Summary of Proposal

Greater Manchester is committed to significantly re-shaping services for people with LD and/or autism. The re-shaping that will take place will ensure that more services are provided in community based setting and closer to home, with a shift away from long-term hospital care.

The signing of the Health and Social Care Memorandum of Understanding with NHS England presents Greater Manchester with an opportunity to make significant progress in reforming LD provision across the conurbation. The opportunity that this presents has been further supplemented by NHS England confirming Greater Manchester’s selection as part of a national fast track programme.

The Health and Social Care Memorandum of Understanding was signed by the 10 AGMA local authorities, 12 Greater Manchester Clinical Commissioning Groups, and NHS England. It was supported by the 15 NHS Trusts and Foundation Trusts in Greater Manchester. This agreement created a genuine new partnership between CCGs, Councils, NHS England and other stakeholders with the shared objective of shaping the future of Greater Manchester health and social care together in the interests of Greater Manchester.

The MoU has afforded Greater Manchester the ability to explore new ways of working, collaboration, integration and the pooling of budgets. The LD Fast Track presents Greater Manchester with the opportunity to:

- Make best use of this new partnership by all partners working collectively to develop a joint transformation proposal;
- Work collaboratively as a health system;
- Design and commission services together;
- Take decisions together in the best interests of place and residents;
- Integrate services;
- Pool budgets;
- Embark on a radical workforce transformation programme.
Greater Manchester’s ambition for Learning Disabilities services is predicated on four key objectives:

1. **60% reduction in non-secure beds** – this will see a reduction in the number of beds from 77 to 30 by 2020 (equivalent to 10.7 non-secure beds per 1 million population). These 30 beds will be comprised of 6 crisis or acute inpatient beds for stays of up to 6 months and 24 continuing care/ rehab / forensic beds for longer stays up to 24 months (with a small number that may be longer term)

2. **34% Reduction in the number of low secure commissioned beds** - although the requirements of low secure in-patient beds are more difficult to forecast we are aiming to achieve a minimum 34% reduction in the number of beds with the potential to achieve a greater reduction through improved use of forensic out-reach support to avoid admissions. This further reduction would see the need for low secure commissioned beds reduce form 53 to 35 by 2020 (equivalent to 12.5 beds per 1 million population)

3. **Improving in / out reach intensive support** – this will ensure greater support within a community based setting and enable the reduction in the number of beds required. Our redesigned / re-profiled community services will adopt principles of positive behaviour support which will filter through into commissioned contracts and workforce development programmes.

4. **Expansion of community based accommodation** - This work will be made possible with an accompanying expansion in the specialist residential flat models in GM providing an additional 4 x 6-8 supported home placements creating a total of 24-30 additional places.

**Current position in Greater Manchester**

In order to support the development of a Fast Track Programme in Greater Manchester, an analysis of the current LD population has been undertaken using nationally available Public Health England profiles. The table below highlights key performance measures for GM. A more detailed analysis is provided in appendix one.
Table 1 – GM performance summary

<table>
<thead>
<tr>
<th>Indicator (2013/14)</th>
<th>England Average</th>
<th>North West Average</th>
<th>GM average</th>
<th>Highest GM figure</th>
<th>Lowest GM figure</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD prevalence 18+ (%)</td>
<td>0.5</td>
<td>0.5</td>
<td>0.4</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Adults known to services (per 1000 population)</td>
<td>4.3</td>
<td>4.6</td>
<td>5.2</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Children with moderate learning difficulties known to schools (per 1000 pupils)</td>
<td>15.6</td>
<td>16</td>
<td>24.9</td>
<td>13.7</td>
<td></td>
</tr>
<tr>
<td>Children with severe learning difficulties known to schools (per 1000 pupils)</td>
<td>3.73</td>
<td>4.23</td>
<td>6.86</td>
<td>2.64</td>
<td></td>
</tr>
<tr>
<td>Children with profound and Multiple learning difficulties know to schools (per 1,000 pupils)</td>
<td>1.27</td>
<td>1.56</td>
<td>1.94</td>
<td>1.51</td>
<td></td>
</tr>
<tr>
<td>Children with Autism known to schools (per 1000 pupils)</td>
<td>9.1</td>
<td>8.7</td>
<td>13.3</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Proportion of eligible adults with a learning disability having a GP health check (%)</td>
<td>44.2</td>
<td>50</td>
<td>57.9</td>
<td>34.3</td>
<td></td>
</tr>
<tr>
<td>Adults using day care services supported by the LA (per 1000 population)</td>
<td>323.7</td>
<td>320.9</td>
<td>535.9</td>
<td>75.6</td>
<td></td>
</tr>
<tr>
<td>Adults with learning disabilities in employment</td>
<td>6.7</td>
<td>5.2</td>
<td>5.2</td>
<td>1.4</td>
<td></td>
</tr>
</tbody>
</table>

Benefits of a new GM approach

The benefits of the new GM approach will mirror the draft national service model (July 2015):

1. My care is planned, proactive and co-ordinated
2. I have choice and control over how my health and care needs are met
3. I live in the community with support from and for my family and paid carers
4. I have choice about where I live and who I live with
5. I have a fulfilling and purposeful everyday life
6. I get good care from mainstream NHS services
7. I can access specialist health and social care support in the community
8. I am supported to stay out of trouble
9. If I need assessment and treatment in 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

In addition to this GM has agreed to inclusion of a tenth outcome:

“I feel and am safe, and I am supported to manage my risk”

As part of the detailed work on the programme we will also be developing a benefits realisation plan. This will build on our principles of GM reform looking at whole system costs and will be based on developing our approach to economic sustainability.

**Delivering the GM ambition**

Greater Manchester is in a unique position to deliver against our challenging ambition for learning Disability services. Our devolution agreement and existing cross public sector governance arrangements mean we take collaborative cross organisational responsibility and decision making and reforming service delivery for the benefit of those living and working in GM.

In order to achieve our GM ambition for Learning Disability services within the timescales agreed there are a number of key enablers that need to be in place:

- Additional funding in the short term to support the increased cost of redesigned community based services and accommodation provision to allow the reliance on bed provision over the first 18 month period
- Development of a long term sustainable change to funding formulas at the local level through the use of incentives for CCGs/LAs as they assume responsibility for previously commissioned services activity through NHS England Specialised Commissioning of secure in-patient beds. This will require additional dedicated specialist collaborative commissioning capacity
- An annual review of bed usage within the aim of delivering continued reduction in and reliance on secure in patient care with an equal increase in the provision of community based care
• Redesigned services to be developed and implemented over the first 18 month period incorporating:
  ▪ Stabilisation and redevelopment programme action at Calderstones Hospital to ensure that existing patients are not unintentionally impacted on through the wider system changes, forensic out-reach support is extended and limited specialist skills are not lost as part of a wider workforce development programme
  ▪ Additional dedicated specialist case management/pre-admission-discharge CTR facilitation and active project oversight
  ▪ Community LD Team and Specialist Autism Team professional development programmes
  ▪ Primary and Acute Health Improvement Programmes

• Overarching workforce development package which facilitates a shift in focus towards developing independence and a person centred culture and practice. In addition to this we will work to develop our commissioning capacity across the system

Governance and stakeholder engagement

The MoU brought together the 10 local authorities, 12 CCG’s and NHS England, supported by the 15 NHS and Foundation Trusts, to ensure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million citizens of Greater Manchester.

Our delivery approach for the programme is therefore built upon binding and collective governance that is being developed both at a locality and a Greater Manchester level.

For Learning Disabilities and the fast track transformation programme this will lead to a new governance structure for delivering:

  ▪ A single locality for the provision of care and choice for people with learning disabilities.
  ▪ A commitment to delivering a commissioning model through pooled budgets.
  ▪ An agreed performance framework for providers delivering LD services in GM.

Workplan

GM has developed a programme of work that will be reported on at each Programme Board meeting. This consists of eight workstreams:
• Extending collaborative commissioning
• Extending case management and pre-CTR at risk and discharge co-ordination Team and support for extended panels
• Development of six GM crisis beds and a GM gate keeping in-reach and outreach specialist support team
• Memorandum of understanding and additional Fast Track positive behaviour support intensive support residential flat schemes
• Community learning and disability team all age development and health facilitation programme building on CQUINs
• Specialist autism teams and extended support programme for complex needs
• Joint training and workforce development programme with NWTDT and NAS for families
• Calderstones – Merseycare forensic care pathway development and transition stabilisation programme

The details of these workstreams is outlined in section 5.1

Funding

The cost of delivering the GM Learning Disabilities transformation programme of activity will cost £10.25m, broken down into £6.25m for the delivery of the Transforming Care Programme and £4m to support the stabilisation and redevelopment programme at Calderstones.

It is suggested this will be funded through:

Transformation Programme:
• GM CCGs commitment of £3.15m to support the transformation programme
• £3.1m GM Fast Track Transformation Fund

Calderstones:
• £1m from GM CCGs
• £1m contribution form Lancashire
• £1m GM Fast Track Transformation Fund
• £1m from Lancashire Fast Track Transformation Fund
The total GM ask from the Transformation Fund is £4.1m

The successful delivery of the above programme of work is predicated on the a local government understanding that NHS will provide recurrent funding for individual patients who are transferring from NHS provided care to local authority provided care (dowries)
**Context for the GM bid**

It is a clear public policy objective that people with learning disabilities should be cared for in the community and as near as possible to their homes and families. They should only be placed out-of-area, or in hospital units with a level of security when so justified by the danger they present to themselves and others (Department of Health, 2001; 2004). While significant progress has been made over the last 30 years to move from a model of institutional care and long term facilities, to care delivered in community settings, large numbers of people are still being unnecessarily cared for in hospitals and/or facing health inequalities.

Greater Manchester is committed to significantly re-shaping services for people with LD and/or autism, to ensure that more services are provided in the community and closer to home, with a shift away from long-term hospital care. The Health and Social Care Devolution Agreement entered into by GM with NHS England presents an opportunity to make significant progress at scale and pace, so that every person with learning disability/autism gets the right care in the right place across GM. This includes improving the health of all of our residents, and providing reliable access to early help will improve family circumstances, help people become and remain economically active, improve educational attainment and strengthen communities. The impact of learning disabilities, autism and/or poor mental health has on life expectancy similarly confirms the potential to add years of life and life to years to residents across the life course and geographical conurbation.

GM’s Public Service Reform objectives aim to enhance our ability to spend public money from different budgets on the same individuals and families in a properly integrated and sequenced way. Consistent access to integrated, high quality, responsive support to people with learning disabilities/autism is, therefore, a necessary pre-condition to ensure GM achieves its growth and reform objectives, given the significant demands of this important but relatively small group of individuals. As such, our fast track plan is predicted on an assumption that the current system needs effective transformational change.

We see the fast track programme as providing a unique connection across all of our Public Service Reform objectives and can drive the wider strategic partnerships required beyond core NHS and social care agencies to wider local government services, GMP, GMFRS, NWAS, Education and others. This is the start of a long journey of sustained system-wide change, with effective interdependence as the focus for those developments necessary to improve the quality of community life for people with learning disabilities/autism. To support our programme of change we will develop the leadership, authority, fair expenditure and new or different kinds of agreements to explore new ways to assure safety and quality.
Based on the complex improvement activities we believe are required, the GM Fast Track plan is supported by a commitment to the following priorities as essential building blocks to enable change:

- Implementation should be led at a Single GM-wide level wherever possible: the strengthening of the GM LD Fast Track Delivery Group as a collaborative commissioning team with additional case management team resources integrated with local CHC and Joint Funding Panel arrangements (and potentially some gain share models with changes to NHS England Secure Specialised Commissioning funds) will require considerable operational, cultural and behavioural change.
- Some elements of implementation or design will only need to be ‘done once’ for Greater Manchester but will need to be tested locally (e.g. implementation of Specialist GM Crisis Beds/Intensive Support Team, Residential Individual Flat models and GM LD Workforce Planning).
- Other elements of the implementation will require oversight and management at a GM/Lancs level (for example during facilitating the specialist and forensic care pathway changes related to the acquisition of Calderstones by Mersey Care, including support for negotiation with staff unions and GM specialist service recruitment) and there will be an on-going requirement for programme assurance, programme management, clinical leadership, and decision making.

Careful planning and wider supporting system changes are essential in terms of informed leadership, collaborative work with families, practical training, reflective problem-solving practice, quality improvement/assurance activities and to support avoidance of admissions or discharges from local community services.

At the core of the GM Health and Social Care devolution programme is a recognition that wider change around new ways of assurance will be key to the success of our transformation initiatives. We need not only to change the focus of service delivery from hospital to community settings, we need to develop more efficient means of monitoring or putting in place better techniques for ensuring compliance.

We would want to separate our programme of work into two phases with a sharper reduction in in-patient activity in the first 18 months conditional on the extra Transforming Care funds, and then sustained over time through the changes to the wider funding formulas and dowries for CCGs/LAs (as they assume gradually responsibility for previously commissioned services activity through NHS England Specialised Commissioning secure in-patient beds moves to CCGs and LAs).

This work will be made possible with a number of enablers – especially by extending, spreading and scaling-up the evident good practice in pockets across GM localities and organisations, through a significant amount of:
- Additional dedicated specialist collaborative commissioning capacity
• Additional dedicated specialist case management/pre-admission-discharge CTR facilitation and active project oversight
• Additional joint training programmes to shift the focus from pure technical skills to ‘effective interdependence’ and person-centred or ‘just culture’ practice
• Community LD Team and Specialist Autism Team professional development programmes
• Primary and Acute Health Improvement Programmes
• Stabilisation and redevelopment programme action at Calderstones to ensure that:
  o existing patients are not damaged through the wider unintended system changes
  o forensic out-reach support extended and the limited specialist skills are not lost as part of a wider workforce development programme
GREATER MANCHESTER LEARNING DISABILITY TRANSFORMING CARE FAST TRACK PLAN

1. Mobilise Your Area

1.1 Current in-patient provision across GM

Current bed usage in GM is 77 through our programme of activity this is expected to reduce to 59 by March 2016 with further reductions to 24-36 by March 2020

<table>
<thead>
<tr>
<th>Fast Track Area</th>
<th>2014/15 Baseline</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Manchester</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of Patients (including those out of area)</td>
<td>144</td>
<td>59</td>
<td>36</td>
<td>24</td>
</tr>
<tr>
<td>Potential Bed Closures</td>
<td>50</td>
<td>18</td>
<td>36%</td>
<td>15</td>
</tr>
</tbody>
</table>

Our aspirational trajectory for bed reduction through to 2020 is in line with national targets and is helping to move faster on bed closures. The table below identifies how this breaks down by individual CCG area in GM.
### Breakdown of CCG Commissioned Patients

<table>
<thead>
<tr>
<th>CCG</th>
<th>Current Total In-Patient numbers at June 2015</th>
<th>Draft Plan by Apr 2016</th>
<th>Draft Plan post Apr 2017</th>
<th>Draft Plan post Apr 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Bury</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Central Manchester</td>
<td>12</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Heywood/Middleton/Rochdale</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>North Manchester</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Oldham</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Salford</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>South Manchester</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Stockport</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Tameside and Glossop</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Trafford</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Wigan</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>GM Total</strong></td>
<td><strong>77</strong></td>
<td><strong>45 (42%)</strong></td>
<td><strong>36 (53%)</strong></td>
<td><strong>24 (69%)</strong></td>
</tr>
</tbody>
</table>

The GM LD FT Early Implementation Programme Plan highlights as follows:

- Overall in-patient service model plans for GM are in line with activity suggested of 10 non-secure in-patient beds per 1 million population as Phase 1 from 2015 -2020.
- Therefore, this would mean for the GM population our plan is for:
  - a 60% reduction in non-secure beds from baseline of 77 patients in non-secure beds (acute and continuing care/rehab/forensic) to a target of 30 patients in non-secure beds
  - broken down to an estimated 6 crisis or acute inpatient beds with an accompanying in/out-reach intensive support team backing up local community services (with lengths of stay up to 6 months for crisis admissions)
  - and 24 continuing care/rehab/forensic beds (with lengths of stay of up to a further 24 months with a small number longer-term)
  - so accommodating 12-15 new acute admissions and readmissions each year
This work will have a direct and significant impact on 2 particular providers for GM – that is Calderstones and Equilibrium Healthcare – and more limited impact on other providers such as 5 Boroughs, ASC Healthcare, Care UK, CWP, Danshell Health Group, GMW/Priory, Lighthouse Healthcare, St Marys/St Georges Hospital and Woodleigh Community Healthcare.

- The planned changes to Low Secure in-patient activity is harder to forecast with a current assessment only recording 24 of the existing 77 low secure patients being deemed fit for discharge.
  - hence suggestion may be that we can plan for at least a 30% reduction in this in-patient group through facilitating discharges to specialist care packages/accommodation and if we can provide better forensic outreach support to avoid admissions
  - this would mean that the plan could be for a reduction in the GM low secure commissioned bed state to approximately 50 low secure beds or a rate of 18-20 beds per 1 million population by 2020
  - This work will have a direct and significant impact on 1 particular provider – that is the planned merger between Calderstones and Mersey Care their Acquisition Outline Business Case contains a plan for significantly greater reduction in low-secure in-patient activity over the next 2-3 years which requires validation by CCGs.

GM LD FT therefore suggests
- a sharper change in the first 18 months conditional on the extra TC funds
- and sustained over time through the changes to the funding formulas and dowries for CCGs/LAs as they gradually assume responsibility for previously commissioned services activity through NHS England Specialised Commissioning secure in-patient beds
- suggested model approach being to revert to the old PCT model of reviewing bed usage on an annual census basis and then CCG funding charges based on 3-year rolling average – hence incentivising CCGs/LAs to reduce reliance on secure in-patient care and also enabling gradual shifts in funding based on sustained performance while maintaining a risk-share approach
- These figures are in line with the original submission to NHS England on 15th July 2015 as the Programme was launched.

- This work will be made possible with an accompanying expansion in the specialist residential flat models in GM – providing an additional 4 x 6-8 supported home placements – that is 24-30 places and redesigned/re-profiled spectrum of community services adopting PBS principles into commissioned contracts and workforce development
Based upon the local responses before 1st September 2015, any difference between the aspirational and aggregated local trajectories will be addressed by escalating to individual CCG boards and accelerating local plans and revising both assumptions and local investment plans. All reductions in inpatient beds will be managed through GM assurance processes.

Further work will also be undertaken to understand and compare the activity and financial assumptions with regard to patient cohorts (as described in the Draft Service Model) in relation to:

- LOS
- Admissions
- Admission prevention
- Impact from and Capacity Assumptions in Intermediate Tier Community Services (including collaboratively-commissioned Crisis beds and Teams) and
- Enhancement of social care services
- Resettlement and Discharge Issues

1.2 Are the key partners identified and signed up to delivering?

In Greater Manchester we are working collaboratively as a single health and social care economy to implement the 10 recommendations of *Healthcare for All* (Report of the Independent Inquiry into access to healthcare for people with learning disabilities, 2008) and more recently by *Bubb* (2014).

The GMFT and GM as a whole have already demonstrated the leadership required to deliver place based transformational change, drawing upon the organisational commitments to work as a whole economy that have embodied the Health and Social Care Devolution MoU.

The establishment of the GM LD FT Programme Board, a partnership between the CCG’s, NHS, local authorities and other key public sector organisations such as Greater Manchester Police and the Criminal Justice Service, is a clear demonstration of the commitment of all commissioning organisations in GM to the transformation of learning disability services and the lives of people with learning disabilities and their families.

The Programme Board are able to draw upon the organisational commitments made to work as a whole economy that
have embodied the Health and Social Care Devolution MoU to deliver transformation change that is required, at the pace and scale needed. They are also able to exercise the required leadership to make this happen.

As part of the fast track process this Board will establish effective linkage with groups and individuals who have learning disabilities. This engagement will draw upon of engagement with people with learning disabilities, their families, carers and advocates. For example, across GM, Pathways, a third sector organisation, has been invaluable in delivering the engagement required.

At this stage it is anticipated that people with learning disabilities will engage with the transformation process through the delivery group, and will be able to enhance ideas about co-production of services. In addition a number of local HealthWatch organisations have completed visits to LD services across GM and could they too will become a valuable source of support, information and critical appraisal.

GM FT remains committed to ensuring the on-going involvement of users, their carers and families in the co-production of models of care and their implementation across GM. This is evidenced through the continued partnership with Pathways to Care. An example of this is described by Manchester City Council (Working Together to produce an all-age Disability Strategy - A focus on co-production with key resident groups (July 2014).

This paper uses a ladder of participation. This tiered approach to participation is also appropriate to developing services for people with LD. Whilst engagement events have been held, it is clear that a core part of the fast track programme will be to develop a communication strategy – this will need also include stakeholder analysis to ensure the GM is as inclusive as it can be when transforming services.

Whilst GM has identified that the reduction in bed numbers will have a significant on two providers, (Calderstones and Equilibrium Healthcare), GM also recognises that its transformational proposals will impact on other providers such as: 5 Boroughs; ASC Healthcare; Care UK; CWP; Danshell Health Group; GMW/Priory; Lighthouse Healthcare; St Marys/St Georges Hospital; and, Woodleigh Community Healthcare.

GM acknowledges that as part of FT transformational programme, further work will be required with the wider provider market, and this will take place as part of the future engagement and consultation process.
2. Understanding where you are

2.1 Understanding our patient population and needs

Comparing the GM data with the Nationally available [PHE population profiles](#) demonstrate a number of significant variations in key areas:

<table>
<thead>
<tr>
<th>Indicator (2013/14)</th>
<th>England Average</th>
<th>North West Average</th>
<th>Highest GM figure</th>
<th>Lowest GM figure</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD prevalence 18+ (%)</td>
<td>0.5</td>
<td>0.5</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Adults known to services (per 1000 population)</td>
<td>4.3</td>
<td>4.6</td>
<td>5.2</td>
<td>3.7</td>
</tr>
<tr>
<td>Children with moderate learning difficulties known to schools (per 1000 pupils)</td>
<td>15.6</td>
<td>16</td>
<td>24.9</td>
<td>13.7</td>
</tr>
<tr>
<td>Children with severe learning difficulties known to schools (per 1000 pupils)</td>
<td>3.73</td>
<td>4.23</td>
<td>6.86</td>
<td>2.64</td>
</tr>
<tr>
<td>Children with profound and Multiple learning difficulties know to schools (per 1,000 pupils)</td>
<td>1.27</td>
<td>1.56</td>
<td>1.94</td>
<td>1.51</td>
</tr>
<tr>
<td>Children with Autism known to schools (per 1000 pupils)</td>
<td>9.1</td>
<td>8.7</td>
<td>13.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Proportion of eligible adults with a learning disability having a GP health check (%)</td>
<td>44.2</td>
<td>50</td>
<td>57.9</td>
<td>34.3</td>
</tr>
<tr>
<td>Adults using day care services supported by the LA (per 1000 population)</td>
<td>323.7</td>
<td>320.9</td>
<td>535.9</td>
<td>75.6</td>
</tr>
<tr>
<td>Adults with learning disabilities in employment</td>
<td>6.7</td>
<td>5.2</td>
<td>5.2</td>
<td>1.4</td>
</tr>
</tbody>
</table>
This data helps us to identify a number of priority areas for GM:

- The number of children with profound and multiple learning disabilities is higher in GM than England or the NW.
- Proportion of eligible adults with learning disabilities having a GP health check in some areas in GM is significantly lower than England or the NW but it should be noted in others performance is higher.
- There is significant variation in the number of adults using day care services across GM with some areas significantly lower than England or the NW

It is important to note that against some performance indicators there are considerable differences across GM. Our programme of activity therefore needs to support progress in lower performing areas, requiring variable levels of investment and priority across localities.

In addition to the national profiles, local data from across GM has been gathered by NECS and analysed to identify the number of people with severe disabilities and complex needs per 1,000 population by age group:

- under 13 years old – 0.6
- 14-17 years old – 2.1
- 18 – 34 years old – 1.6
- 35 – 64 years old – 1.6
- over 65’s - 1.8

The prevalence of complex needs within the 14-17 cohort demonstrates the need for successful transition to adult services as part of the Fast Track programme. In addition to this the mortality rates for people over 65 within this cohort is higher than would be expected and may be the result of lower access to general health care services (for example cervical screening amongst women in NW is 60% but for women with learning disabilities it is around 30%)

Our current data also shows:

- There are less 65+ than expected in the general population, but this proportion has increased in the last 20 years and is expected to continue to do so.
- 150 people from GM are currently using in-patient facilities. As well as the decrease in bed numbers admissions
run at 11 per 6 months

- There are currently 215 placements at risk of breakdown, within this the 18-34 year old cohort are at greatest risk of placement breakdown (however this wide age band may mask a greater proportion in the under 25 age group which could potentially be linked to transition)
- The majority of support packages can be categorised as costing either £50k – £99k or £100k - £199k – this data however does not include those currently cared for at Calderstones or people supported by smaller care packages. As people leave hospital and return to the community funding will need to flow with these patients putting pressure on both hospital and community budgets during this re-profiling phase. The data also doesn't consider the resource being delivered by family carers
- Mental health, challenging behaviour and autism are the highest occurring conditions. However the data contain a significant number of people categorised as ‘other’. This needs to be further investigated to ensure needs are understood and feeds into our strategic planning
- The number of people currently supported in a local residential setting is just below 900
- Approximately 300 people are supported out of area – it is not clear from the data collected how many of these are outside of GM or out of borough but placed within another borough inside GM. This work needs to be led by the GM collaborative commissioning group
- GM has the second highest number of inpatients per 10,000 population across the country

<table>
<thead>
<tr>
<th>2.2 Current Provider base</th>
</tr>
</thead>
</table>

The original published in-patient bed use trajectories were reported by NHS England with a minimum expectation of a 10% reduction and greater ambitions related to fast track programmes

Current non-secure bed usage in GM is 77 and through our programme of CTR activity this is predicted to reduce to 30 by March 2020, made up of 6 crisis / acute beds and 24 continuing care. In addition to this we are aiming to reduce low secure beds from 53 to 35 in the same time period.
The detailed trajectories of these reduction are outlined in the table below:

<table>
<thead>
<tr>
<th>Occupied LD IN-PT beds</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>High secure</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medium secure</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Low secure</td>
<td>41</td>
<td>32</td>
<td>28</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Secure Total</td>
<td>53</td>
<td>44</td>
<td>40</td>
<td>35</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Acute LD</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Complex continuing care / rehabilitation / forensic rehab / step down</td>
<td>67</td>
<td>43</td>
<td>36</td>
<td>28</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Non-Secure Total</td>
<td>77</td>
<td>53</td>
<td>42</td>
<td>36</td>
<td>32</td>
<td>30</td>
</tr>
<tr>
<td>GM Total</td>
<td>130</td>
<td>97</td>
<td>82</td>
<td>71</td>
<td>67</td>
<td>65</td>
</tr>
<tr>
<td>Rate per head of population (million)</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>High secure</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Medium secure</td>
<td>3.9</td>
<td>3.9</td>
<td>3.9</td>
<td>3.6</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Low secure</td>
<td>14.6</td>
<td>11.4</td>
<td>10.0</td>
<td>8.6</td>
<td>8.6</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Secure Total</strong></td>
<td><strong>18.9</strong></td>
<td><strong>15.7</strong></td>
<td><strong>14.3</strong></td>
<td><strong>12.5</strong></td>
<td><strong>12.5</strong></td>
<td><strong>12.5</strong></td>
</tr>
<tr>
<td>Acute LD</td>
<td>3.6</td>
<td>3.6</td>
<td>2.9</td>
<td>2.9</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Complex continuing care / rehabilitation / forensic rehab / step down</td>
<td>23.9</td>
<td>15.4</td>
<td>12.9</td>
<td>10.0</td>
<td>9.3</td>
<td>8.6</td>
</tr>
<tr>
<td><strong>Non-Secure Total</strong></td>
<td><strong>27.5</strong></td>
<td><strong>18.9</strong></td>
<td><strong>15.0</strong></td>
<td><strong>12.9</strong></td>
<td><strong>11.4</strong></td>
<td><strong>10.7</strong></td>
</tr>
<tr>
<td><strong>GM Total</strong></td>
<td><strong>46.4</strong></td>
<td><strong>34.6</strong></td>
<td><strong>29.3</strong></td>
<td><strong>25.4</strong></td>
<td><strong>23.9</strong></td>
<td><strong>23.2</strong></td>
</tr>
</tbody>
</table>

Further work is planned in understanding and comparing the activity and financial assumptions with regard to different specific at-risk patient cohorts in relation to:

- Lengths of Stay against national RCP/CQC best practice guidance
- New Admission demands
- Reducing Admission rates and other prevention activity
- Impact of (and from any Capacity Assumptions) of the introduction of Specialist Intermediate Tier Community Services (including collaboratively-commissioned Crisis beds, Teams and Residential Care options)
- Enhancement of and reductions in social care services/capacity
- Related specific Resettlement and Discharge Issues
As part of the work to date GM LD fast track has gathered information across the GM localities during August 2015.

- GM demonstrates a wide range of service options
- There appear to be higher levels of in-patient contracts than would be expected
- Many of these currently are based on single commissioner contracts and from the responses there are only a small number of pooled budgets, GM LD FT will seek to establish a more appropriate level of pooled budgets and joint contracts.
- Many providers have been used for between 5 and 10 years which means than there are opportunities to invite new providers with innovative ways of working.
- Many of the contracts have a length of tenure that has survived a number of NHS and Local Authority reorganisations. There is an opportunity within the GM LD FT to introduce new providers and new ways of working as part of this programme we will undertake a market review to support this.
- It is clear from the mapping exercise there are opportunities to increase the current use of pooled and joint budgets
- Also the mapping exercise indicated that out of area placements seem high. There is a need to understand the type of placements and associated costs and if working as a single unit will provide flexibilities that are not available currently.
- From the data available across GM there are more than 150 providers delivering some LD services. There is no guidance as to what is a good number for any given population. However, where there are a high number of small contract value providers it makes it difficult to maintain standards where there are a small number of commissioners. Within this there is still a need to maintain a person's choice as to the care that best meets their needs.
- There is a commitment from the GMLDFT to work collaboratively across GM, but there is additional work to understanding the finance, capacity and resilience planning for each locality that forms this whole system.
### 2.3 Case for change

Several individual patient stories and themes have been reviewed on a weekly basis through the *Fast Track* programme activity to illustrate real problems and ways forward such as:

**‘Jane’**

Jane was taken into care in her home authority (outside of GM) at age 10 due to being abused by members of her close family. Her grandfather is the only member of her family who maintained contact. Subsequently her home authority placed her in a series of children's home placements in GM, specifically to move her away from her abusers and the ructions the case caused in her small home community.

When Jane reached adulthood she was placed in a supported tenancy service in GM. In her early 20s she was sectioned under the mental health act and was placed with a secure residential service for adults with learning disabilities. Jane has been diagnosed as having an autistic spectrum condition (ASC).

Jane’s time in the learning disabilities service was particularly challenging due to the on-going effect of the abuse, disconnect from her family and her frustrations with her autism and the environment of the service. Responsibility for Jane’s care was split between GM NHS who sectioned her, and her home local authority who initially placed her in GM.

Jane’s story is not unique amongst other residents at the service. Many were abused in early childhood by close family, or with family’s knowledge. All have a diagnosis of ASC and/or Attention Deficit Hyperactivity Disorder or Personality Disorder. All were taken into care relatively young and have a history of moving from residential school/unit/etc. Many present risks of self harm or violence to property or other patients and staff. All entered secure services at or shortly after transition into adult services.
‘Annie’

Annie was referred to the Adult Learning Disability Team in 2012 following an escalation in Annies's behaviour and concerns for her health following recurrent infections both in her urine and her ears.

Annie has autism, a severe learning disability and is registered blind. Annie lives in a single supported tenancy with 24 hour staff support. Annes’s behaviour was occurring on a daily basis, having a major impact on her quality of life. Annie’s behaviour included: pacing, throwing items, vocalisations, removing clothes, pulling/pushing others, hitting herself in her face, banging her arms, back of hands, elbows on hard surfaces. These behaviours, signs of distress could occur at any time of day and followed a gradient of intensity that could last for long periods of time.

A support plan and series of interventions were put in place for Annie, including: a visit to G.P to discuss health concerns related to Annie’s weight loss and hearing problems, a series of investigations followed with treatment support and Annie was prescribed a new drug regime and diet plan, she was also able to have her ears syringed. A communication passport was also developed for Annie. She was also referred to an Occupational Therapist who undertook a sensory assessment and recommended a sensory diet including regular brushing of her arms and legs, a night time routine including wearing lycra clothing. The outcome of this was that Annie was able to sleep through the night and wear her clothes at all times.

The programme of treatment resulted in Annie’s behaviour improving, including: behaviours have significantly reduced; participating in more activities; appearing much more satisfied (not hungry); wearing her clothes and pyjamas; a good sleep pattern; more relaxed.

Annie’s new drug regime has fewer side effects and she has had health investigations that she would not have previously undertaken without the use of treatment support. As a result she is in less pain, a support plan is in place and she has been able to do things that previously she wouldn’t have been able to, for example travelling in a vehicle.

There are many examples of good practice across GM including:

- In and out-reach models in CAMHS /Dementia that reduce reliance on beds - GMW/Pennine Care
- Complex Case Management linked with CHC Teams - Bury/HMR/Oldham/Tameside
- Market management and set-up of step-down individual supported complex-needs living and residential schemes and accompanying Provider Engagement - Bolton/Oldham/Tameside
- Early Intervention and Transition approaches - Manchester/Tameside/Wigan
- Family CB/Sleep Training Workshops - NAS
- Support Primary Care and Acute Health action/SAF work - Salford/CMFT/UHSM/PACT
- Autism TES Case Management Model - Bolton/Trafford
- GMP Street Triage/Liaison and Diversion/LDD Offender Health support - Wigan/GM Probation/CRC
- CLDTs and Pooled Budgets - Salford
- Needs and Service Utilisation Reviews - Trafford
- Supported Work/IPS - Stockport/Pure Innovations
- Personal Health Budgets - Trafford
- Positive Behaviour Network and Training - Salford/NWTDT

These examples are however within individual or groupings of localities within GM rather than across the whole sub region. Through our programme of activity we will work towards scaling up best practice approaches such as these that are known to work. This approach is in line with the principles of GM’s approach to the wider Health and Social Care Devolution by understanding and scaling best practice across GM.

As part of the Fast Track programme of work GM has identified a number of potential areas of development that will enable us to ensure continuous improvement of care and outcomes and potentially form part of a collaborative commission strategy for learning disability services across GM. Given the current differences in provision across the 10 localities in GM, not all of these areas for development apply to all the localities. The table below sets out these areas and the localities they apply to.
<table>
<thead>
<tr>
<th>THEME</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BLTN</td>
</tr>
<tr>
<td>Accommodation – availability/ suitability</td>
<td>✓</td>
</tr>
<tr>
<td>Care Co-ordination</td>
<td>✓</td>
</tr>
<tr>
<td>Integrated working across agencies/specialisms</td>
<td>✓</td>
</tr>
<tr>
<td>People at Risk Register (inc. risk stratification)</td>
<td>✓</td>
</tr>
<tr>
<td>OATS</td>
<td>✓</td>
</tr>
<tr>
<td>Physical Health inc HAPs</td>
<td>✓</td>
</tr>
<tr>
<td>Personal health budgets</td>
<td>✓</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>✓</td>
</tr>
<tr>
<td>Crisis Unit capacity and capability</td>
<td>✓</td>
</tr>
<tr>
<td>24x7 Intensive Support</td>
<td>✓</td>
</tr>
<tr>
<td>Parenting</td>
<td>✓</td>
</tr>
<tr>
<td>LD Workforce planning / Skills availability</td>
<td>✓</td>
</tr>
<tr>
<td>Employment – skills/funding</td>
<td></td>
</tr>
</tbody>
</table>
Service user engagement forms a critical part of our approach to reforming services. In support of this people with Learning Disabilities were invited to take part in an event where they were asked to express their views and concerns. The outcome identified key issues including:

- Listening to the views of service users and family members is important – support to be individuals
- Building relationships and in particular having consistent carers is essential
- Feeling safe is important
- Support to remain in the community and in appropriate good quality accommodation
- Communications and engagement with service users and family members is important
- Service users should have greater influence and control over what happens to them
- Discharge from hospital should be quicker and services available in hospital should be available in the community
- Wider health support is important including GPs and dentists for example

Similarly commissioners have been asked to identify their concerns with current services and the national strategy. This identified a number of issues:

- There is more work needed to understand early intervention in children and young people.
- There is a need to understand the stages in difficulties in sustaining placements in 14 and 17
- Some of 18-34 are transition issues will be occurring in people up to the age of 25 leaving a core of 25-64 with smaller group if people but more complex needs.
- Another cohort are older people becoming more frail and experiencing dementia, frailty and LTC as older people of the general community do but with less access to general health care.
- There are also people with LD and palliative care needs which are not being met.
- Good practice examples need to be disseminated across GM as an integrated part of the FT.

3 Develop Your Vision for the Future

3.1 Aspirations and expected progress
The benefits of the new GM approach to Learning Disability services will mirror those in the draft national service model (July 2015):

1. My care is planned, proactive and co-ordinated  
2. I have choice and control over how my health and care needs are met  
3. I live in the community with support from and for my family and paid carers  
4. I have choice about where I live and who I live with  
5. I have a fulfilling and purposeful everyday life  
6. I get good care from mainstream NHS services  
7. I can access specialist health and social care support in the community  
8. I am supported to stay out of trouble  
9. If I need assessment and treatment in 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  

In addition to this GM has agreed to include a tenth outcome:

“I feel and am safe, and I am supported to manage my risks”

The information collated as part of the FT process demonstrates current variation in outcomes for people across the localities. As part of our programme we will look to share best practice and scale up evidence based approached to ensure a more consistent experience for service users across GM.

The emerging model will also ensure sustainability through a shared commitment of all partners to meeting the needs of people with learning disabilities through the delivery of high quality, cost effective services, across all partners. This will
include detailed agreement on the use of pooled budgets to deliver our collective visions for health and social care.

**Principles of a GM approach**

Greater Manchester has 7 principles within which service delivery models will be developed and delivered. These are based on recognised best practice:

- All people with learning disabilities and / or autism will be supported within the community wherever possible
- People with severe disabilities and complex support needs will be integrated into typical neighbourhoods, work environments and community settings, rather than creating a situation where people with severe disabilities and complex support needs get stuck at the wrong (most restrictive) end of a continuum, or in more restrictive placements that do not prepare them for moving to less restrictive placements
- Support will be provided for the placement of individuals with severe disabilities and complex needs in homes and natural settings. This will include earlier interventions and support at times of crisis to minimise the reliance on in-patient services and the need for out-of-area placements
- Community living arrangements will be family-scale and / or in line with age-appropriate communal styles. They will all enable individual to have their own space
- We will encourage the development of social relationships between people with severe disabilities and complex needs and a range of other people
- Individuals will be supported to participate in busy community life and develop functional, meaningful, interesting and community living skills
- Families and service users will be involved in the co-design, development, active delivery and monitoring of services. This will incorporate a real and honest appreciation of where choice and self-control need to be balanced with safety and well-being issues

**Outputs**

We will use the FT process, engagement of people with learning difficulties and their families / carers / advocates to develop a consistent performance management approach that is both quantitative and qualitative. This will build on best practice, include both Commissioners and providers will also be involved in this process and will clearly articulate what
service users can expect.

Our early conversations have already highlighted a number of potential elements for inclusion as part of an overall framework:

- Reducing the number of people who have in-patient admissions
- Compliance with pre-admission and discharge best practice processes
- Individual outcome measurement tools eg STAR outcomes measures / HEF
- Clinical outcome measures
- Number and % of people in settled and secure accommodation of their choice
- Achievement of service quality standards eg. Performance management of frequency and quality of care reviews
- Number and % of adults in employment
- % of people with health checks and health action plans
- Measured health outcome improvement eg reduced % of people with LTCs, evidence of healthy living including numbers of people taking regular exercise

In addition to this people with learning disabilities and their families have started to articulate a number of key indicators that reflect what matters to them:

- Have highly trained staff providing high quality care to all people with learning disabilities
- Having regular people who provide care across health and social care services
- To feel safe and secure with people you know and trust around you
- Where requested the strong involvement of family in the planning and provision of care
- Remaining in local communities (though important for professions to listen to where the person would like that local community to be, but not to make assumptions)
- Care to be person centred, and listen and understand the specific needs and aspirations of the individual
- To encourage independence and not to be overly hindered by a risk averse system (recognising high risk does need to be appropriately managed)
- Involve peers and experts by experience in the review, planning and delivery of care to help to provide challenge to professional to ensure care in personalised.
Due to the engagement so far of people with LD, their families and advocates there is an opportunity that GM will be able to use quantitative measures of performance delivery as well as qualitative views of the care being delivered. GM FT support for this triangulation across providers, commissioners and services users will be a powerful driver of change.

**The Commissioning Challenge**

In developing a new approach to services in GM there a five key commissioning challenges we will consider and build in to our approach:

- Ensuring a person centres and integrated approach to delivery and use of capacity across the whole system
- Development of clinical capacity around early intervention and crisis support
- Joint funding, panel and oversight review capacity
- Increasing capacity around expert care management
- Supporting provider development and capacity

To delivery against this we will undertake a review of existing capacity across current provision including community teams, undertake an accommodation review including out of area placements, market analysis. It is intended that this will lead to improved care co-ordination, pre and post discharge co-ordination, person centred plan and a workforce development strategy that enables our collective workforce to provide improved services.

**3.2 Is the plan ambitious and realistic?**

GM expects to rise to national declared challenge of reducing reliance on out-moded in-patient and crisis-models of care. We expect as part of that to transform the culture of care and support for people with LD and/or autism in the context of our wider ambitions to transform public services and connect all of Greater Manchester’s residents to the benefits of a thriving economy.

We have confirmed in detail the conditions required to secure that shift in the models of care for patients with LD and/or autism, the shift in bed capacity we expect to establish, financial profile of that shift, the capacity required for both commissioning and specialist case management to support patients through this change and the workforce reforms.
necessary to make that change sustainable.

Greater Manchester has a long history of collaboration and delivery which underpins our confidence and credibility of delivering against this plan. The Governance of both commissioning and provision developed further as part of our Health & Social Care Devolution Programme provides the country’s most advanced collaborative governance model to drive the Fast Track Pilot.

4. **Design a Model of Care to Deliver that Future**

4.1 **Future system of care**

Our future model of care will be underpinned by a number of key principles:

- Continued co-production
- GM Devo commitment and principles of GM pooled budget
- Integrated commissioning arrangements including pooling of commissioning capacity and resilience,
- Development of single GM locality to provide flexibility in terms of both commissioning and delivery of services, increasing choice to individuals and their families.
- Culture changes amongst the providers staff to accept and develop new ways of working.
- Provider reviews and market development.-More attention on services for children and parents
- Capital issues such as building requirements and IT are still to be identified.

Our Delivery Model is centred on an understanding of the whole person, their aspirations and individual circumstances. It has reliable access to specialist clinical capacity to provide early intervention and crisis support. It contains individual care management, right for each patient. It rests on integrated commissioning and secure processes of provider development to support the culture change we envisage.
Our expected outputs of the new model include:

- Improved Care Co-ordination
- Pre and Post Discharge Co-ordination
- Review of Community Teams as part of LD Workforce Strategy Development and implications for procurement
- Person centred plans (PCPs)
- Out of Area review and accelerated repatriation
- Accommodation review
- Market analysis
- Provider review

4.2 Strategic Alignment
The diagram below highlights the strategic alignment of our future service delivery model. GM has secured collective agreement through the Fast Track Programme Board to the objectives and process for transformation. The objectives are consistent with well tested principles of Public Service Reform across GM. This enables us to look beyond organisational interests and pursue a long-term vision for future care and support of individuals.

Integrate local services, ensuring the right support is available to the right people at the right time – tackling their specific barriers to work

Develop an evidence based approach, ensuring reform is based on an understanding of what works

Take a holistic based approach, recognising that barriers to work and the causes of poor mental health may lie beyond the individual
4.3 Evidence that there is a collective system response and all other interdependent strategies and plans have been identified and in place

The GM FT is established under the recently established Greater Manchester Agreement: Devolution to the Greater Manchester Combined Authority and transition to a directly elected Mayor.

The GM FT is confident that these principles have already brought together health and social care commissioners with Police and Fire Service and is confident that the partnership to deliver this plan is there (also section 1.3).

5. Plan for success

5.1 Work streams

The GM LD FT Programme Board has met on a weekly basis to shape and develop an outline transformation plan. In doing so have identified programme of work that will deliver the new model of care. The key work streams that have been identified are:

1. **GM Extended Collaborative Commissioning.**
   This is an initial non-recurrent augmentation of the current commissioning structures. This recognises the significant commissioning challenge of ensuring the transformation of services to people with LD, and the wider GM health and social care devolution commitment to work at scale across GM while also recognising that some services are best delivered (and commissioned) locally. This proposed interim structure will see the creation of a central co-ordinating commissioning hub, that can take advantages of the opportunities presented by working at scale across GM, whilst retaining a local commissioning presence within localities. This will support the implementation and delivery of the fast track plan and the structure will be reviewed post 2017.

2. **GM Extended Case Management and Pre-CTR AT Risk and Discharge Coordination Team - and support for extended Panels**
   This investment will see additional clinical resource in GM to ensure effective care co-ordination and the development of CTRs for all people who are at risk of admission, as well as those in inpatient settings. It will also provide improved leadership and management of these systems, ensuring the delivery of planned care and improved personal outcomes (including continuing to receive care close to or in their own homes). This funding is for a period of 18 months and during this time the capacity requirements for services will be reviewed by commissioners.
3. Six GM Crisis Beds and GM gate keeping in-reach and outreach specialist support team
   This service will see the development of six crisis beds and an intensive support team across GM on a permanent basis. CCGs have already committed to the ongoing investment required to deliver these services. This is proposal is viewed as an invest to save initiative, whereby (on average) a single avoided hospital admission would cover the costs of this service. The initiative is expected to realise further efficiencies to commissioners.

   This additional FT investment will support the development of four residential schemes of individual flat clusters, alongside accompanying residential and nursing support. This service will be available to people with complex needs over a period of time before moving on to greater levels of independence. Again, this is presented as an alternative to hospital placements.

5. Community Learning Disability Team all-age development and Health Facilitation Programme building on CQUINs
   This work will build on the current CQUIN schemes to improve the physical health care outcomes for people with LD. The project will also look at the need to develop Children and Adolescent Mental Health Service and Community Learning Disability Team services including early intervention and prevention programmes. The pilot project will be subject to evaluation, whereby commissioners will consider the findings and commission services in accordance with them.

   This will be a pilot service for a period of 18 months to provide targeted interventions for people with complex needs and autism who are at risk of hospital admission. The pilot will be evaluated and considered as a future developmental area.

7. Joint Training and Workforce Development Programme with NWTDT and NAS for families
   The joint training and workforce development initiative will increase the availability of training packages around: parenting; early interventions; positive behavioural support to individuals; their carers and families support workers; and their managers. The training will be supported and delivered by relevant experts with experience.

In addition to the seven workstreams identified above, Greater Manchester and Lancashire have jointly identified the need
for a stabilisation and redevelopment programme at Calderstones.

8. **Calderstones - Merseycare Forensic Care Pathway Development and Transition Stabilisation Programme**

   This investment is required over the FT period to support the provision of safe transitional care to those people being discharged, and also the rationalisation and re-modelling of inpatient services.

   Drawing upon the working practices established in the delivery of the wider health and social care devolution programme, relevant and suitably experienced leads will be identified for each of the workstreams above. The workstreams will be managed by adopting the same programme management principles that we are using on our wider PSR work, and will ensure that we are able to effectively and appropriately manage both change and risk.

   The programme will be delivered with a clear structure and will have clear, transparent, and structured linkage back into the Programme Board.

5.2 **Governance**

The wider health and social care approach underpinning our LD transformation strategy

The Greater Manchester approach to transformation of LD services is built upon the core principles that underpin the Greater Manchester Health and Social Care Devolution Memorandum of Understanding.

The MoU brought together the 10 local authorities, 12 CCG’s and NHS England, supported by the 15 NHS and Foundation Trusts, to ensure the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million citizens of Greater Manchester.

Our delivery approach for the programme is therefore built upon binding and collective governance that is being developed both at a locality and a Greater Manchester level.

From October 2015 (in shadow form) Greater Manchester will have in place a Joint Commissioning Board that will be responsible for those services that are appropriate to be commissioned at a pan GM level. This Board will bring together commissioners from the 23 core commissioning bodies in Greater Manchester: 12 CCG’s; 10 Local Authorities; and, NHS England. It will be the single largest commissioning vehicle in GM. The LD Fast Track Programme Board is already recognised as one the core advisory groups that will support the Joint Commissioning Board to deliver its commissioning
objectives.

Uniquely, Greater Manchester will also have in place a Strategic Partnership Board, that will encompass the entire health economy, and bring together representatives form all 10 local authorities, 12 CCGs, 15 NHS and Foundation Trusts, as well as representatives from other key stakeholder groups. This Board will be responsible for developing and setting the strategy and vision for the health economy including commissioners and providers, for Greater Manchester.

As part of the health and social care devolution programme, localities will be coming together to work in an integrated way at a scale not previously seen. This integration at a locality level will include an increased level of pooling of budgets, and will result in services being designed to meet the needs of the population by increasing providing those services in the community.

The core principles that underpin the wider health and social care devolution are set out below:
Building upon these foundations NHS (CCG) and local authority commissioners have come together and are committed to delivering transformation of care for people with learning disabilities. This will be delivered through an agreed vision for GM, and a model of care that has developed through a process of co-production with people with learning disabilities, their families, and advocates working with Pathways to Care. An example of this is the model of engagement already employed in GM.

For Learning Disabilities and the fast track transformation programme this will lead to a new governance structure for delivering:

- A single locality for the provision of care and choice for people with learning disabilities.
- A commitment to delivering a commissioning model through pooled budgets.
- An agreed performance framework for providers delivering LD services in GM.

These new governance arrangements will be in line with the requirements of NHSE and meet the accelerated
commissioning timetable outlined by Bubb (2014). Developing the Transforming Care Fast Track Plan in line with the requirements of NHSE, GM has developed LD specific governance arrangements to enable the acceleration of these plans, supported by additional transitional funding from NHSE.

This has included the development of:

- A Greater Manchester Learning Disabilities Fast Track Programme Board jointly chaired by Caroline Kurzeja (Chief Officer, South Manchester CCG) and Theresa Grant (Chief Executive, Trafford Council). This board brings together senior officers from across the public sector in Greater Manchester including local authorities, Greater Manchester Police, and the NHS. The members of the board are expected to be accountable to the constituent group that they represent. For example, Theresa Grant is the lead Chief Executive for AGMA/GMCA, and Caroline Kurzeja is lead Chief Officer for GMACGG.

- GM LDFT Delivery Group chaired by Sandy Bering, Strategic Lead Commissioner, Trafford CCG, with membership from across GM health and social care commissioners including people with LD, their families and carers.

### 5.3 Key risks and mitigating actions

In developing the Fast Track proposals that are outlined, GM has undertaken a robust assessment of risk. An extraction from this register, including identified mitigating actions is set out below.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Consequence</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Mitigation Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted plans will not reflect needs of community</td>
<td>Programme will not be successful in achieving desired outcomes, and or will need significant revision</td>
<td>Medium</td>
<td>Medium</td>
<td>GM Lead highlights issues and uses Technical Support where appropriate. Service mapping data being collected.</td>
</tr>
<tr>
<td>Workforce will not move from inpatient setting to community care</td>
<td>Increased cost due to recruitment and delays</td>
<td>Medium</td>
<td>Medium</td>
<td>Resource planning, early engagement with providers</td>
</tr>
<tr>
<td>Plans are not supported by appropriate governance</td>
<td>Programme will be delayed and/or disrupted in roll-out/implementations</td>
<td>Medium</td>
<td>Low</td>
<td>Clarify LD Plan sign-off procedure, engagement with governing groups etc</td>
</tr>
<tr>
<td>Plans not in line with national guidance or NHSE expectations including commitment to the use of Independent Personal Budgets, involvement of 3rd sector etc</td>
<td>Transformation plans won't be rolled out on time</td>
<td>High</td>
<td>Low</td>
<td>Understanding of national guidance to develop a service model to reflect that standards defined within.</td>
</tr>
<tr>
<td>Community does not sign up to final transformation plan</td>
<td>Programme will not be successful in achieving desired outcomes</td>
<td>Medium</td>
<td>Low</td>
<td>Engage users and public, use specialist legal advice, CCGs, LAs, and NHSE</td>
</tr>
<tr>
<td>Calderstones becomes destabilised</td>
<td>The delivery of wider programme could be delayed, as resource is deployed to destablise. Any destabilisation, could lead to a lack of clarity in how the new service models will be utilised.</td>
<td>High</td>
<td>Medium</td>
<td>Dependencies upon the Calderstones provider and the Mersey Care acquisition timeframe need to be understood and managed. Clear programme of redevelopment and stabilisation drafted.</td>
</tr>
<tr>
<td>Service mapping data shows a different picture to that expected</td>
<td>Programme will be delayed and/or disrupted in roll-out or plans won't be rolled out</td>
<td>Low</td>
<td>High</td>
<td>Data collected via service mapping to be tested against the proposed new model to identify any gaps or deficiencies.</td>
</tr>
<tr>
<td>The bed closure trajectory is unrealistic</td>
<td>Programme will not be successful in achieving desired outcomes</td>
<td>Medium</td>
<td>Medium</td>
<td>Robustly model reductions in inpatient beds versus demographic and other data. Sensitivity analysis recommended.</td>
</tr>
</tbody>
</table>
As has been described elsewhere within this document, the programme will be delivered drawing upon the principles that have been utilised to deliver the wider health and social care devolution programme.

Risk management will form a key part of our programme management plan, and we have already identified the governance that is place to support this. The risk register that has been produced, and will be reviewed regularly, will be owned by the Programme Board. This will ensure that the Board is able to capture and appropriately mitigate any risks that are identified/materialise. In support of this, the risk register will be a standing agenda item at board meetings.

5.4 Enablers

It is critical that GM transitions to a new model of care that focuses on a reduced dependency on in patient care and moves towards a model of care that focuses on high quality outcomes gained from community based services. However, of equal importance is that existing in patient provision remains safe to both patients and staff, and is sustainable from an organisational perspective as the provider moves to a new model of delivery.

There are a number of critical work streams that need to be developed to ensure that GM is able to successfully deliver on the ambition of the Fast Track programme in line with the national ambitions. That is:

- To ensure that programme can be delivered in a structured manner that operates within a clear accountability and governance a Programme Management function will need to be established.
- There will be a need to establish GM wide databases to: enable more efficient performance management of CTR outcomes; better understand the case management of our most vulnerable individuals at risk of admission; more effectively manage our out of area placements.
- To enable necessary specialist GM-wide capacity to establish an MoU regarding Continuing Responsible Commissioner obligations and local Joint Resource Funding Allocation Panels (including S117).
- To expand specialists Tenancies and Individual Residential Schemes – including reconfiguring existing hospital services as community options.
- To develop fit-for-purpose all-age Community LD teams and specialist Autism teams working in line with best practice guidance.
- To establish GM-wide Crisis Support Team and Beds (including extended access to respite, in-patient options and step-down).
- To develop multi-agency joint training and development programmes, including:
Early Intervention with Families

- Providers (targeting middle managers, schools, mainstream health services and including service users and families as co-trainers).
  - The development of both GM-wide and locality-specific investment and service improvement plans.
  - The agreement and implementation of a national model for dowries and the transfer of NHSE secure service reconfiguration funds.
  - A comprehensive workforce development programme (see below for further detail) that facilitates a meaningful transformation of the specialist learning disability and mainstream workforce capacity that is capable to deliver the new model of care to put in place and sustained over time.

Existing Provision

Of equal importance is that existing in-patient provision remains safe to both patients and staff, and is sustainable from an organisational perspective as the existing in-patient providers move to supporting the new models of delivery.

Clearly, many of the specialist skills and experience that the existing provider staff have need to be transferred to community services, and so attention to this area is an important and critical enabler of success. This is particularly the case for Calderstones as the largest LD in-patient provider in the country impacted by the GM Transforming Care plans. To address this joint proposals for significant Strategic Transition Support has been developed with Lancashire.

This co-produced investment and action programme will ensure adequate and sufficient clinical leadership and management capacity to deliver the required re-configuration of in-patient services at Calderstones, and thereby enable:

- A workforce development plan to equip workers with the education, skills, values, knowledge and behaviours they need to effectively deliver and improve services, both now and in the future – ensuring the service is supported in providing a range of professionals and workers with the right attitudes and skills
- Rationalise and merge ESS/Low Secure resources to enable speeding up of discharge care pathways over the next year to support transition placements
- Re-design of specialist and criminal justice systems/forensic support diversion care pathways; including expanding the Forensic Outreach Support Service

- Build on the Calderstones LDD NOMS national best practice work with GM Probation Trusts and GMP, including work to:
  - Identify and improve outcomes for offenders who have a Learning Disability or Difficulty (LDD), or a
communication difficultly.

- Better identify the prevalence of learning disability/difficulty within offending cohorts reducing the discrepancy between the reported number of cases in GMPT with a learning disability or difficulty compared to the expected prevalence as identified in the research.
- Extend cross criminal justice service working parties including GMPT, Greater Manchester Police, HMP Manchester, the National Autistic Society, and partnership agencies such as the National Careers Service and Work Solutions – and targeting work centred around identifying an offender's pathway through the criminal justice service and solving the 'roadblocks', gaps in provision and best practice, in the areas of screening, identification, information sharing, safeguarding and sentence planning.
- Continued use of the Communication Reflection Tool developed by Calderstones to gauge levels of communication skills within probation and prison cohorts.
- Support offender managers to avoid misinterpreting the behaviour of offenders with a communication need as non-compliance, rather than that of an individual with a communication need and so improve the early identification of offenders who have a learning disability or difficulty.
- Improve offender engagement through more effective use of existing workforce skills and competencies.
- Enhance interventions through the development a range of practice tools.
- Improve assessment and planning by a clear focus on presenting need and improved professional judgement.
- Ensure that the new ways of working are embedded in business as usual models.
- Promote more effective multi-agency responses to risk and vulnerability.

**Workforce development**

The workforce development elements of the GM Fast Track Plan will deliver a meaningful transformation of the learning disability professional and wider mainstream workforce. We will further design, develop and implement a workforce development plan as the mechanism to equip all key workers with the education, skills, values, knowledge and behaviours they need to effectively deliver and improve services, both now and in the future.

The workforce development that is required will not focus solely on those staff that are working in specialist LD services. We will need to engage a broader cohort of the workforce and include a wider group of stakeholders including: Police/CJS; social care partners; and, primary care.

We will need to work to better align the work force that serves children; ensuring that we are able to provide an appropriate response. As part of this our offer will need to be more inclusive to prevent a fragmented service offer that fails to capture all of those that require support. The interventions and services that we provide, and the work force that provides them,
needs to meet the needs of residents, and not the institutions that serve them.

As part of our workforce development programme we will need foster a culture that:
- Empowers staff to take responsibility for delivering the outcomes that are required.
- Provide a framework of support to ensure that this happens
- Doesn’t just do ‘more of the same’. We therefore need to develop a system that can respond to the changing needs of the people with LD/autism.

We recognise that the developmental programme that we mobilise will need to address:
- The skills needed to deliver effective face-to-face support in the community.
- The skills and role of specialist learning disability services to support people, their families and direct support staff.
- Awareness raising in society and in government about people with learning disabilities.
- The skills and attitudes of staff in mainstream primary and secondary health and social care services.
- The changing needs of children and young people with learning disabilities.

5.5 Engagement

The successful delivery of the LD Fast Track programme is predicated on the successful engagement of a wide range of stakeholders. We are already committed to working with one of our largest providers, Calderstones, and will be working closely with our other providers to ensure that they are not only sighted on our ambition, but form part of it (in so fare that that is possible).

Commissioners from across GM are already actively engaged in the development of our transformation proposals, and the successful mobilisation of both a Programme Board and delivery group are examples of GM’s ability to engage organisations around the delivery of a shared ambition.

We are committed to working extensively with service users amongst others to better shape our transformational proposals, and will be working closely with patient representation and the trade unions as our plans begin to further take shape.

Greater Manchester has an enviable track record of large scale engagement, this is clearly demonstrated by the Healthier Together consultation – one of the, if not the, largest consultation in the NHS.
One of the dividends of devolution has been the ability Greater Manchester now has to engage with, and have productive conversations with a range of bodies that other regions are not able to. For example Greater Manchester is in process of developing a MoU with Health Education England to enter into co-commissioning arrangements for workforce development, and is in advanced conversations with Monitor to ensure that decisions about organisations in GM are taken with GM.

5.6 **Financial case for the plan**

In order to construct the proposed new model of care that is set out within this document, Chief Financial Officers from across the 12 CCG’s have worked collectively to establish the Fast Track investment requirement (as identified at 5.7 below).

To ensure that the development of the plan and in particularity the models of delivery set out within were set within a context of financial achievability, the Programme Board extended an invitation of membership to Mike Tate, CFO at Wigan CCG. This particular step has ensured that the current funding arrangements, and the proposed new models of delivery are reconcilable. It also ensures that any further programme planning, is always undertaken in the context of the available fiscal envelope.

Work is also progressing to ensure that local authority finance colleagues are engaged in the process. This mirrors the collaborative working arrangements that have been utilised to deliver the wider health and social care devolution programme. The collaborative working arrangements that have developed to support the wider health and social care programme, in particular as Greater Manchester establishes a robust financial baseline for the health.

At this stage of the planning cycle Greater Manchester is unable to quantity the level of efficiencies that could be extracted from the existing LD budgets. However, one of the core workstreams for the Programme Management Office, will be to undertake a rigours Benefits Realisation exercise to better understand where savings could be attained.

As part of the development work that will be required, a detailed analysis will be undertaken across to GM to better understand where and how budgets are currently spent. This will mirror the approach already taken in Trafford.

However, what is clear at this stage is that GM is committed to fundamentally overhauling its LD provision which will see:

- A reduction in the number of high cost bed spaces, as we increasingly focus our investments on community based interventions.
An increasingly preventative approach will be taken across our health system, this will see the number of non elective and costly admissions to hospitals reduce
A commitment across the health economy to pursue integrated service provision and the pooling of budgets.

### 5.7 Projected costs and benefits

The cost of delivering the GM Learning Disabilities transformation programme of activity will be £10.25, broken down into £6.25m for the delivery of the Transforming Care Programme and £4m to support the stabilisation and redevelopment programme at Calderstones.

GM has committed £3.15m funding from CCGs and a further £1m respectively to support these two programmes. This will match the request for funding through the Fast Track Transformational Fund of £4.1m.

The additional £2m required to deliver the overall programme will be funded by a £1m contribution from Lancashire CCGs and £1m through the Lancashire bid to the Transformation Fund.

Please refer to the table below for further detail of how the programme will be funded:
The successful delivery of the above programme of work is predicated on local government understanding that NHS will provide recurrent funding for individual patients who are transferring from NHS provided care to local authority provided care (dowries).

The bid also assumes that an element of the funding, that is attached to workstreams set out in the above table, will be utilised to ensure that the management of the programme is properly resourced. Therefore, there will be a resource requirement to develop a programme management office. The cost of this is included.

**Further note on Dowries and Expectations.**

Local government (including ADASS/LGA) are emphasising that their clear expectation of transformation is that the NHS will fully fund local government for the additional costs they incur from any transfer of patients.

In support of this view they note a commitment made by the Department of Health in their response to Winterbourne View: Where responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as
part of a pooled budget arrangement.”

Local government is clear that the proposed future care models need careful phasing to take account of the overall financial context. In the medium term, GM is expecting:

- NHS England to reduce recurrently the expenditure on specialised LD inpatient services;
- CCGs to spend recurrently more on preventative support for the LD and autism ‘in-patient’ at risk and/or forensic population; and
- For the NHS as a whole to spend recurrently less on inpatient services and partly in its place local councils to spend recurrently more on social care.

The availability of finance has a significant bearing on the pace of change, including the funding of dowries, whether recurrent or non-recurrent and the level they would be set at. As such, GM expects the following to be made clear:

- The dates to which the policy applies, to avoid any delays to patient discharges.
- That the policy applies retrospectively to when CCGs were created; or to all current inpatients.
- CCGs to gain some funding support from specialised commissioning arrangements via gain-share arrangements.
- To assess the recurrent cost implications for LAs (and CCGs) for each long stay patient transferred in 2015-16 or planned for 2016-17, and putting in place bespoke recurrent transfer funding packages for these costs.

The final GM LD Fast Track Transformation Plan will therefore work on the basis of several caveats already shared with NHS England.

That is:

- Funding should follow the patient.
- The draft national LD commissioning service model should be revised to recognise the need for an option to fast track patient discharges from both current CCG and NHS England commissioned in-patient beds (ATU, step/down-rehab and low secure).
- For an agreement to develop a small number of schemes involving individual linked flats within a residential scheme with/or without nursing support model across GM (all with in-built access to additional on-going clinical support)– all underwritten with a formal Memorandum of Understanding to clarify continuing responsible commissioner funding roles
- Changes to the CQC registration/model of some existing commissioned services so these are no longer hospital units
- Any changes in place matching patient needs
<table>
<thead>
<tr>
<th>5.8</th>
<th>Value for money</th>
</tr>
</thead>
</table>
| Greater Manchester acknowledges that in producing this document a formal detailed VFM exercise has yet to be undertaken. As indentified above, a key part of the programme mobilisation process will be to undertake a rigorous benefits realisation exercise. However the model that has been developed and the principles that have established to support its production will provide value for money. The LD Fast Track transformation programme will demonstrably reduce the number of high cost in patient beds (both non secure and low secure). The shift towards increasingly community based provision (whilst requiring investment) will enable GM to move people into community based settings, and ensure that those people with LD/autism can realise their potential in non institutional setting. The programme has been developed in line with the wider health and social care devolution programme, the over arching ambition for which is to achieve the quickest and largest possible improvement in the health and wellbeing of the residents of Greater Manchester. This core principle applies to the LD fast track programme. Greater Manchester believes that the transformational proposals set out will improve the quality of life for those with LD/autism by further shifting the focus of service delivery to a community based setting, and ensuring that services are designed with the needs of the patient at the heart of them. Further value for money will be gained from the transformation work by investing in a significant workforce development programme (as per above). Such an approach will ensure that wherever possible, every patient contact is a positive one. There are clear value for money opportunities arsing out of the intention to commission collaboratively across the whole economy. Whilst it is acknowledged that not all services can be commissioned and delivered on a GM footprint, there are clear benefits to developing clear and common commissioning principles to commission services in GM. These principles will ensure that the standardisation at scale ambition embedded within the wider approach to health and social care, is embedded at the core of LD commissioning. In addition by working collaboratively across GM, GM has unique opportunity to develop the provider market in way that serves the needs of the population. Localities across Greater Manchester are currently working to develop 10 locality plans as part of our commitment to to deliver a clinically and financially sustainable health economy. LD will form a key part of this, as such there are huge
opportunities that arise out GM's increasing commitment to work collaboratively.

Whilst the financial benefit is at this stage difficult to quantify, devolution and the collaboration set out within the LD fast track will benefit from clear place based leadership in way never seen before. The clear opportunity that is presented by this cannot be understated, as for the first time the health economy will work as one – with the common goal of improving the health outcome for the residents of GM as quickly as possible.

The joint training and workforce development initiative will increase the availability of training packages around: parenting; early interventions; positive behavioural support to individuals; their carers and families support workers; and their managers. Again, whilst at this stage difficult to quantify, there is a clear benefit from delivering programmes of work that increase the resilience of families, carers and individuals. This benefit extends well beyond the level of financial savings that can be achieved from the new models of care, we will create increasingly resilient families.

We are committed to embarking on a large workforce development programme, this will deliver a flexible workforce that is suitable skilled to meet the changing needs of the population. As important, we will be working to foster a culture of staff empowerment – this will ensure that our staff identify the correct level of intervention at the earliest opportunity.

Finally, it is widely acknowledged that Greater Manchester has some of the worst health outcomes and inequalities in the country. However we are committed to improving these collectively, by working collaboratively, and by delivering change at pace and scale. LD will form a key part of this.
### Appendix 1

**Data for Lancashire including Greater Manchester.**

**Public Health England Learning Disabilities Profiles**

- **North West region**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>North West region</th>
<th>Blackburn with Darwen</th>
<th>Blackpool</th>
<th>Bolton</th>
<th>Bury</th>
<th>Cheshire East</th>
<th>Cheshire West and Chester</th>
<th>Cumbria</th>
<th>Halton</th>
<th>Knowsley</th>
<th>Lancashire</th>
<th>Liverpool</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>Sandwell</th>
<th>St Helens</th>
<th>Stockport</th>
<th>Tameside</th>
<th>Trafford</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability: QOF prevalence (10+)</td>
<td>2013/14</td>
<td>0.5</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>6.5</td>
<td>0.6</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
<td>0.7</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
<td>0.4</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults (15 to 64) with learning disability known to Local Authorities per 1,000 population</td>
<td>2013/14</td>
<td>4.3</td>
<td>4.6</td>
<td>4.7</td>
<td>4.9</td>
<td>4.2</td>
<td>3.8</td>
<td>4.6</td>
<td>5.3</td>
<td>4.6</td>
<td>6.0</td>
<td>7.6</td>
<td>4.2</td>
<td>4.6</td>
<td>3.7</td>
<td>4.4</td>
<td>5.7</td>
<td>4.2</td>
<td>5.0</td>
<td>6.6</td>
<td>4.4</td>
<td>5.2</td>
<td>4.3</td>
<td>4.2</td>
<td>3.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Children with Moderate Learning Difficulties known to schools</td>
<td>2013/14</td>
<td>15.6</td>
<td>16.0</td>
<td>11.3</td>
<td>21.3</td>
<td>15.8</td>
<td>24.9</td>
<td>5.9</td>
<td>10.4</td>
<td>-</td>
<td>12.4</td>
<td>50.7</td>
<td>12.7</td>
<td>18.7</td>
<td>17.1</td>
<td>13.7</td>
<td>18.6</td>
<td>15.4</td>
<td>16.9</td>
<td>15.8</td>
<td>17.4</td>
<td>18.6</td>
<td>19.3</td>
<td>18.3</td>
<td>17.1</td>
<td>13.3</td>
</tr>
<tr>
<td>Children with Severe Learning Difficulties known to schools per 1,000 pupils</td>
<td>2013/14</td>
<td>3.73</td>
<td>4.23</td>
<td>4.08</td>
<td>-</td>
<td>3.89</td>
<td>4.24</td>
<td>3.33</td>
<td>3.04</td>
<td>7.16</td>
<td>-</td>
<td>-</td>
<td>3.20</td>
<td>5.66</td>
<td>6.86</td>
<td>2.64</td>
<td>4.97</td>
<td>4.85</td>
<td>1.83</td>
<td>-</td>
<td>3.23</td>
<td>-</td>
<td>2.87</td>
<td>2.28</td>
<td>4.77</td>
<td>-</td>
</tr>
<tr>
<td>Children with Profound &amp; Multiple Learning Difficulty known to schools per 1,000 pupils</td>
<td>2013/14</td>
<td>1.27</td>
<td>1.56</td>
<td>1.68</td>
<td>-</td>
<td>1.54</td>
<td>-</td>
<td>1.17</td>
<td>1.61</td>
<td>1.57</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.54</td>
<td>1.95</td>
<td>1.51</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.14</td>
<td>2.32</td>
<td>1.94</td>
<td>-</td>
<td>0.82</td>
<td>-</td>
<td>1.24</td>
</tr>
<tr>
<td>Children with Autism known to schools per 1,000 pupils</td>
<td>2013/14</td>
<td>9.1</td>
<td>8.7</td>
<td>4.4</td>
<td>7.3</td>
<td>5.8</td>
<td>8.0</td>
<td>6.1</td>
<td>9.2</td>
<td>6.7</td>
<td>10.0</td>
<td>11.0</td>
<td>8.7</td>
<td>12.6</td>
<td>8.7</td>
<td>13.3</td>
<td>12.3</td>
<td>4.3</td>
<td>12.6</td>
<td>14.1</td>
<td>9.1</td>
<td>5.9</td>
<td>6.9</td>
<td>7.6</td>
<td>4.8</td>
<td>16.6</td>
</tr>
</tbody>
</table>
### Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>North West region</th>
<th>Blackburn with Darwen</th>
<th>Bolton</th>
<th>Bury</th>
<th>Cheshire East</th>
<th>Cheshire West and Chester</th>
<th>Cumbria</th>
<th>Halton</th>
<th>Knowsley</th>
<th>Lancashire</th>
<th>Liverpool</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>Sefton</th>
<th>St. Helens</th>
<th>Stockport</th>
<th>Tameside</th>
<th>Trafford</th>
<th>Wigan</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion (%) of eligible adults with a learning disability having a GP health check</td>
<td>2013/14</td>
<td>44.2</td>
<td>58.6</td>
<td>46.7</td>
<td>51.1</td>
<td>51.0</td>
<td>52.1</td>
<td>75.8</td>
<td>43.4</td>
<td>57.0</td>
<td>34.3</td>
<td>44.2</td>
<td>45.4</td>
<td>53.5</td>
<td>43.8</td>
<td>46.9</td>
<td>39.0</td>
<td>40.8</td>
<td>40.8</td>
<td>46.3</td>
<td>46.3</td>
<td>57.9</td>
<td>73.0</td>
<td></td>
</tr>
</tbody>
</table>

### Accommodation and Social Care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>North West region</th>
<th>Blackburn with Darwen</th>
<th>Bolton</th>
<th>Bury</th>
<th>Cheshire East</th>
<th>Cheshire West and Chester</th>
<th>Cumbria</th>
<th>Halton</th>
<th>Knowsley</th>
<th>Lancashire</th>
<th>Liverpool</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>Sefton</th>
<th>St. Helens</th>
<th>Stockport</th>
<th>Tameside</th>
<th>Trafford</th>
<th>Wigan</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with learning disabilities in settled accommodation (%)</td>
<td>2013/14</td>
<td>74.9</td>
<td>87.5</td>
<td>86.5</td>
<td>86.6</td>
<td>86.4</td>
<td>85.6</td>
<td>85.6</td>
<td>82.8</td>
<td>80.6</td>
<td>92.6</td>
<td>89.1</td>
<td>94.1</td>
<td>94.1</td>
<td>94.1</td>
<td>92.2</td>
<td>83.2</td>
<td>87.9</td>
<td>89.2</td>
<td>93.6</td>
<td>85.7</td>
<td>91.9</td>
<td>92.2</td>
<td>85.6</td>
</tr>
<tr>
<td>Adults with learning disabilities in non-settled accommodation (%)</td>
<td>2013/14</td>
<td>21.7</td>
<td>10.3</td>
<td>6.2</td>
<td>7.6</td>
<td>10.4</td>
<td>14.9</td>
<td>11.4</td>
<td>9.4</td>
<td>15.0</td>
<td>7.9</td>
<td>8.8</td>
<td>11.2</td>
<td>10.7</td>
<td>10.3</td>
<td>7.6</td>
<td>16.1</td>
<td>5.0</td>
<td>5.7</td>
<td>13.4</td>
<td>11.4</td>
<td>11.4</td>
<td>14.4</td>
<td></td>
</tr>
<tr>
<td>Adults with learning disabilities living in accommodation whose status is unknown to LA (%)</td>
<td>2013/14</td>
<td>3.38</td>
<td>1.81</td>
<td>6.02</td>
<td>3.96</td>
<td>1.23</td>
<td>2.49</td>
<td>4.25</td>
<td>2.59</td>
<td>11.83</td>
<td>0.74</td>
<td>0.17</td>
<td>0.77</td>
<td>0.85</td>
<td>11.54</td>
<td>0.62</td>
<td>7.14</td>
<td>0.00</td>
<td>1.43</td>
<td>0.04</td>
<td>19.46</td>
<td>19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with learning disabilities living in severely unsatisfactory accommodation (%)</td>
<td>2013/14</td>
<td>0.25</td>
<td>0.17</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Adults with learning disabilities in employment (%)</td>
<td>2013/14</td>
<td>67</td>
<td>5.2</td>
<td>2.4</td>
<td>2.4</td>
<td>1.4</td>
<td>6.1</td>
<td>5.0</td>
<td>5.7</td>
<td>5.4</td>
<td>2.9</td>
<td>4.4</td>
<td>7.7</td>
<td>8.9</td>
<td>3.4</td>
<td>3.4</td>
<td>2.3</td>
<td>5.0</td>
<td>12.2</td>
<td>5.7</td>
<td>12.6</td>
<td>6.7</td>
<td>5.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Adults with learning disabilities receiving direct payments (%)</td>
<td>2013/14</td>
<td>30.5</td>
<td>29.1</td>
<td>31.6</td>
<td>17.8</td>
<td>26.4</td>
<td>33.3</td>
<td>28.8</td>
<td>30.0</td>
<td>44.3</td>
<td>34.4</td>
<td>20.6</td>
<td>26.7</td>
<td>11.8</td>
<td>55.3</td>
<td>50.8</td>
<td>20.9</td>
<td>39.8</td>
<td>44.3</td>
<td>29.1</td>
<td>27.8</td>
<td>44.8</td>
<td>23.3</td>
<td>24.7</td>
</tr>
<tr>
<td>Rates of referral for abuse of vulnerable person per 1,000</td>
<td>2012/13</td>
<td>108.3</td>
<td>118.2</td>
<td>430.4</td>
<td>23.8</td>
<td>153.5</td>
<td>50.6</td>
<td>276.4</td>
<td>65.2</td>
<td>52.9</td>
<td>100.4</td>
<td>107.9</td>
<td>70.0</td>
<td>171.8</td>
<td>129.5</td>
<td>134.5</td>
<td>23.8</td>
<td>98.5</td>
<td>176.1</td>
<td>164.2</td>
<td>62.1</td>
<td>94.3</td>
<td>44.6</td>
<td>222.2</td>
</tr>
</tbody>
</table>
## Coordination and local planning

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>North West region</th>
<th>Blackburn with Darwen</th>
<th>Bolton</th>
<th>Bury</th>
<th>Cheshire East</th>
<th>Cheshire West and Chester</th>
<th>Cumbria</th>
<th>Halton</th>
<th>Knowsley</th>
<th>Lancashire</th>
<th>Liverpool</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>St Helens</th>
<th>Stockport</th>
<th>Tamworth</th>
<th>Trafford</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Wirral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison of LA and QOF prevalence estimates</td>
<td>2013/14</td>
<td>-0.1</td>
<td>-0.1</td>
<td>-0.1</td>
<td>0.9</td>
<td>-0.4</td>
<td>21.8</td>
<td>19.3</td>
<td>0.0</td>
<td>-0.2</td>
<td>-0.1</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>-0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.7</td>
<td>-0.4</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Comparison of pupils with learning difficulties and LA prevalence estimates</td>
<td>2013/14</td>
<td>80.2</td>
<td>80.0</td>
<td>75.4</td>
<td>*</td>
<td>*</td>
<td>61.9</td>
<td>70.9</td>
<td>*</td>
<td>*</td>
<td>78.2</td>
<td>85.9</td>
<td>76.1</td>
<td>*</td>
<td>80.6</td>
<td>78.6</td>
<td>*</td>
<td>83.4</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison of pupils with severe and Profound and multiple LD and LA prevalence estimates</td>
<td>2013/14</td>
<td>13.5</td>
<td>19.7</td>
<td>18.8</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-0.4</td>
<td>46.0</td>
<td>57.0</td>
<td>2.2</td>
<td>*</td>
<td>37.3</td>
<td>*</td>
<td>24.3</td>
<td>-0.2</td>
<td>-0.3</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults using day care services supported by the LA (per 1,000 people)</td>
<td>2013/14</td>
<td>323.7</td>
<td>320.8</td>
<td>329.1</td>
<td>329.4</td>
<td>360.5</td>
<td>367.1</td>
<td>362.2</td>
<td>296.3</td>
<td>433.8</td>
<td>260.9</td>
<td>263.2</td>
<td>241.4</td>
<td>93.2</td>
<td>301.4</td>
<td>397.5</td>
<td>330.0</td>
<td>364.1</td>
<td>265.7</td>
<td>756</td>
<td>352.4</td>
<td>535.9</td>
<td>319.8</td>
<td></td>
</tr>
<tr>
<td>Adults receiving community services supported by local authorities (per 1,000 people with learning disabilities)</td>
<td>2013/14</td>
<td>754</td>
<td>813</td>
<td>819</td>
<td>805</td>
<td>852</td>
<td>872</td>
<td>861</td>
<td>745</td>
<td>819</td>
<td>763</td>
<td>824</td>
<td>891</td>
<td>853</td>
<td>712</td>
<td>788</td>
<td>935</td>
<td>762</td>
<td>935</td>
<td>762</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children with learning disabilities known to schools per 1,000 pupils</td>
<td>2013/14</td>
<td>20.6</td>
<td>21.8</td>
<td>17.1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>16.4</td>
<td>14.5</td>
<td>*</td>
<td>25.9</td>
<td>25.8</td>
<td>17.9</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>22.9</td>
<td>*</td>
<td>*</td>
<td>21.3</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA gross current expenditure relating to residential personal social services for adults</td>
<td>2013/14</td>
<td>22165</td>
<td>19208</td>
<td>4476</td>
<td>27407</td>
<td>23269</td>
<td>31619</td>
<td>16214</td>
<td>7268</td>
<td>9203</td>
<td>18183</td>
<td>6204</td>
<td>29244</td>
<td>23753</td>
<td>26742</td>
<td>19873</td>
<td>20918</td>
<td>9614</td>
<td>23647</td>
<td>16369</td>
<td>12735</td>
<td>13479</td>
<td>20417</td>
<td>16735</td>
</tr>
</tbody>
</table>