



Delivering Transformation in
Northamptonshire

**The Commissioning Strategy for
People with a Learning Disability
2019-2022**

Working Together: Improving lives



Corby Clinical Commissioning Group



Nene Clinical Commissioning Group

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1. Introduction: Living in Northamptonshire with a learning disability

Welcome to the Northamptonshire Learning Disability Commissioning Strategy. This document sets out the approach of Northamptonshire County Council and the Northamptonshire Clinical Commissioning Groups to supporting people with a learning disability and their family carers over the next 3 years. This strategy should be read alongside of the recently published Northamptonshire Autism Strategy and the Northamptonshire Transforming Care Plan.

The Council has a statutory responsibility to ensure the well-being and safety of all vulnerable adults across a wide range of living activities and the Clinical Commissioning Groups have a statutory responsibility to ensure the provision of universal and specialist health care in order to improve the health of the whole community. As part of these overarching responsibilities and as commissioning organisations committed to a safe, healthy and more inclusive Northamptonshire we work with the people who use and deliver all kinds of services to help Northamptonshire be a place that celebrates difference and enables equal citizenship.

We know that people with a learning disability have many skills, talents and aspirations that improve the social well-being of our communities where good integration has enabled active contributions to the vibrancy of a locality as well as economic growth through employment and training. We want to make sure that people with a learning disability can live as independently and safely as possible and have the best chance of long-term good health.

To achieve these ambitions the local system will need to embed new ways of working and commission a provider landscape that focusses on progression and outcomes; developing early intervention and prevention models that reduce or defer the need for ongoing care; offering innovative housing options that allow individuals to flourish through ordinary life experiences.

There is significant work to do if we are to reduce spend and provide room to invest in new models that provide sustainable transformation; we have year on year growth in expenditure in learning disability services equating to an approximate £5m increase in spend every year against a relatively static population - this means that we are spending more every year on the same individuals without evidence of improved outcomes or evidence of the benefits that are derived from the services we commission. Our system spend has to show that we are making a difference and that individuals experience a very real benefit from the support they receive.

2. Demography and key facts

Northamptonshire is home to around 560,400 adults and PANSI and POPPI estimate that almost 116,000 of them have some form of disability; some 20.68% of the population, which is lower than most of our neighbouring authorities and below the regional and national averages of 22% and 21.1% respectively.

The proportion of adults with a physical disability in Northamptonshire is below the national and regional averages at 18.35% but the proportion of adults with learning disabilities in Northamptonshire is similar to the regional and national averages at 2.33% of the adult population.

Approximate number of adults with a disability in each borough/district:

Corby 10,350

Daventry 13,500

East Northamptonshire 14,950

Kettering 16,000

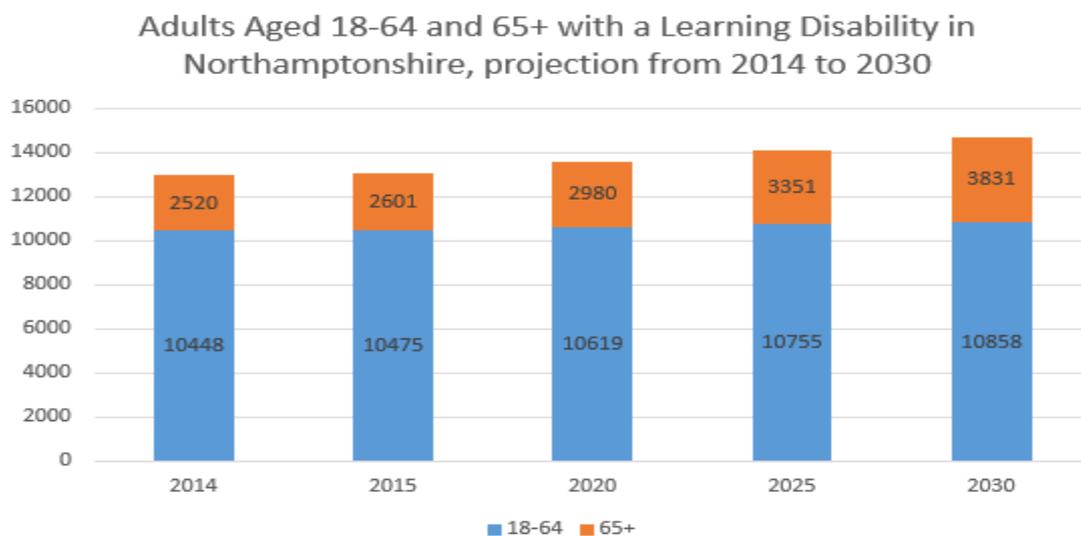
Northampton 33,000

South Northamptonshire 14,800

Wellingborough 13,250

89% of the above have a physical disability. The remaining 11% have a learning disability.

PANSI and POPPI prediction tools have a uniform description for learning disabilities for all adults, so the two age groups can be shown on one figure, the figure below shows the baseline estimates.

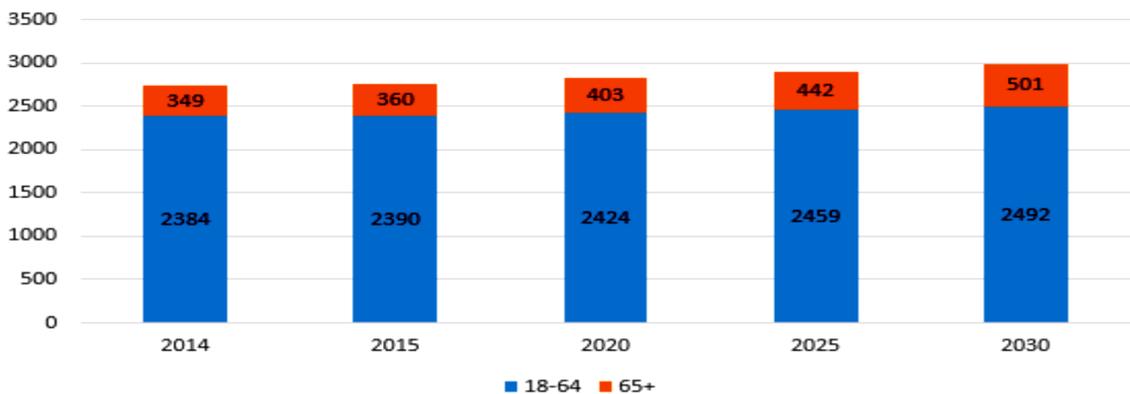


The numbers of adults with a learning disability in Northamptonshire is **predicted to increase by around 1,000 from 13,076 in 2015 to 14,106 in 2025**. In the subsequent 5 years to 2030, numbers are expected to rise by another 500 or so to 14,689.

Younger adults aged 18-64 make up the majority of adults with a learning disability in Northamptonshire, but the figure shows that the older age group, 65 and over, is the one that will grow by the most over the next 10 and 15 years.

The following figure shows the numbers of adults with a learning disability whose condition is deemed to be either moderate or severe. Again the age groups are 18 to 64 and 65 and over.

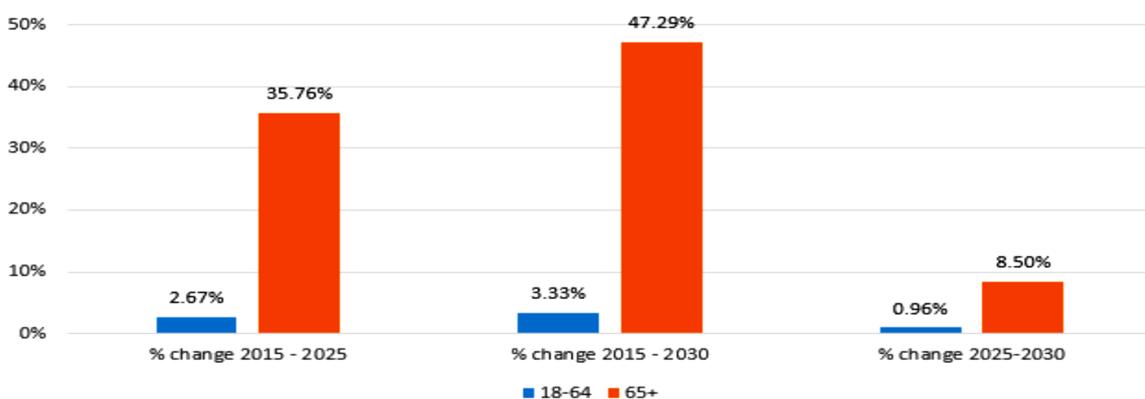
Adults Aged 18-64 and 65+ with a Moderate or Severe Learning Disability in Northamptonshire, projection from 2014 to 2030



The figures above also show the prediction that the number of younger people with a moderate or severe learning disability is expected to increase by around 100, the number of older people by around 150 by 2030.

The figures below show the anticipated percentage changes in the numbers of people in Northamptonshire with a learning disability between 2015 and 2025, 2015 and 2030 and the change between 2025 and 2030. This shows the large increases in older people with a learning disability much more clearly:

Estimated Percentage Change in Population with Learning Disabilities of Northamptonshire between 2015 and 2025, 2015 and 2030 and 2025 and 2030



Estimates suggest there will be around 450 more adults with an autistic spectrum disorder by 2025 than there were in 2015, around 350 of these will be aged 65 and over. The following five years to 2030 will see that number increase by another 250 or so, the majority again being older people.

Disadvantage

A 2010 study by the Improving Health and Lives Learning (IHaL) Disabilities Observatory found five key determinates of health inequality. These are;

- A greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnection
- An increased risk of health problems associated with specific genetic and biological causes of learning disabilities
- Communication difficulties and reduced health literacy
- Personal health risks and behaviours such as poor diet and lack of exercise
- Deficiencies relating to access to healthcare provision

The study noted that people with a learning disability have poorer health than their non-disabled peers; differences in health status that are, to an extent, avoidable. It also noted that health inequalities faced by people with a learning disability began in childhood and were often caused by a lack of access to timely, appropriate and effective healthcare.

A study conducted by the CIPOLD (Confidential Inquiry into Premature Deaths of People with a Learning Disability) examined the deaths of 249 people with a learning disability against deaths of people without a learning disability with comparator causes. It concluded that the median age of death in people with a learning disability is 65 for men and 63 for women. This is 13 and 20 years younger than the general population.

42% of the deaths in the CIPOLD study were found to be premature and 49% were what the Office of National Statistics classify as potentially avoidable. Applied to the number of Northamptonshire residents with a learning disability using just the top 3 causes of death this equates to around 2,900 premature deaths and around 3,400 potentially avoidable deaths. Following the CIPOLD enquiry, the British Medical Association (BMA) Board of science produced a report on 'parity of esteem' a term which is used in the Government's mental health strategy for England. However, the term is not defined in that strategy. This report defines it as 'valuing mental health equally with physical health' which aims to deliver equality of access to [effective, safe care](#). The report also adds to this definition a number of system wide requirements, including equal status in healthcare education and practice and recognition of equally high aspirations for people with mental health issues or learning disabilities.

The figures presented in the report on life expectancy of people with learning disabilities draw on the work of the Confidential Inquiry which showed that 22% of people with a

learning disability were under 50 when they died, which compares with only 10% in the general population. These statistics are unacceptable.

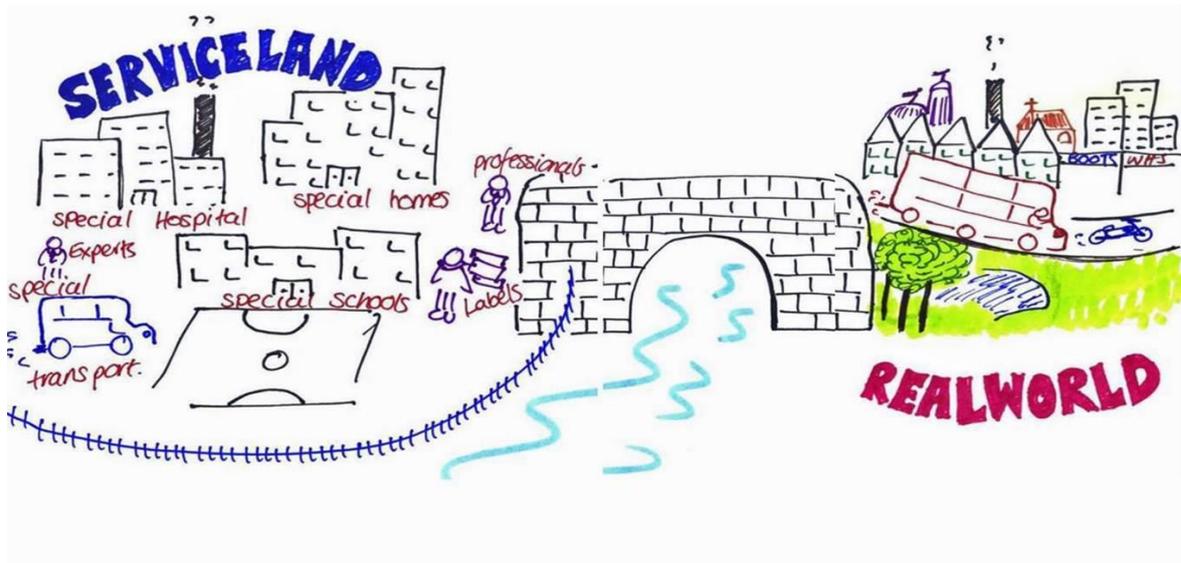
3. Embedding change that reduces inequalities and increases parity of esteem

In 2016 NHS England and National Partners published a second iteration of 'Building the Right Support' (Ref: Transforming Care) as a blue print to embed sustainable transformation across the whole range of learning disability provision nationally. A standardised service model was published in order to guide commissioners and providers in achieving the ambitions of equality, citizenship and improved outcomes focussed on community based support and the reduction in inappropriate specialist hospital admissions. In addition to this we have ongoing requirements to address inequalities that are systemic for people with a learning disability; access to healthcare and responsiveness to health problems, access to ordinary housing and access to training and employment.

As system leaders we have engaged and co-produced extensively over the past 3 years. The Council has worked in partnership with the Clinical Commissioning Groups to complete a range of events, forums, focus groups and surveys in order to establish what matters to people with a learning disability as well as what matters to the informal carers and supporters of people with a learning disability. These activities ran over the course of an 18 month period and were called 'Building the Right Support' and 'The Big Plan.'

The principles of our Northamptonshire learning disability strategy embed the national requirements and seek to address local weaknesses highlighted in part by the national requirements and what we have not yet achieved, but also the issues that people with a learning disability have told us about and that we as commissioning organisations must respond to.

It is important that we collectively move away from the idea of separate services and fully adopt the principle of supporting people with learning disabilities to gain equal citizenship. This means having choice and influence over where they live, where they work, what happens during the day and how they spend their leisure time. It also includes how they access services available to us all such as healthcare. The illustration below was produced by a Community Interest Company called 'Community Catalysts' as part of a wider national conversation with people who have a learning disability, supported by ADASS, about 'citizenship' and shows how the creation of 'special' services has reduced their ability to live what they perceive to be ordinary lives.



4. A new focus on Outcomes

Through co-production we have arrived at a set of Outcomes that mean the most to people who use learning disability services in Northamptonshire - these are Outcomes that matter to the very people they concern; they are resilient to public challenge because they represent customer views and when measured can give providers and commissioners a view on whether the care and support commissioned is making a difference.

The Outcomes have been arrived at through **descriptions of experience called 'I statements'**. Unsurprisingly they focus on a need to maintain ordinary life experiences - the importance of family and relationships, of having somewhere to live that provides security and a sense of well-being, of having some control and being supported with opportunities for improved lifestyles, better health and employment and training. A singular overarching **ethos of ordinary life** forms the basis of all outcomes and their measurements. Beyond ethos is the expectation of all providers delivering **strengths and progression based services** in some shape or form – progression and independence means different things to different people – small steps and big steps. Independence is not at all considered as meaning being without, or free from support because all services should be enabling ordinary living and citizenship. Services should be there for the period they are required. As an individual grows in confidence and ability services should 'step away' in a graduated, planned and safe way in order to allow that individual to flourish.

The overarching outcomes described as being the outcomes that matter to people with a learning disability and their carers in Northamptonshire are:

1. People get the help they need when they need it
2. People have, and hold on to, relationships that have meaning to them
3. People feel in control
4. People have equal access to healthcare, training and occupation
5. People feel safe and are supported to take risks
6. People have somewhere to live they call home
7. People live longer
8. Carers are able to continue caring

What has been difficult is translating what people have told us into action - that is, helping individuals achieve what matters to them through community development and contractual arrangements that change culture and reverse the trend of focussing most of our spend on crisis support and complex needs. The change momentum has been hindered not because of a lack of desire or commitment but because of financial stability. We have achieved a great deal in the past 3 years in spite of facing very difficult financial circumstances and continued demand. It is precisely because of the need to assert ongoing financial constraint and better demand management that now is the time to transform. In Northamptonshire we continue to face a very difficult financial future across health and social care; as commissioners and providers we are challenged to do more with less; by learning from others; using technology intelligently; making better use of universal services and by working collaboratively across the independent & voluntary sectors and with the wider community wherever possible. Most importantly, we must enable people with learning disabilities to reduce their dependence on funded support services by creating opportunities for them to maximise their independence and autonomy as an integral part of 'being a citizen.'

5. Where we are now

In taking stock of the services provided to people with a learning disability and what is being achieved, through listening to what people with a learning disability have said and continue to say, we know what we do well and what we need to do better:

- Our contracts with providers talk about the importance of outcomes and of having enabling approaches with individuals. However the contracts do not **mandate the use of co-produced outcomes for support planning purposes** and it is difficult to measure what has been achieved with individuals and equally what has been achieved with the money we have spent.

- In adult social care we have seen a year on year **increase in the commissioning of individual supported living/ordinary living arrangements** and a commensurate reduction in the use of residential care. This is a service option we will continue to grow because we know it generally achieves the multiple aims of enhancing citizenship, delivering better person centred support and is generally less expensive than residential care in the long term.
- The use of **personal budgets to enable choice and control** across health and social care is common rather than exceptional, although we could be doing more to integrate health and social care personal budgets where an individual has both health and social care needs. We could also be using different types of personal budget arrangements that support flexibility and choices in delivering outcomes.
- **We support people with very complex needs** who would otherwise be in specialist hospital settings to live safely and meaningfully in community settings. There are still a number of individuals in restrictive settings currently commissioned by NHS England who will need to step back down into Northamptonshire in the next 2 years. We will need to commission specific types of support for this group to experience ordinary living and citizenship safely.
- We have strong acute hospital liaison services to embed **reasonable adjustments** and ensure an individual's rights and best interests are appropriately considered when they are unwell and in one of our general hospitals. We also have strategic health facilitators who work across community services to embed reasonable adjustments and who continue to work with GP's to make sure people with a learning disability are known and receive annual health checks. However- we need to go further in making sure every person with a learning disability receives an annual health check and a Health Action Plan where this is required and go further with challenging for reasonable adjustments across all types of services in ensuring equality of access and in reducing extraordinary spend because an individual has a learning disability.
- We have a **dedicated adult social care assessment and review team** for people with a learning disability who need statutory social care support and a **dedicated NHS team** who work with people with a learning disability and their families to manage a spectrum of healthcare needs. We have co-located these teams as a first step to integration and called it the **Northamptonshire Learning Disability Service**. Throughout the next 12 months we will be bringing policies and procedures together so that we have common and shared approaches to how we work together for people with a learning disability, including having one telephone number to access any member of the team.
- We have a team dedicated to embedding the use of **assistive technology** – clever gadgets that enable independence and remove the need for human resources that can be oppressive and risk averse. We will work with our learning disability providers to use these gadgets more widely and more creatively in order to increase autonomy and reduce unnecessary spend.

- We have a dedicated **Transitions team to support individuals between the ages of 18 and 25** into adulthood, but we also need to work more closely with our health and social care children and young people's teams, and importantly with families, so that preparation for transition into adulthood, where the legal frameworks change and the types of support on offer are different, is effective and better understood. Life takes on a different meaning for everyone when we turn 18; it provides choices, opportunities and responsibilities and inevitably having to make our own 'grown up' decisions about how we want to live and what we want from life. We seek guidance sometimes from people that matter to us and who know us. Our parents or guardians want the best for us and want us to be safe. It is no different for people who have a learning disability, except parental fear and anxiety can be greater and the concept of 'independence' for individuals who need support every day can be confusing and frightening. The way we commission adult services and the expectations of our contractors must allow for the changes that occur from the age of 16 and we need to be better at beginning conversations about adulthood at this age using real life examples and offering peer support from parents and guardians who have lived experience.
- We have workers with **specified roles relating to autism, positive behaviour support and crisis support**. The roles work across the health and social care workforce in the widest sense – they provide advice and guidance and coaching to frontline workers as well as to our Providers. We aim to focus these roles more directly to our Providers in order to improve the skills and knowledge in the services we commission to provide day to day support to people with a learning disability.

But there is more to do....

In spite of all of the good work and changes that have taken place over the past 2 years, we still have individuals who fall through gaps and only become known to us in crisis, we still have some providers who supply sub-acceptable care to the detriment of the individuals in receipt of that care, we still have individuals who are not supported to move on or progress and we still have a year on year increase in spend which is paid out against roughly the same number of people. Put simply; we are paying more and more money for services but remain unclear about what is being achieved with that money. Additionally our Regulators – the people in Central Government who assess what we do and how well we do it – require specific targets to be met. These targets are incumbent on all Clinical Commissioning Groups and all Councils nationally and are designed to improve the lives of people with a learning disability.

6. What our Regulators ask us to do for people with a learning disability

We are addressing the regulatory requirements in this strategy and in the accompanying Commissioning Plan that describes how we will do things and when we will do things.

However in summary we are specifically required to:

	Action	Where we are now	Where we need to be
1.	Increase the uptake of annual health checks of all those on GPs registers	31.5%	66%
2.	Reduce the numbers of people using specialist hospital beds (adults and children)	33	21
3.	Increase the numbers of people with a learning disability gaining employment	3.15%	RANGE 4.3% - 6.0% (regional-national average)
4.	Review and report on every death of someone with a learning disability within 6 months	0%	75%
5.	Increase compliance with the completion of Care and Treatment Reviews (CTRs)	35%	90%

1. The percentage achievement against requirement goes up and down. Annual Health Checks are not always conducted at regular intervals throughout the year and peaks and troughs can cause the overall position to fluctuate. The current performance may also be indicative of the pressure on GP surgeries.
2. The numbers of people in specialist hospital beds also fluctuates – for example there may be 3 discharges in a one month period, followed by 3 admissions a month later. The primary cause of being outside of performance requirements is attributed to the ongoing numbers of children and young people being admitted to specialist hospital settings.
3. Northamptonshire has been at low performance against this target for a number of years. Low performance is mostly attributed to insufficient data collection, for example, gathering information from different funded services.
4. Nationally and regionally performance against this requirement is low. An investment in resources is required to achieve the target.
5. The percentage achievement against requirement also goes up and down. Further training is required across the system in order to achieve compliance. The CCGs are also investing in additional capacity during 19/20 to oversee compliance.

7. The key principles of our strategy



1. Changing culture and shifting power

Seeing people with a learning disability and/or autism as citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. Focussing on outcomes that matter, and measuring the achievements.

2. Embedding an understanding that 'challenging behaviour' is not a diagnosis

Individuals display behaviours that *challenge us* as a means of communicating that something is not right- it is a by-product of an interaction between the individual and their environment. The individual factors are the characteristics people bring with them; the severity of their learning disability and the presence of additional needs. Examples of additional needs include autism, sensory impairments and/or mental illness. Environmental factors include the support systems in place such as skills, knowledge, and training and the appropriateness of the built environment. Contextually then, behaviours that challenge are a way in which people respond to, and try to gain control over difficult situations. This may include indicating pain, anxiety, illness and/ or boredom. It might also

mean that the individual is experiencing normal physiological or emotional changes that we all experience but is having difficulty making sense of those changes.

Locally we want to stop labelling the individual and give absolute emphasis to the fact that the responsibility for change sits with the systems of support around the individual. Commissioning high quality systems of support at the right time and as early as possible will be key to reducing the numbers of people who present with a challenge. Managing and supporting individuals with these types of behaviours requires skill and consistency in approach - we have many stories of individuals who displayed severe behaviours that challenged who have over a period of time reduced those behaviours and are experiencing an improved quality of life.

3. Being explicit in our contracts with providers about the expectations of supporting people with a learning disability

Particularly with behaviours that challenge. We must be clear about what is legal and appropriate in the use of any form of restraint, 'hands on' or otherwise, and in deprivation of liberty- what is good practice and what is considered to be poor practice. We will embed the use of Positive Behaviour Support and increase the requirements of training and therefore increase skills in supporting individuals who may be at risk to themselves or to others. At the same time we will embed a strengths based approach – an approach that starts with the assets and strengths of an individual; what they can do and what they contribute, what is right and what goes well, rather than the immediate focus being on what is wrong or what deficits need addressing. We will deliver 'what matters to you?' approaches in assessment and care and support planning rather than 'what's the matter?' approaches.

4. Building the right community based services to support individuals to lead active, ordinary and sometimes extraordinary lives

Supporting individuals and their families into ordinary living routines and opportunities as well as contracting for services that work with individuals to access employment and training opportunities, increasing life skills and autonomy. We will strengthen learning disability provision in the 3rd Sector; establishing different short term offers that enable people to gain skills and confidence, with contracts that evidence the outcomes achieved. We will increase the range of services on offer and contracted for and collect information about the impact those services are making. Specifically we will increase the offers available to unpaid carers for respite; increasing the range of options available in order to respond to the reality of carers who are in need of a break – sometimes frequent but short respite intervals are more helpful than waiting for a fortnight twice a year.

5. Commissioning services that provide individuals with the right support at the right time and recognise changing need

The right support at the right time means being outcome focussed and working with individuals and families to a normal routine and baseline – having more services that are short term in nature and designed to offer additional support for the time that it is needed. This will help us avoid unnecessary hospital admissions and reduce the numbers of specialist hospital beds nationally as well as reducing the need for long term expensive care and support arrangements. This means making sure we have services that are good at a range of things with skills in managing episodes of heightened need and crises. Individuals may need these services at different points in their lives for short periods. Some individuals will also need constant monitoring so that we can identify problems or issues early and intervene in a planned way.

Equally; having the right support at the right time is about recognising changing need - we have more and more adults with a learning disability with needs associated with frailty and older age. Adults with learning disabilities typically experience age-related difficulties at different ages, and at a younger age, than the general population. Generally, the needs of older people with learning disabilities fail to get the same attention as those of younger people with learning disabilities. We all face transitions at different stages of our lives. When people in learning disability services talk about ‘transition’ they are usually referring to the transition from childhood to adulthood. The transition into old age for people with learning disabilities is equally important and needs the same sort of co-ordinated focus and joined-up, person-centred planning. Older people should have the opportunity to ‘age in place’ if this is important to them. This means ensuring the home environment can be adapted if necessary. It also means equipping staff to become more age aware and develop their knowledge and competence to support people in later life. Supporting people to continue living in their family home when their parents die requires the identification of families in order to support them to plan for the future. Ageing in place might not be right for everybody; some individuals might need or want to move as they get older. The key is planning for transitions when needs change and ensuring support and care remains person-centred. Current health and social care policies stress personalised approaches, human rights, inclusion and more choice and control – but so few people with a learning disability are supported to plan their transition into old age and make it a smooth and successful one. We must ensure that the needs of older people with a learning disability are included and implemented in a joined-up and inclusive way.

6. Increasing the use of professional discussion and formal Care and Treatment Reviews in a timely manner to make sure we intervene to reduce, prevent or delay

We know that both of these activities lead to creative solutions, admission avoidance, improved outcomes and reduced long term spend. In Northamptonshire we still have much to do to ensure we are adhering to the national requirements that specify timelines for the completion of Care and Treatment Reviews and making sure we have a robust register of people whose circumstances are fragile and may be at risk of admission to a more restrictive setting. This is a mandated requirement of the system but ideally we should be working together to identify individuals who would benefit from multi professional discussions and meetings that aim to **avoid** the need for formal processes and seek only to work together to offer solutions that manage individual needs well and supports families through difficult periods.

7. Acknowledging the often detrimental impact of specialist hospital admission and/or the over-provision of care

Avoiding admissions to specialist hospitals where admission is made because of a need for a safe place or because of a presentation of behaviours that challenge. This is particularly true for young people. Equally what is not widely acknowledged is the detrimental impact of over-provision; where individuals are over protected with sometimes oppressive support arrangements involving multiple support workers at any one time. The impact of these arrangements can be lifelong and frequently individuals stay in hospital longer, or remain in intense support arrangements longer than is necessary because there is an inequitable (as a comparison to people needing admission for mental health problems) lack of focus on managing effective discharge or care reduction at the right time. Changes in environments, being removed from familiar faces and having to adapt to different dependent relationships often make the situation worse and increase the likelihood of behaviours that challenge. Individuals 'spiral up the system' and it becomes harder to support that individual to return to any baseline of what is normal for them. Both of these scenarios cost the health and social care system a lot of money and have a long term negative impact on the individual as well creating a long term dependency on high levels of care and support. Where individuals do require hospital admissions due to mental health needs then we must ensure we follow proper process for a CTR in a planned way and at the same time plan for discharge.

8. Reducing the prescribing of unnecessary medication such as psychotropic drugs which have harmful side effects and are frequently inappropriately and over-prescribed for people with a learning disability

Psychotropic medications are commonly used for people with mental illness or acute anxiety. Used in the right context and with the right medical support they can help people to recover from mental ill health and cope with day to day life. Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy.

Sometimes they are also given to people because their behaviour is seen as challenging; people with a learning disability, autism or both are more likely to be given these medicines than other people. Although these medicines are right for *some* people *sometimes* there are other ways of helping people so they need less medicine or none at all.

Public Health England says that every day about 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines when they do not have the health conditions the medicines are for. Children and young people are also prescribed them. Psychotropic medicines can cause problems if people take them for too long, or take too high a dose, or take them for the wrong reason.

It is not acceptable to use medication alone to reduce behaviours that challenge and medicines should not be seen as the preferred choice of intervention. The use of positive behavioural approaches and/or increasing the quality of support should always be the first consideration. In order to improve the life chances and health of our learning disability population, there are two national programmes helping to stop the over use of these medicines - the STAMP programme (Supporting Treatment and appropriate Medication in Paediatrics) and the STOMP programme (Stopping the Over Medication of People with a learning disability, autism or both). Many different organisations are working together nationally and locally to prevent the over use of these medicines.

NB: It is not safe to change the dose of these medicines or stop taking them without help from a doctor.

9. Continuing to embed a necessity for individuals to have access to regular health checks that identify health problems early

And in so doing lead to treatment and /or monitoring of health issues in the same way people without a learning disability would expect. Embedding regular health checks is important for people with a learning disability as they may not be able to communicate physiological changes, pain or discomfort in the same way as the rest of the population. Often physiological changes are missed and changes in an individual's normal functions or behaviours are considered as being a result of their learning disability rather than being symptomatic of a health or medical problem. When people see only the learning disability instead of the symptom this is called 'diagnostic overshadowing.' As a result people with a

learning disability die younger than their peers without a learning disability. This is called 'premature mortality.'

10. Reducing premature mortality in people with a learning disability in Northamptonshire

As part of the national programme, through system education and change, we will review the circumstances and events surrounding the deaths of people aged 14 years and over who have a learning disability in order to embed lessons learnt and continuously improve the care expected and delivered across the system.

11. Educating and challenging the local system to make reasonable adjustments that enable better and equal access to services

A reasonable adjustment is a change that has been made to a service so that people with learning disabilities can use them like anyone else. This is required in law. We regularly hear of individuals who have received appropriate reasonable adjustments across public sector services that have made a real difference to an individual's health, well-being and human rights. However, we have to keep going further in making sure that people with a learning disability are not denied access to services by sole virtue of having a learning disability. This includes making sure access criteria for services are not denying individuals the same opportunity as would be afforded individuals without a learning disability.

12. Engaging with the right Partners across Northamptonshire to work together to improve outcomes for people with a learning disability

We have some excellent examples in Northamptonshire of cross- sector working to improve pathways of care and support where Health, Social Care, the Third Sector and Independent Sector have worked with users of services to co-produce pathways for self-care, prevention and early intervention, reablement and recovery and crisis support. We will bring that learning and experience into learning disability services to improve the overall offer to people with a learning disability and their carers.

8. Moving on to the 'how'

Our next step is to make this strategy come to life – describing the 'how' of change. We will commit to:

1. Ensuring that people with a learning disability are involved in the ongoing commissioning of services by including them in the process of shaping services through co-production - with the support of family and others, facilitate a collective voice that is valued and able to influence change
2. Co-producing plans that look at the bigger picture and where we want to be in 3 years' time; accepting that transformation does not happen overnight if we are to embed real changes that matter. By engaging the wider community's skill, experience and imagination to create diverse and relevant high quality services that achieve excellent, well-directed outcomes over a lifetime.
3. Placing greater emphasis on delivering changes that have a measurable and positive lifelong impact on people with learning disability, drawing on the longstanding framework of government policies affecting health and social care for people with a learning disability and making those requirements business as usual in Northamptonshire

Our Commissioning Plan will detail the things we are going to do to keep improving and make lasting changes. We will keep checking-in on the 'what and why' we are changing described in this strategy so that we stay focussed on what people have told us and what we have said we will do.

Working Together: Improving lives

Appendix A: Spend on Learning Disability services in Northamptonshire

Northamptonshire Health and Social Care Spend on Packages of Care for people with a learning disability.

