also escalated at the school and the final straw was when I was called to the school. I then made the decision because of the risks, to remove him from mainstream education. It was at this point that my mental wellbeing deteriorated and I was signed off sick. This really frustrated me as I have never been out of work in my life. I have since had to resign from my job because of my deteriorating health. I have suffered from breast Cancer and as a result of treatment I now have peripheral neuropathy. My daughter is fantastic and has stepped up. She has started taking a more caring role with me making sure I take my medicines and asking if I've eaten, which I feel really bad about as I feel she shouldn't have to be doing this at such a young age. She attends Young carers support group which she thoroughly enjoys. Trying to juggle my son's condition, recovering from cancer and doing this all on my own has been incredibly hard and in March I unfortunately, reached my trigger point and ended up having a full breakdown.

What would make a difference?

- Good to have a support worker when my son was first thought to be on spectrum (first point of contact).
- Advertise more widely the local offer – people may not even know what a local offer is.
- Improve access to assessments once diagnosis reached, need support worker to help guide me to services and support available and appropriate.
- Advice and support needs to be available in the interim between identifying a problem and diagnosis.
- Crisis support needs to be available 7 days a week.
- Only place can currently get help is Police or A&E.

- Too frightened to take to A&E in case my son is taken from me.
- Both my daughter and son responded really well to play therapy which they went to only for the duration whilst I was receiving treatment for Breast Cancer. Shame this had to stop or that there is nothing similar outside of the hospital.
- Seems to be a lack of social workers for children with mental health problems.
- Buddy system – parents who are new to the system, helping them and advising them through experience.
- need advice re: benefits/finances
- education within schools and other services (I have since developed a training package to help with this gap but not sure where to take it as there has been some reluctance when I've approached some schools)
- Signposting to services available. I also want to be reintroduced back into work and realise my potential. I would love to work as a Family Support Worker, helping other families in similar situations.
- Severe lack of use or interest in patient passport within the Trust (apart from the Paediatric ward).
- Need a break but would currently have to pay for one which I cannot afford. End up giving up on support much needed and end up just dealing with the situation as everyday life.

Carer 4

I am 65yrs old and retired. We have two daughters who are adults. Since retiring my wife and I have spent all our spare time preparing our daughters (financially, emotionally, domiciliary etc.) for the time when we are not able to look after their wants and needs.

About the girls

My daughters live together in a house very close to us. They have a private bedroom, toilet and lounge each to promote independence and share a kitchen and shower room. There is also a bedroom for carers to stay overnight. Carers are supplied by local company and financed through direct payments. Both girls have learning difficulties from birth and went through the education system, one accessing a specialist school and the other in mainstream with extra help.
After feeling I could help add something to the local community, a friend and I established a sheltered workshop to provide training in marketable skills for people with learning disabilities and work in a safe, stress free environment. After 18 years "Supported Community Business (special needs) ltd" has survived and thrived, providing 22 places for trainees, employment for 6 able bodied staff.

What would make a difference?

- Consistent approach from those involved in assessment of need. Each carer's experience is unique and the process should be carefully and sympathetically managed.
- Carers should always be treated with dignity and respect recognising life can be tough.
- Treat people with respect and dignity be careful when writing letters to carers and what words are used.
- Make changes regarding Direct Payments simple and easy for the carer.

Carer 5

I am 81 years of age and care for my son. He has both physical and psychological disabilities as a result of a road traffic accident 30 years ago.

Following the accident my son moved back to his wife`s home town but sadly she died and he came home to Crewe to live with my wife and I. Just one year later my wife passed away following a cancer related illness so I press on doing my best to make my son's life as fulfilling as I can.

What are your caring responsibilities?

Initially, my son had great difficulty coping with even the simplest of everyday tasks due to the severity of his brain damage and the associated physical problems as he is left side hemiplegic and virtually no sense of balance. Fortunately, we had already adapted our home to meet my son's circumstances and he has a bed downstairs in an extension we had built for him and his wife, so that they could spend holidays with us. We also had a wet room built on to our house which means most things he needs are on one level.

Before taking on the responsibility of bringing my son home we contacted the Cheshire East Occupational Therapist who was excellent and rapidly provided us with all the information and equipment we required for his needs i.e. Shower trolley /Turntable /Grab Rails.

During the first year of my Caring I had to support my son with all his personal chores but gradually after lots of experimentation and perseverance he has gradually become more independent. I still have to help and supervise showering but now he is able to dress himself and manages his personal toilet needs with minimal support, providing of course everything is set up

Because of his hemiplegic condition he purchased a special one armed drive wheelchair which enables him to steer himself more easily round the house with his right hand. He has an electric power operated buggy for outside expeditions which is a great help as I would find it difficult to push him any distance in a normal wheelchair.

During his working life my son was a chef in the Royal Navy and I am now exploring options to improve wheelchair access to the kitchen to enable him to be able to get in and make simple meals. At the moment I do all the cooking but he does sit at the kitchen door and 'talks me through' new recipes.

I take care of all the other household chores like shopping, washing and ironing, cleaning the house and gardening. Haven`t found time to carry out decorating yet but I am still hopeful.

We get out as much as we can together and I really enjoy going for walks with him using the Powered Buggy to those areas listed in, The Access to All Booklet issued by East Cheshire.

We attend a short mid-week service at our Local Church and have become members of a Group for people aged 55 plus where we join in with the activities which include dominoes, scrabble, quizzes talks and other social events.

I take my son to a community support group every Monday where he does one to one baking and to another Church led Computer Club on Thursday Mornings again with one to one guidance.

We aim to have a meal out and a drink with our friends at least once a week.

I try to get a day off once a week to pursue my own personal interests. These include hill walking, cycling and visiting National Trust /English Heritage sites but obviously, I can`t be away for more than 6 hours which is pretty restrictive.

I have friends who will come and prepare the odd meal for my son and spend time chatting while I`m on these once a week trips but I`m always conscious that I have to limit my outings to fit in with the time my friends can spare. This can be a nightmare especially when using public transport if there is disruption.

What's important to me?

At the moment Respite - I currently have an allocation of 56 days flexi respite which I have been taking in blocks of 7 days. The one or two day option doesn't really work for us (except in an emergency situation) as there is too much preparation /recovery to give any benefit to a carer.

I have been having treatment for my own medical problem and recently I had to go into the Christie Hospital for surgery. I initially thought I could cope with a two day Respite break but this was over ambitious as I felt too stressed after the operation and I ended up taking a week to recover, which thankfully I was able to arrange at fairly short notice

What would make a difference?

- Knowing if the respite will be available for me when I need it and also where this will be or how I will be able to book it and pay for it.
- Reassurance with regards to crisis support.
- My age profile and possible changes in my own physical ability to continue providing ongoing adequate care at my home give me lots of concern so I am constantly having to use valuable time exploring options for my son`s long term care and I find this very stressful. Specific help with this planning would certainly make a difference and would be much appreciated.

Making it happen: Delivering the plan

A work programme for each of the five priority areas has been identified to deliver the outcomes contained within the strategy.

A two year delivery plan, follows on from the work programme and describes the actions required and will be regularly tracked, updated and reported on to ensure we achieve the aims set within it. Each priority area will have an identified lead from with Cheshire East Council or NHS Eastern or NHS South CCG who will work in partnership to the achieve the outcomes agreed. The delivery plan will be a driver for change, focussing upon those key areas that will make a real impact upon improving the health and wellbeing of carers.

1. Assessment of Carer Needs and Crisis Support

The voice of the carer and the person they care for to be paramount in the assessment of their care package, this is especially where people, don't recognise themselves as carers.

Improvement statement:

Improvements have been made to the uptake and quality of carer's assessments and support plans. The assessments are accessible to carers and reinforce the collaborative approach to assessing the carer's needs and planning for the future. Improved understanding of carer needs and how these will be met through:

- additional carers assessments being completed, reviewed annually.
- carers reporting they are satisfied and provide individual feedback on the quality of the services they receive and outcomes they have achieved following their carers assessments.

- training of all staff to ensure a consistent and enabling approach to assessment which includes the principles of power of attorney/court of protection.
- single point of access for carers via integrated health and social care teams where they share their information once and the 'Cares ACE Card' Crisis Support Plan.
- The introduction of a public facing 'self-assessment' tool to support carers to access support appropriate to their needs at a time when they need it.

2. Information Service

Health and Social Care professionals have a key role in identifying and supporting carers and in providing information and advice at the time when it is needed.

Improvement statement:

Timely, accurate quality information and advice is available. Information which assists 'Hidden Carers' to recognise that they are undertaking a caring role achieved through:

- a range of delivery methods and media providing Information and Advice to carers within Cheshire East.
- an integrated Cheshire East Information and Advice resource for Children and Adults with a caring role.
- ensuring that information from carers assessments, carers surveys, carers engagement events and commissioned service monitoring information is used to continually improve support available to carers.
- information being provided to carers in a timely manner on Continuing Health Care and End of Life Planning for their choice and control along with the person they care for.

3. Respite Services and Carer Breaks

The terms 'short break' and 'respite' tend to be used interchangeably. Some carers and users of services prefer the term 'short break' or 'break from caring, 'signifying a break from the routine'.

Improvement statement:

Increased flexible, personalised short breaks provision, leading to better outcomes for carers and the people they care for through:

- an increase in the number of carers who access a break from their caring role.
- an increase in the opportunities for flexible, personalised short breaks available to carers in Cheshire East.
- respite services that have been quality assured through formal contract monitoring and feedback from carers who have used those services.
- partnership working across health ,social care and third sector organisations.

4. Realising Carer Potential

Carers in Cheshire East should get similar opportunities for education and training as those in non-caring roles. Young carers need to be identified early and supported during their education to enable them to realise their education and employment potential.

Improvement statement:

Improved access to education, employment and health and wellbeing outcomes for children and adults in a caring role in Cheshire East through:

- working with schools to identify carers early and put appropriate support plans in place.
- working with local businesses and chambers of commerce to identify and support carers to inform and consider their polices about workplace health, flexible working.
- signposting carers to access education, training or employment opportunities and advice to support them in identifying their personal development plans for education, training and career aspirations.

5. Engagement and Co-production

Carer involvement and participation in commissioning, design and procurement of services is essential to empower carers, and to ensure that services properly take account of carers' needs.

Improvement statement:

Carers will be further involved in the planning, shaping and delivery of services and support with increasing evidence of personalisation through:

- co-producing the role of carers champions with carers themselves.
- a robust engagement framework to capture and share the views and experiences of a wide range of carers.
- carers involvement on the carer break funding panel.
- promoting the Expert Patient Programme

Joint Carers Strategy 2016 -2018

'Valuing Carers and Supporting their Health and Wellbeing in Cheshire East'

Carer Priorities	Achieved Through	Measures of success How will we know we have done it?
I have access to a **carers assessment** which includes **Crisis Support** Planning	• An increase of carers assessments by 10% in year one and review annually. • high satisfaction on the quality of services carers receive and outcomes matched to assessed needs • training of all staff to ensure a consistent and enabling approach to assessment which includes the principles of power of attorney/court of protection. • a Caring Together and Connecting Care Integration Programmes process for identifying and supporting carers through integrated health and social care teams where they share their information once for proactive care and crisis support. • The introduction of a public facing 'self-assessment' tool to support carers to access support appropriate to their needs at a time when they need it.	• carers feedback through surveys complaints/compliments/customer satisfaction reports. • Number of individual carers taking up commissioned services. • carers strategy sponsors can evidence improvements • The number of carers who have had an assessment of 'their' needs where it has led to positive outcomes. • increased numbers of carers with agreed crisis plan • quality measures from commissioned services. • National performance measures as contained in the National Survey (e.g. Social care-related quality of life) • Quarterly monitoring of the delivery plan • Carers feedback via carers networks, carers' events, newsletters and an annual survey. • Value
I have access to a range of **information** which is up to date and **relevant**	• a range of delivery methods and media providing Information and Advice to carers within Cheshire East. • an integrated Cheshire East Information and Advice resource for Children and Adults with a caring role. • ensuring that information from carers assessments, carers surveys, carers engagement events and commissioned service monitoring information is used to continually improve support available to carers. • information being provided to carers in a timely manner on Continuing Health Care and End of Life Planning for their choice and control along with the person they care for.	
I have access to a variety of **RESPITE** services and Carer **BREAKS**	• an increase in the number of carers who access a break from their caring role. • an increase in the opportunities for flexible, personalised short breaks available to carers in Cheshire East. • respite services that have been quality assured through formal contract monitoring and feedback from carers who have used those services. • partnership working across health ,social care and third sector organisations.	
As a Carer I am able to **realise my potential**	• working with schools to identify carers early and put appropriate support plans in place. • working with local businesses and chambers of commerce to identify and support carers to inform and consider their polices about workplace health, flexible working. • signposting carers to access education, training or employment opportunities and advice to support them in identifying their personal development plans for education, training and career aspirations.	
I am involved in **ongoing** and meaningful **engagement** and co-production	• co-producing the role of carers champions with carers themselves. • a robust engagement framework to capture and share the views and experiences of a wide range of carers. • carers involvement on the carer break funding panel. • Promoting the Expert Patient Programme	

Care Act 2014 National Priorities:

Identification and Recognition ***Realising and Releasing Potential*** ***A Life Alongside of Caring*** ***Supporting Carers to Stay Healthy***

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Monitoring and Evaluation

The progress of this plan will be monitored regularly by a carer reference group with representation from all the key stakeholders who will report through the Health and Social Care Joint Commissioning Leadership Team (JCLT) There will be regular reports to the Cheshire East Health and Well-being Board (HWBB).

The following implementation plan details each of the five priority areas described in this strategy and each year the strategy will be reconsidered, refreshed if necessary, and detailed plans developed for the forthcoming year.

Clear measures have been identified to capture and report on progress against the objectives in the delivery plan and what difference the Strategy is making.

The Strategy and delivery plan will be monitored at service level as well as at a strategic level via the Joint Commissioning Carers Lead, Joint Commissioning Leadership Team (JCLT), Carers Focus Groups and the Cheshire East Health and Well-being Board (HWBB).

We will measure the impact of our progress through:

- The carers who have shared their stories in this strategy and what has changed for them through the development and implementation of the strategy.
- The number of carers who have had an assessment of 'their' needs and the outcomes of those assessments.
- National performance measures as contained in the National Survey and others set up specifically to measure progress against the delivery plan locally and these will be included in our evaluation of progress.
- Quarterly updates provided to the Joint Commissioning Team with issues escalated to the Health and Well Being Board.
- Carers in Cheshire East being given the opportunity to feedback on progress and achievements made at regular intervals, via carers' fora, carers' events, newsletters and an annual survey.
- Through the contract monitoring of carers specific and universal services commissioned to support carers.
- Wider carer's engagement and feedback on the strategy.
- Evaluating '*value for money*' from commissioned services and whether they are achieving positive outcomes for carers who use those services.

Caring for Carers…..A Joint Strategy for Carers of All Ages in Cheshire East 2016-18

Delivery Plan

In the first year following its implementation Cheshire East Council are establishing a baseline against which future targets can be set. An Annual review of targets will need to take account of the anticipated need and annual financial allocations. Plans for an independent audit will be undertaken.

1. Assessment of Carer Needs and Crisis Support

Improved uptake and quality of carer assessments and support plans. The assessments are accessible to carers and reinforce the collaborative approach to assessing carer needs and planning for the future. Understanding of Carer Needs and how these will be met achieved through:

	Actions	What will we measure…	Who is responsible	Start by	Complete by
1.1	Work with Primary care (GP surgeries) to increase number of carers being recognised and added to the Carers register	Increased number of carers on GP registers and carer outcomes captured. **Target: Every practice should have a Carers champion**	CCG commissioners of primary care. Practice Engagement Managers Children's Services Commissioned Services	June 16	March 17
1.2	Identify the support offered to carers by GPs.				
1.3	Develop Carer Champion role in GP Surgeries				
1.4	Carer awareness training to be given to community based professionals.	Increased number of carers identified on GP registers and carer outcomes captured. Increase number of services being accessed by carers.	CCG commissioners of primary care.	Aug 16	March 18
1.5	Development of self-assessment tool	Number of carers accessing the tool	CEC Strategic Commissioning Managers	April 16	March 17
1.6	Work with discharge teams to implement Discharge planning to include carers assessment for support and local offer information pack on discharge.	Evidence of carer support required and plan agreed prior to discharge from hospital or community service. Number of carers with local offer information pack on discharge.	Acute Care Providers Community care providers Principal Manager CEC	April 16	
1.7	Continuously collate identified carer needs through assessments and surveys to inform future commissioning needs of carer's services.	Carer feedback.	JCPM (Joint Commissioned Project Manager) Strategic Commissioning Managers Children's Services Commissioned Services	April 16	

			Nigel Moorhouse / Head of Service – Preventative Services CEC		
1.8	Training to be made available for all staff providing assessments	Number of assessors receiving training Carer satisfaction feedback. Ace card feedback	Principal Manager CEC/ Sheila Wood CEC Children's Services Commissioned Services Nigel Moorhouse /Head of Service – Preventative Services CEC	April 16	
1.9	Feedback card to be created and given to carer following assessment.	Number of cards completed following assessment.	JCPM, Service Manager CEC, Nigel Moorhouse/ Head of Service – Preventative Services CEC	April 16	
1.10	Help prevent potential safeguarding incidents by Including risk assessments within: • Carer assessments • Health checks	Spot check case audits to check risks identified are dealt with appropriately Carer feedback on whether risks identified/understood and managed effectively and report they feel safe following intervention.	Health and Social care safeguarding leads	April 16	
1.11	Evaluate through the pilot STAIRRS Project carers presenting needs in crisis.	Number of carers supported through the STAIRRS project.	Service Manager, Adult Social Care CEC	April 16	March 2017
1.12	Ensure carer assessment identifies advocacy needs and the resource pack includes information on advocacy services.	To be developed with advocacy services and social care assessment. Number of carers who have been offered and accessed advocacy service (Demand vs Capacity).	Principal Manager CEC Nigel Moorhouse/Head of Service – Preventative Services CEC	April 16	
1.13	Ensure carers are aware of the Ace Card.	Work with peaks and plains to understand what information is captured on registration and following crisis.	JCPM CEC Commissioning Lead CCG Commissioners of Primary care	April 16	
1.14	Ensure assessment includes information on ACE Card.	Number of new carers who are registered for an ACE card.	Principal Manager CEC	April 16	

2.0	**Information Service** Timely accurate and good quality information and advice is available for someone new to caring and information which assists "Hidden Carers" to recognise that they are undertaking a caring role achieved through:				
	Actions	What will we measure…	Who is responsible	Start by	Complete by
2.1	Create a range of information for both Adult and Young Carers using different media: Resource pack developed age/context specific Evidence of multimedia information services Signposting to information on benefit entitlement	Monitoring website hits. Carer feedback via survey and engagement events	Corporate Commissioning Manager CEC Nigel Moorhouse /Head of Service – Preventative Services CEC	April 16	March 17
2.2	Carers are provided with support plans and information on long term/end of life care support if appropriate.	Support plans in place (if required) to manage long term care. Number of people who make an advanced decision.	Principal Manager CEC End of Life Partnership (South Cheshire CCG).	April 16	
2.3	Increase the numbers of carers who have been signposted to benefits advice.	Total number of carers signposted Numbers of carers maximising their income. Carer feedback.	Business manager CEC Service manager Client finance CEC	April 16	March 18
3.0	**Respite and Carer Breaks** Flexible, personalised short breaks provision, leading to better outcomes for carers and the people they care for through:				
	Actions	What will we measure…	Who is responsible	Start by	Complete by
3.1	Increase the number of carers who access a break/respite from their caring role.	Number of Adult/Young and Parent carers who need a break/respite(Inc. Relaxation vouchers) identified via: • Adult social care and children's services • 3rd sector organisations: numbers for carer breaks to help measure demand (initial number vs number taking up the service) • Number of carers accessing the carer breaks/carer relaxation vouchers/service - Adult/Young carers and 3rd sector providers • Carer feedback on quality of break/service • Personal Health Budgets	Principal Manager CEC Children's Services Commissioned Service – Young Carers	April 16	March 17
3.2	Capture information on capacity and demand.		JCPM CEC Performance team	April 17	March 18
3.3	A wide ranging menu of choices published in the local offer.		(JCPM)	April 16	May 16
3.4	Establish processes (for example feedback/reviews) to evaluate the quality of respite services currently commissioned and recommission /decommission services.		Commissioning Manager Contracts & Quality Assurance CEC	April 16	March 17

	(To occur annually – April 16 and April 17)	**Target: an increase of 10% in the number of carer's assessments completed.**			
4.0	**Realising Carer Potential** Improved access to education, employment and Health and Wellbeing outcomes for Children and Adults in caring role in Cheshire East through:				
	Actions	What will we measure…	Who is responsible	Start by	Complete by
4.1	Ensure our own organisations are carer friendly.	Carry out survey with staff (CEC and CCGs) to find hidden carers/their perceived needs / whether their needs are being met/whether they have accessed carer services or a carers assessment and quality of life.	Cheshire East Council Commissioning Manager JCPM Commissioning Support Unit Survey team.	April 17 (roll out)	March 18
4.2	Work with the Cheshire East Council Business Development Team to ensure new businesses in Cheshire East are 'Carer Friendly' (pilot).	Pilot scheme measures to be developed through scheme	JCPM CEC Carers Commissioning Lead	Sep/Oct 16	Dec 16
4.3	Research the demand and opportunities for carers to share skills and undertake voluntary work.	Increased numbers of carers who have been supported to retrain, gain confidence and retain or enter employment. Capturing the demand for volunteer work and the opportunities available to meet this demand.	JCPM CEC Carers Commissioning lead Nigel Moorhouse /Head of Service – Preventative Services CEC CEC	April 16	March 18
4.4	Ensure carers have the opportunity to access education, training and employment in Cheshire East. To link the Carers strategy with the proposed Cheshire East Council Skills and Growth company and the services they will deliver supporting access to education, training and employment in Cheshire East.	Improved educational outcomes and those entering post school full time education seen in improved NEET Statistics (not in education, employment or training).	JCPM CEC Carers Commissioning Lead Nigel Moorhouse / Head of Service – Preventative Services CEC		
4.5	Develop carer outcomes (capturing what outcomes carers want to achieve).	Outcome measure to be developed/ongoing.	Principal Manager Nigel Moorhouse / Head of Service – Preventative Services CEC		
4.6	Promote training to carers on how to be a carer.	Quarterly monitoring reports	Principal Manager	May 16	March 18
4.7	Ensure carers are supported by Community	Sample a group of carers who are supported through the	Occupational Therapy Team	Sep 16	March 18

	Occupational therapy staff and at discharge from hospital with the use of equipment, interventions such as, tube feeding.	district nursing service/Speech and Language Therapist.	manager Speech and Language Therapists/ District Nurses.		
5.0	**Engagement and Co-Production** Carers will be further involved in the planning, shaping and delivery of services and support with increasing evidence of personalisation through:				
	Actions	Success Measures	Who is responsible	Start by	Complete by
5.1	Work with carers to help develop the role and purpose of carer champions across health and social care.	Measure to be developed once the role is agreed.	Principal Manager CEC Head of Service – Preventative Services CEC	May 16	June 16
5.2	Provide education and training on co-production.	Number of staff attending training. Number of carers attending training. Carer feedback (feedback card to include question on whether included in decision making about support and care plans for carer and cared for).	Workforce Development Manager CEC	Dec 16	
5.3	Hold engagement events with carers.	Numbers of carers attending the events. Number of events held. Carer's feedback. Using the events sessions to find out whether carers feel they are valued and involved in service development and delivery.	Workforce Development Manager CEC JCPM Communications and Engagement Teams CCG Nigel Moorhouse /Head of Service – Preventative Services CEC	April 16	March 18
5.4	Ask a young and adult carer to join a panel of people (adult and young person in an advisory role) that allocate funds to third sector organisations who provide carer break services.	All carers feedback	JCPM Viki Kehoe	June 16	Sep 16
5.5	Develop: • local carers surveys • feedback cards (pilot scheme) • Develop a communication plan to engage with schools, colleges and key partners which promotes a better appreciation for the support that young carers may need	Data measure and evaluation of the results of the survey/feedback cards. The number of schools and colleges who have been contacted and have made reasonable adjustments for young carers.	JCPM	April 16 April 17	March 18 June 17

	to be able to get to school on time.				
5.6	Promote the Expert Patient Programme amongst carers.	Increased numbers of carers aware of programme • Engagement events • Survey • Review number of carers involved **Target: Deliver a minimum of 7 engagement events annually**	JCPM Existing groups and channels – Patient Participation Group and Expert Patients via CCG Communications and Engagement Team	April 16 May 16	April 16 March 18

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th March 2016
Report of: Fleur Blakeman, Strategy and Transformation Director
Subject/Title: Caring Together Update

1 Report Summary

1.1 NHS Eastern Cheshire CCG is the lead partner of the Caring Together programme, the local health and care transformation programme in Eastern Cheshire. Since the last report to the Health and Wellbeing Board in November 2015, the Caring Together Programme Board has led the development of a new and refreshed strategic Local Delivery Plan (LDP) for the local care system. The new LDP builds on existing work, providing greater clarity on the scale of change required and has been aligned to the guidance to establish a Sustainability and Transformation plan across Cheshire & Merseyside. A summary version of the LDP is currently in production including a public summary leaflet to raise awareness of the changes to services being planned.

1.2 Aligned to the new Local Delivery Plan, governance arrangements for the Caring Together programme and associated implementation plans have been strengthen. With the appointment of a new independent chair, Dr Neil Goodwin.

1.3 An update on the work already underway is as follows:

- **Caring Together Contract in General Practice** - All 22 GP practices in Eastern Cheshire have signed the new Caring Together contract for general practice which will be rolled out progressively through 2016.
- The new contract will ensure that all 204,000 people registered with an Eastern Cheshire practice will enjoy the same access to services of the same standard with their local community regardless of which practice they register with.
- Local people will directly benefit from; easier access to services, better coordination of care, local access to pre-operative assessments, more local diagnostics and a range of other services available from their local practice.
- Work is now underway to support practices to work in a more federated way and to explore further options for transforming services in general practice which will include addressing any issues raised through the patient and staff satisfaction surveys and the recent access survey completed by Healthwatch Cheshire East.

- **Community Based Coordinated Care -** Work has been ongoing to develop a business case to support the introduction of Community Based Co-ordinated Care (CBCC) in Eastern Cheshire, one of the key objectives of the Caring Together programme. The intention is to integrate existing services and base additional staffing in the community to support the delivery of care closer to home and to enable more people to be cared for in the community, avoiding unnecessary admissions to hospital. The evidence shows that whilst the outcomes and costs of care are similar to those achieved when people are cared for in a hospital setting, patient and staff experience and satisfaction are much improved and the quality of care is reportedly much better. There is as yet no confirmed implementation date.

- **Integrated Diabetes Care** - The closing date for expressions of interest to provide integrated diabetes care in Eastern Cheshire is 8 March 2016. We are hopeful that we receive expressions of interest that meet the service specification in full. The new service is scheduled to be implemented from the end of the July 2016.

- **Cheshire Care Record** - The Cheshire Care Record is scheduled to go live on 1 April 2016 containing hospital based, GP and mental health data with community and social care data to follow. Training is already underway in GP practices to enable staff to access the new record. Patient information leaflets are being distributed to GP practices to raise awareness of the new care record and to outline the process for obtaining individual consent for their records to be shared. A benefits realisation manager has now been appointed to ensure we accurately capture the benefits of implementing the new care record to East Cheshire NHS Trust and Mid Cheshire NHS Foundation Trust.

1.4 Whilst still subject to agreement it is anticipated that the next wave of priorities for the Caring Together programme will include:

- Implementation of Integrated Community Teams
- Completion of the current financial sustainability review.
- Implementation of the National review of maternity services.
- Transforming Paediatric Services

1.5 NHS Eastern Cheshire CCG is an Associate Member of the Healthier Together programme in Greater Manchester and is actively involved in agreeing and implementing new pathways of care for people living within or accessing health services within Greater Manchester – which a large proportion of Eastern Cheshire residents do.

1.6 The CCG together with East Cheshire Trust are working closely with Stockport Foundation Trust to review and implement proposed changes to Stroke services and Acute General Surgery.

2 Recommendations

2.1 Health and Wellbeing Board members are asked to note the content of this report.

3 Reasons for Recommendations

3.1 To inform the Health and Wellbeing Board of progress regarding the transformation of care services in Eastern Cheshire.

For further information relating to this report please contact the report writer:

Name: Fleur Blakeman
Designation: Strategy and Transformation Director, Eastern Cheshire CCG
Tel No: 01625 663476
Email: f.blakeman@nhs.net

This page is intentionally left blank

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15 March 2016

Report of: Michelle Creed, Deputy Director of Nursing,
Jackie Rooney, Patient Safety & Experience Manager
Chief Nurses and Directors of Quality Cheshire & Merseyside CCG's.

Subject/Title: Transforming Care Update

1 Report Summary

1.1 The purpose of this report is to update partners with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

2 Recommendations

2.1 The Board are asked to;

- Note the attached paper
- Note their support for the work being undertaken by the Cheshire and Merseyside Transforming Care Partnership and the sub-regional workstreams.
- Note arrangements for work to develop local services through the Cheshire and Wirral Delivery Hub.
- Note the draft Cheshire and Merseyside Transforming Care plans
- Receive a further update on progress later in September 2016

3 Reasons for Recommendations

3.1 As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

3.2 Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

3.3 There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes

of why so many people remain in, and are continuing to be placed in, hospital settings.

3.4 The Cheshire & Merseyside Learning Disability Network has undertaken much work from the Winterbourne View Recommendations over the past 3 years. Discussions through this network resulted in a consensus to progress developments via one Transforming Care Partnership across the Cheshire & Merseyside footprint to ensure commissioning at scale. There are three delivery hubs within the partnership area as outlined below.

Cheshire and Merseyside Unit of Planning			
Hub	CCGs	Local Authority	Total Population
Hub 1 Cheshire	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383 population

3.5 The approach described builds on:

- 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

3.6 Governance arrangements for the Cheshire and Wirral Delivery Hub and the Cheshire and Merseyside Transforming Care Partnership are detailed in the attached paper.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The three key outcomes identified in the Health and Wellbeing Strategy should all be applied to people with learning disabilities and/or autism.

4.2 At the time of writing, the delivery plan for the Transforming Care Partnership Area is still in draft form and will not be fully scoped until later in the year. However, we have already identified a number of workstreams that will deliver change over the course of the three year plan. The different footprints for the workstreams reflect opportunities for working in a consistent way across a large area balanced against the need to develop services that reflect local need and existing services etc.

4.3 At Cheshire and Merseyside level, there will be a focus on;

- Workforce
- Estates
- Communications and Engagement
- Finance
- Health Provider Hub

4.4 At Cheshire and Wirral Delivery Hub Level, we will work on;

- Access to mainstream services
- Positive Behavioural Support Framework
- Review of Community Learning Disability Teams including intensive support, forensic and criminal justice services
- Short breaks and respite
- Inpatient/outreach and extra care facilities
- Children and Transition
- Autism Strategy
- Personal Budgets

4.5 The potential impact of this work on other local services, including health, social care, housing and other statutory provision will be assessed as the delivery plan is further developed.

5 Background and Options

5.1 The focus of Building the Right Support and the new service model is on people with learning disabilities and/or autism who display behaviour that challenges including those with a mental health condition.
However, some of the priorities within the new service model e.g. access to mainstream services, apply to anyone with a learning disability.

5.2 There is a significant focus within the new model upon reducing admissions to inpatient services with an associated reduction in the number of beds that will need to be commissioned. The guidance states that we should commission no

more than 10-15 inpatient beds per million population. Cheshire and Wirral currently commission 16 beds for a population of 1,078,866 with a further six beds provided locally for spot purchase by CCGs outside of Cheshire.

5.3 In order to achieve a reduction in admissions to hospital, we need to ensure that there is robust support in the community to prevent people reaching the stage where admission is needed. This support could encompass; training for independent sector and third sector providers, outreach support and access to step up/step down services to enable situations to de-escalate.

5.4 Another area of significant focus within the new service model is the repatriation of people who are currently placed out of area. Work is planned to assess the collective needs of people who are living out of area in order that equivalent services local services can be developed.

6 Access to Information

6.1 The draft Cheshire and Merseyside Transforming Care Plan is attached in full.

The background papers relating to this report can be inspected by contacting the report writer:

Name: Catherine Mills
Designation: Clinical Project Officer, NHS South Cheshire CCG
Tel No: 01270 275295
Email: catherinemills2@nhs.net

Cheshire & Merseyside Transforming Care Plans 2016 - 2019

Cheshire & Merseyside Transforming Care Plans 2016 - 2019

Version number: 8

First published: **February 2016**

Senior Responsible Officers:
Alison Lee, **Chair, Senior Responsible Officer** Cheshire & Merseyside, Transforming Care Programme Board, Accountable Officer, West Cheshire Clinical Commissioning Group

Jonathon Hurley, **Co-Chair**, Cheshire & Merseyside Transforming Care Programme Board, Expert by Experience, Cheshire and Merseyside Self Advocates Group.

Sue Wallace Bonner, **Deputy Chair** Cheshire & Merseyside Transforming Care Programme Board, Director of Social Care, Halton Borough Council

Prepared by:
Jackie Rooney, **Programme Lead**, Quality & Safety Manager, NHS England North (Cheshire & Merseyside)
Michelle Creed, Deputy Director of Nursing & Quality, NHS England North (Cheshire & Merseyside)
Jane Lunt Chief Nurse Liverpool CCG on behalf of North **Mersey Commissioning Hub**
John Edwards Mental Health Commissioning Service Manager Integrated Commissioning Team St Helens Chamber of Commerce on behalf of **Mid Mersey Commissioning Hub**
Catherine Mills Clinical Projects Manager NHS South Cheshire and Vale Royal Clinical Commissioning Groups on behalf of **Cheshire/Wirral Commissioning Hub**

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

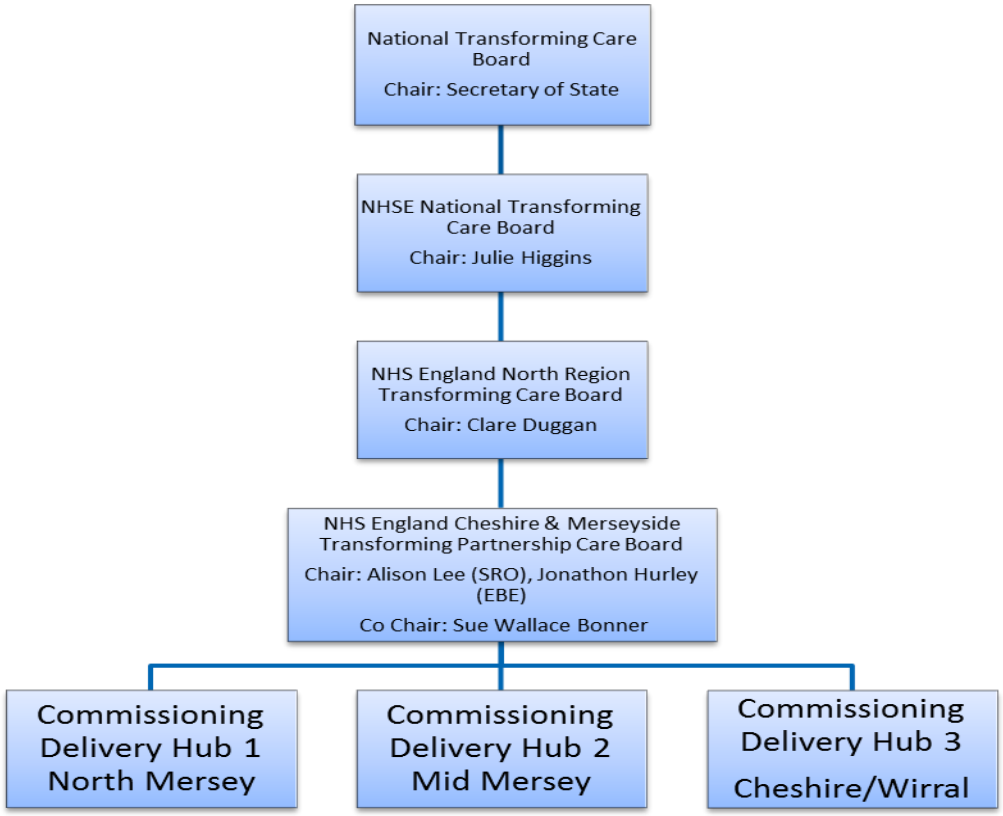


Table 2:

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

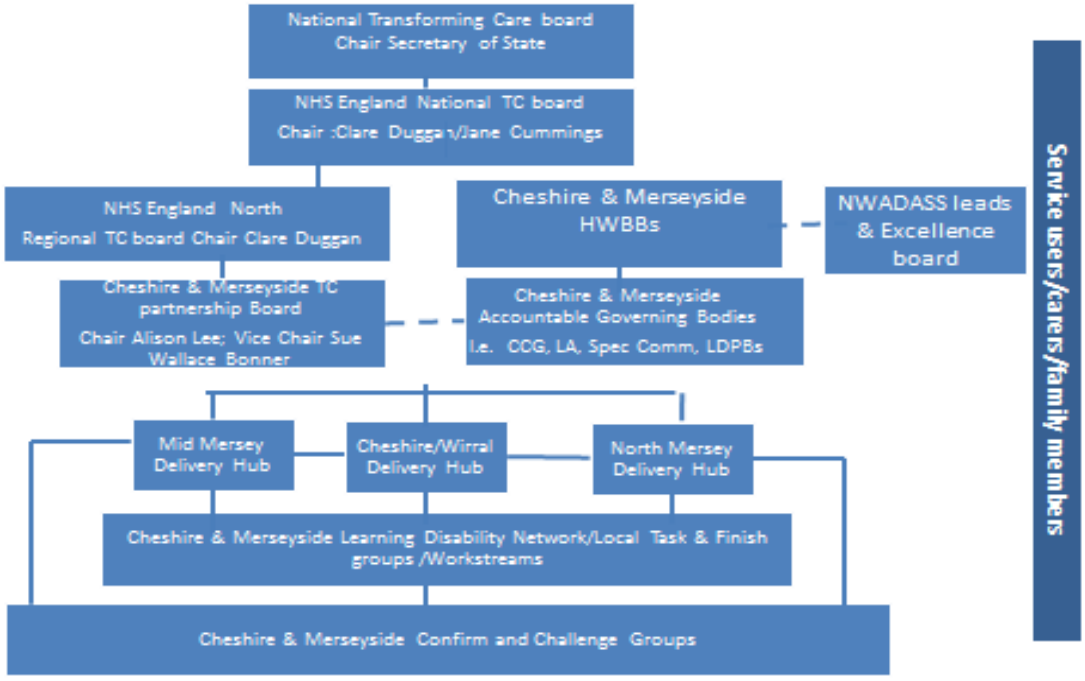


Table 3

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

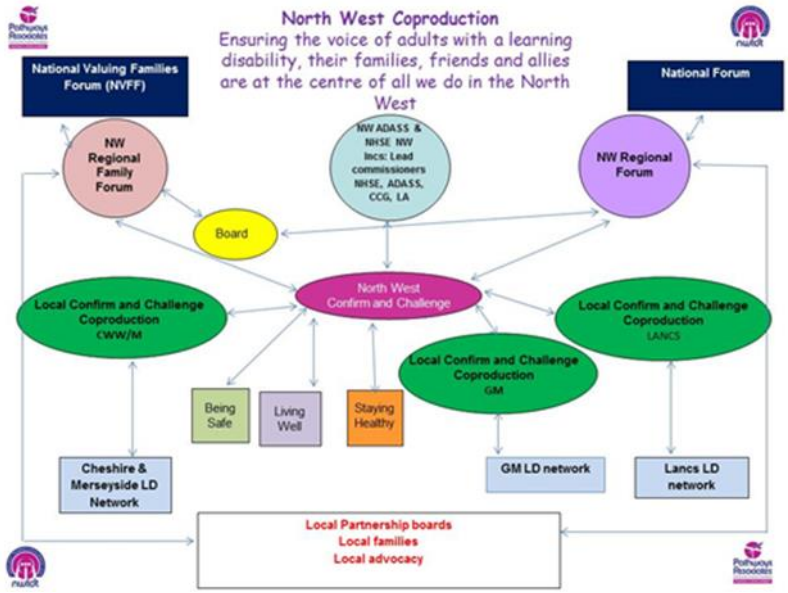
Co-production is strong, and we have coproduction structure groups in place (Table below). NWTDT/ Pathways have worked closely over the last 18 months to support the development and engagement in the Coproduction, Reducing Health Inequalities and Safe and Responsive Services Work streams lead by the 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)

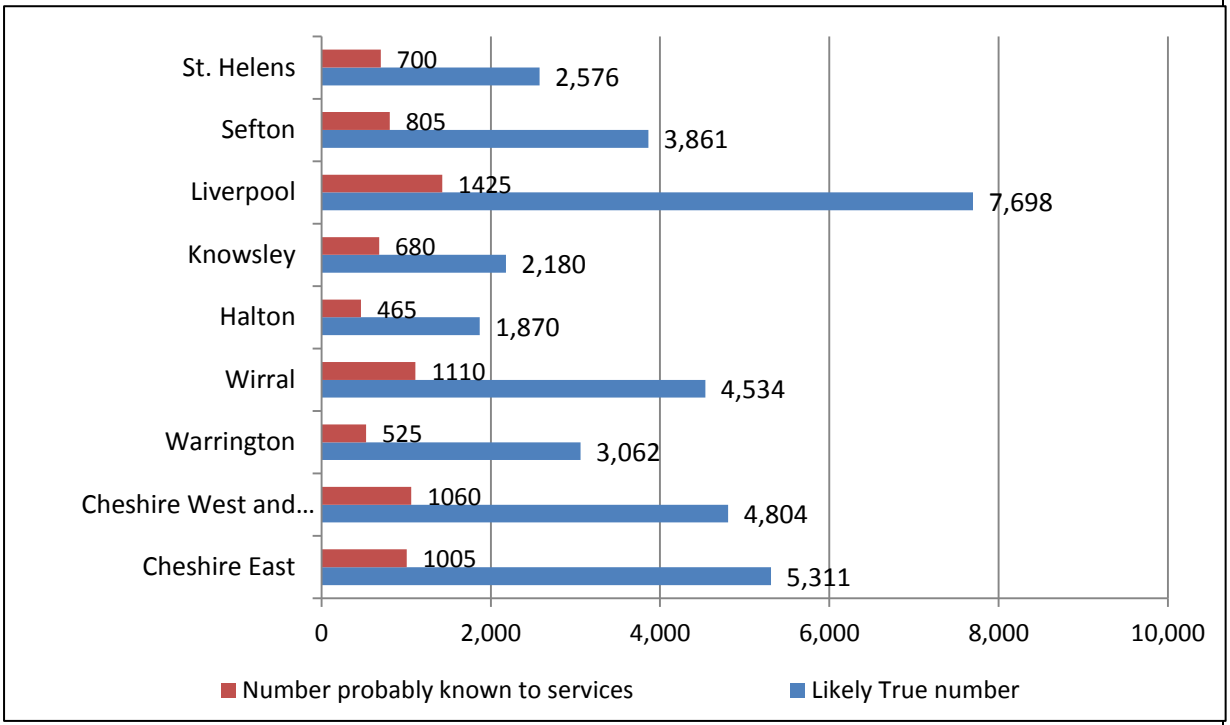


Table 5 Source: PANSI, 2015

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%).

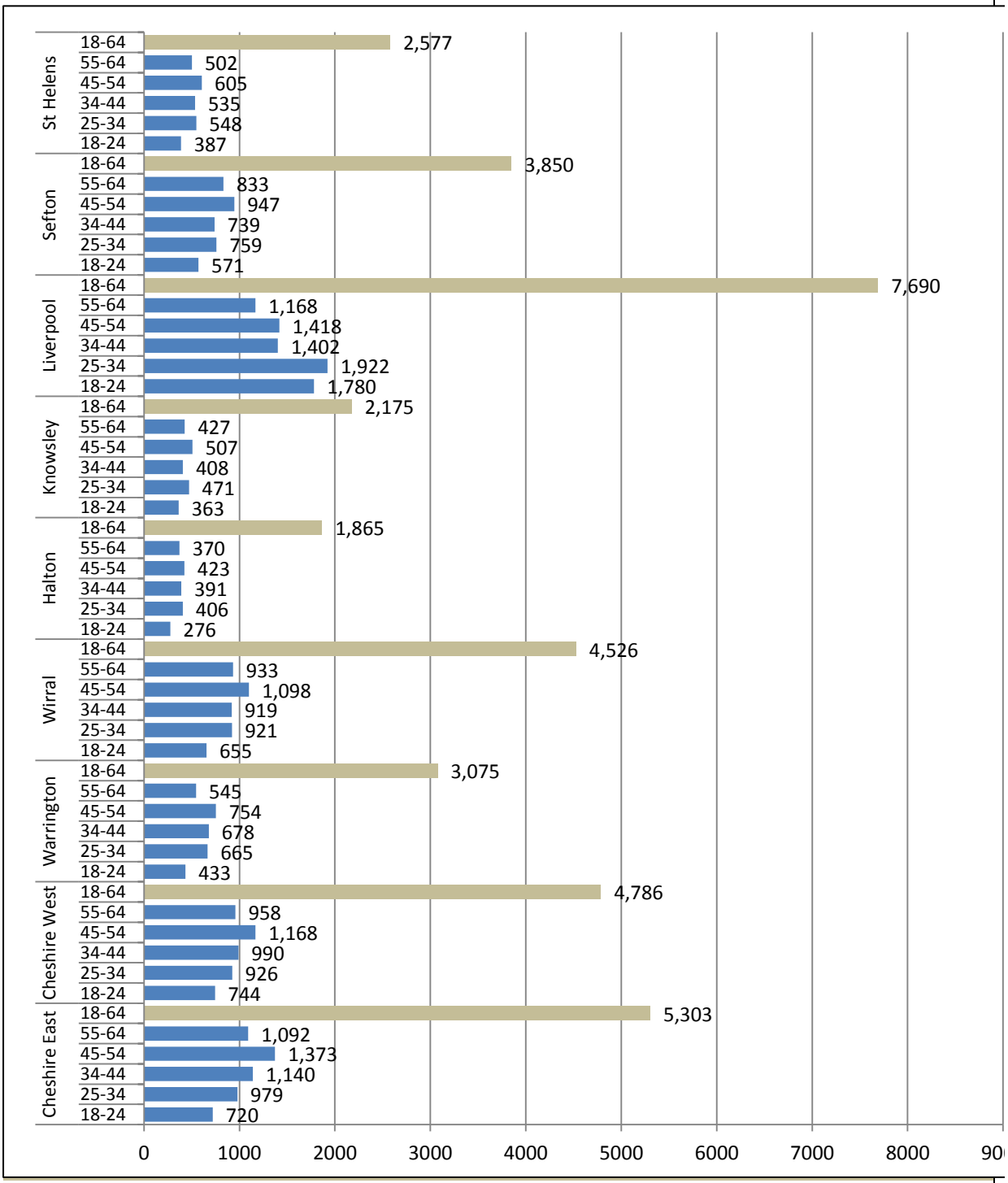


Table 6: Source: PANSI-8

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.

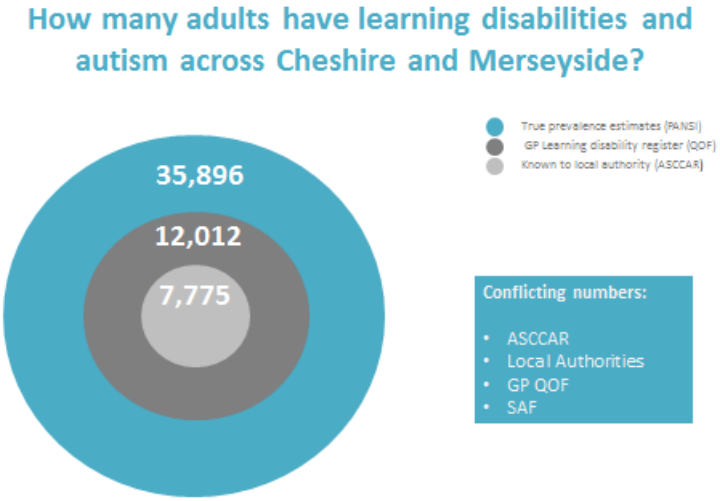
Due to the availability of data, the health and social profile sections of this report have focussed more on learning disability than autism. This will be addressed further via the commissioning hub plans.

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.

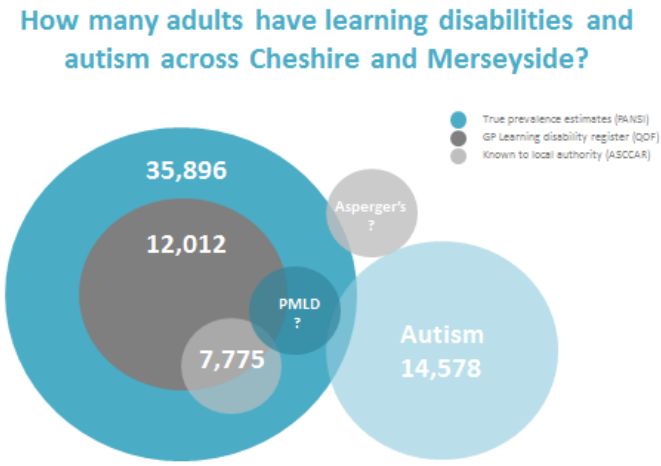
There is no consistently collected data on the number of children with learning disabilities. However we do know how many children locally have been identified as having a learning difficulty. It has been estimated that just over three and a half children in every 1,000 has a severe learning difficulty. 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.

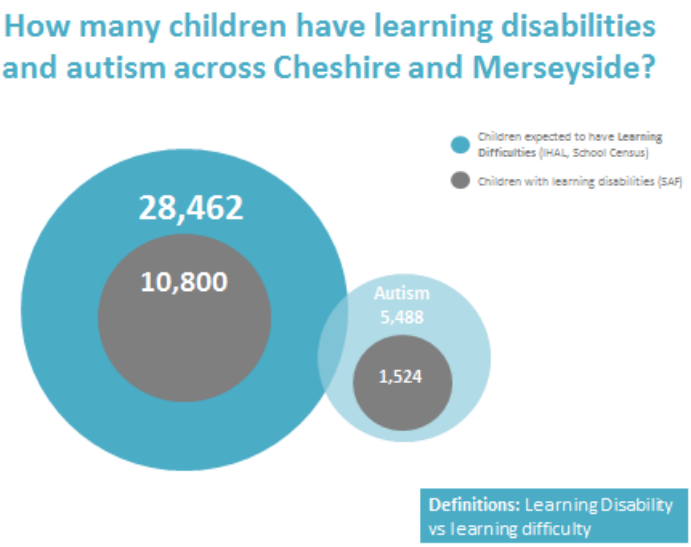
More positively the number of adults with learning disabilities known to GPs is broadly similar to the numbers local authorities have on their registers. However, there is a lot of variation in GP figures across practices and self-assessment framework (SAF) data does not always give an indication of 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.

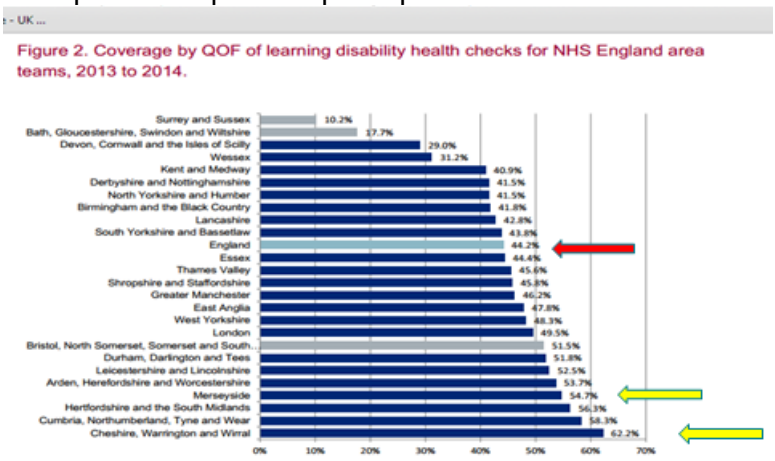


Figure 2. Coverage by QOF of learning disability health checks for NHS England area teams, 2013 to 2014.

Areas shaded grey probably reported incomplete data – see page 15

Figure 3 shows the proportion of general practices participating in the scheme in each area. In the middle half of area teams areas, participation ranged from 58% to 76% of practices, practice participation strongly predicted coverage of numbers of learning disability health checks as a proportion of the number of people on GP learning disability registers in each area team area. The 2 areas appearing to perform least well on coverage also appeared to have

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.

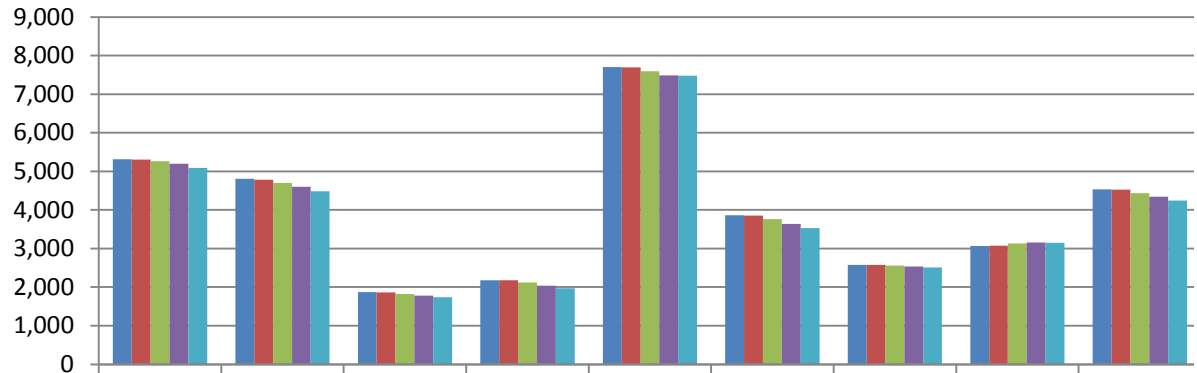
The number of mean learning disability inpatient days per patient per year at Mersey Care and CWP were 12.5 and 18 days respectively, with Mersey Care seeing a rise in the number of mean patient days and CWP seeing a decline. There were approximately 30,000 contacts per provider in 2014/15 of which two 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.

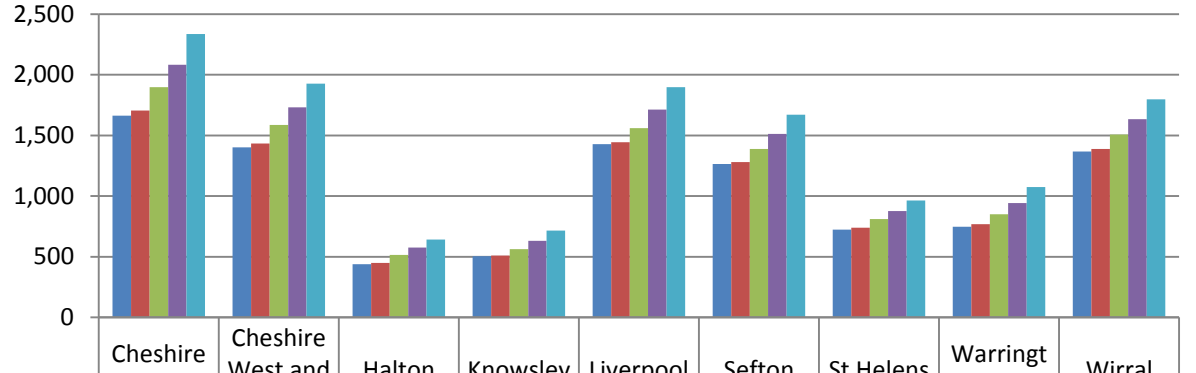
Table 7: Projections to 2030 of numbers of people aged 18-64 predicted to have a learning disability



	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.

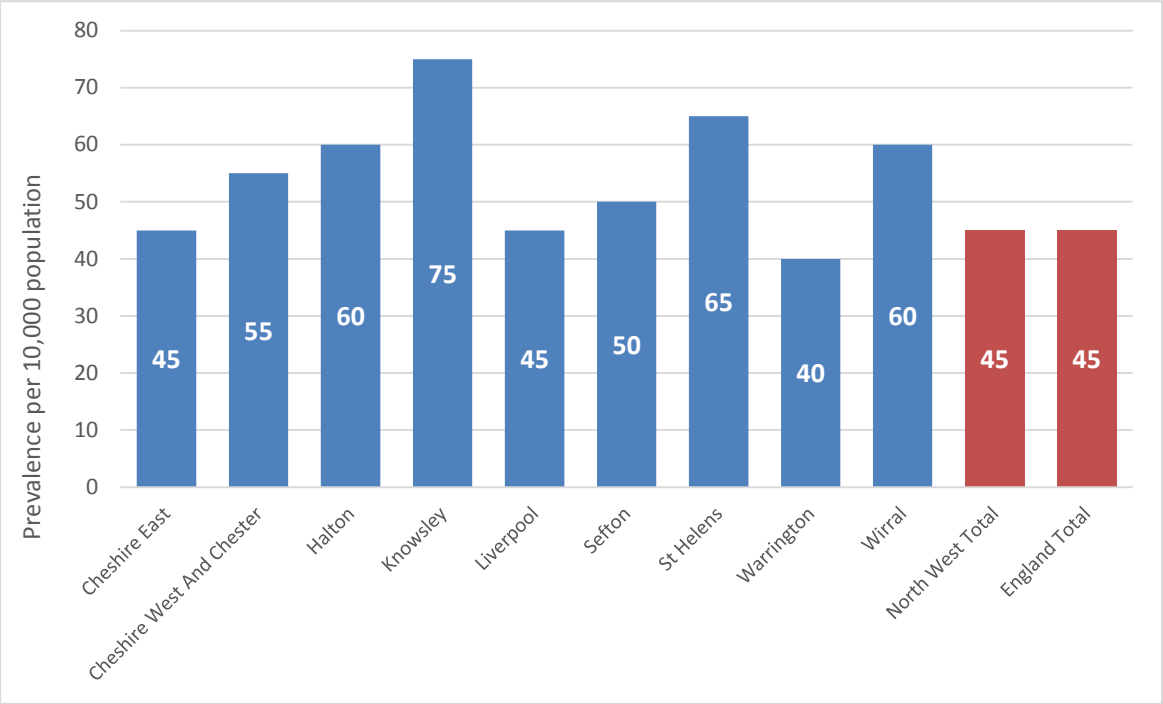
3.8 Adult Prevalence

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.

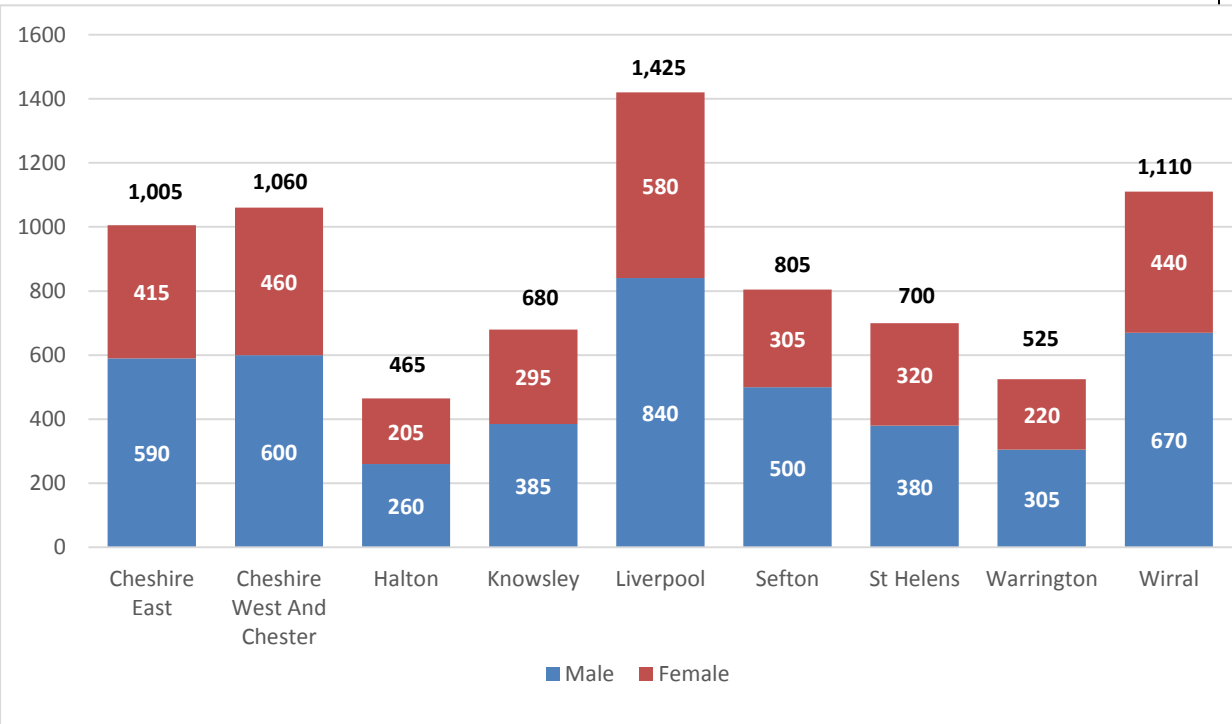
Table 17 : Prevalence of learning disabilities: People known to the local authorities as

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)

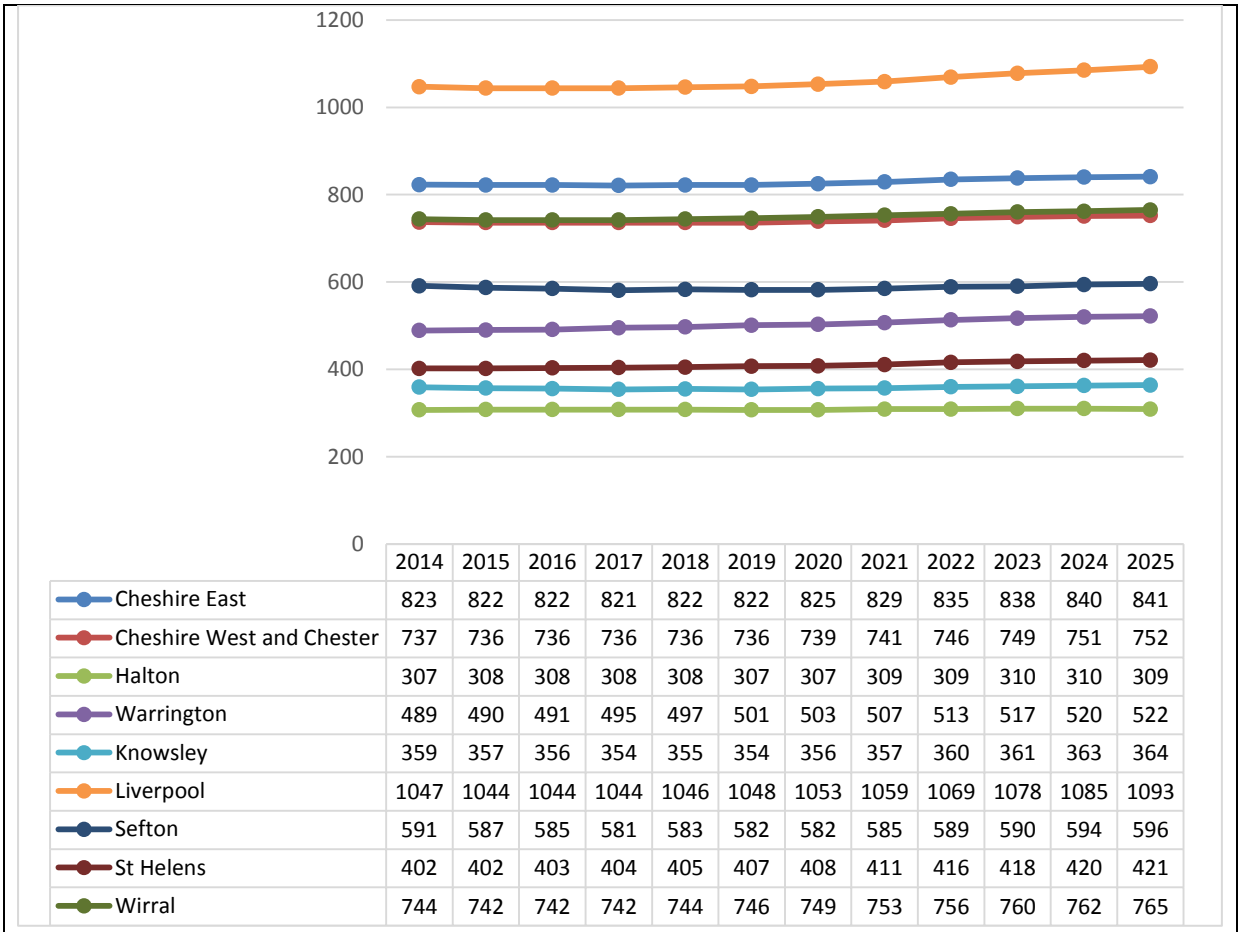
3.9.1 Learning disability and autism

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:

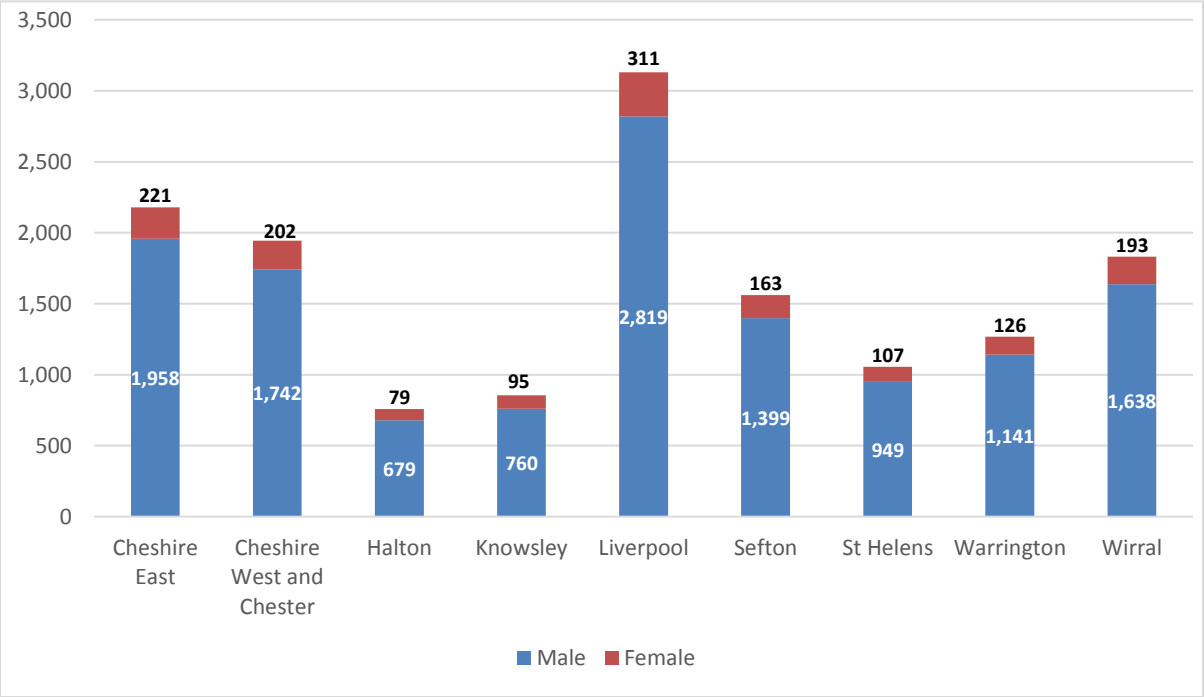
An assessment of the issues arising from completion of the local authority autism self-assessment framework in 2011 was undertaken (Roberts et al, 2012a). Issues included the identification of a major gap in local information about people with autism, such as the number of people with autism, and what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

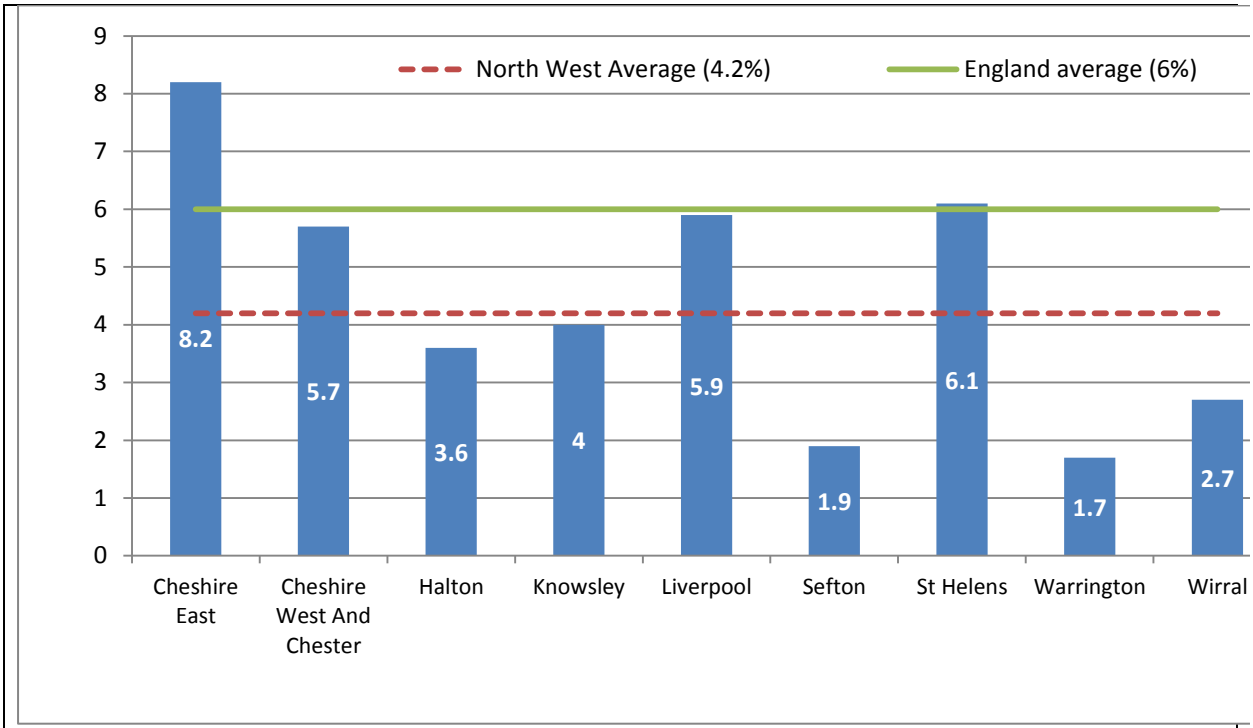
The Criminal Justice liaison system is in place between the Courts and Merseycare NHS Trust to enable vulnerable adults including those with ASC (autism spectrum condition) to receive appropriate NHS interventions. Joint planning with health partners is in place. The MARAC process is well established 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

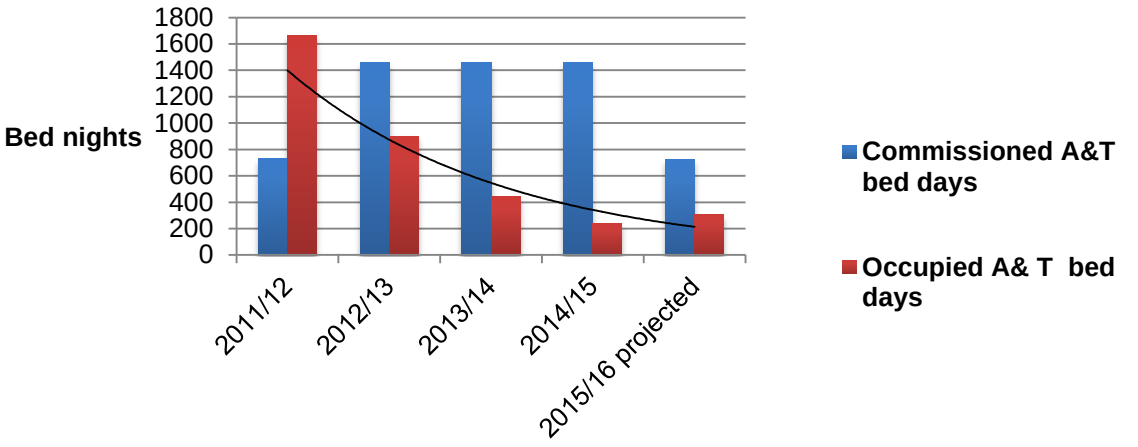
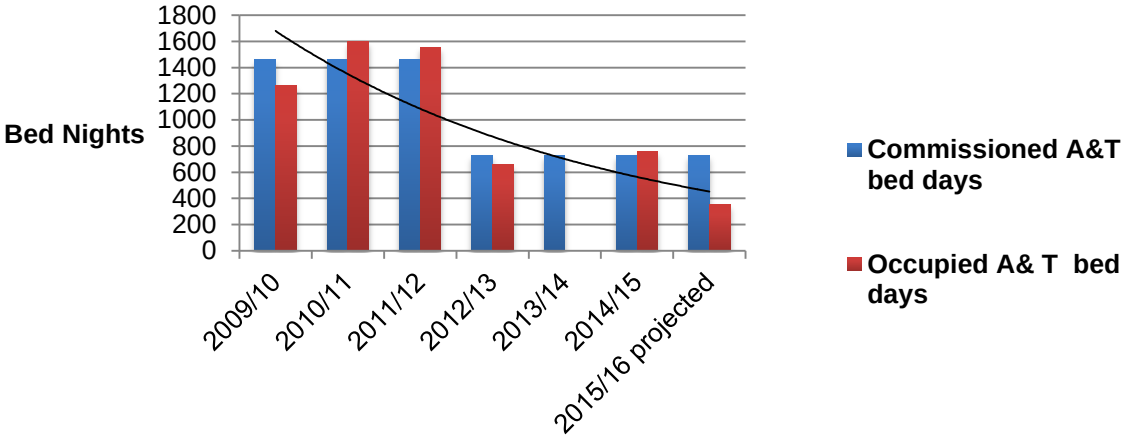
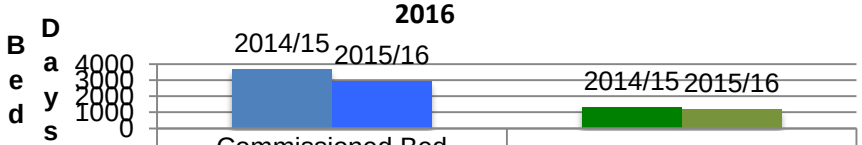


Table 35: Knowsley A&T bed days 2009-2015

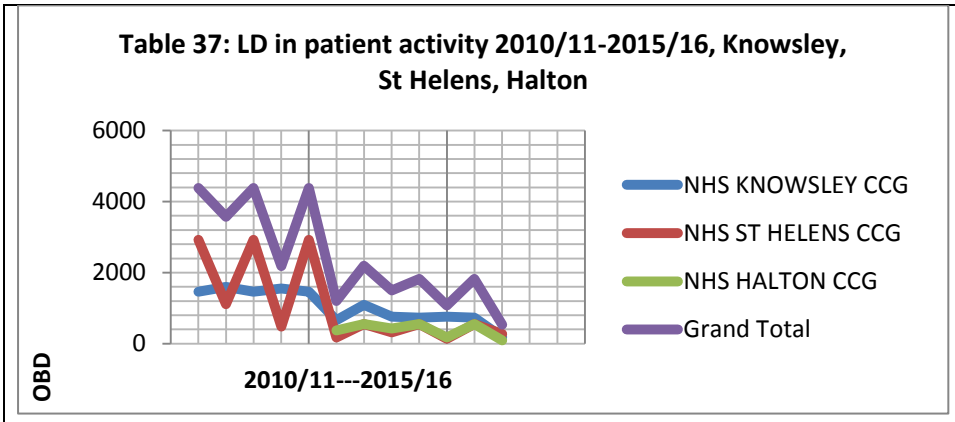


Tables 36 & 37 demonstrates that from the activity trends presented, Learning Disability occupied beds days within A&T units for the whole Mid Mersey area (Halton, St Helens, Knowsley, Warrington) is projected to fall by 128 bed nights, or 13% in 2015/16 compared to 2014/15.

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

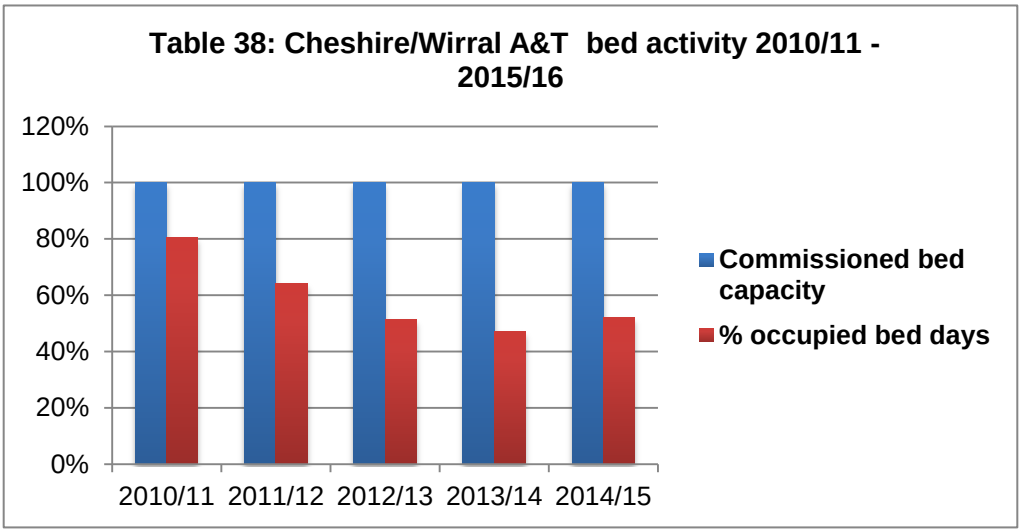


Table 39: CWP Ward specific occupancy rates

	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**

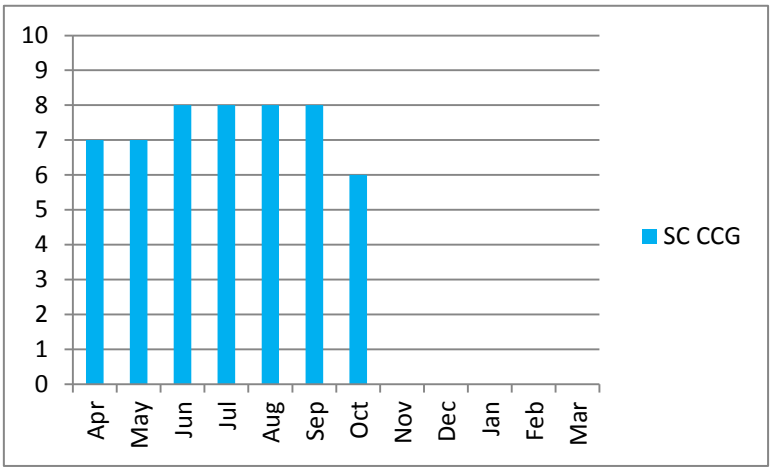
(Data Source Cheshire Wirral Partnership FT)

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):

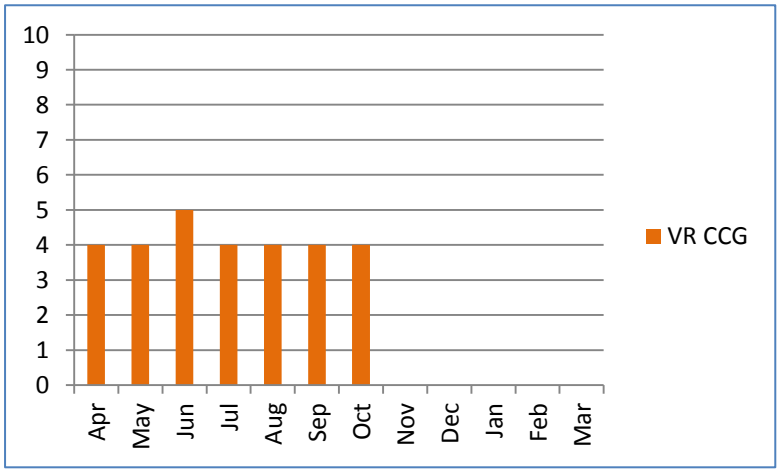


Table 41

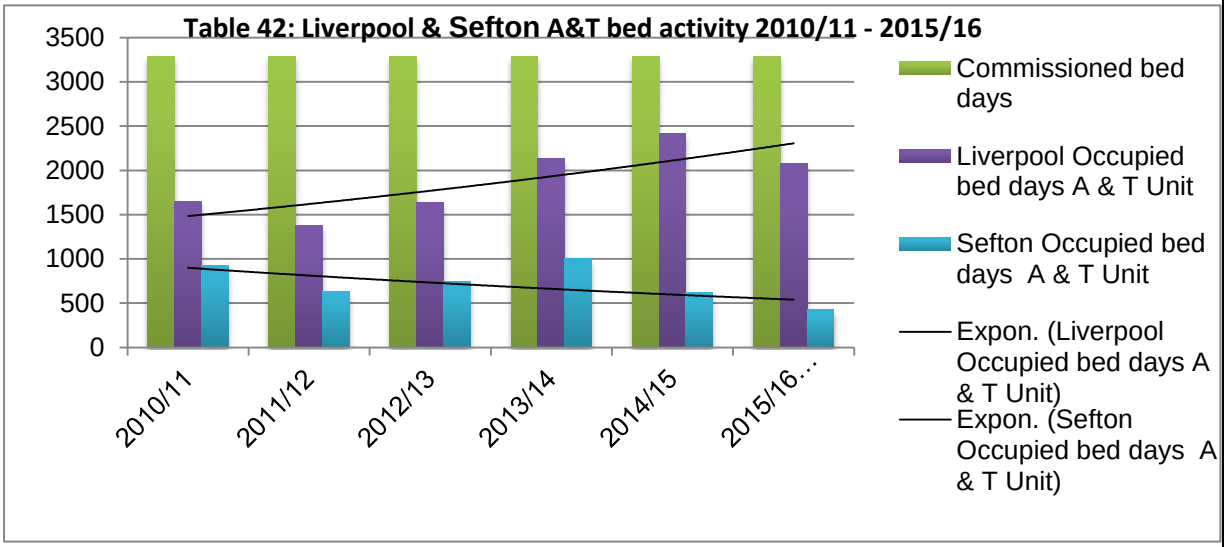
Admission and discharge data for all five Clinical Commissioning Groups is being collated for inclusion in the next draft of this plan.

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.

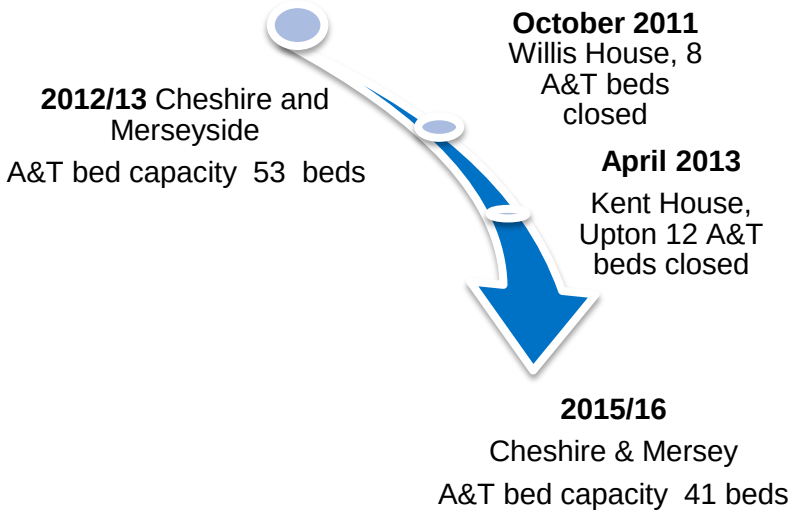
Furthermore, a significant number of people were regarded as unsuitably placed in the service at admission, some point during the admission or due to their discharge being delayed.

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)

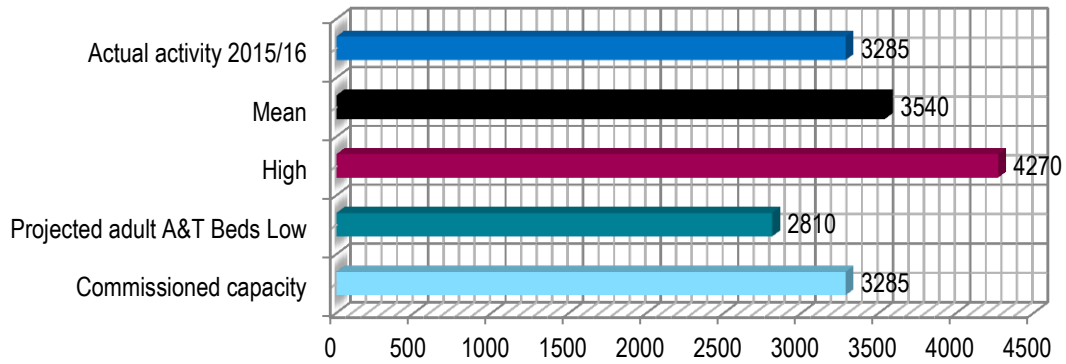
Table 13 below provides a projection of national planning assumptions onto CCG populations and onto Transforming Care commissioning delivery hub populations.

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.

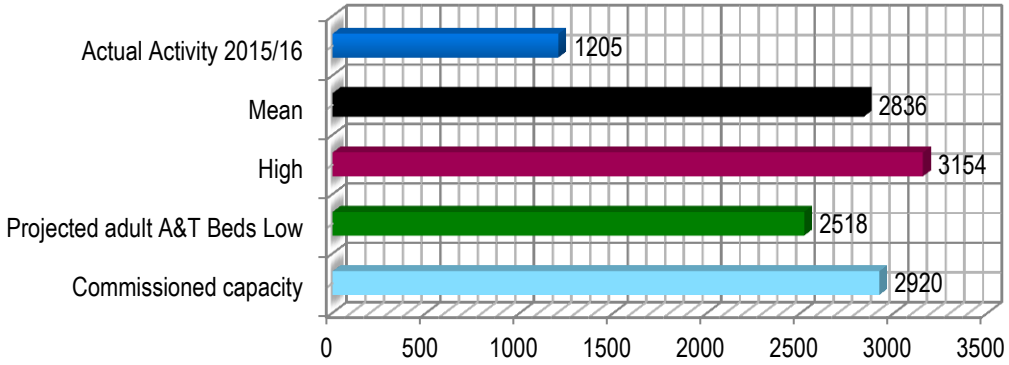
Sefton CCGs are utilizing approximately 450 beds nights per year, in keeping with the lower national projection, and Liverpool CCG utilizing approximately 2350 bed nights per year, which is below the highest national projection but above the national projected mean average.

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

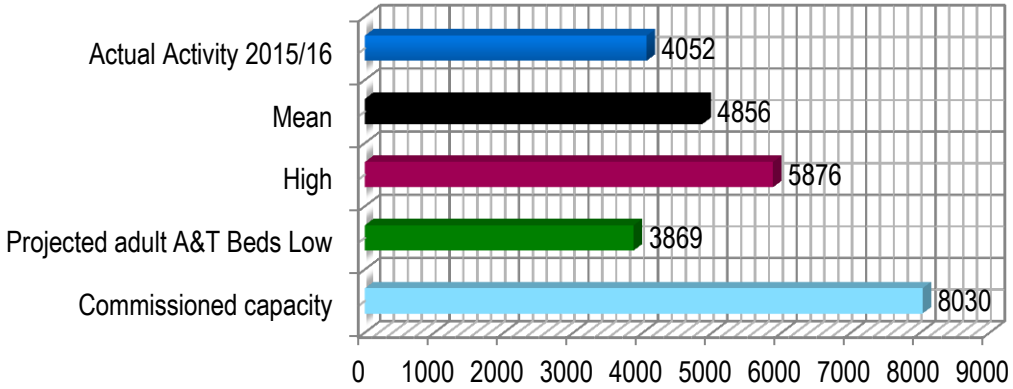


Mid Mersey's current commissioned capacity is 2920 beds or 90 bed nights above the mean

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.

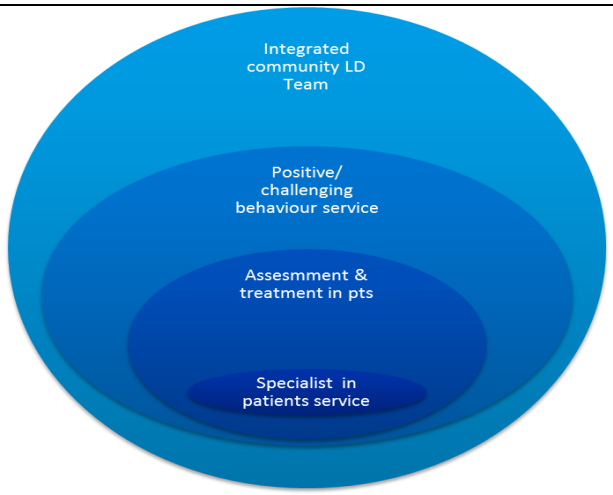
5.2.4 Transition Arrangements
Each area will have in place robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults.

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.
- 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.

5.5 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.

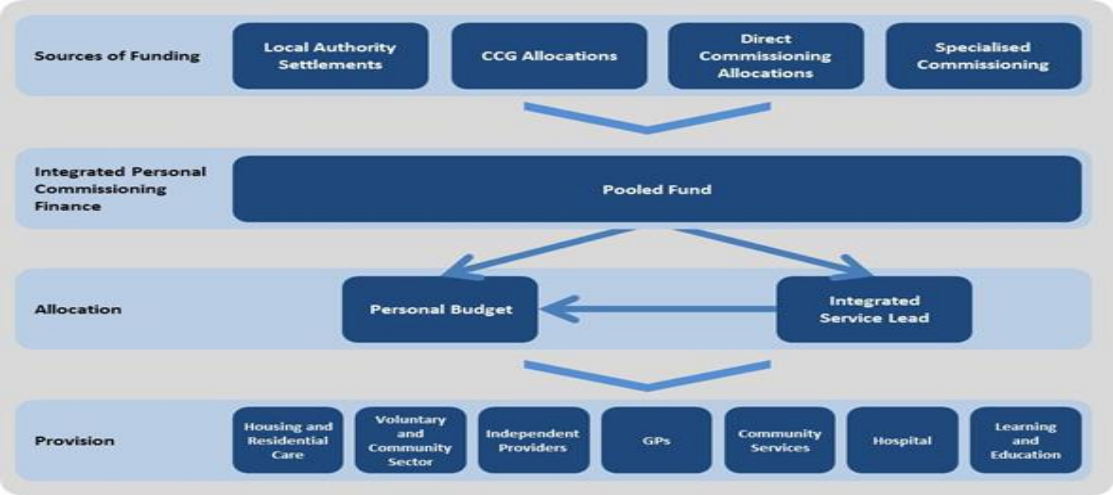
5.5.2 North Mersey
There will be a review of models of delivery to allow for better usage – e.g. forensic support. There will be reductions in general residential placements, that allow for a more personalised approach to commissioning support
Reduced use of A&T beds

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.

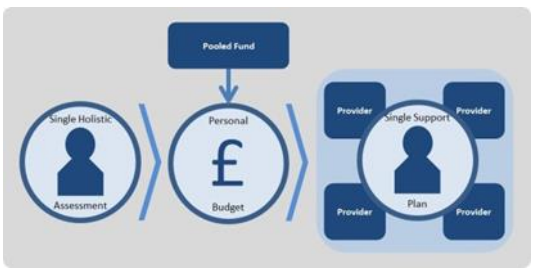
5.8 What will care pathways look like?

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

This page is intentionally left blank

NHS England

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

January 2016

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Version number: 1

First published: December 2015

Prepared by:
Michelle Creed, Deputy Director of Nursing,
Jackie Rooney, Patient Safety & Experience Manager
Chief Nurses and Directors of Quality Cheshire & Merseyside CCG's.

Classification: OFFICIAL

1. **Purpose of report**

   The purpose of this report is to update Cheshire and Merseyside Health and Wellbeing Boards with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

2. **Background**

   As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

   Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

   Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

   There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

   The five areas in the Transforming Care programme are:

   - **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

   - **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

   - **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

   - **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

   - **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress (Appendix 1).

3. **National Transforming Care Programme 2015 - 2019**

   Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published,

which sets out nine overarching principles which define what ‘good’ services for people with learning disabilities and/or autism whose behaviour challenges should look like.

These principles will underpin how local services are redesigned over the coming months and years – allowing for local innovation and differing local needs and circumstances, while ensuring consistency in terms of what patients and their families should be able to expect from local decision-makers.

The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will ‘test; the draft Service model during the summer of 2015.

NHS England have continued to seek the views of clinicians, commissioners, providers, people with learning disabilities and/or autism who have a mental health condition or display behaviour that challenges (including offending behaviours) and their families, ahead of the publication of a final version published in autumn 2015. This will help to support commissioning intentions and financial planning 2016/17.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 18 months, allowing the closure of inpatient beds and facilities.

Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; ‘Building the right support: A national implementation plan to develop community services and close inpatient facilities and a ‘New Service Model’ (2015).

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

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

While local areas will be able to design bespoke services with those who use them, the national plan (2015) also sets out the need for:

- Local councils and NHS bodies to join together to deliver better and more coordinated services

- local housing that meets the specific needs of this group of people, such as schemes where people have their own home but ready access to on-site support staff
- a rapid and ambitious expansion of the use of personal budgets, enabling people and their families to plan their own care, beyond those who already have a legal right to them
- people to have access to a local care and support navigator or key worker, and investment in advocacy services run by local charities and voluntary organisations so that people and their families can access independent support and advice
- pooled budgets between the NHS and local councils to ensure the right care is provided in the right place
- Using the nine principles set out in the 'New Service Model' (2015) TCPs should have the flexibility to design and commission services that meet the needs of people in their area

There is also an expectation as part of the national Transforming Care programme of work for:

- A 10% reduction in in-patient admissions using the pre 31.3.15 cohort of patients as the baseline, by 31 March 2016 and,
- Care and Treatment reviews (CTRs) for all people in an inpatient bed to become 'business as usual'.

4. Transforming Care Partnerships (TCPs)

Cheshire & Merseyside have had an historic Learning Disability Network that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. Discussions through this network resulted in an agreed consensus to progress developments via one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outline below.

Cheshire and Merseyside Unit of Planning			
Hub	**CCGs**	**Local Authority**	**Total Population**
Hub 1 Cheshire	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383 population

This approach builds on:

- 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

NHS England has proactively facilitated the bringing together of local delivery hubs and local discussions have already commenced

4.1 Cheshire & Merseyside Transforming Care Board

In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established; with Alison Lee, Accountable Officer, West Cheshire CCG as Senior Responsible Officer for this programme of work and Sue Wallace-Bonner, Director of Adult Social Care Halton Council as Deputy Chair. There are current discussions underway with the North West Confirm and Challenge service user group to establish a co-chair position.

The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

    - Performance as measured in the LD Self-Assessment Framework over this period.

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

The target completion date for this work is January 2016.

It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

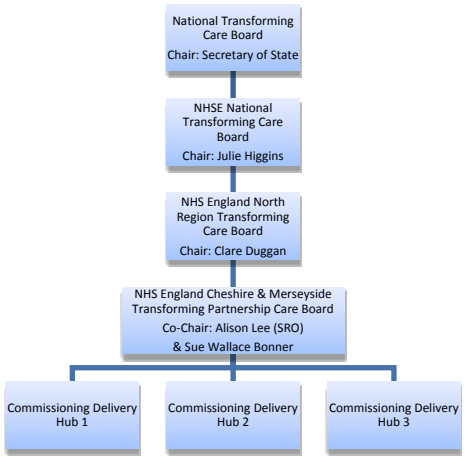
- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment.
- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities.
- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible.
- Repatriation of out of area placements

4.2 Governance arrangements to support delivery

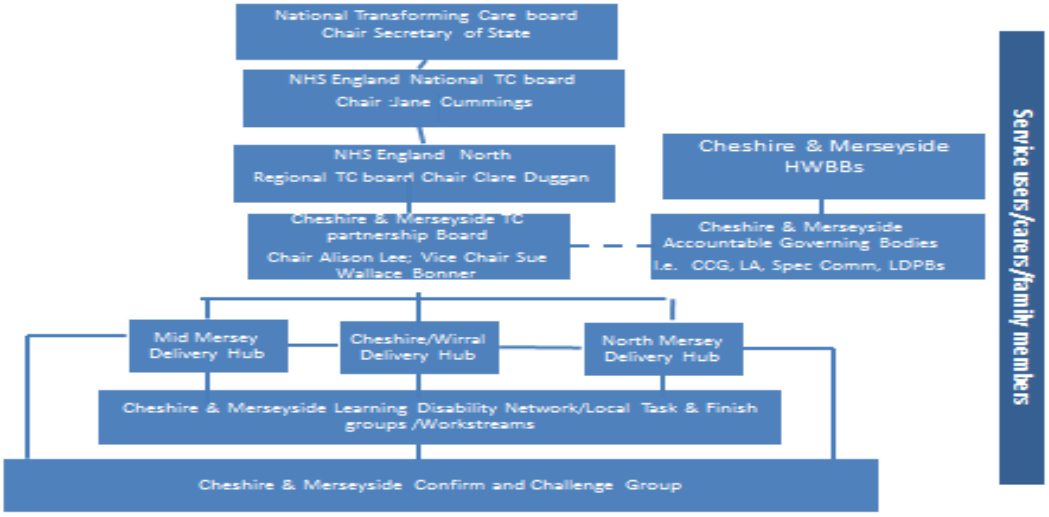
There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

The **national governance structure** to support delivery of the national plan is outlined below:



As NHS England is not a Governing body the suggested **local governance structure** to support delivery of the national plan is outlined below:



4.3 National and Local Focus 2016 – 2019

The expectation is that the non-fast track areas (Cheshire & Merseyside being one of them), will start to mobilise using the learning from the fast track areas and begin collaborative working to enable the system to realise the start date of April 2016 for:

- A reduction in in-patient admissions using the pre 31.3.15 cohort of patients of 10% by 31 March 2016
- Long term learning disability bed closures in
    - Assessment and Treatment beds
    - Locked Rehabilitation beds
    - Neuro Psychiatry beds

  (Forensic beds, low, Medium and High secure are being led by Specialised Commissioning)
- Development of new models of care.

4.3.1 Care and Treatment reviews

Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time. More recently the expectation is that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter.

Cheshire and Merseyside CCGs and 3 main LD NHS Providers (Merseycare, 5 Borough Partnership and Cheshire Wirral Partnerships NHS Mental Health Trusts) are fully engaged in the CTR process and have pooled clinical resource to enable delivery in a consistent manner. Pathways Associates/North West Training and

Development Team provide Experts by Experience (service users, families and carers). There has been local proactive development of local operational models to ensure CTRs are 'business as usual' from September 2015. The patient stories of individuals who have had Delayed discharges have been collated which is useful in detailing some of the challenges in the system and will be considered in the new service models.

As of December 2015:

- 135 CTRs have been undertaken across CCGs for CCG commissioned services.
- There are 5 patients who have a delayed discharge; the main reasons being accessing an appropriate community provider, no local care package availability and requirement for housing adaptations to be undertaken.
- The use of the pre admission / blue light CTR protocol has avoided 4 hospital admissions during the period October-December 2015

Specialised commissioning

CTRs are also undertaken for patients in forensic/secure commissioned services. The aim being to progress the patient along the secure/forensic pathway into CCG commissioned services or community settings.

To aid progress NW Specialised Commissioning team have established quarterly meetings with local commissioners to ensure the number of Cheshire and Merseyside patients moving along the secure/forensic pathways of care into CCG commissioned placements is planned and funded for.

As of December 2015 the number of Cheshire and Merseyside patients in Specialised Commissioned services is outlined below:

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		1	2
Knowsley		1	1
South Sefton	1	4	3
Southport		0	0
St Helens		3	2
Liverpool	1	5	4
Totals	2	23	17

(Data source NHS England Specialist Commissioning Tracker Dec 2015)

4.3.2 In patient reduction & bed closure programme

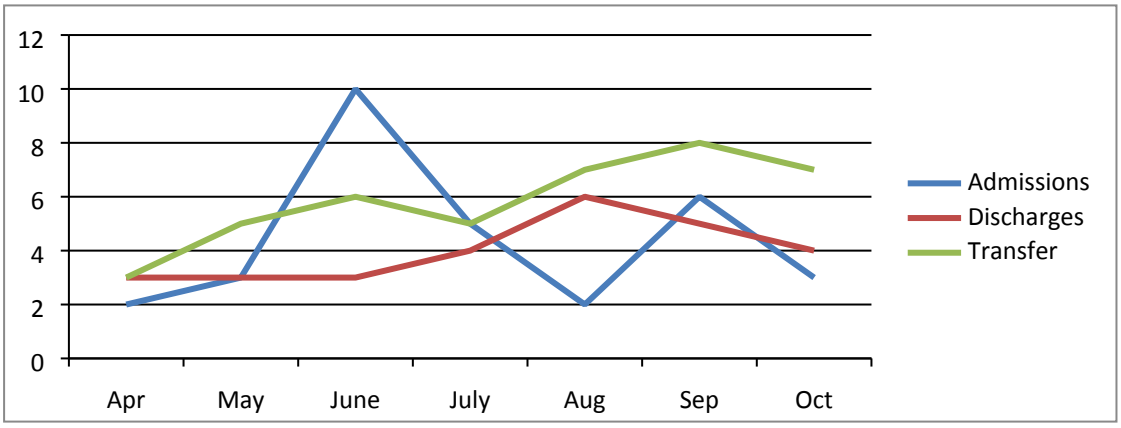
In patient reduction

One of the main responses to the Winterbourne View Concordat (2012) was the requirement to discharge patients from in patient settings if clinical safe to do so. The National Transforming Care board set a national discharge trajectory of between 10% - 13% for patients currently in an inpatient setting as of 31.3.15 to be achieved by 31. 3.16

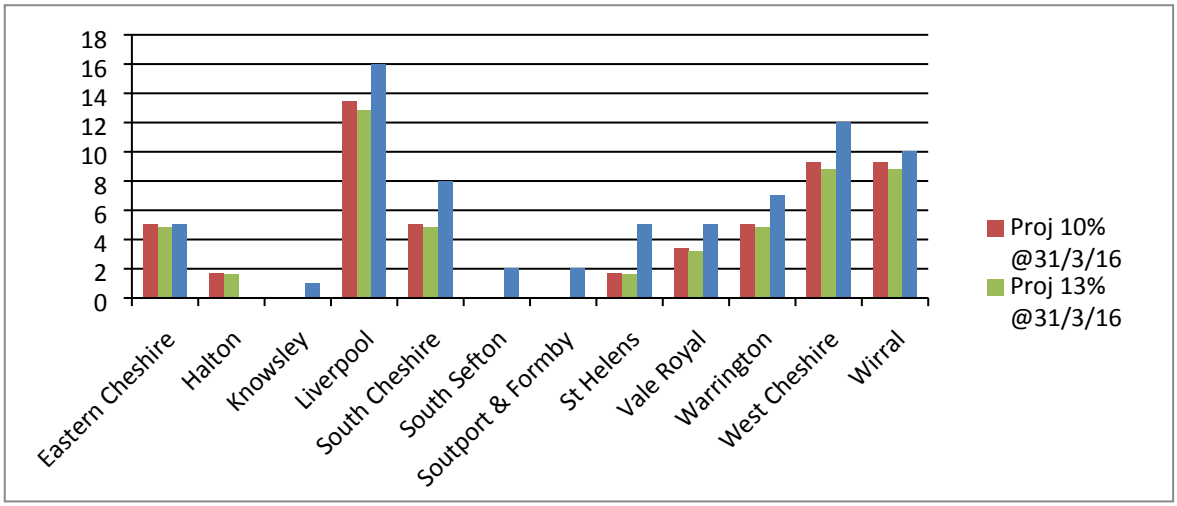
Progress to date for Cheshire and Merseyside's discharge trajectory is outlined below;

Team / CCG	Baseline@31/3/15	April	May	June	July	Aug	Sep	Oct	Nov	Proj 10% @31/3/16	Proj 13% @31/3/16	Diff to P1	Diff to P2
North of England	994	928	950	969	970	979	954	959	947	893	861	-66	-98
Cheshire & Merseyside	64	56	61	66	73	69	71	68	73	54	51	-19	-22
Eastern Cheshire	6	5	5	5	5	6	6	5	5	5	5	0	-0
Halton	2	2	1	0	0	0	0	0	0	2	2	2	2
Knowsley	0	0	0	1	1	1	1	1	1	0	0	-1	-1
Liverpool	16	15	16	15	17	17	17	16	16	13	13	-3	-3
South Cheshire	6	7	7	8	8	6	7	6	8	5	5	-3	-3
South Sefton	0	0	0	1	2	1	1	1	2	0	0	-2	-2
Soutport & Formby	0	0	0	0	1	1	1	1	2	0	0	-2	-2
St Helens	2	1	2	2	4	4	4	5	5	2	2	-3	-3
Vale Royal	4	4	5	5	5	5	5	5	5	3	3	-2	-2
Warrington	6	4	6	6	6	6	7	7	7	5	5	-2	-2
West Cheshire	11	9	9	12	11	10	11	12	12	9	9	-3	-3
Wirral	11	9	10	11	13	12	11	9	10	9	9	-1	-1

Data source: HSCIC Assuring Transformation dataset & NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15

4.3.3 Bed closure programme

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 populations
    - Cheshire & Merseyside target = 25 – 37 (CCG beds)
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations
    - Cheshire & Merseyside target = 50 – 62 (specialised beds)

The Cheshire and Merseyside Transforming Care board are currently undertaking the following baseline exercise which will help inform commissioners of bed activity as the new models are care are developed:

- A retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision with assessment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

The detail from the baseline report will be available January 2016.

4. Potential risks that may prevent delivery

Risk	Risk Level	Mitigating Actions
Lack of robust baseline data	Medium	• Commissioned LD JSNA to understand robust population based needs • Timescales for completion of LD JSNA not in line with timescales for service development

Risk	Risk Level	Mitigating Actions
		• Commissioned look back exercise of bed state
Requirement for Efficiency savings	High	• Work with CCG/LAs to ensure funds are ring fenced for LD service development & delivery • Bids for capital funds available for adaptions etc. via NHS England
Viability of Providers	High/medium	• Providers to develop models of care that ensure trust viability • Providers to commence discussions with legal teams regarding consultation • Commission at scale to ensure viability of providers
Delayed discharges / transfers	High	• Work with LAs to ensure robust process in place to move patient to suitably commissioned supported living placements • Map current provision of commissioned services and benchmark against LD profile • Commissioners to hold providers to account in ensuring planned discharge date for individual on admission
Lack of sustainable community LD teams /services	High	• Commissioners to collaborate to develop strategic provider / preferred provider frameworks with commissioning collaborations need to be as local as possible • Work with commissioner to understand what community services are current commissioned – mapping & identifying 'what goods look like' to support shaping of future local service models • Development of bids to 'double run' services
Disruption to natural patient pathway/flows	Medium	• Clinical Leadership • Clear communication
Limited personalised social care	Medium	• Mapping of housing providers and social care providers • Establish market place

5. Service Change Assurance

The scale of change being envisaged (introduction of new care models and removal of beds may be considered a significant change, with associated risk of Judicial Review or referral to the Secretary of State.

To mitigate these risks NHS England with key partners (LGA, ADASS, Service users etc.) has a role in assuring the service change proposal before progress to the next stage. The assurance would need to be tailored to the specific circumstances and scale of the proposal. Details of assurance process are outlined in the document below:

9) Transforming Care Assurance Process Flc

6. Next steps

Following local discussions at the Regional Transforming Care engagement workshop (9 November 2015) the following areas were identified as essential to support delivery of the national implementation plan:

- Clear governance structures
- As the national plan is reflective of all age ranges, further mapping of stakeholders to ensure all relevant stakeholders engaged in local development work i.e. Children's commissioners, CAMHS etc.
- Review of current community learning disability team (CLDT) specifications
- Review of out of area patients and development of repatriation programme
- Mapping of current social care/housing providers with CCG & LA commissioners with the potential to develop a social care framework
- Hold social care provider forum to establish current and potential services on offer
- Consideration of interim residential placements for current in-patients cohort with delayed discharge
- Development of 'Step up Step Down beds' to support crisis management building on what models that are nationally/regionally evidenced to support local developments
- Establish a provider forum
- Strength the 'at risk register' development's with all stakeholders: including development and agreement of data sharing agreements
- Strength local authority involvement in work programme via ADASS leads
- Pooled budgets
- Hold a local stakeholder dialogue event

7. Cheshire & Merseyside Stakeholder event

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.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. As Senior Responsible Officer for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:

- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like

- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHS England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relevant governing bodies.

8. Conclusion

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of work with regard to service provision for people with learning disabilities and/or autism, and/or behaviours that challenge.

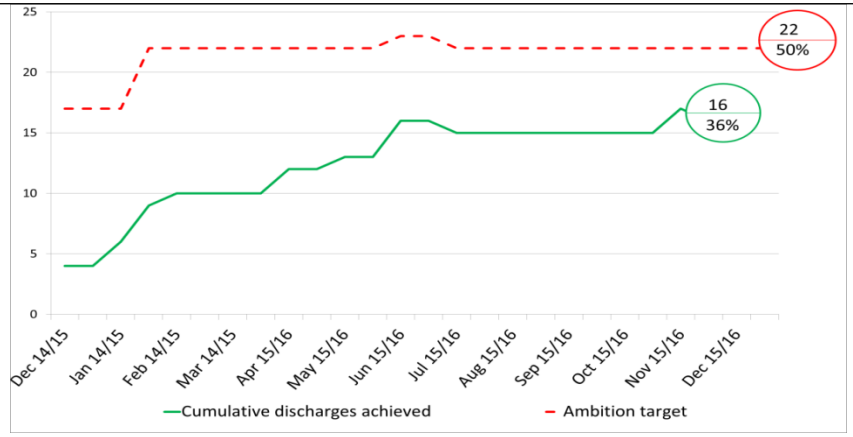
Telling the story of the journey so far is significant when reviewing in-patient provision to ensure we have adequate support for people who require it in times of deteriorating health or crisis. Alongside this the development of high quality services closer to home will enable people to live independent lives closer to their friends, family and carers.

The Cheshire & Merseyside Transforming Care Partnership Board will strive to delivery that national priorities locally, ensuring this is done in a co-productive manner with the patient's voice at the centre of the service model. Cheshire and Merseyside Health and Wellbeing Boards are asked to note the content of this report and support its implementation as a high priority area of work.

ENDS

Appendix 1. Cheshire & Merseyside Local Progress 2015/16

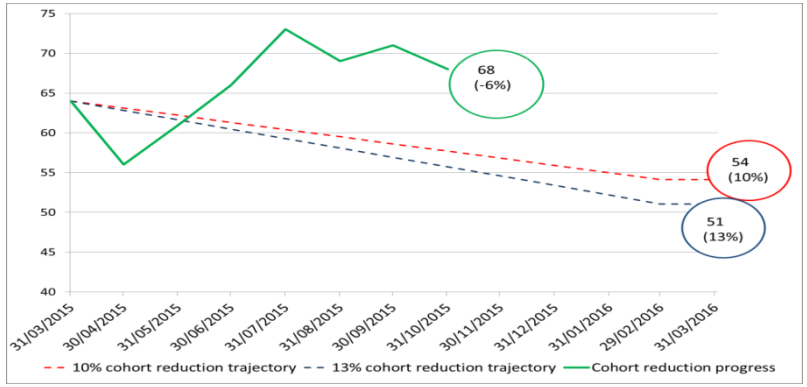
Empowering Individuals	Empowering people with learning disabilities and their families to have greater rights and say in their care, underpins the Transforming Care programme. We have been working with partners across the health, local authority and voluntary sectors to strengthen the collective voice of individuals with learning disabilities and their families, to ensure greater personalisation, increased choice about care, and greater influence over service design and delivery. An important milestone this year was the public consultation issued by the Government, 'No voice unheard, no right ignored', to strengthen the rights of people with mental health issues, learning disabilities and autism, so they can live independently, be included in their community, and make choices about their own lives. Locally we continue to work closely with Pathways Associates in: • Developing an expert hub of clinical reviewers and experts by experience to undertake Care and treatment reviews • ensuring we are asking whether people are getting support from advocacy through the revised approach to Care and Treatment • Reviewing Assuring Transformation data to gather information that tells us what sort of advocacy a person is receiving. • Developed a Co-production workstream to ensure the voice of the service user/Family carers is heard locally, regionally and nationally As a result of the work undertaken local we have successfully presented our methodology and how we have utilised the LDSAF validation process to improve and drive forward quality for people with LD locally at 2 national workshops run by IHAL. The workshops were held in June 2015 in Manchester and Bristol. Wirral CCG presented how this work at been used strategically at a local level to drive forward a joint action plan. As part of this they have streamlined processes, integrated stakeholders and worked towards joint ownership. **Governance: Co-production Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Right Care, Right Place, Right Time	The national ambition is to discharge 50% of patients from an inpatient facility at 1 April 2014 to the community by 31 March 2015; and to carry out care and treatment reviews for any patients in that cohort who have not got a discharge date and are in a low secure setting. Cheshire & Merseyside position at November 2015:



50% discharge ambition: Currently on trajectory to achieve discharge ambition of 65% by Q4 leaving 15 inpatients from the 31 March 2014 cohort with discharge dates during 2016/17

There is a renewed focus on reducing hospital admissions from the 2013/14 baseline by 10% during 2015/16, reducing length of stay and tackling delayed discharges. This will require a focus on developing community based provision locally. Improving the patient experience and outcomes is a key factor to drive this initiative.

Cheshire & Merseyside position at November 2015:



10% discharge ambition: despite an increase in admission numbers over summer months (due to CCG's has found patients who were out of area) now on a downward trend and confident that the 10% ambition will be achieved by end of Q4. Current focus on 3 CCGs with highest admission rate: West Cheshire, Wirral and Liverpool CCGs.

Governance: Commissioning Hubs of the Cheshire & Merseyside Transforming Care Board.

Regulation & Inspection	NHS England has established an Enhanced Quality Assurance Programme (EQAP) with the specific role of making sure people are safe and monitoring the quality of care reviews. EQAP will seek the firmest assurances that patients have clear care plans and are receiving the support they need and deserve. CQC is working to ensure that its assessment methods are fully adapted to ensure robust inspections of hospital and community learning disability services. The CQC is further developing the work on registration, to ensure that: • Applications by any service provider to vary their 'service type', that describes the services that they offer, are only agreed when the new 'service type' accurately reflects a changed model of care. This will also ensure that any inappropriate models of care for people with learning disabilities do not continue after the 'variation' has been agreed; and • new applications are only agreed when the application reflects the agreed model of care for people with learning disabilities, which is currently being defined by the Transforming Care programme and outlined in the new Service Model for commissioners **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Workforce	Since the publication of Next Steps (July 2015), Health Education England (HEE) has been working with its Transforming Care partners, including Skills for Health and Skills for Care, to ensure that workforce development and planning supports the wider service re-design across health and social care. Work to date will includes the development and testing a new Learning Disability Skills and Competency Framework that outlines the competencies that staff needs to have, to fulfil certain roles, to ensure that we have the right skills in the right place. This Framework will be rolled-out in January 2016. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Data and Information	Health and Social Care Information Centre (HSCIC) is the national electronic information data analysis system for the Assuring Transformation Clinical Platform. All local CCGs are registered with HSCIC and actively submitting data. Local CCG/LA leads are also required to submit fortnightly data to NHS England via the local Transforming Care tracker. This enables the local monitoring of CTRs, admissions, in patient length of stay and progress being made towards individual, anticipated and planned discharge dates. Work is currently ongoing between NHS England Transforming Care analytical team and HSCIC to enable all clinical data fields to be submitted via one clinical portal on HSCIC system. It is

	envisaged that the NHS England TC tracker will cease in December 2015. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Learning Disabilities Mortality Review (LeDeR) Programme	The new Learning Disabilities Mortality Review (LeDeR) Programme has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and will run from 2015 – 2018. The Programme has been established as a result of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The aim of the Programme is to make improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities, through national and local reviews of deaths. There will be a phased roll-out of the programme across the 12 NHS Clinical Senate geographical areas of England from January 2016, following a piloting phase in autumn 2015. Once known, dates for C&M will be disseminated locally. **Governance: Health Inequalities Sub Group of the Cheshire & Merseyside Transforming Care Board.**

Appendix 2

Transforming Care Stakeholders event 16 December 2015 Daresbury Park Hotel Warrington

Cheshire Delivery Hub

Who's missing?
• Family Carer's • Carer's • CCG's • Eastern Cheshire CCG's • Educational Sector • Employment Services
Overall Vision for People with Learning Disabilities
• Care in the community / Closer to home • Safety • Proportionate risk taking • Right care, Right Treatment, Right time. • Own front door (Housing) • Working together (CCG, LA's, Independent Sector) • Forums - Culture change - Workforce development - Market shaping • 'Nothing about us without us'. • Honest • Self-Advocacy • Community Development • Leading 'own' support (Self/peer advocacy) • 'Good Lives' – People leading • Sharing Data • Working with service users. • Reducing Barriers. • Stream less Services / Transitions. • Sharing Resources - Useful tools - More co-production • Gaps in service (Autism) • Good Communication - Person centered. • Culture Change • Right People? - Employers - Children's Services
Shared Vision
• Meeting needs at times of crisis - Appropriate planning - Step up/step down beds - Person led • Individuals taking control of care planning • Safe happy and well • Supporting services to meet peoples neds • Individuals More in control of own budgets
What could be improved?
• Patient voice being heard.

- 24/7 support for service users in the community
- Transparency
- Patient-led care
  - Managing own budget
- Contingency planning
  - Crisis support
- Employment Service Users
  - Autism/LD
  - Opportunities
  - Improving quality of life, achieving goals.
- Involvement of employment and children's service and stakeholder groups.
- Care within home – Not sending out of area / secure units etc.

What does success look like?

- Working alongside service users - Closer collaboration.
  - Getting the best out of the services.
- Transparency
  - Between Services
  - Available Services
  - E.g. Development of land
- Shared Vision
- Meeting needs
  - Times of crisis
  - Appropriate planning step up / step down
  - Person-Led
- Individuals taking control of care planning.
- 'Safe, Happy and Well'
- Supporting services to meet person's needs.
- More In control of own budget (Service users)

What's Working Well?

- Local area coordinator's scoping available services – Individualised.
- Person – centred planning
- Improved communication – Hospitals / GP's
- Lots of work with Hospitals
  - Reasonable adjustments
  - GP Training
  - Health Champions (Training)
- Caring (CQC)
- Effectiveness (CQC)
  - Communication / Staff and carers
- Service users key role in recruitment.
- Service users assessing services
- Fewer people LD in assessment

What keeps you awake at night?

- Safeguarding issues – Problematic providers.
- Quality of service provision – Leadership
- Sending service users out of area
- Isolation
  - No support company

How are you going to progress locally?

- Out of area
  - Jan 16 meeting CCG's service users
- Single plan
  - Commissioner led
  - Strategic group set up
  - Joining commissioners / joined-up commissioners.
- Strategic Visions
  - Work streams working to same vision.
  -

Mid Mersey delivery Hub

Overall Vision for People with Learning Disabilities
• Gaps in provision need to be addressed such as post diagnostic services – for people with Autism / Asperger's. • Clarity of responsibilities of health provider 5BP • Better planning around transition and people coming through the service. • Involvement of voluntary sector to meet needs – potentially? • Housing / Builders being on board with transitional planning (Affordable housing) • Smarter intelligence and how we collate information of people coming through the transitional system. • Greater involvement of people of all ages including younger people. • Greater support for parents to understand the transitional process. Positive communication with people from birth.
What could be Improved
• Autism Post Diagnostics (decisions making) what will be decided when • Transitional Process • Reasonable adjustments process, explaining to people (Staff as well as service users) • Embedding reasonable adjustments in general practice. • Educating the wider population around learning disability awareness – Autism and Aspergers Syndrome. • Community Cohesion / resilience?
Gaps within the Process
• No Children's Service representation. • Ensuring the right cohort of people are involved (E.g. LD Social Work) • We need to ensure all professionals are communicated with. (E.g. GP's/CCG's) • Strategic Planning and building positive relationships with housing providers. • Ensuring people receive the right care in the right setting – -Improving transitional processes -Partnerships is second -Care particularly elder carers
What Does Success Look Like?
• Seamless Services • Establishing what is important to the individual • Co-ordinated support through the journey (navigation role)
What is Working Well?
• Cohesive approach and relationships. • Good advocacy • Integration • Co-production (Partnership boards) • Voluntary sector involvement to develop groups • Learning Disability Pathway • Skill up the workforce (Educate workforce) • Positive behaviour support working well in some areas. • PBS not a short term solution for crisis – Community teams generally pick VW's?? up.
What keeps you awake at night?
• Impact on family carers, particularly older family carers / significant others. • Needs to be more communication between professionals.

North Mersey Delivery Hub

Who's missing?
• Sefton Local Authority • Liverpool City Council • Autism Initiatives • Options • Natural Breaks • People First • Sefton and Liverpool Partnership • Education
Overall Vision for People with Learning Disabilities
• Right Care, Right Time, Right Place, Right Professionals • Individual/Personalised Care Packages • Care primarily provided in the community not hospital. • Communities that welcome support. • Care pathway relating to OATS • Efficient funding • History of wrap around care – third sector. • Good third sector providers.
What could be improved?
• Information and support to families early on. • Inclusive education systems. • Avoiding the cliff of transition. • Insufficient capacity in the autistic spectrum.
Gaps within the Process
• Post diagnostic support – Autism • Autism (Big Gap) • Crisis management capacity is not robust. • Refresh Green Light Tool Kit • No short term care in the home. • Crisis House – Crash Pads • Lack of agreed definition. • Pool budgets, Joint funding – Something needs sorting out. • Horizontal and vertical care integrated.
Quick wins.
• Develop a pathway – OATS repatriation. • Utilise Merseyside Partners and the Joint Training Partnership – To be invested in. • Review of the past five admissions. • Audit Green Light Tool Kit • Test PBS • Agree Service Specifications – CLT • Repatriate OATS • Revisit SAF • HWB Report • TC-The Local vision for CCG's

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th March 2016
Report of: Lucy Heath (Consultant in Public Health)
Subject/Title: Supporting the Mental Health of Children and Young People

1 Report Summary

1.1 This report presents "Supporting the mental health of children and young people" strategy.

1.2 The strategy is based on the findings of the children and young people's JSNA and the recommendations from the Annual Public Health Report (2015).

1.3 One of the priority areas is "Put front-line mental health care and support into every community ". One of the key actions to deliver this objective is further development of the Emotionally Healthy Schools Programme. A second report in regard to this action accompanies this report.

2 Recommendations

2.1 The Health and Wellbeing Board endorse the "Supporting the mental health of children and young people" strategy.

2.2 The Health and Wellbeing Board consider the Emotionally Healthy Schools Programme Paper.

3 Detail

3.1 The detail can be found in the attached strategy document.

4 Partnership Governance

4.1 The Joint Health and Wellbeing Strategy (2014-2016) identifies 'starting and developing well' as one of its three outcomes. The Health and Wellbeing Board delegated the detail of this to the Children's Trust Board.

4.2 The Children's Trust Board developed The Children and Young People's Plan (2015-2018) in response to this. This plan has been endorsed by the Health and Wellbeing Board.

4.3 The Children and Young People's Joint Commissioning Group (CYPJCG) is responsible for commissioning actions needed to deliver the Children and

Young People's Plan. The CYPJCG is a sub-group of the Children's Trust Board and the Joint Commissioning Leadership Team.

4.4 Priority 3 of the Children and Young People's Plan is "Children and young people experience good emotional and mental health and wellbeing". This strategy describes six strategic priorities and objectives that will lead to improvements in these areas. A draft of this strategy has been supported by the CYPJCG

4.5 The CYPJCG is developing similar strategy documents for each of the six priority areas identified in the Children and Young People's Plan.

5 Individual Partners Governance

5.1 These papers have been considered by the Public Health and Children and Families Senior Leadership Teams. They have been considered by the councils Management Governance Board. They have been considered by Informal Cabinet.

5.2 These papers have been considered by NHS Eastern Cheshire's Mental Health Strategy and Transformation Meeting and by the CCG Board.

5.3 These papers have been considered by NHS South Cheshire's senior team and will be considered by the Governing Body in April..

The background papers relating to this report can be inspected by contacting the report writer:

Name:	Lucy Heath
Designation:	Consultant in Public Health
Tel No:	01270 685696
Email:	lucy.heath@cheshireeast.gov.uk

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th March 2016
Report of: Lucy Heath (Consultant in Public Health)
Subject/Title: Emotionally Healthy Schools Programme

1 Report Summary

1.1 This report describes the Emotionally Healthy Schools Programme approach, progress with the initial pilot in six secondary schools is described and the evaluation approach is shared.

1.2 Investment and potential investment is described and recommendations made in order to secure this. Spend to date and remaining available budget is described.

1.3 Options of how the available investment should be prioritised are provided.

1.4 Sustainability of the programme is discussed with recommendations of how investment could be secured to facilitate this.

2 Recommendations

2.1 The Health and Wellbeing Board supports schools as a setting for addressing the mental and emotional needs of children and young people.

2.2 That Cheshire East Council accepts the £135,000 from EC CCG and £126,000 from SC CCG to the Emotionally Healthy School Programme budget and support the transfer of £400,000 from the 2015-16 Public Health ring fenced grant to a ring-fenced Emotionally Healthy School Programme budget hosted by Cheshire East Council. Members of the Health and Wellbeing Board sign up to an Memorandum of Understanding to allow this to happen.

2.3 That the Health and Wellbeing Board gives permission to procure a further roll out of the programme up to the value of the £1.2m funding available and that this is delegated to the Emotionally Health Schools Steering Group to undertake under the governance of the Children and Young People Joint Commissioning Group.

2.4 That the Health and Wellbeing Board considers whether additional funding should be identified to increase the scope of the programme.

3 Emotionally Healthy Schools Programme

3.1 The Emotionally Healthy Schools Steering Group was first established in response to the Children and Young People's Plan priority around happiness and mental health. Evidence suggests that increasing resilience of children and young people will contribute to improved performance on a number of public health outcomes (e.g. NEETs, under 18 conceptions, alcohol related admissions). Mental Health was also identified as a key priority for the Youth Council and through voice of the child work.

3.2 Emotionally Healthy Secondary Schools Programme is a transformational programme that will contribute to changing the mental health system. It will do this in a number of ways:

- Develop the geography of schools as the unit of currency for place based commissioning for children's and young people's mental health.
- Provide manageable sized populations to facilitate a whole population approach to be taken with a focus on identifying hidden or unmet need.
- Earlier intervention in the child's life.
- Shifts resource upstream focusing on prevention and developing resilience in addition to targeted support for those with existing needs.

3.3 The Emotionally Healthy Secondary Schools Programme has been developed around the framework on the next page which was published in "Promoting children and young people's emotional health and wellbeing A whole school and college approach" (Public Health England/ Children and Young People's Mental Health Coalition, March 2015).

3.4 In addition to this PHE report, the evidence presented in 'Future in Mind - Promoting, protecting and improving our children and young people's mental health and wellbeing'[1] has also been applied.

3.5 An Emotionally Healthy Schools Steering Group, formed about a year ago, brings together partners across the Cheshire East to develop this approach together. This has been a truly partnership approach with schools being a particularly prominent partner.

3.6 Small teams are being developed in each school whose aim is to improve emotional health and wellbeing of their students.

3.7 In preparation for the project start, each school undertook a self assessment using the framework. This involved attributing a score out of six to progress in each of the eight areas, providing evidence of existing work to support this

[1] DH, NHS England (2015) Future in Mind Promoting, protecting and improving our children and young people's mental health and wellbeing

score and identifying actions that could lead to improvement. These identified actions will be prioritised and use to develop an action plan.

4 First Year Pilot

4.1 Commitment has already been given to pilot the Emotionally Health Secondary Schools programme in six secondary schools.

4.2 We had planned for the programme to start in September 2015. However, due to delays in procurement and recruitment this was been delayed to January 2016. As a result of the delays, the first phase of the programme will run until December 2016.

4.3 An initial workshop for school leads was held in June 2015 and a second workshop for school leads and school nurses was held on 21st October 2015.

4.4 Action plans are in draft and implementation will start once the project workers have been recruited and the full school team is in place in January 2016. The

action plans include activities informed by the evidence base that meets each schools priority needs and builds upon their assets.

4.5 As a result of our developed partnership we successfully bid to be part of a national CAMHS school links pilot. The schools leads (secondary schools and partner primary schools), EHS staff, school nurses and CAMHS staff attended their first training day in January. A second day is planned for March.

5 Evaluation

5.1 We are confident that a whole school approach to improving emotional health is the correct framework to achieve a wide range of positive outcomes for our children and young people in Cheshire East.

5.2 Therefore an evaluation focusing on the activities delivered through the Emotionally Healthy Secondary Schools Programme pilot has been commissioned from Salford University.

5.3 The value of the evaluation will be to provide learning about how and why activities were chosen in each school and which activities were successful and why.

6 Children and Young People Mental Health Transformation Plans

6.1 The Children and Young People's Mental Health Transformation Plan is written using the Future in Mind framework – with transformation described in the following areas:

- Resilience, prevention and early intervention for the mental wellbeing of children and young people
- Improving access to effective support – a system without Tiers
- Care for the most vulnerable
- Developing the workforce

6.2 The Emotionally Healthy Schools Programme is a key action in the Children and Young People's Mental Health Transformation Plan and contributes to all four areas.

6.3 *Resilience, prevention and early intervention for the mental wellbeing of children and young people*. Actions are described across the workforce and the actions for 11-19 year olds are delivered through the Emotionally Healthy Schools Programme.

6.4 *Improving access to effective support a system without Tiers.* These actions will increase capacity in specialist services. Pathways will be developed across the system with schools considered as key starting point for all pathways. Place based commissioning and provision for CAMHS will be developed (around the geographies of our 24 secondary schools). Links

between CAMHS and schools will be strengthened through our participation in the national CAMHS school links pilot.

6.5 *Care for the most Vulnerable.* The Emotionally Healthy Schools will provide a focus on children and young people with risk factors for mental health. Cheshire East has successfully bid to be part of a national pilot. This involves collating data on the school footprint identifying children with risk factors, using soft intelligence to identify hidden need and setting up systems to assess the impact of these risk factors on mental health and support these individual children and young people. This will work with developing systems around early help.

There is a commitment to aligning mental health, school services and the health child programme. This would include all pathways being available to all children aged 0-19. It will also focus on the transition from school age to adulthood for the most vulnerable.

6.6 *Workforce development.* Cheshire East has successfully bid to be part of a national pilot. This will provide staff in 20 schools (primary and secondary), school nurses, CAMHS staff and our project staff with two days of training and development together.

7 Finances – income

7.1 £1 million of the public health ring fenced budget in 2014-15 was transferred to Children's commissioning to support transformational projects that achieved public health outcomes in children. £570k of this £1 million was allocated to the Emotionally Healthy Schools Programme.

7.2 The Emotionally Healthy Schools Steering Group supported both CCGs (Eastern Cheshire and Southern Cheshire) in successful bids to be part of a national CAMHS school links pilot. This attracted £50k for each successful CCG, i.e. an additional £100k. The CCGs are transferring this to the council to support the Emotionally Healthy Schools Programme.

7.3 The CCGs have submitted our Cheshire East Children and Young People's Mental Health Transformation Plan. This has been developed under the governance of the Children's Trust Board as it describes how we will achieve priority 3 of the Children and Young People's Plan 2015-2018: Happiness and Mental Health. This plan was submitted to NHS England on 16th October. The assurance process was completed in the first week of November. With the exceptions of minor details around eating disorder services and engagement and partnership, NHS England assured our plans. As a result, EC CCG will receive £382,720 and SC CCG will receive £342,712 as part of their November allocation. EC CCG has allocated £85k of this to the Emotionally Healthy Schools Programme and SC CCG has allocated £76k.

7.4 There is £400k available in the 2015-16 public health ring fenced grant. This is allocated to mental health prevention. It is recommended that this is invested in the Emotionally Healthy Schools Programme and as a result transferred to the Emotionally Healthy Schools Programme budget.

Emotionally Healthy Schools Programme Income	
Children's Public Health Allocation 2014-15	£570,000
NHSE/DfE CAMHS School Link Pilot via CCGs	£100,000
East Cheshire CCG 2015-16	£85,000
South Cheshire CCG 2015-16	£76,000
Public Health Allocation 2015-16	£400,000
Total Income	**£1,231,000**

8 Finance

8.1 CWP has been commissioned to provide clinical support to pilot the emotionally healthy schools programme in 6 secondary schools. This contract runs from July 2015 to December 2016 and costs £80,000.

8.2 Visyon has been commissioned to provide resource to pilot the emotionally health schools programme in 6 secondary schools. This provides a project manager, 3 project workers and administration support. Visyon has sub-contracted some of this work to Just Drop in and Children's Society. This contract runs from July 2015 to December 2016 and costs £220,000.

8.3 A budget of £3,500 has been allocated to each of the six pilot secondary schools to facilitate transformational change.

8.4 Salford University has been commissioned to evaluate the Emotionally Healthy Schools Programme in 6 secondary schools. This contract runs from November 2015 to December 2016 and costs £40,000

Emotionally Healthy Schools Pilot Programme Expenditure	
CWP contract	£80,000
Visyon contract	£220,000
Schools allocation (6 pilot secondary schools)	£18,000
Evaluation	£40,000
Total Expenditure	**£358,000**

8.5 The difference between the anticipated income and the current expenditure is £891,000.

8.6 This therefore provides the opportunity to expand the Emotionally Healthy Schools Programme beyond the pilot phase.

9 Options for expansion

9.1 **Option 1:** Expand the pilot phase into primary schools. The CAMHS school links pilot is involving 14 primary schools. Following discussions with these schools additional support could be procured to develop the programme for primary schools.

9.2 **Option 2:** Roll out the programme to all secondary schools in Cheshire East. The pilot programme has cost approximately £50,000 per school. Assuming costs remain the same there is almost sufficient resource to commit to this. It is anticipated that the pilot will generate significant learning about the processes needed to bring about change. Therefore the subsequent roll out in other secondary schools may be more efficient and potentially free up time to work with primary schools.

9.3 **Option 3:** The Emotionally Healthy Secondary Schools Programme is an intensive intervention. This will create a system change on the footprint of the school. As a result the existing available resources (as a minimum: school pastoral staff, CAMHS, school nurses and voluntary sector mental health support) will work differently together. However, in order to sustain change it is anticipated that additional ongoing investment will also be required. What this investment will be used for and how much will be needed is not understood at this time.

9.4 **Option 4:** A combination of the above options.

9.5 Therefore, it is recommended that the Health and Wellbeing Board identifies the preferred option and gives permission to procure the further programme support up to the value of funding available.

9.6 In an ideal world we would commit to a sustainable full roll out to all primary and secondary schools and colleges. It is recommended that Children and Young People's Joint Commissioning Group describes a process against which other elements of the programme can be prioritised against other demands for investment

The background papers relating to this report can be inspected by contacting the report writer:

Name: Lucy Heath
Designation: Consultant in Public Health
Tel No: 01270 685696
Email: lucy.heath@cheshireeast.gov.uk

This page is intentionally left blank

Supporting the Mental Health of Children and Young People

Strategy

Cheshire East

Children and Young People's Plan Priority 3

2016 – 2018

Cheshire East
Children & Young People's Trust

MENTAL HEALTH PROBLEMS AFFECTING CHILDREN AND YOUNG PEOPLE

In Cheshire East in 2015:

13.1% or approximately 12,500 children and young people aged between 0-24 years have a mental health disorder

PERINATAL MENTAL HEALTH
1,170 to 1,915 women affected in pregnancy and the year after birth

CONDUCT DISORDER
3,290 affected age 3-16
190 new onsets annually

ADHD
1,330 (severe) to 2,660 (all cases) age 3-24 (67 - 134 new annually)

ANXIETY DISORDERS
3,000 affected age 5-24

DEPRESSIVE DISORDERS
3,040 affected age 5-24

SELF-INJURY BEHAVIOUR
2,270 affected age 12-24
7,330 self-injuries annually

LEARNING DISABILITY
3,300 young people age 0-24 have LD. 1,190 will have a MH problem

PSYCHOTIC DISORDERS
170 affected age 12-24
16 new onsets annually

EATING DISORDERS
145 affected age 10-19
25 new onsets annually

TOURETTE SYNDROME
590 affected age 5-18

AUTISM SPECTRUM DISORDER
60 babies affected each year

SUBSTANCE USE DISORDERS
3,650 age 11-15 have tried drugs. 11,700 age 16-19 'lower-risk' drinkers

These figures are based on national prevalence or incidence figures applied to the population of Cheshire East.

Indicator	Cheshire East Value	England value	England Worst/ Lowest	England Best/ Highest
Long-term illness	15.9%	14.1%	18.6%	9.2%
3 or more risky behaviours	15.2%	15.9%	23.8%	3.2%
Physically active	14.7%	13.9%	8.3%	18.8%
Regular smokers	4.5%	5.5%	11.1%	1.3%
Been drunk in the last 4 weeks	19.1%	14.6%	27.0%	2.6%
Mental wellbeing score	48.0	47.6	45.4	48.9

These figures are based on the national 'What about youth?' survey which surveyed over 2100 15 year olds in Cheshire East.

Levers for change

1. The five key themes identified in the "Future in Mind" report from the Mental Health and Wellbeing Taskforce (2015)
    1. promoting resilience, prevention and early intervention
    2. improving access to effective support – a system without tiers
    3. care for the most vulnerable
    4. accountability and transparency
    5. developing the workforce
2. Department for Education - Counselling in Schools – a blueprint for the future (2015)
3. PHSE Association – Teacher Guidance – Preparing to teach about mental health and emotional wellbeing (2015)
4. Public Health England - Promoting children and young people's emotional health and wellbeing: a whole school and college approach (2015)
5. Cheshire East Emotionally Healthy Schools Programme. Service stocktake and CCG Local Transformation Plans
6. NHS England - £725,000 new recurrent funding for Cheshire East to implement the local transformation plans
7. Cheshire East Children and Young People's Mental Health Joint Strategic Needs Assessment
8. Cheshire East Annual Public Health Report

Key issues identified from needs assessment:

- Inadequate support for mothers mental health during and after pregnancy
- Little use of CAMHS by the under-fours
- Inconsistency in what the upper age for CAMHS should be
- Many services are not being "joined-up" for young adults
- Poor support for teenagers who self-injure
- Many young people with autism spectrum disorder or a learning disability not receiving effective support

Strategic Priorities

1. Put front-line mental health care and support into every community
2. Support all women who experience anxiety and depression during pregnancy
3. Diagnose and treat young children with mental health problems during their second year of life
4. Improve awareness and support for young people with autism spectrum disorder and learning disability
5. Help teenagers to deal with the dark feelings that can lead to self-injury
6. Bring together all emotional health and wellbeing services for young people, possibly up to the age of 25

Priority 1 - Put front-line mental health care and support into every community

Needs

CCG Transformation Plans		Need
Tier 4	specialised day and inpatient units	56
Tier 3	specialised child and adolescent MH teams	1,390
Tier 2	specialised primary MH workers and counsellors	5,250
Tier 1	non-specialist primary care workers	11,250

Capacity across the system is not completely understood. There is capacity in NHS CAMHS services to support tier 3.

New Approaches to Care and Support

Signposting, self management and on off contact

Goals focussed, evidence informed and outcomes focussed intervention

Risk management and crisis support

Extensive treatment

Gaps

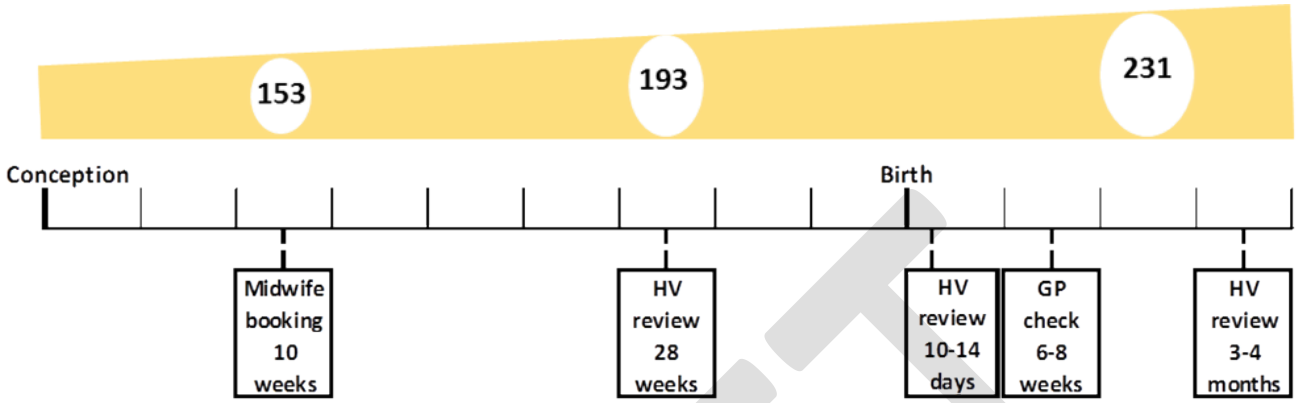
1. Services still designed around tiers. Minimal investment at tier 2

Objectives

1. Initial focus on schools as a setting for front-line mental health care and support building on the emotionally healthy schools programme.
2. Pilot elements of the THRIVE model in Cheshire East's Emotionally Healthy Schools Project
3. All schools should be using the Strengths and Difficulties Questionnaire in a consistent way
4. Understand current capacity and quality of school based counselling and emotional health and wellbeing services and ensure all schools in Cheshire East make such services available to their pupils. Develop pathways to ensure these work alongside specialist mental health services
5. All schools should be able to refer some children with suspected conduct disorder (based on SDQ score) directly to treatment
6. Baseline survey of the new PSHE lesson plans for mental health and emotional wellbeing.
7. Better support for young people to be able to self-manage chronic conditions (e.g. diabetes, asthma, epilepsy, eczema) at school.
8. All school-based and voluntary sector counsellors for children and young people should have access to CYP-IAPT training.
9. The Children's Consultation Service could co-ordinate certain mental health referrals
10. Access to psychological support for young people who have physical health problems
11. Programme of surveys to measure levels of change in mental wellbeing and risk factors

Priority 2 - Support all women who experience anxiety and depression during pregnancy

Estimated need in Cheshire East each year



The figures indicate the estimated number of women who may be affected by depression prior to, during and after pregnancy and who could be identified by health professionals at various contact points. Around a quarter of women may have already been affected prior to pregnancy, and another third may develop depression during pregnancy. Together there are likely to be around 580 women affected each year.

Gap

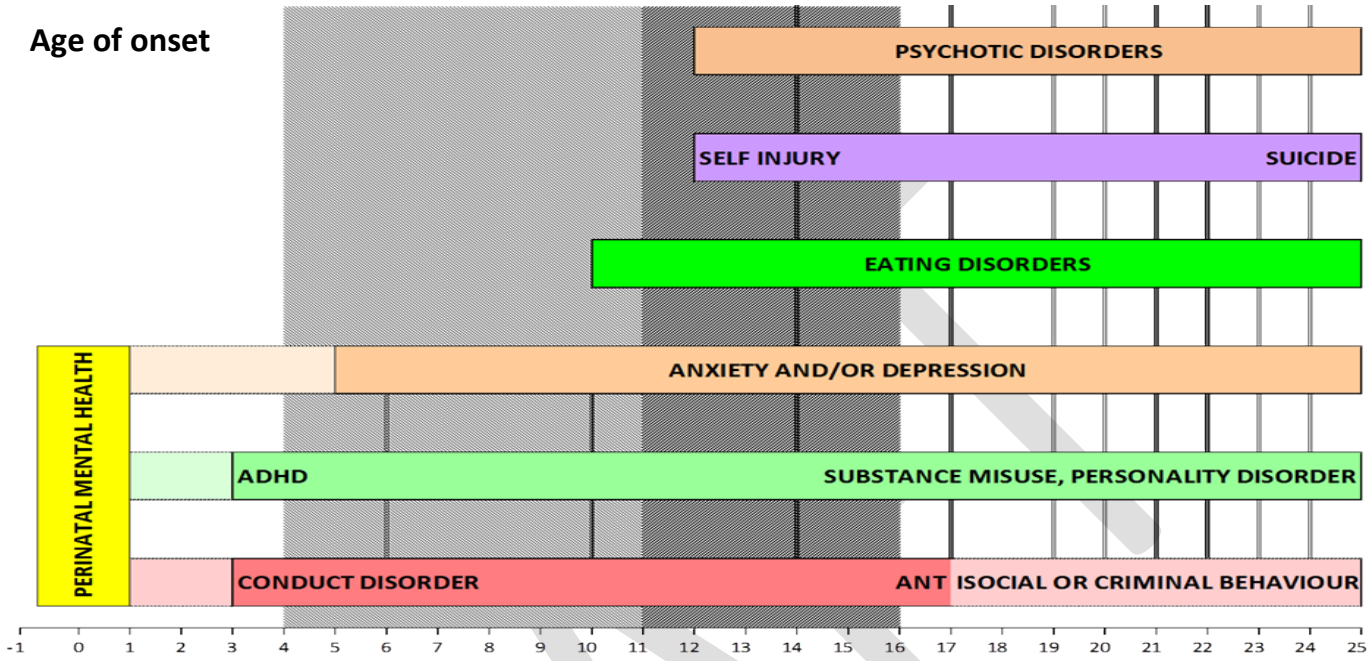
1. No specialist perinatal mental health services locally – women with major problems are being managed by general services
2. Inadequate prevention, recognition and management of many common mental health problems that occur during pregnancy
3. Significant scope to prevent future mental health problems from occurring in around 150 babies born every year

Objectives

1. Consider the use of depression and anxiety screening in women who are planning a pregnancy
2. Change guidance that women are assessed for depression only once during pregnancy
3. Tackle the multiple barriers to identifying mental health problems during pregnancy
4. Include depression and anxiety screen as part of health visitor review during pregnancy
5. Acknowledge the impact of relationships, social support and housing on pregnant women's wellbeing and her families future wellbeing. Identify needs in pregnancy and prioritise access for pregnant women in services that can provide practical help.
6. Commission specialist community care for women with serious mental health problems affecting 3-4% of pregnancies

Priority 3 - Diagnose and treat young children with mental health problems during their second year of life

Need



Conduct disorder is the most common mental disorder in childhood. The peak onset is around 2-3 years. It affects more boys than girls. Conduct disorder can be prevented in high-risk groups and effective treatment is available (NICE recommends treatment from the third birthday onwards) Most children do not need specialist CAMHS input. The core behaviours of ADHD typically arise around the age of 3 years.

Gaps

1. Little use of CAMHS by the under-fours
2. Under-recording of autism spectrum disorder by schools.

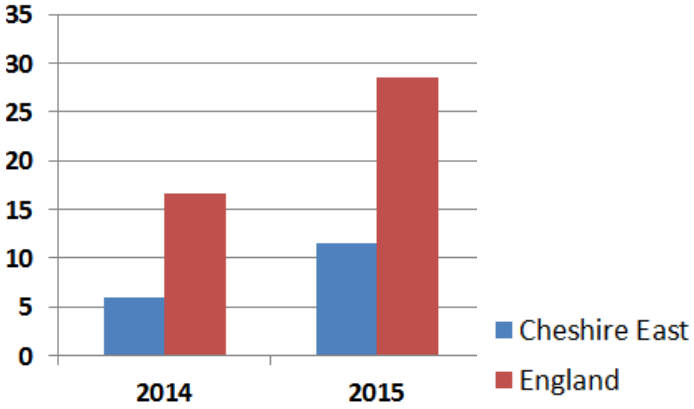
Objectives

1. Early identification of conduct disorder, ADHD and autism through the Parent Journey
2. Primary schools can do initial assessment of children with suspected conduct disorder
3. Have prevention and treatment programmes for conduct disorder throughout Cheshire East including some nursery and school based programmes (classroom-based emotional learning and problem-solving programmes for children aged 3 to 7, and group training for their parents).
4. Offer parent training programmes at times and locations when parents can attend
5. Primary school counselling services should cover pre-school children aged three and four
6. Access to CYP-IAPT training for all staff who work with children under five and those who work with children with autism.
7. Health and education professionals to liaise with parents/ carers to identify the impact that ADHD has on a child
8. Clinicians should use educational and psychological approaches to ADHD before medication

Priority 4 - Improve awareness and support for young people with learning disability

Need

Moderate Learning Disability Rate per 1,000 pupils



Number of pupils with moderate LD

	2014	2015
Primary Schools	189	466
Secondary Schools	130	159
Total	**319**	**625**

Gaps

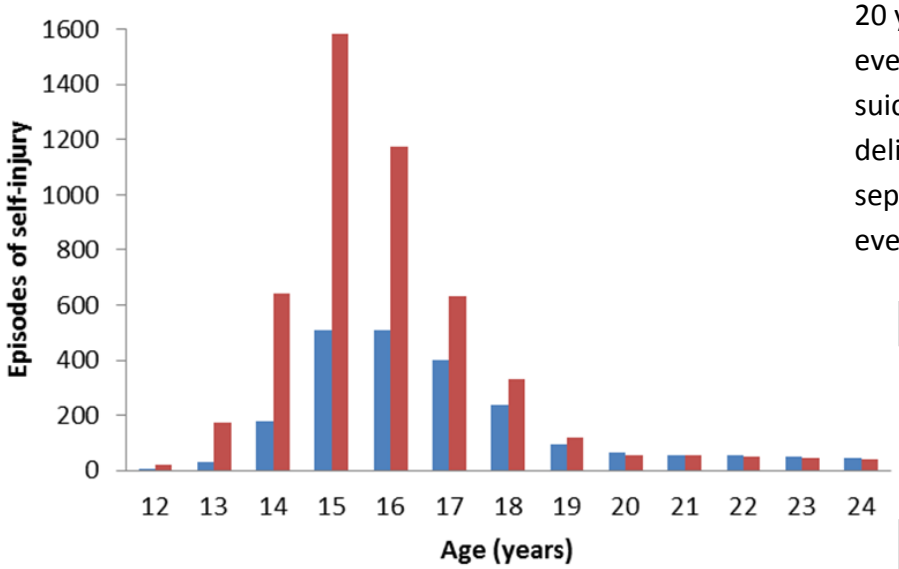
1. Underreporting of learning disabilities particularly in secondary schools.

Objectives

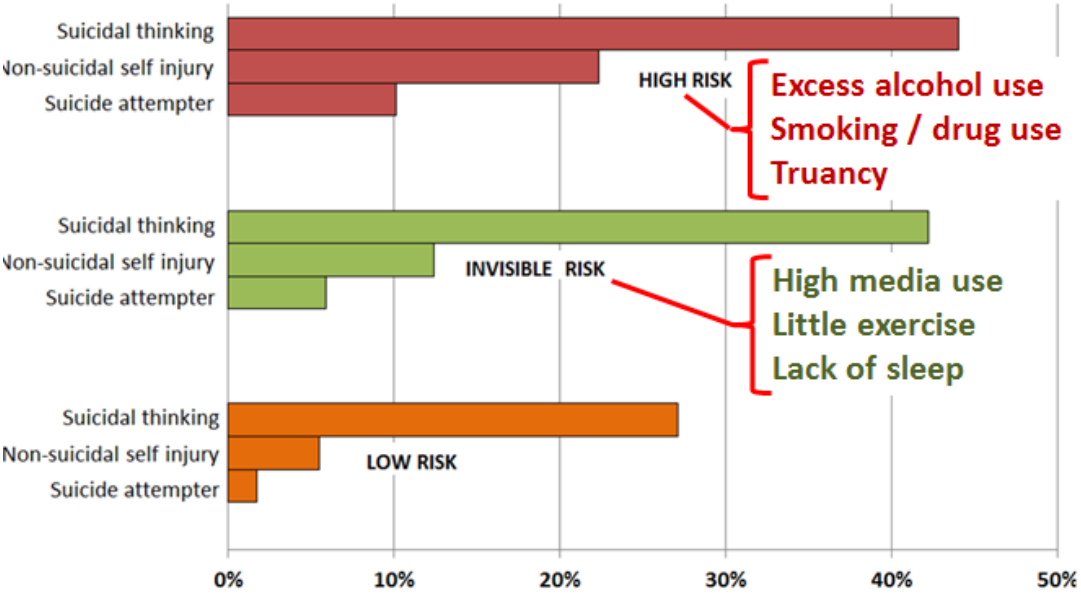
1. Better recording of moderate learning disability in secondary schools – Macclesfield, Crewe, Congleton, and Wilmslow
2. Develop pathways to help young people with a learning disability to receive mental health support
3. Schools inform the general practitioner when a learning disability is newly identified
4. Ensure that Cheshire East's strategies and approaches for reducing child poverty are particularly sensitive to the needs of families who are bringing up a child with a learning disability.
5. Encourage parents to provide their perspectives of need to the Disabled Children's Database
6. Access to CYP-IAPT training for all staff who work with children with learning disabilities

Priority 5 - Help teenagers to deal with the dark feelings that can lead to self-injury

Need



20 young people injure themselves every day, and 5 of them think of suicide. About 2,270 young people deliberately injure themselves on 7,330 separate occasions in Cheshire East every year, mainly through a skin injury

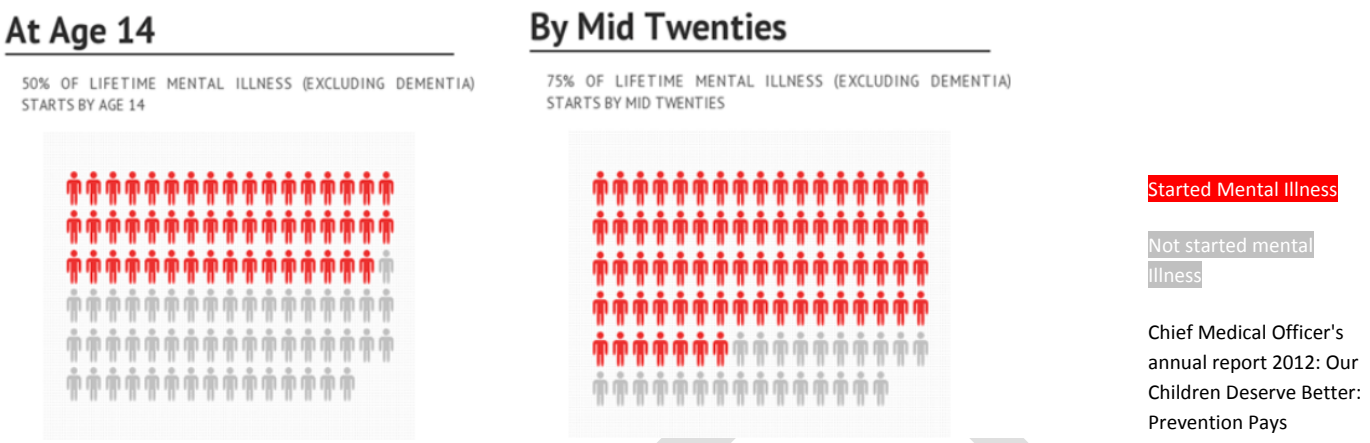


Objectives

1. Reduce access to medicines and sharp objects in the home
2. Promote good sleep patterns and less texting and gaming at night
3. Regular exercise and plenty of sport
4. Smoking and alcohol reduction schemes
5. Reduce bullying and give support for sexual orientation and other worries
6. School counselling services should be visible to and easily accessible by pupils
7. Immediate access to emergency care for a young person who discloses a self injury who when asked also discloses self-poisoning or suicidal thoughts.
8. Young people need access to a rapid and supportive response during a time of crisis
9. Information, advice and guidance on signs and symptoms and alternative behaviours.

Priority 6 - Bring together all services for young people, possibly up to the age of 25

Needs



New mental health problems can develop around the age of twenty and existing problems can worsen. Mental health problems increase in frequency as young people leave the protective factor of living in the family home and begin to experience social welfare legal problems, which are defined as rights-related problems concerning housing, homelessness, welfare benefits, debt, employment and education. These problems can be compounded by being out of employment or education, or being socially isolated. These risk factors are cumulative in their impact on mental health. Young people are prone to delaying or giving up seeking help.

Gaps

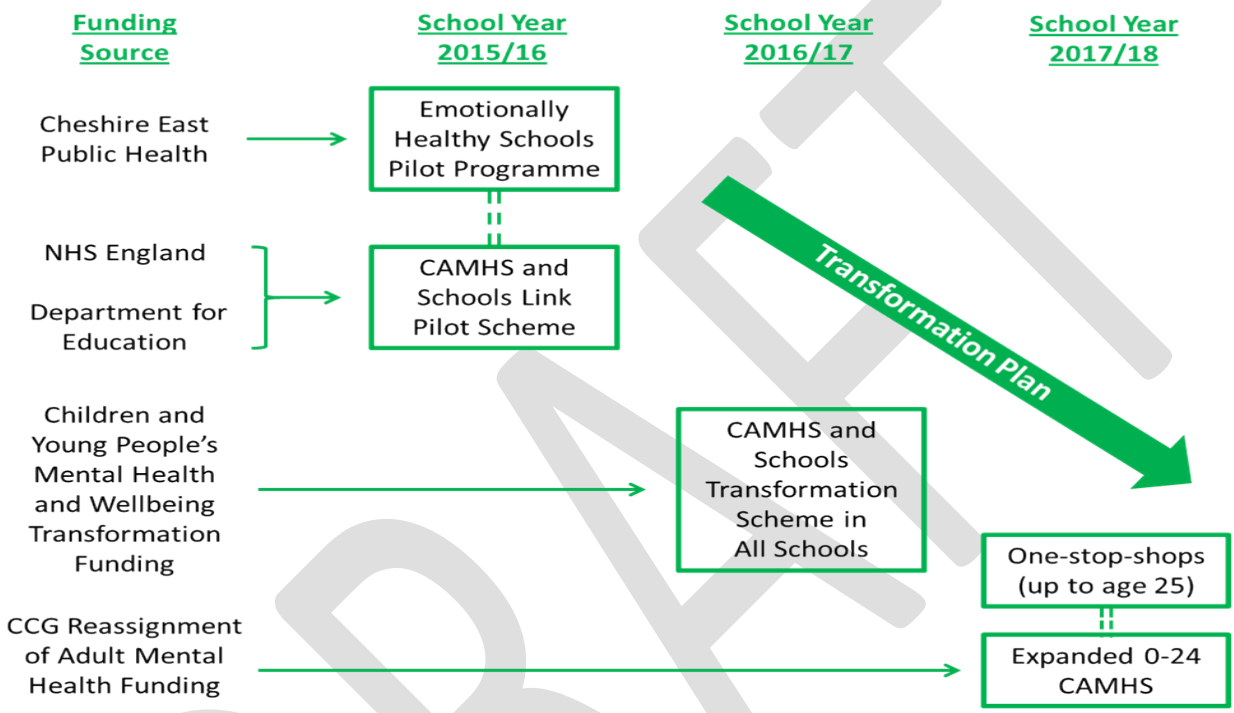
1. Many services are not being "joined-up" for young adults
2. Young people often experience a "cliff-edge" between children's and adult services.
3. Age boundaries for statutory services can differ unexpectedly and often seem to be set arbitrarily.
4. In some instances, it is not clear which service should respond to young adults, just at the point they are expected to become independent users of services for the first time.

Objectives

1. Identify and target young people with multiple risk factors for poor mental health.
2. Ask young people aged 18 to 24 about how mental health services can best meet their needs. Incorporate how young adults can continue to access children and young people's mental health services into the Transformation Plan
3. Adult and children's commissioners' work together to review how the needs of under 25 years olds are met. This may necessitate some reassignment of funding from adult mental health services
4. Develop flexible ways to access services including drop-in sessions, telephone and web access
5. Ensure speedy assessment, early first appointments, fast tracking of emergencies and offer of support while waiting to access services, such as counselling, to help keep young people engaged
6. Develop youth information, advice and counselling services that can provide social welfare legal advice alongside mental health interventions in accessible young person-friendly settings
7. Ensure voluntary sector, Youth Information Advice and Counselling Services should be a key part of any universal local offer with an increased number of one-stop-shop services based in local communities

Opportunities to achieve some change quickly

Although all the actions are important, it may be possible to achieve some more efficiently than others. The actions summarised in the diagram below already have funding allocated and a certain degree of partnership engagement. Therefore with additional discussion and debate these could gain full commitment from all partners and large scale change could be achieved quickly.



NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th March 2016
Report of: Helen John, Health Protection Manager
Cheshire East Council
Subject/Title: Health Protection Forum

1 Report Summary

1.1 The Public Health department wishes to establish a Health Protection Forum as a sub-group of the Health and Wellbeing Board, to be chaired by the Director of Public Health. The Board's support for this proposal is required. Draft Terms of Reference are attached as Appendix One.

2 Recommendations

2.1 That the Health and Wellbeing Board supports the creation of Cheshire East Council's Health Protection Forum.

3 Reasons for Recommendations

3.1 The Health Protection Forum will have responsibility for ensuring that plans are in place to protect the health of the population of Cheshire East. This will be done by identifying threats, assessing risks and reviewing health protection arrangements and plans that all associated organisations have in place. Thus it will be able to provide assurance to the Cheshire East Health and Wellbeing Board that there are safe and effective arrangements in place. In addition, the Forum will improve integration and partnership working on health protection between the Local Authority, NHS, Public Health England and other local services.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The Director of Public Health's responsibilities for health protection arise from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 - and related Regulations. (Department of Health: Directors of Public Health in Local Government: Roles, Responsibilities and Context. October 2013.)

4.2 A Public Health Outcomes Framework indicator also exists in relation to "Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies"

4.3 There are separate arrangements for emergency planning, with a joint management and governance model between both Council areas in Cheshire.

5 Background and Options

5.1 In line with guidance published by the Department of Health, Public Health England and the Local Government Association, the health protection duty of local authorities can include establishing a local forum to review interagency plans and issues, and provide feedback and/or escalation. (May 2013)

5.2 Draft Terms of Reference have been prepared based on examples from elsewhere and these are attached as Appendix One. Colleagues from partner agencies, who it is proposed are core members, have been consulted and are supportive of this approach.

6 Access to Information

6.1 Directors of Public Health in Local Government. Roles, Responsibilities and Context. (Department of Health, October 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249810/DPH_Guidance_Final_v6.pdf
Protecting the health of the local population: the new health protection duties of local authorities (Department of Health, Public Health England, Local Government Association, May 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf
The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013
http://www.legislation.gov.uk/uksi/2013/351/pdfs/uksi_20130351_en.pdf

The background papers relating to this report can be inspected by contacting the report writer:

Name: Helen John
Designation: Health Protection Manager
Tel No: ext 85801 (01270 685801)
Email: helen.john@cheshireeast.gov.uk

Cheshire East Health Protection Forum

Terms of Reference

Purpose:
To provide a forum to identify threats and assess risks to health to the population of Cheshire East, to review health protection arrangements and plans, and to provide assurance to the Cheshire East Health and Wellbeing Board that there are safe and effective arrangements in place to address threats and risks.

To improve integration and partnership working on health protection between the Local Authority, NHS, Public Health England and other local services.

The scope of health protection and threats to be covered by the forum will include:

- Prevention and control of communicable diseases, including management of outbreaks. This will cover healthcare-associated infections; food borne, water borne, blood borne and respiratory infections; and anti-microbial resistance
- Vaccination against infectious diseases
- National screening programmes which promote the early detection of disease
- Emergency planning and response including extreme weather events
- Environmental hazards including air quality, contaminated land, noise and statutory nuisances

Functions:
1. To provide strategic oversight of the health protection system in Cheshire East, and provide assurance to the Health and Wellbeing Board that there are safe and effective health protection arrangements and plans

2. To provide a forum for discussion by local partners of health protection plans, risks and their mitigation and opportunities for joint action

3. To provide oversight of key health protection intelligence, including outcomes and information derived from incidents, complaints and investigations and surveillance of infectious diseases

4. To produce an annual report, summarising key elements of assurance across the local Health Protection system

5. To highlight risks and provide recommendations on behalf of the Health and Wellbeing Board about the strategic management of these risks

6. To share and escalate concerns and risks to commissioners and appropriate bodies when health protection plans and arrangements may be inadequate to provide sufficient protection of patients or public safety. The appropriate escalation route will depend on individual concern or risk, e.g. Health and Wellbeing Board, Senior Management team of Cheshire East Council, CCGs, NHS England (C&M), Local Health Resilience Partnership

7. To share and escalate concerns to commissioners and regulators, where relevant, when a provider's management of healthcare associated infections is, or may be, inadequate to provide sufficient protection of patients or public safety

8. To review the reports of significant incidents and outbreaks, consider recommendations for change as a result, and promote quality improvement of the health protection system through encouraging implementation of recommendations

9. To promote reduction in inequalities in health protection across the Local Authority area

10. To identify key health protection needs for collaborative work to feed into the Joint Strategic Needs Assessment process

Reporting Structures:

The minutes of the Health Protection Forum will be provided to the Health and Wellbeing Board quarterly through the Director of Public Health. Where there is a need to escalate concerns to the Board more urgently, this will be done through the Director of Public Health or their nominated deputy.

Chair and Membership

The Director of Public Health will chair the group. The Consultant in Public Health (Health Protection) will be deputy chair. Core membership will be as listed below:

Title	Organisation	Name
Director of Public Health	Cheshire East Council	Dr Heather Grimbaldeston
Consultant in Public Health (Health Protection)	Cheshire East Council	Dr Guy Hayhurst
Consultant in Communicable Disease Control (or deputy)	Health Protection Team, Public Health England	Dr Anjila Shah
PHE Consultant in Screening and Immunisation (or deputy)	C&M Area Team, NHS England	Dr Daniel Seddon
Manager, Joint Cheshire Emergency Planning Team (or deputy)	Cheshire East Council	Chris Samuel
Principal Manager, Regulatory Services and Health (or deputy)	Cheshire East Council	Tracey Bettaney
Extreme Weather Planning Team	Cheshire East Council	Guy Kilminster
Health Protection Manager	Cheshire East Council	Helen John
Lead Commissioner for Drug and Alcohol services	Cheshire East Council	Shelley Brough
Quality and Performance Manager	NHS Eastern Cheshire CCG	Jacki Wilkes
Quality Lead	NHS South Cheshire CCG	Dr Andrew Hudson
Microbiologist	MCHFT and ECT joint role	Dr Raj Rajendran
Lead for Infection Prevention and Control (or deputy)	East Cheshire NHS Trust	Anita Swaine
Lead for Infection Prevention and Control (or deputy)	Mid Cheshire Hospitals NHS Foundation Trust	Karen Egan
Community Infection Control Service Manager/ Lead Nurse	Staffordshire and Stoke-on-Trent Partnership Trust	Carrie Felgate

Non – core membership
Other organisations and departments may be called upon to provide information and assurance to the forum, such as TB lead nurse, sexual health commissioner, children's services commissioner, adult health and social care.

Administration of Meetings
Capacity will be identified through the Office of the Director of Public Health to take minutes and distribute papers.

Frequency of meetings

The group will meet on a quarterly basis, or more frequently if required. The schedule of meetings will be agreed at the inaugural meeting.

Items for the Agenda

- Healthcare Associated Infection reports, covering MRSA/ Clostridium difficile etc. Available for previous 12 months as monthly rolling and quarterly data for trusts and CCGs.
- Environmental Health reports for significant food and water borne infections
- PHE reports for communicable diseases
- Immunisation and screening uptake reports
- Emergency Planning/ Incident response reports
- Public Health Outcome Indicator profiles relating to health protection
- Relevant JSNA sections related to health protection

An outline timetable will be developed to indicate which members will be discussing their areas of responsibility over a 12 month period, to enable them to be allocated over the year.

This page is intentionally left blank