



SCOTTISH EXECUTIVE

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**LEARNING DISABILITY  
ASSESSMENT AND TREATMENT EVENT  
6<sup>TH</sup> OCTOBER 2006**

**jit**  
joint improvement team



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## INTRODUCTION

The implementation of *The same as you?* review of learning disability services has seen a real improvement in the quality of life for many people across Scotland. However there are still a number of people with learning disabilities, often with complex and challenging needs, in NHS beds whose quality of life has not improved and who have not felt the benefits of *The same as you?*.

*The same as you?* made clear that people's homes should not be in hospital and real progress has been made towards the closure of long-stay hospitals, with those few remaining open and other long stay beds due to complete closure by December 2007. The Scottish Executive and NHS Quality Improvement Scotland made visits in 2005 to those areas with long stay hospitals remaining open. It was clear from the visits that those involved in the service re-provisioning had concerns about the definition of assessment and treatment beds and whilst people with learning disabilities may have been discharged from a learning disability hospital some remained as long stay NHS patients. Clearly there is still a need for a small number of inpatient places in the NHS for assessment and treatment. This event aimed to examine who is currently using them, who they should be for, and how these beds can be used effectively to contribute to maximising the quality of people's lives. Service developments and redesign need to be informed by the evidence available and this work builds on an earlier conference held in November 2005 focusing on Research Into Practice (<http://www.jitScotland.org.uk>)

NHS beds do not exist in isolation. Placement breakdown in the community can lead to inpatient care, and beds will become blocked if the right support services are not available for people to move into the community. A whole systems approach and joint working will be central to any successful models of care, so the involvement of both health professionals and local authority representatives in the event was welcomed.

Open and honest discussion about who is in NHS beds and why is essential in recognising the barriers that prevent people from moving back into the community and identifying a way forward. Participants were encouraged to share openly the challenges faced in their own areas and discuss possible solutions that would ensure improvement in the quality of life for people with the most complex needs.

## NHS QIS National Overview of learning disability services - key findings

Dr Margaret Whoriskey (Advisor with QIS until March 2005) and Michael McCue (part time Advisor with QIS from March 2005 – March 2006) provided an overview of the findings from the NHS QIS Learning Disability National Review which was published in February 2006.

[http://www.nhshealthquality.org/nhsqis/files/NHSQIS%20Learning%20Disability%20National%20Overview%20\(Feb%202006\).pdf](http://www.nhshealthquality.org/nhsqis/files/NHSQIS%20Learning%20Disability%20National%20Overview%20(Feb%202006).pdf)

The review focussed on four key areas:-

1. Involvement of children and adults with learning disabilities and their family carers. (Quality Indicator 1)
2. Meeting complex health care needs.(Quality Indicator 4)
3. In-patient services and daily life. (Quality Indicator 5)
4. Planning services and partnership working. (Quality Indicator 6)

A further two areas – Promoting Inclusion and Wellbeing (Quality Indicator 2) and Meeting General Health Care Needs (Quality Indicator 3) have not been subject to external review by NHS QIS.

The review focussed specifically on **progress with hospital closure**.

- Since 1998 11 long-stay hospitals/ NHS long stay units for people with learning disabilities closed with 8 still to close and therefore not meeting the target date of December 2005 set by *The same as you?*.
- There are less than 300 people living in hospital including those in longer-term assessment and treatment/rehabilitation services and in out of area placements.
- Since 1980 over 6,5000 people with learning disabilities have left hospital to live in their own local communities – a significant achievement.

- All areas now have plans in place to close remaining long-stay hospitals and units and develop more appropriate community-based services. It is recognised however that there are a range of models for hospital closure and service provision and the QIS local reports provide a lot more detail on these.
- A number of issues are identified relating to hospital closure which include a number of people still living in longer-stay hospital units following hospital closure with plans not yet agreed for future service provision.
- There are a number of people whose discharge is delayed from assessment and treatment units sometimes for many months (or even years). An audit undertaken in 2004 identified that over one third of assessment and treatment beds were occupied by people whose discharge is delayed thereby not available to others requiring the service.
- There is a lack of robust community-based services to support people with complex needs and the lack of planning for people in out of area placements. Key challenges are:
  - agreeing models of care
  - agreeing financial frameworks with partners
  - investment in community infrastructure and evidenced-based services
- There is a need for health and social care partnerships to review the needs of people discharged as part of earlier hospital closure programmes who may now be living in services not ideally appropriate to their needs. In particular there was a significant number of people discharged to large group living services eg care homes.

The QIS national overview report and 16 local reports provide the detailed findings across all the quality indicators reviewed. The presentation focussed specifically on services for children and adults with complex needs.

## **Children and Adults – Services for people with complex needs (Quality Indicator 4) – Overview**

For children over 65% of the indicators in this section were rated *partially or scarcely developed*. There are major gaps in services and challenges in areas around supporting transition, provision of appropriate services for children and young people with challenging behaviour and those with mental health needs and the needs of young people with learning disabilities who may be vulnerable to offending behaviour.

For adults over 70% of the indicators received *partial or scarcely rating*. Some of the key challenges include the need to develop robust community-based responses for people with challenging behaviour and services for ASD.

### **Key findings relevant to hospital closure/service redesign**

A number of specific indicators were identified as being particularly relevant in the context of hospital closures, service redesign and the provision of assessment and treatment services. These included:

- Effectively involving adults and family carers in the planning and delivery of services (only 3 out of 16 NHS Board areas rated substantial development).
- Provision of advocacy services (only 2 out of 16 NHS Boards - substantially developed).
- Provision of appropriate in-patient accommodation suitable to the needs of people with learning disabilities (4 out of 13 NHS Boards - substantial development).
- Provision of specialised services for children and adults with complex needs (4 out of 16 NHS Boards – substantially development)
- Community based services to meet the needs of adults with challenging behaviour – 5 out of 15 NHS Boards substantially developed.

The national overview points to progress being made but more to do, particularly in the context of developing appropriate effective community-based models for people with complex needs. The issue of recommendations having being made several times previously in other SHAS/ QIS reports particularly in relation to the need to provide appropriate mental health services for children, crisis intervention services for children and adults and robust needs assessment do not appear to have been taken forward systematically across Scotland. There is a need for early and sustained intervention and support for people. Health and social care partnerships need to develop more evidence-based commissioning.

User involvement is developing but needs ongoing and continued focus.

Partnership working, some good examples from hospital closure, needs to lead to implementation and development of joint services and there requires to be support to health and social care partnerships to support implementation.

## Key Themes from Speakers

### **Professor Eric Emerson, Professor of Disability and Health Research, Institute of Health Research at Lancaster University: What evidence tells us**

<http://www.lancs.ac.uk/fass/ihr/staff/ericemerson.htm>

- To date services have failed to focus adequately on prevention and early intervention. There requires to be strategic partnerships with child and adolescent mental health services to develop more effective joint working.
- There is a need to consider the relationship between social deprivation and prevalence of learning disability with good evidence now to suggest that 60% of children with learning disability and mental illness are living in poverty. This has implications in relation to a rationale for allocating resources and the service models needed.
- People with learning disabilities who have challenging behaviour and mental health needs are denied access to evidence-based support and services.
- Intervention needs to be over the long term. Evidence shows that challenging behaviour does not respond to short and medium term intervention and requires a sustained approach over decades. Assessment and treatment services are only a fraction of the solution and require to be considered within a whole systems approach.
- There are significant costs associated with our failure to support people effectively.
- There is now evidence that some approaches work, for example, psychological approaches and some medication. However big concerns around the numbers of people with learning disabilities on anti-psychotic medication for challenging behaviour. The Disability Rights Commission have recently raised this concern.
- The majority of people do not gain access to evidence-based support. People are more likely to get things that do not work rather than things that do work.

- Evidence now points to the need to provide services in non-congregate settings. A number of recent studies have shown no benefits to congregate settings for people with challenging behaviour.
- The role of assessment and treatment units need to be considered carefully. The persistence of challenging behaviour over time points to limited benefit of short-stay admissions and instead a need to address issues of assessment and treatment in peoples' own environment.
- The need to identify the high risk population and to use resources more effectively. Interventions and therapy are not going to solve problems on their own and there is a need to adopt a public health prospective, invest in preventative and early intervention services. There is good evidence of the benefits of early intervention from the States including significant economic benefit.

**Sue Carmichael**, Valuing People Team, Department of Health ([www.valuingpeople.gov.uk](http://www.valuingpeople.gov.uk))

In England there are under 200 people with learning disabilities still living in long-stay hospitals and these will be closed in the near future. However a number of people have ended up living in NHS campuses – a hangover from hospital closure programme. There were no strong levers in Valuing People on this issue and also issues about definitions of NHS campuses etc. The recent Health and Social care White Paper has now stated that **nobody should live in the NHS** and all the NHS campuses should close by the year 2010.

There has been a trend towards people going to out of area placements with 1500 people in private health care services in England. Work is underway in England to address out of area placements.

There are a number of resources on the Valuing People Website including the *Green Light Toolkit* which is an approach to rating where partnerships work effectively together.

A follow-up to the Mansell Report (1993) is being undertaken and will be available early in 2007.

## **Experience and practice of some local services**

### NHS Ayrshire and Arran

Tommy Stevenson provided an update of ongoing work in Ayrshire and Arran including:

- investment in an assessment and treatment unit of 16 beds,
- three Community Learning Disability Teams (CLDT) with the aim of avoiding admission where possible,
- partnership commissioning,
- the development of robust entry and exit strategies and integrated practice.

In Ayrshire and Arran there are 24 people in continuing care and 12 in assessment and treatment beds with the longest stay recorded as 46 months.

### **The influencing actors for this group were;**

- Existing community supports intense and continuous
- High risk of breakdown due to complexity of need
- Currently limited response to influence admission avoidance
- Families unable to manage crisis leading to eventual breakdown
- Profile of current population, all have complex needs
- Prolonged stay in NHS accommodation detrimental to re-establishing community presence
- Care provider breakdown influenced by significant turnover of staff, maintaining competency levels and original commissioned package inappropriate

### **The lessons learned from the retraction process;**

When establishing service models for people with complex needs, priority has to be given to establishing effective partnerships between agencies. This has been the key success factor influencing the retraction plan/process;

- Common goals
- Common assessment process/shared needs profile
- Agreement on commissioning options prior to discharge
- In-place financial plan

- Agreement on care management and PCP process
- Named worker
- Critically important is an agreed time frame for discharges
- Commissioned options should include continuous high level support as required

Tommy highlighted the importance of recognising that people with complex needs require services on repeated occasions and over prolonged periods of time. The management of complex need is continuous. Periodic discrete episodes of care will not address the complexity of their support needs and importantly the support needs of staff involved in their care.

Realistically, service models need to provide long term involvement with individuals and their families (these people are the new continuing care group). The model of service needs to provide a context in which new behaviours and skills can be fostered and consistently reinforced within the individual's living environment.

#### **Current trend in NHS Ayrshire & Arran**

- Increase in numbers requiring admission
- Average stay lengthening
- Admitted clients far more complex
- High risk of beds being blocked/delayed discharges
- Specialist services become compromised and less responsive
- Community services become saturated in both Health and Local Authority

#### **Key Influencing Themes for Statutory Services:**

- Increase in complex needs
- Affordability in delivering supports
- Sustainability of existing models of support

## NHS Forth Valley

Allison Ramsay and Keith Bowden shared their experiences of hospital closure and partnership working to re-provision services in Forth Valley through joint commissioning; the partnership in practice agreement and integrated learning disability teams.

In reviewing their assessment and treatment service they looked at the admission process, population, discharge issues, how to facilitate discharge and where the opportunities were.

## NHS Greater Glasgow and Clyde

Michael McCue highlighted the key challenges for NHS Greater Glasgow and Clyde with regards to the use of assessment and treatment beds as;

- Continuous service 'sensitivity'
- Local vs central services
- Changing service users needs
- The 'duality' of risk

## **Round Table Discussions**

### **1. Current position and challenges**

We do have strengths and experience, joint working is beginning to happen.

#### **But:**

- Alternative models (from in-patient) to assessment and treatment are needed. There was a feeling that we are in between models (longer term care and rehabilitation).
- There are higher levels of need across age groups.
- There is no clarity around joint commissioning and responsibilities and partnership and no real joined up strategy for future services.
- Mental Health services have no strategic approach to take account of changes to learning disability services.
- Quality of care in the community is variable, we need to build capacity.
- Responses and commissioning are crisis driven and variable across Scotland.
- Major issues in staffing roles and responsibilities. Need sufficient skilled staff and management.
- Current financial resource threatens the equity of care for the wider learning disability population. Creative use of resources is needed.
- Responsibility and priority of health boards to the learning disability population is not clear.

## **2. Definitions of Assessment and Treatment**

- Assessment and treatment should be for people with significant mental health issues and/or challenging behaviour and/or forensic management. It should be used when people cannot be sustained safely at home. There should be a small number of temporary beds with inpatient treatment that lasts only as long as necessary.
- All Assessment and Treatment should not necessarily be in health.
- It is important that admission is at the time of optimum benefit. The focus should be on prevention and early intervention. Needs should be continually assessed.

### **What should services look like?**

- Joint responsibilities and commissioning are essential.
- Multi-disciplinary/multi-agency risk assessment and associated flexibility of support from integrated services.
- Local providers should be accountable and responsible through joint planning.
- There should be a 24/7 'inreach' model of skilled, flexible staffing. Specialist staff should be available in remote areas.
- Robust community infrastructure is needed with protocols for support in own home for those who regularly have periods of difficulty.
- Both the person and receiving infrastructure should be ready for discharge.
- Tiered services are needed from community support to robust intensive support and planned crisis/respice care.

### 3 How do we take this forward?

- i. Investment is needed in early intervention (based on the evidence now available). More radical/creative kinds of intervention need to be considered for the next generation. This requires to be taken forward at a national level linked to the implementation of the CAMHs Strategy and at a local level which should see strategic alliances developing across learning disabilities and CAMH services. (This is specifically referred to in the QIS quality indicators). There is an urgent requirement to start now. A number of people suggested a real proactive change to early interventions would need pump-priming.
- ii. There is an opportunity to focus on the needs of people with learning disabilities in the context of the work now being taken forward by Community Health Partnerships on long-term conditions. This would enable issues such as health inequalities to be addressed as well as robust predictive modelling to ensure the services are targeted at those at greatest risk.
- iii. There is a need to develop strategic alliances and arrangements for the operational delivery of services between learning disability and mental health services locally. There is significant work being undertaken in local areas around mental health and in-patient redesign and there is a requirement to consider the interface with learning disability services.
- iv. There is a need for robust evaluation of service redesign underway to inform future service provision and share experiences with other partnership areas. (*e.g. model in Borders being developed with no assessment and treatment beds but ability to access Lothian bed*).
- v. Of crucial importance is to ensure effective commissioning of services. Building on a conference held in November 2005 with ADSW, JIT and the Mental Welfare Commission, the JIT is now involved in developing a toolkit/ guidance to support the use of evidence-based commissioning and joint commissioning. This will be available in late 2006.

- vi. There is a need to support the research agenda to inform implementation. Evidence about saving resources in the long term by investing in prevention and early intervention should be strengthened.
  
- vii. There is strong support for more events - need to engage with other stakeholders eg providers, housing etc. There need to be opportunities that are facilitated for shared learning. This could involve:
  - a. Funding of national demonstration projects,
  
  - b. Development of website /weblinks to encourage shared learning and dissemination of relevant materials.
  
  - c. Arranging further events potentially hosted by local areas partnership on specific topics eg early intervention, long-term conditions etc. There could be two to three events a year with local areas taking the lead on this with some support from the centre.
  
  - d. Further development of MCNs
  
- viii. Honesty is needed about who should be in assessment and treatment beds. The “continuing care” population needs to be identified and appropriate models and costs of care need to be scoped.
  
- ix. Workforce development to ensure all staff provides appropriate support. Staffing issues need to be considered including burnout, turnover, training, rotation and resources.

## **CONCLUSION**

Some actions were identified for local partnerships, some for work with the Scottish Consortium of Learning Disability and some for further national consideration. At a national level the same as You National Implementation Group and the Partnership in Practice Network will be updated on the discussions and ideas about how to develop successful service models.

We would welcome views from participants and others involved in the support and care of people with learning disabilities on how a network for shared learning could be taken forward.



APPENDIX A

## Learning Disability Assessment and Treatment Event

The Scotsman Hotel, Edinburgh

Friday 6<sup>th</sup> October 2006

### PROGRAMME

- 9:30**                      *Registration and Coffee*
- 10:00**                      **Chair's Introduction and Welcome**  
**Ms Jean McClellan**  
Head of Adult Support and Protection Unit, Scottish Executive
- 10:15**                      **NHS QIS National Review - Key findings**  
**Margaret Whoriskey, Michael McCue**  
Assistant Director, Joint Improvement Team
- 10:45**                      **Round Table Discussion**  
Current position.
- Coffee*
- 11:30**                      **Evidence and outcomes- implications for commissioning and delivery**  
**Eric Emerson, Professor of Disability and Health Research**  
Institute of Health Research at Lancaster University
- 12:15**                      **The Valuing People experience**  
**Sue Carmichael**  
Valuing People Team
- 12:45**                      *Lunch*
- 13:30**                      **Round Table Discussion**  
What should services in Scotland look like?
- 14:15**                      **Experience and practice – Scottish services. A view from some local services.**
- 14:45**                      **Round Table Discussion**  
How do we get there?
- 15:25**                      **Discussion and next steps**
- 15:40**                      *Close*

## **APPENDIX B**

### **List of participants**

Tommy Stevenson	NHS Ayrshire & Arran
Jim Begbie	NHS Ayrshire & Arran
Jenny Thompson	South Ayrshire Local Authority
Sheena Gault	North Ayrshire Local Authority
Marion Paterson	NHS Borders
Dr Tracy Sanderson	NHS Lothian
Dr Sheila McDonald	NHS Lothian
Daniel McGuinness	NHS Lothian
Michael Brown	NHS Lothian
Denis Rowley	NHS Lothian
Rona Laskowski	City of Edinburgh Council
Duncan McIntyre	Midlothian Council Social Work
Robert Samuel	Scottish Executive
Dr K Mackay	NHS Grampian
Dr J Oliver	NHS Grampian
Susan Carr	NHS Grampian
Michael McClements	Glasgow Learning Dis/ Partnership
Annemarie Monaghan	Glasgow Learning Dis/ Partnership
Dr Robin McGilp	Glasgow Learning Dis/ Partnership
Dr Gail Fleming	Glasgow Learning Dis/ Partnership
Margaret Serrels	NHS Lanarkshire
Allison Ramsay	Forth Valley Primary Care
Stuart Landels	Clackmannanshire Council
Carole Jones	Falkirk Council
Janet Smith	Stirling Council
Dr Stephen Anderson	Forth Valley Primary Care
Joe McGhee	NHS Forth Valley
Cindy Wallis	East Renfrewshire CHCP
Doug Adams	NHS Greater Glasgow & Clyde
Pat Colville	NHS Fife Learning Dis/Services
John Alexander	Fife Council Social Work Service
Dr Rosemary Logan	NHS Fife
Alison Robertson	NHS Fife Learning Dis/Services
Susan Manion	NHS Fife
Arthur Fulton	West Lothian Council
Stuart Storrie	NHS Tayside
Julia Fitzpatrick	West Dunbartonshire CHP
Morag Dendy	North Lanarkshire Council
Fiona Rafaelli	South Lanarkshire Council
Donellan Mackenzie	Highland Council
Judith Proctor	Dumfries & Galloway

Morag Scoular	NHS Dumfries & Galloway
Stephen Hodgson	Dumfries & Galloway
Heather Harscoet	Dumfries & Galloway
Colin Lewis	Dumfries & Galloway
Bruce Kidd	NHS Dumfries & Galloway
Keith Bowden	NHS Forth Valley
Ian Cairns	Mental Welfare Commission
Jenny Pickthall	Scottish Executive
Marion Thompson	Scottish Executive
Eric Emerson	Lancaster University
Sue Carmichael	Valuing People Support Team
Jean Maclellan	Scottish Executive
Michael McCue	NHS Greater Glasgow & Clyde
Lisa Curtice	Scottish Consortium for Learning Disability
Douglas Erdman	Renfrewshire Council
Alan Monks	Social work department, Comhairle Nan.Eilean Siar
Frances Daniels	Western Isles Learning Disability Nursing Service
Ross Blackman	Western Isles Health Board
Margaret Harlin	NHS Grampian
Maria Brown	Inverclyde
Alex Davidson	South Lanarkshire Council
Margaret Anne Gilbert	Mental Welfare Commission
Margaret Whoriskey	Scottish Executive