



Learning Disability Change Programme

'A Strategy for the Future'

Proposed Service Specification for Adult Learning Disability Services in
Greater Glasgow & Clyde

MAY 2014

CONTENTS

- 1. Introduction**
 - 2. Vision / Values and Aspirations**
 - 3. Policy Context**
 - 4. Our Resources**
 - 5. Our Service Principles**
 - 6. Current Model / Challenges and Case for Change**
 - 7. Activity Audit**
 - 8. Our Proposals**
 - 9. Future Service Model/ what we want to achieve**
 - 10. Eligibility / Inclusion**
 - 11. Co-dependencies / Co-working**
 - 12. Network / Whole System Approach**
 - 13. Leaner and more effective**
 - 14. Clinical Governance / Service Improvement / Quality**
 - 15. Learning & Development**
 - 16. Next Steps / Implementation and timescales**
- Appendix 1 - Range of Services**
- Appendix 2 - Mechanisms which support delivery**
- Appendix 3 – Dietetics**
- Appendix 4 – Podiatry**
- Appendix 5 – Workforce Proposals**
- Appendix 6 – Resource Allocation**

1. Introduction

1.1 This document presents the outcome of the Learning Disability Change Programme in the form of a service specification which describes the future role and function of Specialist Adult Learning Disability Services across NHS Greater Glasgow & Clyde (NHS GGC). The scope of the Change Programme has incorporated all Specialist Services currently delivered by the Board.

1.2 Engagement with a range of stakeholders, including professionals working in Learning Disability services, individuals with learning disabilities, families and carers, staffside organisations, voluntary organisations, academic colleagues and the wider NHS and Local Authorities has informed this service specification.

1.3 This specification also takes cognisance of local and national policy / strategy including, The Keys to Life The Healthcare Quality Strategy, the Public Bodies(Joint Working)(Scotland) Bill as well as a wide range of relevant local and national documents such as Strengthening the Commitment; Allied Health Professionals as Agents for Change; the National Health Needs Assessment for People with Learning Disabilities in Scotland and the Local Health Needs Assessment, produced in 2011 by NHS Greater Glasgow & Clyde.

1.4 NHS GGC covers 6 local authority areas with a population of 1.2 million. Prevalence of learning disabilities in adults is however small, with the Learning Disability Local Enhanced Services (LES) Register ascertaining a learning disability population in the region of 5,200. Reflected at the heart of this service specification is the move towards new integrated local services, reflecting local variations whilst retaining what is essentially an economically viable service for a minority of the population.

2. Vision / Values and Aspirations

2.1 The 'Strategy for the Future' document clearly outlines our aspiration to provide a future service which focuses on providing good outcomes for people with a learning disability and to support people to live healthy, happy, independent lives within the community.

2.2 Our vision is underpinned by human rights, fairness and equality and this specification demonstrates our intent and obligation to provide opportunities which enable people with a learning disability to access good quality healthcare which is knowledgeable and sensitive to their specific needs and aspirations.

2.3 People with a learning disability continue to experience significant inequalities; this service specification aims to address these by creating a fairer system which listens to what people with learning disabilities want and need from specialist services and to develop better ways of supporting our mainstream partners.

2.4 Our intent is to enable individuals with a learning disability to access the right healthcare, at the right place, at the right time and to support our mainstream colleagues to understand and better cater for the needs of people with a learning disability.

2.5 Engagement with people with learning disabilities has defined what people expect from NHS Services such as less reliance on bed based services, greater meaningful participation, more control and an ability to access the service which best meets their needs regardless of the presence of a learning disability.

3. Policy Context

3.1 The 'Strategy for the Future' which is the precursor to this specification reflects the direction of local and national policy. The Keys to Life, the Scottish Government's strategy for people with a learning disability outlines 52 recommendations, which collectively aim to address the significant health and social inequalities that people with learning disabilities continue to face. The strategy emphasises the role that NHS Boards have in addressing these inequalities.

3.2 'Strengthening the Commitment', the UK review of Learning Disability Nursing also marks the first significant review of the Learning Disability Nursing profession. It provides a useful career framework which is based on the particular future skills required of the profession to meet changing need and be responsive across the life span of people with a learning disability. The Keys to Life and Strengthening the Commitment are both new policies and have yet to be defined in terms of local implementation; however both assist in setting the direction by which NHS services are obliged to shape future Learning Disability Service provision.

3.3 The triple aim of the Quality Strategy (Person centeredness; Safe & Effective) underpins the framework of this service specification.

3.4 Looking further afield to other models of service across the United Kingdom and taking account of the late Jim Mansell's recent report on Winterbourne View has assisted our thinking in terms of what it is that specialist services need to be focussing energies on. We need to develop services in the community which reduce the need for admission to In Patient facilities. We need to ensure that resilience and skill is available in teams to support people with learning disabilities when they need us most and ensure that this is available consistently and delivered locally across NHS GGC.

3.5 The role of Allied Health Professions in Scotland (Allied Health Professions as Agents for Change) has also given helpful direction in the development of the model. In particular it states the importance of enablement approaches and guides where all professions within the context of a specialist team can work better together. We have been explicit re the future skills which need to be developed to meet changing demand.

3.6 The principles of the Scottish Government's workforce 20/20 vision: Everyone Matters (2013) have been considered whilst developing this service

specification. The Learning Disability workforce have contributed extensively to its development, by examining what current practice looks like and outlining practice in the future which focuses on anticipatory care and responds to the changing demographics of the population. Included within this has been identifying the Learning & Education needs of the workforce.

3.7 The Learning Disability change programme parallels the Board wide Clinical Services Review process which looks to the future balance of service provision across primary and secondary care. This is an important driver in developing and strengthening relationships between clinical services.

3.8 The Equality Act 2010 and the Equality Act 2010 (Specific Duties) (Scotland) regulations place an obligation on organisations to eliminate discrimination, and advance equality of opportunity and foster good relations between people who share a relevant characteristics and those who do not.

3.9 The Equality Act specifically refers to the duty of NHS GGC to ensure that we focus on developing better access to all services for people with a learning disability and that Specialist Services work more closely and in partnership with all NHS colleagues and service providers. There is therefore a statutory responsibility to take forward a future service delivery model which enhances enablement and co-working approaches to ensure that we address inequalities. These duties are captured within 'Meeting the requirements of Equality Legislation – A Fairer NHS Greater Glasgow & Clyde 2013 – 2016'.

4. Our Resources

4.1 The financial resources associated with Learning Disability services are unevenly distributed across NHS GGC. This is due to historical factors including previous redesigns, hospital closure programmes and changes in the Health Board catchment area. In the future, financial resource will be allocated based on adult population figures.

4.2 The Resource Allocation Model which will be applied was agreed by NHS GGC Directors in 2012. The formula agreed uses a straight adult population methodology. Although there is some ¹published evidence available to inform resource allocation based on Learning Disability population and deprivation this evidence is scarce and has limitations.

5. Our Service Principles

During the development of the service specification, conversations and dialogues with health care professionals have highlighted a number of emerging principles which are consistently shared by all professional groups as being key to the effective delivery of LD services in the future.

¹ Cooper, S-A., McConnachie, A., Allan, L.M., Melville, C., Smiley, E., and Morrison, J. (2011) Neighbourhood deprivation, health inequalities, and service access by adults with intellectual disabilities: cross sectional study. *Journal of Intellectual Disabilities Research*, 55 (3). pp. 313-323.

5.1 The existing **multi-disciplinary model** should remain, with each locality having local access to a full range of expert practitioners, either within a dedicated Learning Disability team or accessed through generic services.

5.2 A new service model with dietetic and podiatry learning disability expert practitioners integrated into mainstream generic services, easily accessible by both learning disability practitioners and individuals alike has emerged.

There is also a need to meet the challenges in the current arrangements for accessing Continuing Professional Development (CPD) via clinical supervision and profession specific staff meetings for the smaller professions, who have historically worked discretely from mainstream services.

5.3 **Local delivery and access** to learning disability services should remain as the service model, however further consideration is required in relation to clinical governance issues which arise from having large geographical areas and a relatively small workforce. The solution to this has been to consider where **Co-dependencies** are required to maintain a safe and effective service.

5.4 The current boundaries that exist between Tiers 3 (community based services) and Tier 4 (Bed based services and specialist community based services) require to be reviewed with a move to a more **person centred approach**. The range of therapeutic interventions provided within Tier 4 should be available from a **network of expertise** across NHS GGC.

5.5 The principle of **enablement** to access mainstream NHS services will be the norm, with additional direct intervention as required with Specialist Services:

- Planning for the future
- Supporting and Enabling
- Directly providing healthcare

5.6 Responses to crisis / adverse incidents are proposed to be managed by **developing joint agreements** between Sectors, CHPs and CHCP's.

5.7 **Professional leadership** should be system wide and integral to the wider NHS GGC professional structures. Clinical supervision for all specialist learning disability practitioners should be robust and evidenced.

5.8 **A local workforce** which is based on population is proposed. Additionally this will require a framework of professional and managerial governance / leadership which allows flexibility in managing challenges in particular in response to staff absence within localities. There is no suggestion of centralisation of any functions; however, due to the small size of the workforce and the impact of absenteeism, there is a need to develop a whole-system approach which allows flexibility.

5.9 **Anticipatory care** will become the focus of teams, where more clinical time is spent on interventions which prevent, prepare and plan for health input in partnership with the wider NHS GGC system. There is a recognition that shifting to an anticipatory focus will require the involvement of many other stakeholders. Across NHS GGC a number of good practice examples exist

particularly around the work of Local Area Co-ordination and Public Social Partnerships. Experiences and learning should be shared with all Learning Disabilities services.

5.10 A large proportion of the work will be carried out ***in partnership*** with primary care, acute care and third sector providers. This will require local and Board wide interfaces to be strengthened.

5.11 The future model will focus on building capacity of direct (family and paid) ***carers*** to enable them to continue to support the people they care for as the demographic profile of people with a learning disability changes.

5.12 The future model should avoid developing services which fill gaps but should focus on ***addressing inequalities*** across the system.

5.13 Eligibility for the service will be based on ***inclusion*** and not exclusion.

5.14 Where an alternative service within the Board is best placed to meet the individual's needs, ***co-working*** will become a more regular feature of the Learning Disability team's clinical work to enable access. This will require a programme of work to further review, develop and implement care pathways.

5.15 That '***all residents of the Board will receive the service which best meets their needs***'. In short, the presence of a learning disability, if it is not the person's primary health problem, will not dictate where they receive their care from.

5.16 Future Clinical Interventions will be based on existing and/or ***emerging evidence***. Partnership working with academic colleagues will be strengthened.

5.17 Performance ***outcome measurement*** is embedded in governance processes.

5.18 Process and procedure is consistent NHS GGC wide but allows local variation where required.

6. Current Model / Challenges and Case for Change

6.1 The Change Programme has used a number of approaches to explore where change is required to improve the outcomes for people with a learning disability, as follows:

What we did

- Review of Local and National Policy to define future obligations
- Review of predicted demographic and health changes of the population
- Short life Working Groups with all professions to establish what we currently deliver, why we deliver the current range of interventions and where these bring value and positive outcomes to the population
- Working Groups which brought together all professional leads to establish the future range of clinical interventions
- Work to determine the current learning and development needs of professional groups against emerging population need

- Analysis of current activity both in terms of 'team' activity and 'practitioner activity'
- Engagement of people with a learning disability, their families and carers

7. Activity Audit

7.1 An extensive audit of caseloads was undertaken in January 2013 and a further audit of all community staffs' individual activity took place during February 2013. The audit was carried out in two stages, firstly gathering 'caseload / team activity' and secondly 'practitioner activity'. Caseload data was collated using a specially designed proforma; practitioner activity was based on a revised version of the NHS QuEST Activity Tracker Tool which included domains specific to Learning Disability professional input - This information was gathered to assist the change programme to:-

- Determine the demand for services
- Understand variances in activity across NHS GGC
- Understand the processes which are currently in place and identify where these could be improved
- Assess the productivity of our current model and identify where this could be improved
- Benchmark the work of the previous Local Health Needs Assessment around population numbers and the actual number of people who receive a service from teams
- Provide a baseline on which to further develop robust audit processes and design key performance indicators

7.2 There are a number of caveats which need to be applied to the results of these audits and a number of problems encountered in extracting the information however, the key messages and results were as follows:

- At the time of Audit, 2,700 adults with a learning disability were receiving a service
- 30% of referral activity to the service was 'new demand' or not currently seen by any other member of the 'health team'
- 70% of referral activity was generated within the teams by cross referrals between disciplines
- Average caseload figures were in the region of 24 (with variances) benchmarked against all whole time equivalent staff (excluding unregistered staff)
- Waiting times were excessive and varied widely – Professional Groups with highest unexpected / unplanned leave showed the highest waiting times, mainly due to lack of cross system cover arrangements
- For some professions' waiting times were so long, the net effect fundamentally was that no service was being delivered

7.3 In terms of individual practitioner audits:

- The split of direct/indirect/support at 19/39/42% (21/43/36% excluding leave) differs from GGC Community Mental Health Team (CMHT) split of 33/33/33% - more indirect than direct patient time is explained by the increased need for care by proxy in LD services
- More time (22%) is spent on clinical administration than is spent on assessing, reviewing and delivering care to patients (19%)
- Rates of supervision and CPD vary significantly across the professional groups
- Time spent liaising with mainstream colleagues is low across all professional groups, in terms of the future direction outlined in this specification, this needs to be addressed as a matter of priority

These results have highlighted where productivity, patient experience and staff experience could be significantly improved. There is however a degree of caution to be applied to the results, as this was the first audit of its kind undertaken. Despite this, they provide an important benchmark on which to develop future services and measure future impact of the revised model.

What we found

7.4 These varying approaches have highlighted a number of essential reasons to apply a revised model. (Further detail from each workstream and detailed reports on activity levels are available). Broad themes which the revised model aims to address are as follows:

- The recommendations from the National Health Needs Assessment for people with a learning disability in Scotland and the Local Health Needs Assessment 2011 have not been implemented fully
- General Duties set out in Equality Legislation are not consistently delivered or measured against performance
- The Learning Disability service does not focus on enabling access to mainstream services; development of self management and anticipatory care
- Many clinical interventions are undefined and lack a strong evidence base, partly due to limited research activity
- Services and clinical interventions vary across NHS GGC
- The connections between professions in these clinical interventions is better defined in some teams than others in terms of the contributions made by each profession
- Care Pathways are underdeveloped and variable both within Learning Disability services and within wider NHS Services, pathways which exclude people with a learning disability require to be reviewed
- Links / Relationships between local geographic teams and generic services are not consistent across NHS GGC

- Whilst some teams have well defined processes in place, many do not
- Many processes are cumbersome and result in ‘multiple hand offs’ between professions which can increase clinical risk and impact on the patient’s experience
- Co-ordinated and coherent learning and development based on future needs of the population is not in place
- Future workforce planning which prepares the next generation of learning disability practitioners is variable
- Inefficient use of senior practitioners due to historical skill mix developments
- Person centred approaches are not consistent across the tiers and geographical areas. Sharing of good practice is not consistent and results in an imbalance of the quality of service delivery; patient experience and results in duplication of effort
- Established and validated outcome measures are not in place
- Information technology is patchy, basic patient management detail cannot be extracted easily
- Professional leadership arrangements vary and clinical supervision across professional groups requires to be strengthened
- Community based and In patient based services require to work more closely together to prevent admission and avoid delayed discharges
- All Learning Disability Services require strengthened relationships and care pathways with all parts of the wider NHS system

8. Our Proposals

8.1 In order to take forward the models and clinical interventions outlined a number of significant changes are proposed.

8.2 Service Delivery

- All Directors will require to agree to a co-dependency and staff governance framework to ensure continuous uninterrupted clinical cover across NHS GGC
- Current system wide services such as Complex Needs Support Team and Learning Disability Liaison Team will be delivered locally. therefore the current teams will be reconfigured in their current form with the clinical expertise they currently provide delivered from the local area. The CNST currently only covers the Greater Glasgow catchment area. In Clyde, local teams have developed in such a way as to ensure ‘competency in complex care needs are reflected within the current workforce. Many of the interventions that the CNST carry out will be encompassed in the learning and development of all LD practitioners in the future – an overall Care Pathway / Network of practitioners will require to be established. The Workforce changes to achieve this are included in the workforce model
- The Learning Disabilities Liaison Team will continue to support general practice to deliver on their locally enhanced service requirements until the outcome of GP contractual negotiations become clearer both nationally and locally. The team will move to an integrated locality based model, retaining central management function in the interim

- Current Out of Hours Nursing which is currently only available in Greater Glasgow will undergo review with the aim being to incorporate it within the Mental Health Out of Hours Service and NHS 24 resulting in a system wide approach
- Specialist Epilepsy Nursing will be hosted within Neurology Services and will complement the Board wide Neurological services via an agreed pathway. Management of the resource will be aligned to a specific locality
- All Learning Disability Practitioners regardless of discipline will develop a core set of competencies based on the range of services provided and those which are unique to the client group. e.g. all Practitioners will have skill and knowledge in legislative frameworks
- Podiatry services will be provided within the construct of mainstream services, existing Learning Disability Podiatrists will provide expertise and knowledge to the wider podiatry workforce thus increasing their skill base in meeting the needs of people with a learning disability
- Dietetics will be provided within the context of a mainstream service, via an explicit care pathway which ensures that the right care is provided at the right time by the most appropriately trained professional
- The current range of In Patient facilities will be redesigned. Longer Stay beds will be closed and existing 'longer stay' people will be supported to resettle into community facilities
- Admission beds will be retained however work will be progressed to explore a model which is delivered in partnership with the third sector to support discharge of people who require robust care packages
- Flexible approaches to enable a variety of uses within admission services will be explored, which avoid the need for admission, focus on out reach / in reach and are person centred. i.e. increased use of day patient admissions, shared care arrangements

8.3 Professional Leadership

- Each profession will have one professional lead. Professional leads will be strategically located across NHS GGC avoiding clusters in one part of the Board area. The aim of this is to provide senior presence and visibility across all of NHS GGC. Professional leads will provide clinical sessions at an advanced level within an agreed locality
- Professional Leads will have a role in contributing to the wider strategic vision of NHS Greater Glasgow and Clyde

8.4 Workforce

- The range of future clinical interventions will be delivered by registered and unregistered practitioners commensurate with the level of skill and experience required for the presenting need
- A framework for Clinical Supervision will be in place across NHS GGC for all professions
- Each locality will link to the Board wide Professional Leadership Structure

- Workforce models have been developed in response to the level of clinical experience required for the interventions which will be undertaken
- The proposed Workforce Model has addressed the need for succession planning and career development by including a blend of grades
- Unregistered Staff are available in all areas and will not be linked to any one specific professional group. Unregistered staff have an important role to play in the delivery of clinical interventions which requires to be better defined and more effectively utilised. A generic support worker role is proposed which reflects the needs of the patient as opposed to the needs of a parent profession

8.5 Management of Teams

- A General Management model is recommended, where all teams have an identified Team Manager who would assume clinical duties in terms of direct patient care only in exceptional circumstances and to the extent required to maintain professional registration
- Any professional discipline would be suitable for the role
- Local decisions on Operational Management models should take into account future integrated structures and will require local discussion and agreement
- The workforce profiles within this specification are clinical / professional structures only; they do not encompass General Management. Each locality will be asked to consider their own General Management arrangements within the principles of the proposed future model

8.6 User and Carer Involvement

- An overall strategy with a clear statement of intent which is linked to the standards set out by the Board for participation and measurement of patient experience should be developed and agreed by all localities as a shared priority. This should include mechanisms to report locally and centrally
- Local systems such as referral pathways embed patient experience mechanisms to ensure routine data capture as part of a standardised process
- Standardised patient experience feedback forms an essential and mandatory feature of the overall governance process
- Actions to improve patient experience are developed consistently and implemented consistently across NHS GGC and linked to corporate equalities
- A Reference Group made up of people with learning disabilities / families and carers is established with a specific remit to monitor performance and support future service improvement

8.7 Infrastructure

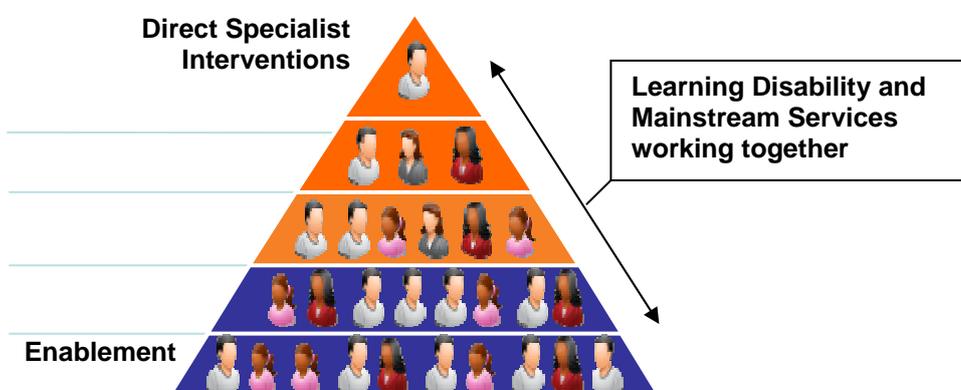
- Resource Allocation and Workforce Model is applied
- Outcomes of the Information Technology workstream of the Learning Disability Change Programme are taken forward as part of the wider, whole system Clinical Services Review process
- All adults with a learning disability become visible in NHS GGC data systems

9. **Future Service Model / What we want to achieve**

9.1 The overarching aim of the service model set out in this document is to provide **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundaries of 'Learning Disability services' and 'mainstream' services. Underpinning this is the aim that people with a learning disability will have positive experiences of healthcare.

9.2 Characteristics of the model such as network approaches and co-working frameworks have been chosen to address the range of issues highlighted during our engagement with staff, practitioners and people with a learning disability themselves.

9.3 Getting this right will enable more intensive support 'direct interventions' for those most in need, and supported self management 'enablement' with rapid access into services when required for the majority of the population. Our range of Services describe what Specialist Services will deliver directly to those individuals who require specialist interventions; it also describes what we will do and how we will support mainstream services to meet the needs of people. It is important to recognise however that adopting a person centred approach will see situations where learning disability services are working together with the wider system, i.e. we may be directly providing interventions and at the same time enabling people to access other parts of the system.



10. Eligibility / Inclusion

Change Programme Review Findings:

10.1 A review of the eligibility criteria for specialist Learning Disability health services currently in use across NHS GGC identified that whilst the eligibility criteria used by each service were broadly similar (adults with a diagnosis of learning disability in need of a specialist Learning Disability health service), clinical interpretation of this varied across teams. In addition, the processes for undertaking eligibility assessments were not clearly defined, resulting in unnecessary delays in patients receiving a service or patients receiving a specialist service when they could have accessed a mainstream service either with support from the LD service or with reasonable adjustment made by the mainstream service.

10.2 The development of a single NHS GGC wide eligibility criteria and eligibility assessment process in agreement with all relevant mainstream health services that includes an emphasis on joint working between specialist and mainstream services wherever this would best meet the person's health needs.

10.3 Take forward work with all relevant mainstream health services to ensure that people with a learning disability are not excluded or immediately re-directed to specialist LD health services purely on the basis that they have a learning disability or because they are already receiving a specialist LD health service.

11. Co-dependencies / Co-Working / Networking

11.1 The term co-dependencies describes the relationships / agreements which require to be in place to ensure that specialist services across NHS GGC support each other in a mutually beneficial way to deliver care and support to the client group. It is proposed that a framework is developed which outlines the scope of the dependency between CH(C)Ps/Sectors across the Board area which is based on the specific clinical interventions which need to be delivered to provide safe and person centred support.

These co-dependencies will predominately focus on issues such as:

- Cross Cover
- Crisis Support
- Learning And Development on a consistent basis
- Board wide outcome measurement
- Clinical Governance
- Clinical Supervision
- Service & Pathway developments

11.2 In terms of Co-Working with other parts of the wider system i.e. (Mental Health and all Acute care specialities) this model will allow people to access the service which best meets their specific needs and would see:

- LD Practitioners working with generic services to enable access and to provide support on person centred adjustments to those services to provide effective care

11.3 The purpose of a co-dependencies framework is to establish a clear, clinically and managerially agreed and robust statement of the process which will be used to ensure continued availability across NHS GGC of all essential clinical interventions.

11.4 Co-working describes the style of service provision which underpins the future model particularly from an enablement perspective. People with learning disabilities will be able to access a range of previously inaccessible services. The role of an LD specialist team is to support both the person and the service to achieve access, support our partners to meet the needs of people with learning disabilities and provide good outcomes which are commensurate with the person's individual needs.

It is important to note that this service specification is very much dependent on a co-dependency framework. The geographical landscape of NHS GGC is large and the workforce comparatively small. To ensure cross cover arrangements, overall good Clinical Governance and seamless services, all local areas will require to agree to, and take part in, these arrangements. In due course, this arrangement will require to be implemented within each of the newly formed Health & Social Care Partnerships (HSCP's).

12. Network / Whole System Approach

12.1 Adopting a supportive network approach to ensure the availability of clinical interventions is intended to achieve the following outcomes:

- Enhance knowledge exchange between Learning Disability staff
- Establish a foundation for the diffusion of innovative practice patterns that will foster collaborative relationships and improve outcomes
- Enhance consistency of service delivery
- Support the management of risk across the system
- Negate the need for duplication of effort
- Improve the patient experience

12.2 In practice, to succeed, the formation of networks across NHS GGC will require the support of all localities. The proposed model is to strategically (via a shared learning and development plan) develop expertise in clinical interventions such as Palliative Care in a cohort of staff which can be drawn upon to support all staff in all areas. The following areas of clinical care would be subject to this approach:-

- Practice Development Approaches
- Working with Learning Disabled Offenders

- Challenging Behaviour Expertise
- Advanced Epilepsy Management
- Palliative and End of Life Care

12.3 The development of this approach would lead to the dissolution of the current Complex Needs Services model in Greater Glasgow and ensure a consistent approach across the Board area.

12.4 The Learning Disability Liaison Team will continue to support General Practice to deliver Local Enhanced Service requirements of the GMS contract. The team will remain centrally managed until the future direction of GP contract negotiations are known both nationally and locally.

12.5 The team will ensure strong links are developed with each locality, a nursing resource being based within each locality. The Team will support local areas to further develop enablement models across primary and acute care services.

12.6 It is important that in-patient and community services work as a single system and the previous fractured relationships between 'tier 4' and 'tier 3' services become a thing of the past. For that reason we are recommending that we explore options which more closely align the implementation of a whole system framework with responsibility for in-patient services and overall co-ordination of cross-system working for learning disability. These options may include hosting within a single Partnership.

13. Leaner and more effective

13.1 Our revised model of service will seek to be leaner, straightforward and address the complex range of varying operational and clinical processes which currently exist.

13.2 This will be achieved by:-

- Being clear about the range of clinical interventions delivered, and which professions are engaged in these (Appendix 1)
- Developing a set of standards and supporting processes (for each operational / clinical activity within teams)
- Developing an NHS GGC wide Learning and Development Plan which reflects the clinical interventions provided and is linked to local development plans
- Embedding consistent Professional leadership
- Creating Co-dependencies and Networks to address issues of cross cover in times of unplanned absence
- Applying Service Improvement methodologies such as lean / DCAQ – (Demand Capacity Activity and Queue) as we support staff through

14. Clinical Governance / Service Improvement / Quality

Underpinning Standards and Processes

14.1 NHS GGC Learning Disability teams do not currently deliver services based on a consistent set of key performance indicators or standards which measure the day to day performance of the service.

14.2 All of the wider NHS GGC policies and procedures apply to the Learning Disability service currently delivered, however they do not adequately meet the needs of the service in terms of its contribution to the lives of people with a learning disability. These policy frameworks should be reviewed to ensure inclusion of issues which affect people with a learning disability.

14.3 A Performance / Standards 'manual' will be developed to describe the range of indicators which reflect the vision set out in this service specification. This will be developed by the Learning Disability Clinical Governance Committee. The Performance indicators will be informed by the needs and wishes of people with a learning disability and will be linked to the organisational performance review framework.

14.4 The Performance / Standards Manual will clearly outline the expectations and processes teams require to follow to maintain delivery of a consistent and equitable service across NHS GGC. There may be a need for a degree of local variation across partnerships, however where this is the case this will be clearly documented within the manual.

Local Management teams will be responsible for the delivery of the standards within the manual and will report to both people with a learning disability and through corporate / local performance frameworks.

Audit

14.5 Regular audit activity will be undertaken by the Clinical Governance Committee. This audit activity will be developed based on the standards set out in the performance manual and also reflect the vision described in this service specification.

14.6 Audit will focus on collation of routine data such as caseload activity and demand for services but will also focus on the two keys elements of this 'Strategy for the Future' an example of a key performance indicator would be:

An increase in activity in relation to enablement and support of mainstream services in their delivery of care alongside audit of community team adherence to the agreed operational processes and standards.

14.7 In terms of enablement of mainstream services, a recent audit of practitioner time has indicated that practitioners spend a small percentage of

time liaising with mainstream colleagues. As this service specification / model is implemented, we would expect to see a rise in this area of activity, locally based Learning Disability Liaison will support this aspiration. Engagement with people with learning disabilities carers and families will also give us qualitative feedback on whether this has been a positive change or if further work is required to address issues.

14.8 An Equality Impact Assessment has been ongoing as part of the redesign process. Outcomes and actions from EQIA will be integrated into final planning arrangements and throughout the implementation stages and beyond to ensure we meet our responsibilities as outlined by the Public Sector Equality Duty (Equality Act 2010). A copy of the finalised EQIA will be published on NHSGGC's website.

15. Learning & Development

15.1 Practitioners across Learning Disability services are incredibly skilled in the service they provide. These skills have partly come from years of experience in various settings and partly due to specific learning and development.

15.2 The Change Programme has identified that although a range of skills exist the current model does not encourage effective use of these skills.

15.3 The current lack of consistency in the range of clinical interventions provided, along with a lack of consistent professional leadership has resulted in teams having difficulty developing a learning and development plan which is targeted to the needs of people with Learning Disability, responsive to changing demographics and able to embed evidence based approaches as they develop.

15.4 All Learning Disability Practitioners will have developed a core set of skills, regardless of discipline, which reflect the needs of people.

15.5 A Learning and Development plan which supports the range of clinical interventions and the core / generic skills which will be delivered will be developed. This will inform NHS GGC Learning and Development plans for all NHS Staff. This Learning and Development plan will utilise the extensive skills within the current workforce.

15.6 The Learning and Development plan will also feature further opportunities for academic study. We will develop validated educational resources with local Higher Education providers to design and deliver education based on the range of clinical interventions we will provide.

15.7 Regardless of discipline, all Learning Disability Practitioners will have developed a core set of skills, which will underpin the specific interventions detailed below, such as:

- Assessment of learning disability and need for specialist service
- Capacity Assessment
- Mental Health Legislation knowledge

- Communication Strategies
- Dysphagia awareness
- Basic Mental Health Screening
- Health Improvement and Enablement methodologies
- Care Co-ordination
- Health Care Advocacy
- Supporting Access to mainstream services
- Clinical Leadership
- Person Centred Approaches
- Psychologically minded working
- Working and engaging with third parties
- Providing Training
- Clinical Governance and Audit Activity
- Autism Awareness
- Epilepsy awareness risk assessment
- Sensory processing awareness sessions

16. Next Stages / Implementation and timescales

This Service Specification outlines the framework and the foundation on which to move to implementation. Alongside describing a model it also identifies some significant pieces of work which now need to be undertaken to move to the next stage.

- Initiation of an appropriate workforce change programme
- Development of a Learning and Development Plan
- Agreement across each of the partnerships to engage in co-dependency frameworks

It is therefore proposed that the component parts of this Service Specification, when agreed, should move to an implementation.

Appendix 1
Range of Services / Clinical Interventions

1. Range of Services / Clinical Interventions

Professionals across the service have worked both individually and as a group to establish the range of key clinical interventions to be delivered by the Specialist Learning Disability Service. This process was informed by the NHS GGC Health Needs Assessment published in 2011, relevant current professional guidance and the current available evidence on the health needs of people with a learning disability.

What follows is a summary of the outcomes of that work:

Physical Health Care

Lead Profession: Nursing

Contributing Professions: Psychology, Psychiatry, Occupational Therapy, Speech and Language Therapy, Physiotherapy, Dietetics, Podiatry

Direct Interventions

Physical healthcare needs will be met in the community by the full gamut of primary and secondary care services. Learning Disability Specialist Teams will have an active role in ensuring that the specific health care needs of people with a learning disability are met by:

- Undertaking comprehensive assessments using validated methods at the point of first contact and advising / supporting both the person and mainstream services to meet identified needs
- Establishing if a Physical Health Care issue is the primary or relevant cause of other needs such as challenging behaviour / mental ill health
- Providing expert assessment and advice on the healthcare needs of people with Profound and multiple learning disabilities
- Routine and regular engagement both at strategic and local level with mainstream colleagues to share practice knowledge and develop care pathways
- Extending the role of the Learning Disability Liaison Team by embedding within geographical areas, providing a link to primary and acute care.

Care Pathways which describe the relationships to ensure consistency across NHS GGC area will be in place.

Enabling Role

LD teams will spend more time supporting mainstream services to meet the needs of the population and address health inequalities both from a person centred approach, where adjustments are made to ensure accessibility, to a strategic level, where knowledge, skills and intelligence will be routinely shared and will inform service developments.

Links to various mainstream services will require to be strengthened however given the evidence which exists in terms of Dentistry, Audiology, Orthotics and Optometry, there should be a particular focus on a supporting and enabling role within these clinical specialisms.

Service Characteristics

LD Services will be actively linked to mainstream services.

Learning Disability Liaison practitioners will continue to support General Practice in respect of their contractual agreements as well as developing stronger links with acute care hospital services. Liaison nursing practitioners will continue to support practice nurses through direct intervention and educational functions.

LD services will have expert knowledge on the health needs of people with an LD across the LD spectrum.

LD services will jointly agree performance indicators with mainstream colleagues which identify priorities in addressing health inequalities and improve patient experience and health outcomes - Existing care pathways may require to be adjusted to achieve this aspiration and where they do not exist, be created and jointly benchmarked against local and nation priorities.

Learning and Development:

All registered practitioners will be competent in the use of physical health care assessment tools.

All registered practitioners will be active in their links with mainstream colleagues.

All unregistered staff will have a high level of knowledge of physical healthcare needs and will be competent in identifying where assessment by a registered practitioner is required.

Recommendation 22 – The Keys to Life

That by the end of 2015 all NHS Boards across Scotland should ensure there is a dedicated primary care liaison resource to support General practice and primary care teams to ensure their services are equitable and, where required, targeted for people with Learning disabilities.

With some exceptions, people with mild LD are more likely to be able to use mainstream health services and be subject to population-wide public health approaches while people with moderate to profound LD are more likely to require a combination of specialist LD and mainstream services and may not benefit from the same public health initiatives, which are not aimed at the needs most relevant to them. However, as people with mild LD are far more numerous and their needs less immediately obvious, there is a greater risk of inadequate or no support being offered. They sometimes access health care without support, and this may contribute to health needs being unmet. NHS GG&C Learning Disability Health Needs Assessment. January 2011

24 Hour Postural Management

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Psychiatry, Dietetics, Podiatry

Direct Interventions

Postural Management Screening and Interventions programme including: Seating and positioning, wheelchairs, orthotics, footwear, Lycra garments, movement programmes, rebound therapy, hydrotherapy, abdominal massage, night time positioning and equipment prescription for pressure management and moving and handling issues.

All contributing professions will be skilled in identifying the range of particular issues that require input of Physiotherapy and joint team care planning. All Professions will be expected to be able to identify deteriorating health state which may symptomatic of deteriorating body shape.

Enabling Role

There will be a proportion of people to whom Physiotherapy will directly deliver Hydrotherapy and Rebound Therapy, but the main part of this role will be in the identification and training for main carers to provide this within available local resources.

Enabling of carers to deliver movement and positioning programmes and abdominal massage.

Physiotherapy has a significant advocacy / enabling role in supporting people to access mainstream acute services and other appointments such as wheelchairs and orthotics, rehabilitation and orthotic clinics

Service Characteristics

In each locality, postural management clinics will be established to screen, monitor and deliver interventions at a local level.

Availability of rebound will be established in each locality. Hydrotherapy requires strategic discussion about availability throughout the Board area, which will involve high level discussions about the future development and accessibility of community facilities.

Learning and Development:

All contributing professions will require awareness training in postural management and problem body shapes.

The role of unregistered staff is important in terms of postural management. A range of training to provide competencies to deliver a variety of postural management activities will feature significantly within unregistered staff's role.

The NNA highlights the importance of postural management for people with multiple physical disabilities in preventing deformities, joint problems, breathing or feeding difficulties, pain, discomfort and major difficulties in moving and handling. In GG&C provision of postural management clinics or full postural management programmes for PWLD is not comprehensive although the LD physiotherapists have been trained to provide it. This lack of local service persists despite the published evidence of benefits. Hydrotherapy and rebound therapy are also in limited supply, although rebound therapy is being expanded in GG&C. The evidence base for using hydrotherapy is limited, and applied to select client groups rather than adults with LD, but a systematic review of the evidence that does exist shows positive results {335}.

Learning Disability Health Needs Assessment. January 2011

Mobility

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Psychiatry, Podiatry, Dietetics

Direct Interventions

For people with complex co-morbidities and moderate to profound learning disability, an assessment of mobility including exercise prescription, gait and balance assessment, transfers, wheelchair and seating and equipment prescription for walking aids and transfers.

Potential options of rebound and hydrotherapy for episodes of rehab for those who have deteriorating mobility.

Enabling Role

Enabling of local domiciliary / rehab physiotherapy services to deliver mobility assessment / development of interventions to people with mild learning disability

Enabling carers through training to deliver exercise programmes, walking support and rebound, hydrotherapy.

Assist / support clients to attend footwear, orthotics, and wheelchair review appointments.

Service Characteristics

Screening and interventions will be available consistently to the wider NHS GGC population, specific involvement with people with moderate to profound LD and requires the service to strengthen relationships in terms of enabling mainstream services to meet the needs of people with mild LD.

Access to specialist physiotherapy, specialist occupational therapy and wheelchair services is essential." Generic physiotherapy and OT have a role to play in working with people with milder LD, but are not sufficient to provide for the needs of people with more severe LD who are particularly affected by problems of mobility, balance and coordination, and who present with more complex problems. NHS GG&C Learning Disability Health Needs Assessment. January 2011

Falls

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Podiatry

Direct Interventions

There is an important role for Nursing and Physiotherapy in identifying risk associated with falls and bone health. A joint approach is necessary to give a full and comprehensive multi-factorial assessment.

Specific interventions and gait and balance assessment through the delivery of the Falls Care Pathway, some of these will include equipment prescription, exercise programme and management of falls via Team care plan development.

Enabling Role

Further work needs to be done to establish if people with an LD below the age of 65 can be enabled by LD physiotherapy to access the generic falls services.

Provision of training to carers to deliver exercise and intervention programme, Support to access community services such as vision screening to establish underlying causes of falls.

Service Characteristics

Individualised screening and intervention programme to people with moderate to profound LD. Strategic realignment of the current landscape of generic approaches to be taken forward to ensure inclusion of people with mild LD.

Learning and Development:

All contributing professions require an awareness of the risks of falling which is consistent across NHS GGC and is based on the standardised falls risk screening tool.

All contributing professions would take part in elements of the assessment to avoid duplication of effort where this could be delivered by the profession involved.

Supporting health improvement and self management to reduce the risk of falls and fragility fractures requires care pathways to be in place for all groups who may be at risk – Health Improvement Scotland 2010.

High rates of accidents and injuries occur amongst people with learning disabilities. In particular, injuries due to falls are common. Appropriate risk assessment and management could significantly reduce the morbidity from accidents and injuries.- .

NHS GG&C Learning Disability Health Needs Assessment. January 2011

Transitions

Lead Profession: All

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy

As young people transition from Children's Services to Adult Services all professionals may have an active role to play.

Each locality will be expected to allocate the professional who is likely to become the lead person in a young person's care at an agreed point in time in the process. The lead profession will ensure that a complete picture of the person's needs and a care plan detailing how these needs will be met is well developed and ready before transition occurs.

Infants and Children 0-5

- Development of a Strategic Network of clinicians which explore the clinical approaches which are employed for children
- Development of a register of children with LD as part of the Learning Disability Liaison function

Children, Teenagers and preparation for Transition 5-16

- Seamless transition is the shared aim of all health care practitioners
- Care Pathways are developed which clearly define the relationships between Learning Disability and Children's Specialist Services which take account of the planning required for all children who transition to Learning Disability Services
- The Clinical Interventions which are in place during transition are understood and competence exists across the workforce to deliver them

Young Adults

- Early intervention and planning with Specialist Children's Services for every child with a learning disability
- Co-ordinated handover from Children's to Adult Services following a consistent pathway

Older People

Support to Older People's Services to better meet the needs of older people with a learning disability.

Epilepsy & Epilepsy Management

Lead Profession: Nursing & Psychiatry

Contributing Professions: Occupational Therapy, Speech and Language Therapy, Physiotherapy, Psychology

Direct Interventions

Learning Disability Nurses in all areas will provide specialist Epilepsy Management. Services for people who require more advanced input will be provided by Neurology Services (in partnership). Learning Disability Epilepsy Specialist Nurses will be available within the Neurology Service.

A concise and consistent Board wide care pathway will be implemented.

Psychiatrists will support the management of Epilepsy locally.

All Other Professions will have an understanding of Epilepsy and its management and be competent in identifying where referral to the appropriate discipline is required. They will also be aware of the impact of Epilepsy on the clinical interventions they directly provide.

Enabling Role

Specialist Practitioners will enable people with learning disabilities to manage their Epilepsy and to minimise the impact this has on their quality of life. Practitioners will also support carers, care providers, primary and secondary NHS staff.

Service Characteristics

All Learning Disability Nurses will be competent in the delivery of Epilepsy Care, consistently across NHS GGC.

Learning Disability Epilepsy Specialist Nurses will be available within the construct of Board wide Neurology Services.

All LD Practitioners will have a depth of knowledge in Epilepsy.

Learning and Development:

All Learning Disability Nursing staff will require training in Epilepsy which reflects the care pathway and partnership approach with Neurology Services.

All registered staff (regardless of discipline) will also require training in core Epilepsy knowledge.

Unregistered staff will also require training commensurate with the care pathway.

Recommendation 19 - The Keys to Life 2013

That by June 2015 all NHS Boards should ensure that people with learning disabilities that have complex epilepsy have access to specialist neurological services, including access to learning disabilities epilepsy specialist nurses and learning disabilities Psychiatrists (where applicable).

Health Promotion and Physical Activity (Exercise)

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Dietetics, Podiatry

Direct Interventions

Provision of Assessment of Exercise needs and tolerance. Prescription of exercise / rebound / Hydro

Enabling Role

Signposting to a range of community based resources, including various initiatives such as swimming, peddle in the park and inclusion in wider health promotional activities which can be accessed widely.

Strategic involvement with developers of community resources to ensure that access for people with an LD and physical disability is incorporated into community facilities.

Service Characteristics

This is primarily an enabling role.

Learning and Development:

All registered staff (regardless of discipline) will also require training in core Health promotion and knowledge of community resources.

Unregistered staff will also require training commensurate with the care pathway.

Over 80% of adults with learning disabilities engage in levels of physical activity below the Department of Health's minimum recommended level, a much lower level of physical activity than the general population (53%-64%) People with more severe learning disabilities and people living in more restrictive environments are at increased risk of inactivity.

(DOH) Health Inequalities & People with Learning Disabilities in the UK: 2011

Eric Emerson, Susannah Baines, Lindsay Allerton and Vicki Welch

MSK and Rehabilitation

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Podiatry.

Direct Interventions

Physiotherapists will provide time limited rehabilitation following discharge from acute / primary care following injury / surgery specifically for people with a learning disability who cannot access generic services due to complex presentations.

Including: Gait re-education, exercise prescription, equipment prescription, Moving and Handling and transfers advice, provision of rebound and hydrotherapy.

Enabling Role

Supporting carers to assist / deliver rehabilitation programmes

Advocacy role to attend acute/primary care appointments for review of injury etc.

Liaise with generic Intermediate Care teams to advise/assist with rehabilitation of people with mild/moderate LD.

Service Characteristics

Primarily people with moderate to profound learning disability and associated physical disability with complex behaviours will benefit from these interventions. There is a specific requirement however to ensure that much of the clinical interventions are delivered by mainstream services where possible and appropriate.

Learning and Development:

Registered Learning Disability Practitioners will require development in identification of Muscular- Skeletal approaches.

The purpose of Intermediate Care is to provide time-limited interventions at points in a person's life where this will restore or avoid a loss of independence and confidence, or reduce the risk of hospital admission (or a longer stay in hospital). Scottish Gov. Maximising Recovery & Promoting Independence: An Intermediate Care Framework for Scotland 2012.

Respiratory Care

Lead Profession: Physiotherapy

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Dietetics

Direct Interventions

People with profound and multiple learning disabilities are significantly at risk from conditions associated with Respiratory health, Aspiration, Pneumonia and conditions associated with thoracic cage distortion.

Physiotherapists will continue to provide care and support and develop clearer care pathways whilst working jointly with respiratory services across the NHS. The scope of the interventions are likely to be in providing advice and guidance on how to promote good health through postural and positioning techniques, early and anticipatory care in terms of potential respiratory issues and monitoring on the use of respiratory equipment such as PEP masks and highlighting concerns or requirement for further review to respiratory teams.

Enabling Role

Supporting carers to develop skills in respiratory techniques to ensure positive health gain and prevention of further respiratory issues.

Service Characteristics

Currently the approach of Respiratory Teams across NHS GGC are not consistent and therefore the response from LD Physiotherapists varies on the basis of this. There is a need to undertake further work to establish where the specific contribution of Physiotherapy can be best used to support people with respiratory care needs such as COPD and respiratory care needs which arise as a result of postural care needs and body shape.

Learning and Development:

All registered and unregistered practitioners will require co-ordinated learning in this area.

Respiratory disease is consistently shown to be the leading cause of death for people with profound and multiple learning disabilities (PMLD), especially pneumonia. This is not the case in the general population and suggests that signs of respiratory disease are not being picked up early enough in this group of people. PAMIS – 'Respiratory Health Needs of People with Profound and Multiple Learning Disabilities' – 2011

Dysphagia Management

Lead Profession: Speech and Language Therapy

Contributing Professions: Nursing, Occupational Therapy, Physiotherapy, Dietetic

Direct Interventions

Speech and Language Therapists will hold overall co-ordination of Dysphagia Cases, as this group of staff are legally qualified to undertake this role.

Clear and concise pathways will exist between Dietetics (which will be embedded in mainstream services) and Speech and Language which will ensure that specialist input is available to those who require it.

Contributing professions will also have a level of skill in identifying Dysphagia care needs and have a clear understanding of the relationship between the interventions they deliver in the context of Dysphagia.

Enabling Role

Speech and Language Therapists have an important enablement role with primary and secondary care services, care providers, families and people with learning disabilities themselves, in supporting them to build skills and competence which reduce risk. This may be in form of consultation or advice and guidance.

Service Characteristics

The majority of the SLT workforce will be qualified in this area of practice, it will be available locally, and a network and co-dependency arrangement will be required to maintain continuous services across NHS GGC.

Learning and Development:

All Registered and Unregistered staff will require learning and development to reach the requirement level of competence in identifying Dysphagia issues.

Dysphagia is a serious problem for some PWLD and in some instances has led to death. Improving the safety of individuals with Dysphagia is essential and providing individual management guidelines can reduce the risks. NHS GG&C Learning Disability Health Needs Assessment. January 2011

Functional Skills Assessment

Lead Profession: Occupational Therapy

Contributing Professions: Nursing, Speech and Language Therapy, Psychology

Direct Interventions

The purpose of completing an FSA is to ascertain the impact of learning disabilities on occupational performance, how this affects someone's life and their engagement in the occupations that are important to them.

Functional skills assessment involves assessing the individual in various environments to establish:-

- Current skills and capacities
- Ability to develop skills and capacities
- Ability to learn and develop new skills and capacities

Occupational Therapists will directly deliver:

1. Baseline measurement for people with suspected cognitive decline/dementia using the Assessment of Process and Motor Skills (AMPS)
2. Supports for parents with learning disability
3. Advice on support packages for clients in the community – new referrals, transition, in-patient discharge, change in health/carer
4. Strategies and support for people with autism
5. Support to carers and agencies to help clients live healthy and fulfilling lifestyles.
6. A baseline measurement for people who have LD and mental health needs and how this impacts on their functional performance
7. A consideration of the impact of presenting behaviours and behaviours which challenge on the person's interaction in their overall occupational performance

Outcomes of assessment/ intervention will be evaluated using the MOHO assessment tools, AMPS and sensory profiling tools depending on focus of OT input.

The implications of the input from occupational therapy is that it improves quality of life and is effective at minimising need for hospital admissions, residential placement and reducing support and care costs.

Learning and Development:

All registered practitioners in learning disability require a wider understanding of the range of assessment tools used and their application to practice. In particular the model of human occupation.

All staff including unregistered (support staff) require support and development in this area which is not in place in the current model of service.

Sensory Integration & Sensory Processing

Lead Profession: Occupational therapy, Speech and Language Therapy

Contributing Professions: Psychiatry, Psychology, Nursing, Physiotherapy

Direct Interventions

Occupational Therapy will take a lead role in assessing the impact of sensory processing disorder and adapt activities and support strategies and recommend environmental modifications to accommodate individuals' needs. Some individuals may however require a specific sensory integrative approach to address their needs and this will require staff to undertake further advanced training to use this approach. Sensory processing assessment requires the support of all contributing professions however Speech and Language Therapists have a key role in developing this approach and in the delivery of care and will jointly take forward this initiative NHS GGC with Occupational Therapist colleagues.

Enabling Role

Occupational Therapists will continue to develop their role within the Multi Disciplinary Team and work alongside NHS colleagues to develop staffs' knowledge and skills in the use of sensory processing assessment tools. This will inform the care plan which can then be delivered by carers and others involved in supporting the client. A detailed sensory profile can be completed and strategies designed to meet individual needs. All staff involved with the client will be able to support carers to implement recommendations in relation to sensory preferences but may require additional support from a highly trained therapist.

Service Characteristics

Each locality will have competencies to deliver sensory processing assessments to a standard level. Expertise and advanced practice using a Sensory Integrative Approach requires staff to undertake advanced training and will be delivered via a network of appropriately trained practitioners.

Learning and Development:

All registered staff should have a basic awareness of sensory issues and will be able to identify when a more detailed Sensory processing assessment would be beneficial and therefore identify and make an onward referral to appropriately trained practitioners within the local network.

Practitioners who have undertaken the advanced training will provide expert clinical interventions.

Many PWLD have communication impairments or complex communication needs affecting their ability to understand and relay information. Sensory impairments, particularly hearing impairments, also impact on effective understanding and communication. A person to person approach to communication support is needed, including: assessing communication needs; adapting interactions and the environment to best meet needs; providing accessible written information; providing training in communication in collaboration with carers; and providing specialist support for e.g. engaging in decision-making, consent to interventions, and adult support and protection. Speech and language therapists can advise and train health staff where required.

NHS GG&C Learning Disability Health Needs Assessment. January 2011

Palliative and End of Life Care

Lead Profession: Nursing

Contributing Professions: Psychology , Psychiatry Occupational Therapy, Speech and Language Therapy, Physiotherapy

Direct Intervention

The " Glasgow- Considerations for Care" in recognising the necessity for good coordination and communication amongst all interested partners has identified the LD Nurse as being the lead coordinator in this process with the ultimate aim being to improve quality of care within a holistic and person centred framework.

The LD Nurse will provide physical, emotional, social and spiritual support and promote this within assessment and care planning, working in partnership and collaborating with others including families and carers as well as health social care and third sector partners.

The LD Nurse will coordinate and support a robust review process to promote communication supporting the patient and other partners to consider current and future planning, anticipating the patient's changing needs and planning appropriately.

Enablement Role

The Learning Disability Nurse will use their skills and knowledge to enable other partners to support people with learning disabilities who have palliative care needs. The role is an enablement role and emphasis is on partnership and collaborative working.

Key Practitioners from LD Nursing have been identified from each LD Team and through a programme of learning and development have developed the skills, knowledge and confidence to support patients and partners with the complexities of palliative care. Key Practitioners have also been identified from palliative care services. Key Practitioners are a link to Specialist Teams and other partners, they share knowledge and expertise and promote evidence based practice. They help bridge the gap between theory and practice and this Network supports and promotes the enablement role.

Learning and Development:

Link practitioners and registered staff will require specific learning in this area.

Nutritional Care Needs

Lead Profession: Dietetics

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy, Psychiatry

Direct Interventions

Learning Disability Dieticians will be located within mainstream services. Mainstream Dietetic Services will deliver care and support to people with a learning disability and will triage these individuals to the most appropriate clinician determined by the presenting need.

Learning Disability Dieticians will both provide support to mainstream colleagues and deliver care to people with complex presentations. They will also provide direct interventions in relation to Prader Willi Syndrome, Phenylketonuria, Ketogenic diets.

Enabling Role

Learning Disability Dieticians have an important role in supporting the wider NHS to recognise and develop robust care pathways and interventions for those most at risk from associated morbidities such as Gastrointestinal complaints.

Dieticians will continue to work closely with Learning Disability colleagues but will equally establish close working relationships with community and acute care colleagues, this will also include ongoing work with families and care providers.

Service Characteristics

All referrals for Dietetic input will be made to the mainstream service; these will be triaged and allocated based on a risk indicator.

Care pathways will exist which strengthen the relationships with key partner professions such as Speech and Language Therapy in the management of Dysphagia.

Learning and Development:

All registered and unregistered staff will require undertaking learning which supports the identification of key dietetic risk factors.

Foot Health

Lead Profession: Podiatry

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy

Direct Interventions

Learning Disability Podiatrists will be located within mainstream services. Mainstream Podiatric services will deliver care and support to people with a learning disability and will triage these individuals to the most appropriate clinician determined by the presenting need.

The podiatric needs of people will be met by individualised referral screening which will indicate where and who would be best skilled to provide the care requested.

Enabling Role

Learning Disability Podiatrists have a major enabling role within their own profession. People with learning disabilities should be able to have their needs met by mainstream podiatry services, and this may require some adjustment to the way in which the service is delivered or accessed. Podiatrists with experience in supporting people with learning disabilities will focus their energies in providing advice, guidance and professional support to the wider podiatry service and fellow professionals.

Service Characteristics

All referrals for Podiatric input will be made to the mainstream service; these will be triaged and allocated based on a risk indicator.

Learning and Development:

All Learning Disabilities practitioners will require development to ensure that they can identify when podiatric needs arise and where and how these needs are best met.

Equipment and Adaptations

Lead Profession: Occupational Therapy

Contributing Professions: Nursing, Speech and Language Therapy, Physiotherapy

Direct Interventions

Occupational Therapy will provide assessment for adaptations and equipment where the individual's learning disability has an impact on their function. Core prescribed equipment can be accessed by other members of the multidisciplinary team. Occupational Therapists can be used in a consultancy role to provide advice in relation to equipment.

Enabling Role

Occupational Therapists will develop clear joint care pathways with LD colleagues and all local authorities to provide a consistent approach to service delivery.

Service Characteristics

Nursing and Physiotherapy will be able to access simple equipment via Equip-u. The multidisciplinary team will be competent in recognising where there is a need to refer an individual to Occupational Therapy for a functional assessment which may lead to the provision of equipment.

(Speech and Language Therapists do not access equipment)

Learning and Development:

Work needs to be undertaken with Local Authorities to agree a more streamlined, consistent approach to joint working between Health and Local Authority Occupational Therapists in relation to case management around equipment and adaptations.

Staff will complete all relevant training to their profession which can be accessed via EQUIP-u

Communication

Lead Profession: Speech and Language Therapy

Contributing Professions: Nursing, Occupational Therapy, Physiotherapy, Psychiatry, Psychology

Direct Interventions

Speech and Language Therapy will take a lead role on communication assessment and interventions, they will also take a lead role in the development of the wider workforce in ensuring that 'as a core skill' all Learning Disability practitioners are skilled communicators, and are communication aware, and able to amend their practice to the communication needs of all people with a learning disability.

Speech and Language Therapists have an important role in supporting all professions to deliver their clinical interventions; an example of this may be in the functional analysis of behaviour disturbance. They will also have an important role in the development of service user experience and opinion initiatives.

Enabling Role

Speech and Language Therapists require to strengthen links with primary and secondary care services to enable them to meet the needs of people with a learning disability.

Service Characteristics

Each area will have access to a clinician who can undertake these direct and enablement functions.

Learning and Development:

Effective and person centred communication is a vital / core role of all LD staff. Development of consistent training requires to be delivered to all practitioners.

A person to person approach to communication support is needed, including: assessing communication needs; adapting interactions and the environment to best meet needs; providing accessible written information; providing training in communication in collaboration with carers; and providing specialist support for e.g. engaging indecision-making, consent to interventions, and adult support and protection. Speech and language therapists can advise and train health staff where required. . NHS GG&C Learning Disability Health Needs Assessment. January 2011

Mental Health

Lead Profession: Psychiatry

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Psychology

Direct Interventions

Learning Disability Services will provide specialist interventions to those individuals who because of the presence of a learning disability require specialist interventions which cannot be met within mainstream services. This will include those individuals with moderate to severe LD who require significantly modified approaches, have multiple co-morbidities / complex presentations. An example of a typical way in which mental health assessment by the Team will be undertaken e.g. Behaviour change initially reviewed by Occupational Therapy (as patient already on Occupational Therapy caseload for sensory integration assessment) → Occupational Therapy undertakes standardised mental health assessment and identifies a number of anxiety symptoms → Occupational Therapy discusses case with Psychiatrist → Psychiatrist arranges diagnostic review and then proposes combination of medication and behavioural relaxation training for anxiety disorder → Occupational Therapy provides behavioural relaxation training and monitors response to medication and feedbacks progress to Psychiatrist = patient has had the vast majority of their treatment and follow up appointments delivered by the one person and has only had to provide the assessment information once.

Enabling Role

Learning Disability Services will work closely with Mental Health colleagues in mainstream services to enable people with a learning disability to effectively access and benefit from the wide range of treatment available. Typically people with a mild learning disability who only require support to effectively benefit through reasonable adjustment to mainstream interventions such as alternative communication styles, support to understand and employ techniques and treatments will benefit from this approach.

Service Characteristics

Psychiatry will lead on all cases, supported by contributing professions in terms of assessment, ongoing delivery of treatment, review and monitoring and eventual discharge.

All initial Mental Health Assessments will be undertaken by the contributing Professions. Nursing will have a more active role in this process, unless the presence of a major mental illness is initially evident on referral. In these cases, Psychiatry will be the first point of contact.

All Team members will be mental health aware, competent in the use of validated mental health assessment tools and risk management approaches.

Learning and Development:

Contributing Professions will require ongoing learning and development to competently deliver care in this area.

Registered staff will require to undertake initial and ongoing education to use agreed assessment / review tools. Knowledge and skill will also be required in the areas of pharmacology, legislation, risk management and treatment options including psychological approaches.

Unregistered staff will also require mental health awareness training which involves recognition of changing mental health states which require further review by registered practitioners.

PWLD experience very high rates of mental ill health and/or problem behaviour. Together these two groups of conditions pose the greatest challenges and workloads to LD services. NHS GG&C Learning Disability Health Needs Assessment. January 2011

Challenging Behaviour

Lead Profession: Psychology,

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Psychiatry

Direct Interventions

Delivery of expert interventions from assessment to the development of Positive Behavioural approaches will be led by Psychology and delivered in partnership with the multi-disciplinary Team. High levels of competency in the assessment, development of care plans and delivery of interventions will be available across all contributing professions. In complex cases where mental illness is a major factor, clinical leadership will be shared with Psychiatry. Psychiatrists will also provide expert opinion on health related behaviour change. Nursing interventions will be multi-faceted incorporating knowledge and skill on the breadth of clinical presentations. Likewise, Occupational Therapy and Speech and Language will be particularly skilled in the delivery of specific interventions such as functional assessment and the impact of sensory impairments. This level of skill will be available NHS GGC wide at the point of local access. Expert initiatives may be shared across NHS GGC in the form of a network where staff with advanced clinical knowledge can be accessed from neighbouring services; this will be based on levels of risk.

Enabling Role

Learning Disability Service's primary focus will be to ensure people with an LD, their carers and families are supported to develop approaches which reduce the impact of challenging behaviour. There is also an important role in supporting all services which deliver care and support to people with an LD such as primary and secondary care in developing strategies which enable access and reduce barriers to receiving services when challenging behaviour is a feature of an individual's presentation. Care providers will have developed expertise in this area and will be engaged with as a partner in the management of risk, links to commissioning strategy will also be formed to take forward service design which is reflective of all agencies skill.

Service Characteristics

All teams will be designed to support individuals presenting with the most complex needs - that is the practitioner will be competent in delivery of care, positive behavioural support model will be embedded in assessment, care planning, and will underpin all therapeutic approaches. There will be no requirement for onward referral to another LD service.

Co-dependencies between teams in terms of specific knowledge and skill will be developed in the form of a network where expertise is shared across NHS GGC.

Teams will be able to support people with a learning disability, their families and carers both in terms of clinical interventions and also in the design of

service specifications in partnership with the third sector.

Learning and Development:

Registered practitioners will require an ongoing programme of learning and development which focuses on the current methods used consistently across NHS GGC. Positive Behavioural Support and any other programmes will be agreed via governance as the identified method which all staff will use in practice.

Unregistered staff will play a key role in the delivery and monitoring of care plans and therefore will also be competent in the methodology applied and be able to identify decreasing or increasing risk and the requirement for further registered staff assessment.

PWLD experience very high rates of mental ill health and/or problem behaviour. Together these two groups of conditions pose the greatest challenges and workloads to LD services. NHS GG&C Learning Disability Health Needs Assessment. January 2011

In Patient Services

The current configuration of Tier 4 in Patient Services was implemented as a result of the Redesign of Tier 4 In-Patient Services. The Redesign had a two-stage approach with the first stage aiming to deliver a model which provided the right care, at the right time, in the right place, and focussing on the acuity of need. There was unanimous support for this 'new' model to include an Acute Admissions facility on a hospital site, which was achieved in May 2012. A further requirement was to redefine the term 'community based assessment & treatment' and be clear about what this meant in relation to therapeutic intervention as part of the care pathway.

Less clear was the need for 'longer stay' provision which is a term uniquely applied to Learning Disability Tier 4 services. There is a cohort of patients who have been resident within NHS facilities either prior to or since the closure of long-stay hospitals, circa 1999, or who have returned to NHS care due to placement breakdown. The Tier 4 Redesign Programme sought to place these individuals within a 'service' which was defined as 'Longer Stay' with a view to exploring their particular future needs in what was termed 'Stage 2' of the redesign process.

Currently NHS Greater Glasgow & Clyde provides a three stage model of in-patient based care.

Current	No of Beds
Acute Admission	12
Community Assessment & Treatment	15
Longer stay	14
Total	41

A series of workstream meetings were held between October 2012 and January 2013. All local areas were represented at these meetings by Adult Service Managers / Heads of Service and a range of clinical Tier 3 and 4 staff.

This workstream explored the current Tier 4 service model and developed a 'Case for Change' proposal identifying the following recommendations for both future admission and longer stay services.

Admission Services

1. A shift from a traditional admission to beds approach to a range of interventions either provided within the facilities on a flexible basis or on an outreach basis in closer partnership with Tier 3 community services and the third sector.
2. Less reliance on complete admission.
3. Development of a robust joint discharge protocol with local authority partners linked to national standards and reporting systems.

Longer Stay Services

In relation to existing longer stay beds/units, there is support to initiate a resettlement programme of individuals who no longer require NHS care and to clearly define what 'longer stay' services in the future would consist of. National policy directs us away from the existing model and will expect that there is a more creative solution developed which is provided in partnership with local authorities and the third sector.

There is also unanimous support to blur the current boundaries of the existing tiered healthcare model particularly between Tiers 3 and 4 and move to a whole-system person centred approach.

Psychological Therapies

Lead Profession: Psychology

Contributing Professions: Psychiatry, Nursing, Occupational Therapy, Speech and Language Therapy

Direct Interventions

Psychologists will provide specialist, high intensity psychological interventions. Psychologists also have a lead role in increasing the availability of psychological interventions whilst retaining a role in ensuring the quality of interventions offered. This will take the form of providing training and supervision to other professions to allow them to deliver or contribute to the delivery of evidence based psychological interventions.

Enabling Role

The psychology role will evolve to one where direct interventions are provided only for those individuals with most severe/complex needs, whilst psychologists' work plans include the capacity to train and supervise other professions in the delivery of psychological interventions.

Service Characteristics

A matched-stepped care approach to the delivery of psychological interventions will be taken, improving access to psychological interventions by increasing the number and range of staff trained to deliver in particular low intensity interventions.

Learning and Development:

A Training Plan has been developed to provide training in key evidence based interventions to meet the psychological needs of the LD population i.e. around Positive Behavioural Support for challenging behaviour, anger management and anxiety management.

Offending Behaviour

Lead Profession: Psychology – Psychiatry – Nursing

Contributing Professions:, Occupational Therapy, Speech and Language Therapy

Direct Interventions

Psychiatry & Psychology will take a lead in assessing the mental health and behavioural needs of people with an LD who offend and will support all other contributing professions to devise relevant therapeutic plans.

A matrix based on clinical expertise and risk management detailing the involvement of both LD Teams and Forensic LD Teams will identify where co – working, case transfer or joint responsibility for an individual is required.

Direct Interventions would encompass the development of an individualised care plan which explicitly identifies the health needs and any interventions which may be based on clinical approaches such as Positive Behavioural Support, communication styles which would be delivered by the appropriate lead care team.

The aim of this work will be to assist in the reasonable and person centred adjustments in re-offending and other programmes which the person may be involved in.

Each team will develop links to local Criminal Justice Teams and prisons within the area and will develop in partnership clear outcome plans which detail the approaches which are used to support people who are subject to criminal justice processes. The interventions which are available will be the same for people not involved in Criminal Justice services who have a need which can be best met by LD Teams. LD Teams will not provide a level of expertise on offending behaviour but will be able to support all other involved services to adapt care and risk management plans to meet the needs of the person.

Enabling Role

Specialist teams will develop links and relationships with all local prisons and criminal justice services. These links will specify what contribution local teams can make to the support of people who offend.

This may involve, direct clinical care of people known to Specialist Services at any point in the Criminal Justice process.

A Scottish Government funded Project is underway and will achieve the following:

- Ensure that there is a systematic and routine approach to screening and identification of people with a learning disability within the criminal justice system and subsequent recording of need
- Establish a clinical performance framework for prison healthcare that includes minimum standards, outcome measures and a service user

- Develop clear pathways of care that describe a person with a learning disability's journey through the criminal justice system, detail the interfaces with other services and agencies and describes their roles and responsibilities
- Work collaboratively with other services delivering care to people with a learning disability to ensure that through care arrangements are as effective as possible in supporting liberated prisoners on release
- Develop and deliver a workforce plan that aims to ensure staff are equipped with the skills and knowledge to meet the needs of people with a learning disability in the criminal justice system
- Review current systems and processes for accessing healthcare in the criminal justice setting to ensure that, for example, written information does not create a barrier for people with a learning disability

Service Characteristics

A care pathway will be developed which describes which clinical interventions which can be offered at what stage.

Learning and Development:

All registered practitioners require learning and development in terms of: Developed risk management processes, patterns of offending behaviour in people with an LD, recognising escalating and jointly working in the overall risk and needs of this group. Knowledge of case co-ordination, legislative frameworks.

Unregistered staff will require awareness of related issues to enable them to deliver specific elements of an individuals care plan with the supervision of registered practitioners.

Recommendation 49

That research will be undertaken across the criminal justice system in Scotland by SCLD and NHS Greater Glasgow & Clyde to understand and analyse the nature and extent of the health needs of people with learning disabilities within the criminal justice system to support the development of appropriate responses that address the distinct health and rehabilitation needs.

Supporting Parents who have Learning Disability

Lead Profession: Psychology

Contributing Professions: Psychiatry, Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy

Direct Interventions

Learning Disability Teams will contribute to the multi-agency assessment and support of parents with learning disabilities. This contribution will be in the form of assessments which allow those supporting parents to more fully understand the impact of the level and nature of an individual's learning disability on their role as parents. Assessment of parenting skills and development of parenting programmes will not be the role of learning disability services.

Psychology, Psychiatry and Occupational Therapy will deliver specific assessments which identify areas of strengths and weakness which can be translated into practical and supportive care plans.

Nursing, Speech and Language Therapy and Physiotherapy will have a role in supporting the individual from a variety of perspectives, this may include emotional support, communication strategies to support the parenting process.

Enabling Role

All other agencies involved may require a degree of support to enable the person to meet the demands of parenting. This should be available from the service and determined on an individual basis.

Service Characteristics

All Practitioners will have an appreciation and ability to recognise the needs of people with a learning disability who are parents. This will include a robust knowledge of child protection issues and the role of the range of services who may be involved.

Learning and Development:

All registered / unregistered practitioners will require further development in this area.

Pharmacy and Pharmacology

Lead Profession: Pharmacy & Psychiatry

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy, Psychology

Direct Interventions

People with a learning disability should be able to access Community Pharmacists freely. Community Pharmacists can manage the day to day pharmaceutical care needs of this patient group, with the appropriate training and support given as needed. Community Pharmacists will know when to signpost a patient to the Community Learning Disability Team, the Prescribing Support Team or the GP

LD Specialist Pharmacists will provide support and guidance to all NHS GGC teams where this is required (including In Patient facilities).

Enabling Role

The Prescribing Support Team should be enabled to confidently review and manage pharmaceutical care issues for this patient group, accessing relevant specialist resources where appropriate.

The role of specialist learning disability Pharmacy Services will be to support, train and facilitate the wider pharmacy services to improve the access to mainstream pharmaceutical care. To concentrate on providing a clinical pharmacy service to the learning disability in-patient units, and out-patient support to the learning disability psychiatrists.

Service Characteristics

LD champions will be developed within the Prescribing Support Team. Providing small group training to this group, and possibly short placements within the specialist service. The Prescribing Support Team will then be enabled to take forward medication review for this patient group. Polypharmacy can be a particular issue for this patient group. There may be scope for ensuring most appropriate treatment for specific health conditions.

Learning and Development:

Learning and Development needs exist for the wider Pharmacy family to ensure that the vision can be translated into day to day practice and skills and knowledge in supporting people with a learning disability is embedded.

Appendix 2
Mechanisms which support the delivery of Clinical
Interventions

Care Co-ordination

Direct Interventions

- Every patient has an identified care co-ordinator (qualified staff only)
- It is the Team Manager's responsibility (with support from senior clinicians in the Team) to allocate the most appropriate care co-ordinator based on presenting need, risk/complexity and banding/grade/skills
- All cross referrals are routed through the Care Co-ordinator
- Care Co-ordinator is responsible for developing and reviewing the Single Multidisciplinary Care Plan
- Care Co-ordinator is responsible for updating the Team database information and identifying high risk cases
- Care Co-ordinator is responsible for discharge from the Team
- Care co-ordinator must receive copies of all other professional input, clinical letters/assessments

Enabling Role

Care Co-ordinators have an essential role in identifying where there may be benefit in the needs of the person being met by another part of the wider NHS system and instigating a co-working approach.

Learning and Development:

The Role of the Care Co-ordinator would need to be clearly defined and all registered staff would require to undertake training in the role.

Legislation

Lead Profession: Psychiatry – Nursing

Contributing Professions: Occupational Therapy, Speech and Language Therapy, Physiotherapy, Psychology

Direct Interventions

All practitioners will be aware of all legislation which is in place to ensure the safe and effective delivery of care and be skilled in identifying where there may be a clinical or social care issue which requires a legislative framework.

Enabling Role

Learning Disability Teams will be a source of support to all relevant partners in the application of appropriate legislation frameworks.

Learning and Development:

All Registered and Unregistered practitioners will be engaged in learning and development which provides the knowledge to undertake this obligation.

Provision of Training

Lead Profession: All

Contributing Professions: Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy, Psychiatry

Direct Interventions

Learning Disability Practitioners will be required to provide training and skill sharing sessions to:

- Their own Teams and the wider Learning Disability Service
- Wider NHS
- All relevant partners including care providers and family carers

Enabling Role

All training will be delivered from the perspective of enablement and building capacity and confidence / competence across the spectrum of health and social care providers of people with a learning disability.

Learning and Development:

All registered practitioners will require development in the skills associated with the sharing of skills and knowledge and may also require specific accredited training on particular areas of clinical care e.g.. Epilepsy

Management of Risk & Clinical Leadership

Lead Profession: Psychology – Psychiatry – Nursing

Contributing Professions: Occupational Therapy, Speech and Language Therapy, Physiotherapy

Direct Interventions

All professions will provide clinical leadership in the scope of their own discipline. Clinical leadership in the context of team and multi-disciplinary working describes the process where high risk cases regardless of the profession involved are subject to an enhanced governance approach.

Psychiatry and Psychology will provide active and robust support to all cases which are escalating through the risk management matrix. There will be no circumstances where cases which have the potential to result in adverse outcomes are not known by the entire clinical team and have an active management plan in place which has been agreed jointly by the Multi Disciplinary Team (MDT).

Learning and Development:

All Registered staff will be competent in anticipating and identifying areas of clinical risk within the context of their own scope of professional practice.

All Registered practitioners will be competent in identifying areas of risk which directly affect the person (Health and otherwise) and routing these concerns through governance systems.

Research and Audit

Lead Profession: Psychology

Contributing Professions: Psychiatry, Nursing, Occupational Therapy, Speech and Language Therapy, Physiotherapy

Direct Interventions

Research and Audit will be a routine feature of the LD service in terms of; monitoring outcomes, developing the evidence base, assessing service effectiveness etc. Given their requirement for doctoral level research training, Clinical Psychologists provide a valuable resource for the LD service in developing a research and audit programme. An overall programme of activity will be established by the LD Clinical Governance Committee, to which Psychologists can contribute through their research training and experience. In Teams, Psychologists can also provide local support to help colleagues develop research and audit projects.

Enabling Role

Psychology will support all professions within Teams to undertake relevant research by enabling all disciplines to develop research/audit projects linked to organisational and national strategy.

Service Characteristics

In the future clinical interventions will have a depth of researched data on their benefit to patient outcomes and service priorities.

Learning and Development:

Registered staff will be supported to understand the foundations of research based initiatives.

Information Management and Technology

Currently there is no consistent use of any particular IT system which meets the needs of Learning Disability Services. A range of systems are used across the Board area.

It is also clear that productivity is substantially negatively affected by the lack of coherent and straightforward systems.

A workstream has focussed on appraising all of these current systems to establish their suitability in terms of:

- Enabling Teams and the service overall to extract data about patient numbers, numbers of patients open to any given profession at any particular time
- Storage of and access to patient information of a clinical nature
- Sharing of clinical information where appropriate with NHS colleagues i.e. Acute Care, Primary Care etc

An options appraisal of all systems which exist such as EMIS Webb, Carefirst, and Trakcare has been undertaken to establish which if any would meet the needs of the service.

This is an area which requires strategic and Board wide agreement on the way forward. The proposal is to produce a range of essential requirements which are fed into the Board's strategic direction in terms of Information Technology, which will influence future decisions on which system would best meet the needs of people with a learning disability and the Specialist teams which support them.

Appendix 3

Dietetics

Purpose of Paper

The purpose of this paper is to describe the outcomes of the Dietetic Workstream for the future delivery of Adult Learning Disability Dietetic Services. These outcomes will inform the next steps in moving towards an agreed model of support across the Board area.

This paper explores the options which were agreed with the Learning Disability Dietetic Team as having merit, when coming to a view about the optimum future delivery of supporting people with a dietetic need who have a learning disability. The paper describes an applied process of 'option appraisal', taking account of a set of criteria against which each option is appraised. These options have also been tested against the challenges and opportunities for the future delivery of each model.

1. Introduction

NHS Greater Glasgow & Clyde (NHS GGC) embarked on a review of Adult Learning Disability Services in 2012, which aimed to ensure that all people with learning disabilities are able to access good services which meet their needs, no matter where they live in the Board area.

“A Strategy for the Future” was developed which identified a number of the challenges people with learning disabilities face and how we think our services need to change to make sure we address these in the years ahead.

This Strategy states that Learning Disability Specialist Services should:

- Support and enable mainstream services to adapt their services to meet the needs of people with learning disabilities
- Provide direct specialist interventions when support cannot be provided by mainstream services alone

These two aims are reflective of the direction of travel in national policy, where “The Keys to Life” strategy document published in June 2013 states that people with learning disabilities should be treated equally and fairly, and have the opportunity to contribute to the communities in which they live, work and socialise.

Service users have also endorsed this direction of travel at an Engagement Event in February 2013, where the outputs included the following suggestions:

- People don't need special care just because they have a learning disability and should be able to get the **same care as everyone else** for routine health problems
- When **we don't need specialist help** any more **leave us alone**, but make sure we can contact you again easily if our needs change
- All **staff must receive training** in working with people with learning disabilities

2. Review of Allied Health Professions

In October 2012, an Allied Health Profession (AHP) Workstream was developed to explore the current landscape of services within Learning Disability and to propose recommendations for the future delivery of all AHP services which would be part of future Specialist Adult Learning Disability Services.

As a result of this initial process, the current configuration of services was defined and a range of anomalies, inconsistencies and challenges were identified. This work also highlighted the positive contribution made by each Allied Health profession, which has enabled each profession to consider specific future design options.

As it stands, in relation to Dietetics, there are a number of challenges, some of which are clinical in nature and some operational.

A summary of the case for change is highlighted below taking into account the clinical and operational challenges:

1. Lack of critical mass of staff able to provide sustainable cover across NHS GGC.
2. Variability of Care Pathways.
3. Professional leadership is inconsistent across NHS GG&C.
4. The specific scope of the clinical interventions delivered is undefined and variable.
5. The expertise of Learning Disability Dietetic staff is at risk as senior staff retire in future years if succession planning and career frameworks are not addressed.
6. Robust clinical support and supervision (supporting professional practice) require to be further developed NHS GG&C wide.
7. On the basis of a defined future role, once the reconfigured workforce is agreed, a dietetic learning and development plan should be developed.
8. On the basis of a defined future role, the relationships with mainstream services, in line with local and national policy, require consistency in the form of straightforward pathways for people with a learning disability.
9. The service requires to plan and place itself in a strong and prepared position in order to meet future demands of people with a learning disability.
10. Providing consistency of cover across the NHS GG&C area.

The current wte Dietetic learning disability workforce configuration is described in the table below.

This resource is to provide services to community learning disability teams and NHS GGC community inpatient beds e.g. Blythswood and Claythorn.

Band	GG South	GG NE	GGNW	East Dun	East Ren	Inver clyde	Ren	West Dun	Total
4			1.0***						1.0
5								0.5**	0.5
6	1.0	0.8		0.2		0.2	0.4*		2.6
8a			1.0						1.0
								Total	5.1

* 0.4 Renfrewshire element provides input to East Renfrewshire

** 0.5 West Dunbartonshire post is vacant

*** 1.0 WTE band 4 covers all Glasgow City and East Dunbartonshire

The current financial Dietetic learning disability resource across NHS Greater Glasgow & Clyde is in the region of £220k

3. Engagement Process & Outcomes

Dieticians working in Learning Disabilities have worked closely with Tom Kelly, Change Programme Manager, and Cindy Wallis, AHP Workstream Lead, to identify the core functions of a specialist dietetic service and the common/generic contribution as Learning Disability practitioners.

Staff identified four key areas for future service delivery for people with learning disability. These are as follows and require to be embedded in the options detailed below:

The interventions are:

1. Enteral Feeding / Nutritional Support.
2. Dysphagia.
3. Gastrointestinal/Bowel Management.
4. Training.

The existing model of Service has been explored in light of its ability to deliver on the four specific interventions highlighted above. In order to establish the best way in which to deliver these interventions discussion has led to five possible options for the future.

4. Options

As agreed with the Dietetic team, five options have been identified:

Option 1.

Do nothing – retain the Service as is, within Learning Disability Services and with the current systems and processes.

Option 2.

Mainstream the Service across Community Dietetic Services.

Option 3.

Mainstream the Service with Paediatric Dietetics.

Option 4.

Mainstream with Adult Acute Dietetic Services.

Option 5.

Mainstream the management of the Service with Community Dietetics but staff remain located in Learning Disability Teams.

5. Criteria

In order to come to a clear view which is based on all of the important factors in reaching a strategic decision, a range of criteria have been applied to these options:

1. Sustainability in terms of ongoing service delivery.
2. Consistency of service NHS GG&C wide.
3. Patient experience.
4. Views of people with a learning disability.
5. Experience of delivering the service within the current model.
6. Patient safety in terms of robust guaranteed future delivery, and robust monitoring of effective practice.
7. Governance in terms of clinical effectiveness, risk, supporting professional practice and staff governance in terms of Learning & Development.
8. Maintain and develop future skills uniquely associated in working with people with a Learning Disability.
9. Efficiency and affordability.
10. Context of national and local policy.

6. Appraisal of the Options

Option 1- Do Nothing

The current service model has, over the years, yielded a number of successes in terms of delivery and quality. This has been challenging but also impressive given the small resource and wide remit of the service. Continuity and consistency have at times been extremely challenging due to operational reasons such as absence, staff leaving the service, inability to provide consistent cover and varying pathways. These challenges have led to clinical risk in terms of access and provision.

The current model is not sustainable across a large NHS Board area and is at risk of frequent disruption when unplanned and unavoidable absence occurs, leading to inconsistent and varying levels of service and access which require to be resolved. The current workforce provides a high level of skill and therefore patient safety is not a concern when the service is operating with full cover, but risk can easily develop when demand for service is higher than expected or capacity is reduced. A further difficulty is the ability to provide robust audit data, measure clinical effectiveness, deliver regular clinical supervision and link to wider developments within the profession generally.

In light of the above it is concluded that retaining the current model is not a viable option.

Option 2 - Mainstream the Service across Community Dietetic Services

This option proposes to move all Dietetic staff and Dietetic support workers in order to mainstream the Service in its entirety, with a focus on practice development including the integration with other specialist services such as approaches used in the treatment of diabetes. Essentially the focus would be to integrate the knowledge and skills available within learning disability and mainstream services and to develop a shared model of knowledge transfer and clinical interventions, delivered on the basis of need.

In relation to the criteria set out above, this option would improve sustainability of the service on a consistent Board wide basis. Patient experience would include a single point of access and delivery of input commensurate with the presenting need and the ability to provide specialist input within that one consistent model.

Straightforward and easy access with adjustments to accommodate specific disability requirements will need to be built in to care pathways.

This option would accommodate an improved governance framework to reduce the risks which currently exist.

An important quality issue for patients is simpler access and better communication between professionals. Work will need to be carried out to ensure that the interface between Learning Disability Specialist Teams (where input is provided) and Community Dietetics is strengthened as this relationship will be key to improving quality in this area.

The Workstream is of the opinion that strengthening practice development would ensure that specialist skills that have been developed are maintained and that knowledge and understanding of meeting the dietetic needs of people with learning disability would be extended across the wider dietetic workforce.

Inclusion and integration within a wider framework would bring benefits in terms of consistent cover, critical mass availability and reduction in risk.

The impact of the redrawing of NHS boundaries can be addressed from the wider dietetic approach.

Future service delivery is directed by national and local policy ensuring health teams across NHS GGC work together to improve the clinical health outcomes for this client group. In the future there will be an expectation to deliver services which provide the broad range of support required from a clinical perspective, reducing the need for cross referrals or multiple 'hand offs' between teams. This option is strong in ensuring that this can be developed.

There is evidence to suggest that there are challenges associated with the current model as well as benefits to patient care with this model. There are

clinical risk issues which could be improved and further work can be progressed with a revised service model.

Continuity and guaranteed future clinical services is a priority which, when benchmarked against this option, emerges favourably.

Option 3 - Mainstream the Service with Paediatric Dietetics

Mainstreaming the service with Paediatric Dietetic Services would bring some benefits in relation to transition for those young people who are complex and require specialist interventions. These numbers are predicted to increase and, although significant, are fairly small. The broad spectrum of learning disability will require to be a focus not just for learning disability practitioners but for the service as a whole. When considered against the needs of the wider adult population, which includes the transfer of support and skills to all health professionals (in this case Board wide dieticians), it would appear that the learning disability practitioner role would be best placed within community based services, but reaching across to paediatrics when required from an enablement, supportive and case management role.

Although an innovative option, in practical terms it would be challenging not only for the Paediatric Dietetic Service but also the Learning Disability Dietetic Team. Therefore, to best meet the needs of the broad scope of people with learning disability, **this option is not viable.**

Option 4 - Mainstream with Adult Acute Dietetic Services

Mainstreaming with Adult Acute Dietetic Services may bring similar challenges to the paediatric option and the focus of the Board and each profession is to prevent avoidable admissions and prevent failed discharges. People with learning disabilities face significant challenges when engaging with secondary care and often present late with more advanced disease. The focus is to support people with a learning disability in the community, undertaking upstream and anticipatory population approaches to reach individuals with a learning disability. This should minimise the requirement for acute admission. **This option is not considered viable.**

Option 5 - Mainstream the management of the Service with Community Dietetics but staff remain located in Learning Disability Teams

The management of Learning Disability Dietetic Team and the resources associated with it would transfer to Community Dietetics; however learning disability staff would remain based within Learning Disability Teams. In the future the relationship between Dietetics and Specialist Adult Learning Disability Teams will strengthen and, as part of the care pathways work for people with learning disability, generally clearer, straightforward arrangements will exist.

There is certainly a requirement for excellent communication and, in some cases, strong co-working; however, there is also a need to focus the small Learning Disability Dietician role where the greatest demand exists. Clinically this is challenging when focussing on the 'whole population' and not only those known to Learning Disability.

Teams. The work of learning disability dietetics needs to focus on the wide spectrum of people with learning disability and, in particular, the enablement role with Dietetic colleagues.

A split arrangement would be challenging to manage effectively and would require further discussion on the actual time spent in each base against the future objectives and priorities.

7. Future Role and Service Configuration

What We Want to Achieve

We need to move to a service which is equitable and provides dietetic support for adults with a learning disability which is patient centred and widens access to the right professional, with the right clinical expertise, supporting these dietetic care needs.

We want a service that fits with a model of supporting carers and the independent sector to be equipped to support self management of their clients.

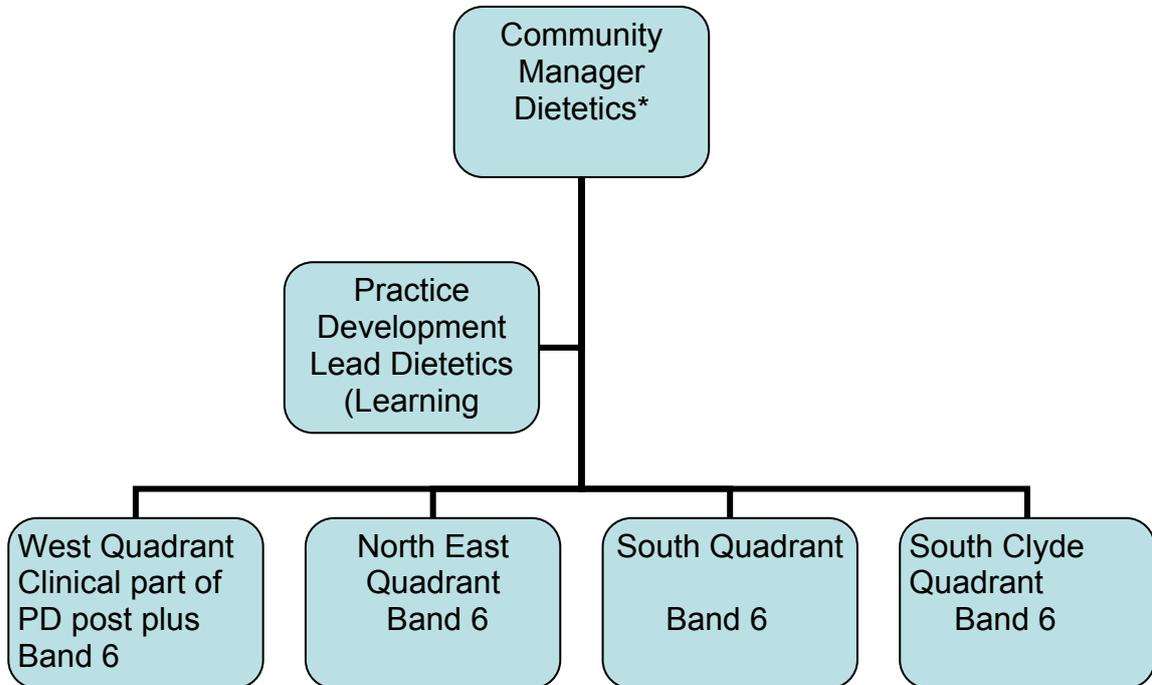
We want to develop the skills of the wider dietetic workforce to support equitable and timely access.

Preferred Option

Option 2 is the preferred model. This option proposes to move all Dietetic staff and Dietetic support workers in order to mainstream the Service in its entirety with a focus on practice development including the integration with other specialist services such as approaches used in the treatment of diabetes. Essentially the focus would be to integrate the knowledge and skills available within learning disability and mainstream services and develop a shared model of knowledge transfer and clinical interventions, delivered on the basis of need.

Proposed Staffing Model

The option for a structure showing the inter relationship with the community structure is shown below



* This post is not part of this option appraisal but is included to reflect the reporting arrangements. Within each quadrant a Team Lead exists which each of the staff would report to.

The allocation of the wte resource can be discussed in relation to the area's caseload and predicted need alongside any HR implications there may be for individual staff.

The 1wte Dietetic support worker is presently spread across three community quadrants and the practice development Dietician, once in post, will discuss the demands placed on the revised structure of how the support worker is best utilised in community quadrants.

In managing this service change, a detailed HR implementation plan will be developed in line with the principles of the NHS GGC Workforce Change Policy. The over arching principle is security of employment for all staff and there will be no compulsory redundancies. Job descriptions will be drafted, submitted for banding and will be made available to affected staff prior to any appointment process taking place. KSF outlines will be obtained and made available to staff after appointment.

There are staff who are affected by this restructuring; whose substantive post will no longer exist and the process for managing placement into new posts in the structure will be undertaken on the basis of current AFC bands.

8. Outcome Measures

In order to ensure that any specialised needs of people with a learning disability continue to be met within the integrated NHS GGC Dietetics Service, the following 4 agreed end outcome measures will be monitored:

1. All people with a learning disability have their nutritional needs met, maximising health and well being through minimising the risk of under nutrition and dehydration. Dietetic support limiting the impact of decline through existing nutritional adequacy
2. The on-going learning and sharing of best practice is available and accessible to all health and social care professionals to address the nutritional health care needs of people with learning disabilities (The Keys to Life).
3. The dietetic service for people with Learning Disabilities is provided in a safe and effective way to “Ensure that patients receive high quality, evidenced-based healthcare from well trained empowered staff”. (The Health Care Quality Strategy NHS Scotland).
4. The 5 Staff Governance Standards are met for Dietetic staff working with people with learning disabilities.

There will be a period of time to support the phased transition from specialist to mainstream community services. We will look at caseload weighting to ensure that specialist knowledge is used to best effect.

The proposed methodology for monitoring and evaluating the consistent delivery of these end outcomes is as follows:

- Consistent approach to data capture using the standard terminology and data standards to ensure consistency of data recording.
- Demonstrate a reduction in unnecessary variations in waiting times with a consistent approach to access and waiting times in line with the principles of ‘New Ways’.
- Improving access for people requiring assessment and advice from a registered Dietician
- Measuring responsiveness and variations in waiting times and how these have improved
- Waiting times should be within 12 weeks from referral to treatment
- Collect annual data/information on user and carer experiences of people with an LD accessing dietetic services within the revised model
- Following needs assessment with service users and their carers report uptake against education and training made available.

Proposed Triage Arrangements to determine level of service against presenting need

This aims to ensure that the level of skill required is commensurate with the level of presenting need and therefore provide a mechanism to provide the right care by the right professional.

Appendix 1 demonstrates how the needs of people will determine where the Direct Clinical Care is provided by a dietician with LD experience and those instances where care is provided by a mainstream dietician. This also highlights the transfer of knowledge and skill across the workforce

9. Next Stages

Once approval for the preferred option has been received from the LD Forum in line with the overall service specification, a further piece of work will be undertaken to outline in more detail the operational arrangements for:

- How the revised care pathways etc will operate
- Governance in terms of clinical effectiveness, risk, supporting professional practice and staff governance in terms of Learning & Development
- Patient safety in terms of robust guaranteed future delivery, and robust monitoring of effective practice
- Maintaining and developing future skills uniquely associated in working with people with a Learning Disability

10. Conclusion

Following consideration of the various options available, it is proposed that Option 2 - Mainstreaming the Service across Community Dietetic Services be taken forward.

There will naturally be a number of questions about the finer detail in relation to how the care pathways and various other processes will be delivered. The intention is to seek agreement on the proposed model, develop the HR process required and further describe the service in the form of a service specification/service level agreement alongside a timescale for the proposed changes to be implemented.

Appendix 4 Podiatry

Purpose of Paper

The purpose of this paper is to describe the outcomes from the AHP Workstream in relation to the preferred model of service delivery for Learning Disability Podiatry Services.

These outcomes will inform the next steps in moving towards an agreed model of support across the NHS GGC area.

CONTENTS

1. Introduction
 2. Review of Allied Health Professions
 3. Engagement process
 4. Scoping Core Functions
 5. Challenges
 6. Proposals and Options for Change
 7. Preferred Service Model
 8. Outcome Measures
 9. Vision on how LD Podiatrists will work
 10. Revised Staffing Model
 11. Conclusion
-
- | | |
|------------|---------------------------------|
| Appendix 1 | Potential LD Caseload by CH(C)P |
| Appendix 2 | Current LD Provision |
| Appendix 3 | Referral Guidelines |
| Appendix 4 | Podiatry Management Model |

1. Introduction

NHS Greater Glasgow & Clyde (NHS GGC) embarked on a review of Adult Learning Disability Services in 2012, which aimed to ensure that all people with learning disabilities are able to access good services which meet their needs, no matter where they live in the Board area.

“A Strategy for the Future” was developed which identified a number of the challenges people with learning disabilities face and how we think our services need to change to make sure we address these in the years ahead.

This Strategy states that Learning Disability Specialist Services should:

- Support and enable mainstream services to adapt their services to meet the needs of people with learning disabilities
- Provide direct specialist interventions when support cannot be provided by mainstream services alone

These two aims are reflective of the direction of travel in national policy, where “The Keys to Life” strategy document published in June 2013 states that people with learning disabilities should be treated equally and fairly, and have the opportunity to contribute to the communities in which they live, work and socialise.

Service users have also recently endorsed this direction of travel at an Engagement Event in February 2013, where the outputs included the following suggestions:

- People don't need special care just because they have a learning disability and should be able to get the **same care as everyone else** for routine health problems
- When **we don't need specialist help** any more **leave us alone**, but make sure we can contact you again easily if our needs change
- All **staff must receive training** in working with people with learning disabilities

2. Review of Allied Health Professions

In October 2012, an Allied Health Profession (AHP) Workstream was developed to explore the current landscape of services within Learning Disability and to propose recommendations for the future delivery of all AHP services which would be part of future Specialist Adult Learning Disability Services.

As a result of this initial process, the current configuration of services was defined and a range of anomalies, inconsistencies and challenges were identified. This work also highlighted the positive contribution made by each Allied Health profession, which has enabled each profession to consider specific future design options.

Included within this work was a consideration of the appropriateness of the existing mixed podiatry service model, where service users in some areas receive a service from an integrated LD Team, while in other areas the service is delivered by mainstream Podiatry. (Appendix 2 refers).

3. Engagement Process

The Podiatry Team working in Learning Disabilities, a Trades Union representative and senior management from the single system NHS GGC Podiatry service have worked closely with Tom Kelly, Change Programme Manager, and Cindy Wallis, AHP Workstream Lead, to identify the issues facing the Podiatry service and the common/generic contribution as Learning Disability Practitioners.

4. Scoping Core Functions

Staff contributed to and completed a core function template, which was used for all AHP services, and allowed identification of activities requiring development and review. For the LD Podiatry service, there are a number of challenges, some of which are clinical in nature and some operational.

It was agreed that there are a number of core competencies required for work within a caseload comprised of people with a broad spectrum of Learning Disabilities that justify a specialist component in the Podiatry workforce.

These include:

- Advanced communication skills.
- “Technical” clinical skills to ensure safe & effective treatment for patients with treatment anxieties and challenging behaviours
- Excellent knowledge of learning disabilities and concurring medical conditions as part of a multidisciplinary team
- Knowledge of the legal legislation regarding the client group
- Advocacy skills
- Immediate access to support within LD teams
- Leading case conferences
- Leading the delivery of multi-disciplinary care packages of which Podiatry is one component
- Provision of support and training resource for Podiatrists working in primary care in relation to people with Learning Disabilities
- Development of seamless care pathways between the service and primary and secondary care for people with Learning Disabilities

5. Challenges

A summary of the challenges facing the Learning Disability Podiatry service are highlighted below:

1. Lack of critical mass of staff able to provide sustainable cover across NHS GGC Board area during planned and unplanned leave.

2. Care Pathways vary across the LD service. The specific scope of the clinical interventions delivered is undefined and variable.
3. Succession planning is required to safeguard the Podiatry expertise within the Learning Disability service as staff retire or leave the service.(Update - 1 WTE has indicated intention to retire in January 2014)
4. A career framework for Learning Disability podiatry requires to be maintained
5. The Learning Disability podiatry workforce requires to be integrated within the robust governance structures present within the single system NHS GGC Podiatry service. This would include clinical support/supervision; staff governance; clinical governance; learning & education planning and workforce planning.
6. The Learning Disability Podiatry service requires to be part of a robust planning process that will enable it to meet current and future demands of people with learning disability including the changing policy context in respect of the recent publication on personal footcare. There is also a requirement to respond to the shifting landscape of service brought about by the closure of LD day centres and Self Directed Support (SDS), as people will no longer congregate and therefore be treated within one service/facility
7. The Qualitative aspects of the Learning Disability Podiatry service must be protected e.g. its accessibility, flexibility and responsiveness.

6. Proposals & Options for Change

In reviewing the current service model, the key drivers for change were the need for:

- Equity of learning disability podiatry service provision across NHS GGC
- Clinical governance to be aligned with mainstream podiatry services
- A critical mass of LD podiatry staff able to provide sustainable cover across NHS GGC during periods of long-term sickness absence

Applying these drivers to the existing service model, highlighted 3 possible courses of action:

Option 1

No change - Identified challenges remain such as inconsistent Board wide access, risk to continuous cover, succession planning and building capacity and knowledge within the wider podiatry workforce

Option 2

Existing Integrated Team model, where podiatry is a core member of the LD Team, is expanded to include CH(C) Ps currently not served.

This option would enable Podiatrists to fulfil a multidisciplinary team role, participating in Clinical Team Meetings, Case co-ordination, and being part of the Screening Rota etc. It would require robust links to be created with

mainstream services re; referral pathways, clinical governance participation in professional supervision etc.

This option would however entail resource implications and would not address the key identified challenges.

Option 3

All LD Podiatrists work as part of the single, integrated NHS GGC Podiatry service providing direct intervention, staff support and training, and a liaison role to specialist LD care.

This model would require integration of current LD Podiatry resources within the existing podiatry service in order to ensure consistency and seamlessness of service delivery to the identified LD population.

The estimated LD caseload for West Dun CHCP, Renfrewshire CHP, Inverclyde CHCP and CAMGLEN (the redrawing of NHS boundaries in terms of CAMGLEN will necessitate a wider system response which can be achieved in the context of this option (equates to around 1wte of current staffing resource). Since these patients are currently being seen by mainstream podiatry the resource is already identifiable within the existing establishment, however this may require to be made more visible as a quadrant resource.

7. Preferred Service Model

Following the consideration of all 3 options, members of the Podiatry element of the AHP Workstream concluded that Option 3 (*all LD Podiatrists work as part of the single, integrated NHS GGC Podiatry service providing direct intervention, staff support and training, and a liaison role to specialist LD care*) was the preferred service model. (This was also shared with the professional leads of all LD services) The rationale for this was that it would most effectively deliver an equitable, clinically robust service, that meets national and user expectations of specialist intervention only when necessary.

Advantages

In arriving at Option 3, the review team identified the following areas of benefit:

- 7.1 Accessibility - all people with a learning disability throughout NHS GGC will have equality of access to a range of podiatry services.
- 7.2 Equality of access – removing, in line with national policy, the stigmatisation of people with a learning disability who have a podiatry issue having to access a learning disability specific service.
- 7.3 Increased Continuity of Care – embedding LD podiatry services within the larger Board wide Podiatry services, will mitigate the risk of service disruption due to staff absences/vacancies

- 7.4 Moving to the open referral system currently operated by the integrated NHS GGC Podiatry service will serve to increase service user accessibility, in line with national policy.
- 7.5 Although concerns were expressed about a move to an integrated Podiatry Service impinging on a Podiatrist's ability to fulfil a multidisciplinary team role, it is noted that multi-disciplinary working is core to all areas of service delivery.
- 7.6 Podiatry staff will in fact have additional clinical time available, as they would no longer be required to participate in non profession related activities/meetings
- 7.7 Embedding skilled LD Podiatrists within the integrated Podiatry Service will have a positive impact on the development of the skills of other professionals within the integrated service, which resonates directly with the views of service users that all staff would benefit from receiving training in working with people with learning disabilities.
- 7.8 Single Use Instruments – the imminent introduction of single use instruments will be less expensive to procure and administer in a larger, Board wide Podiatry service, where economies of scale will apply

Areas for Development

In order to ensure that the needs of people with a learning disability continued to be met within the integrated NHS GGC Podiatry Service, the following issues will require to be developed:

- 7.9 Use of user-friendly literature, signage etc – it is noted that existing mainstream services have already undertaken much of this work in accordance with equalities requirements. There will however be a requirement to ensure that is rolled out to consistently cover all 4 quadrants of the integrated Podiatry service.
- 7.10 Reasonable adjustments will require to be made to the way in which mainstream services operate and will be taken forward as part of the wider EQIA process which is under development. This will include ensuring referral pathways are user friendly, straightforward and easily understood, not just by people with a learning disability, but by the wider population also.
- 7.11 The relationship with mainstream services, in line with local and national policy, requires consistency in the form of care pathways for people with learning disability that have been developed in partnership with service users, advocates, carers and families. Referrals to the LD Team must follow the referral pathways of the Operations Manual, and use the Single Point of Access Referral Form.

7.12 On the basis of a defined future role, once the reconfigured workforce is agreed, a staff learning and education plan will need to be developed.

8. Outcome Measures

In order to ensure that any specialised needs of people with a learning disability continue to be met within the integrated NHS GGC Podiatry Service and in line with the proposed 2013/14 NHS GGC Podiatry Service Key Performance Indicators, the following outcome measures will be monitored:

Key Performance Indicator Descriptor	Process/Outcome Measures
80% of a sample of staff employed by the podiatry service between 1 st April 2013 and 31 st March 2014 will report a positive experience of working within the service and will have benefited from the inclusion of LD Podiatry colleagues	Staff experience survey to be sent out along with staff stress survey
All patients with learning disability will be appropriately triaged and treated by the appropriate service	Audit of Priority triage and clinical indicators risk matrix
All Mainstream podiatry staff will be aware of and know the implications for practice in terms of the inclusion of LD podiatrists within the service construct	Communication with all staff and opportunities to engage with between staff in all areas, audit at the end of year 1
80% of a sample of podiatry domiciliary patients who have received podiatry services between 1 st October 2013 and 31 st March 2014 will report a positive of access the service	Telephone interviews and content and process to be defined
90% of a sample of patients with active foot disease between 1st September 2013 and 31 st March 2014 will be seen in an acute setting for specialist intervention within 48 hours of receipt of referral	Month of October
95% of podiatry staff in post and at work on the day CS is scheduled will have access to and will have attended all the clinical support sessions timetabled for their quadrant between 1 st August 2013 and 31st March 2014	Managers will maintain a quadrant record of attendees against the dates of each of the clinical support

	sessions.
PWLD have a higher incidence of foot problems than the general population. The report of the health check information states 55% had seen a podiatrist at least once within the past 12 months, 60% of PWLD population are seen by Podiatry service in 12 month period	Specialist Podiatrist in each Quadrant monitors PWLD contact – HoS/Managers produce annual service wide activity report

9. Vision on how LD Podiatrists will work within the context of a mainstream service

LD Podiatrists will continue to provide direct clinical interventions to those individuals who have an assessed need for this level of skill.

It is proposed that a triage system will be implemented where a number of clinical indicators will determine by whom and where delivery of care to an individual takes place. The table below describes the clinical needs which would determine, right professional at right time

Suggested Clinical Indicators	Mainstream or LD Podiatrist
<p>Priority 1. Known to or receiving service from Specialist Learning Disability Service and:-</p> <p>a. Individual has Profound and Multiple Learning Disability and a complex range of co-morbidities or</p> <p>b. Presence of significant challenging behaviour requiring detailed care planning to provide treatment in conjunction with Learning Disability teams such as legislative frameworks or</p> <p>c. Presence of foot care issues specific to cause of learning disability</p>	<p>Direct Clinical Care Provided by LD Podiatrist with opportunities for sharing learning and experience with mainstream colleagues dependent on the treatment required</p>

Suggested Clinical Indicators	Mainstream or LD Podiatrist
<p>Priority 2. Known to Learning Disability Services and:- a. Moderate learning Disability with alongside complex care issues requiring adjustment to method of provision or b. Presence of significant challenging behaviour or c. Requirement for legislative frameworks to deliver care and treatment</p> <p>Priority 3 Known to Learning Disability Services and :- a. Individual has mild Learning Disability and a range of complex care issues</p> <p>Priority 4 Not known to Learning Disability Services and:- a. has a learning disability and b. requires footcare</p>	<p>Enablement of Mainstream podiatrists to deliver direct clinical care Co-working arrangements in place to provide support, advice and guidance to care planning process and liaison with range of services which may be involved.</p> <p>Direct Clinical Care provided by mainstream podiatrists, LD podiatrists are aware of the individual and available for advice and support.</p> <p>Direct Clinical Care provided by mainstream podiatrists.</p> <p>Training and support is delivered routinely which includes awareness of additional health needs of people with LD and associated communication needs and possible adjustments to service delivery model.</p>

10. Revised Staffing Model

Under Option 3, the proposed staffing model that would be adopted has been agreed as follows:

The NHS GGC Podiatry service is managed through a geographical Quadrant structure as outlined in Appendix 4.

A specialist Band 7 would undertake to:

- provide direct clinical care in the quadrant in which they are based.
- support the implementation of a triage system and the development of a priority matrix (see example above).
- Co-ordinate training and development for the wider podiatry workforce
- monitor the care pathways and routes of communication between mainstream podiatry services and LD services and

- Assume responsibility for supporting and embedding strategic policy changes in terms of mainstream services' response to the implementation of equality sensitive practice

A Specialist Podiatrist, Band 6, would co-ordinate, action interventions, and develop systems and procedures to manage specific LD need locally, specifically but not exclusively around communication, in each of the Quadrants.

This role would include identifying, developing and delivering the training requirement of the generic clinical staff in order to ensure, maintain and support equitable and timely access.

The Band 6 Specialist role would be subject to governance structures in line with the generic service.

In managing this service change, a detailed HR implementation plan will be developed in line with the principles of the NHS GGC Workforce Change Policy. The over arching principle is security of employment for all staff and there will be no compulsory redundancies. Job descriptions will be drafted, submitted for banding and will be made available to affected staff prior to any appointment process taking place. KSF outlines will be obtained and made available to staff after appointment.

11. Conclusion

Following consideration of the various options available, it is proposed that all LD Podiatrists work as part of the single, integrated NHS GGC Podiatry service providing direct intervention, staff support and training, and a liaison role to specialist LD care.

In pursuing this option, further work needs to be undertaken on a number of areas of development to ensure that the needs of service users continue to be demonstrably met and that staff continue to be supported throughout the transition process.

The intention is to seek agreement on the proposed model, develop the HR process required and further describe the service in the form of a service specification/service level agreement alongside a timescale for the proposed changes to be implemented.

Appendix 1

Ascertained number of people with learning disabilities in CH(C) P, by age (As at 18/08/2009)

Age group	East	East Dun	East Renfrew	Inver-clyde	North	North Lanark	Renfrew -shire	South East	South Lanark	South West	West	West Dunbar	Grand Total
16-19	4	3	7	1	20	2	20	6	0	2	11	5	81
20-24	69	24	26	32	38	5	74	42	30	58	81	41	520
25-29	54	35	27	29	44	4	66	46	24	52	61	29	471
30-34	61	32	23	20	34	7	47	30	18	47	57	25	401
35-39	77	31	14	21	31	7	66	32	24	69	64	38	474
40-44	88	30	33	36	47	8	77	48	37	83	86	40	613
45-49	103	28	30	46	58	6	77	59	29	108	97	39	680
50-54	75	34	25	44	50	9	54	44	30	75	72	55	567
55-59	68	23	19	32	27	2	34	39	23	68	57	30	422
60-64	55	13	10	22	27	1	40	49	19	49	55	31	371
65-69	27	15	16	19	14	2	21	30	15	47	49	16	271
70-74	21	13	9	12	13	0	22	13	4	27	20	15	169
75-79	10	8	6	5	9	0	12	9	0	12	19	5	95
80-84	4	7	3	4	4	0	4	5	1	3	4	0	39
85+	1	2	4	5	1	0	3	2	1	3	4	0	26
Total	717	298	252	328	417	53	617	454	255	703	737	369	5,200

Source: Local Enhanced Service LD Register

Note: There is an undercount in the 16-19 year age group, as the LES for LD focuses on ages 18+.

Appendix 2

Current LD Podiatry Provision

NHS GGC employs 2 distinct models of care for Adult LD patients accessing Podiatry.

1. Learning Disability Podiatry (as part of the LD Integrated Team) serves the LD population for Glasgow City CHP, East Dunbartonshire CHP and East Renfrewshire CHCP. An established staff of 3.0 wte provide Podiatric care for LD clients as appropriate. Referrals are received from the established LD caseload i.e. from members of the LD Team, GP's, carers, self referrals, social work colleagues, provider agencies and from colleagues in mainstream health, where a referral to learning disability podiatry is indicated.

The service is organised geographically

<u>Area</u>	<u>Weekly Contacts</u>	<u>Monthly Contacts</u>	<u>whole time equivalent/grade</u>
North West NW Sector City CHP South Sector CHP South Lanarkshire East Ren CHCP	27	112	1.0 Band 7 (Team Lead role)
North East NE Sector City CHP East Dun CHP	36	138	1.0 Band 6
South West South Sector City CHP East Ren CHCP NW Sector City CHP	33	136	1.0 Band 6

The active caseload (March 2013) = 936 patients.

The LD population for Glasgow City CHP, East Dun CHP and East Ren CHCP = 3,833

Podiatry caseload for this LD population equates to 25%

The service is delivered in a variety of locations including patients' own homes, adult resource (education), work centres, and established LD Podiatry Clinics in Bridgeton, Easterhouse, Gorbals, Maryhill, and Kirkintilloch Health Centres.

2. Current Mainstream Provision: (as part of the integrated core Community Podiatry Service) serves the LD population of Inverclyde CHCP, Renfrewshire CHP, West Dunbartonshire CHCP and through a service level agreement, CAMGLEN locality NHS Lanarkshire .

LD patients in these areas are seen as part of the community podiatry service and any particular requirements are co-ordinated through the local LD Team.

Referrals are received using the established referral pathways with assessment appointments establishing care plans by podiatric need and if appropriate local arrangements put in place in order to allow for specific LD issues on a patient by patient basis. Referrals are received from GPs, health care professionals and carers/self referral.

Patients seen in these areas are assessed on podiatric need and will not routinely have an LD need/condition recorded on assessment/podiatric record card

These patients are seen in a variety of locations including patients' own homes, adult education centres, health centres and clinics.

To determine (estimate) the active caseload for the areas not served by the integrated LD Podiatry team:

The current LD population = 1,367

Applying the same % proportion as model 1 = estimates a caseload of 341.

Summary:

Podiatry caseload for LD patients by integrated LD Team = 936 (Glasgow CHP, East Ren CHCP, East Dun CHP)

Podiatry caseload for LD patients from mainstream Podiatry = 341 (Renfrew CHP, West Dun CHCP, Inverclyde CHCP, CAMGLEN)

Appendix 3

Referral Guidelines for Learning Disability Podiatry

The guidelines for referral include:

Any person over the age of 16 years who has a diagnosis of a learning disability.

People with complex physical health needs, profound and multiple impairments ensuring podiatry's essential contribution to the multidisciplinary team approach to care.

Management of foot care where the foot is medically at risk, due to poor circulation or neurological impairment that may require frequent and/or intense episodes of podiatry care.

Diabetes where potentially foot care is compromised by the person's learning disability, requiring flexible and responsive additional podiatry support – in partnership with mainstream service.

Assessment and treatment of routine foot conditions that may require additional time or alternative approaches to treatment to achieve the desired podiatric therapeutic outcome.

Professional / Service Lead reporting to HH&PC Renfrew CHP

<u>North West</u>	<u>North East</u>	<u>Clyde</u>	<u>South</u>
North West Glasgow West Dunbartonshire Gartnavel General Hospital Western Infirmary Vale of Leven Hospital	North East Glasgow East Dunbartonshire Stobhill Hospital Glasgow Royal Infirmary	Renfrewshire Inverclyde Royal Alexandra Hospital Inverclyde Royal Hospital	South Glasgow East Renfrewshire Southern General Hospital Victoria Hospitals
Manager x 1	Manager x 1	Manager x 1	Manager x 1
Team Leads x 2	Team Leads x 2	Team Leads x 2	Team Leads x 2

Appendix 5
Workforce Proposals

Occupational Therapists

Staffing Profiles

Occupational Therapy

	wte								
	West Dumbarton wte	Renfrew wte	Inverclyde wte	East Dumbarton wte	East Renfrewshire wte	Glasgow wte	Prof Lead wte	Lan wte	Total wte
Current									
Band 8a	-	-	-	-	-	3.00	-	-	3.00
Band 7	-	-	-	-	-	-	-	-	-
Band 6	1.00	1.00	0.50	1.00	-	6.40	-	-	9.90
Band 5	-	-	-	-	-	1.80	-	-	1.80
	1.00	1.00	0.50	1.00	-	11.20	-	-	14.70
Proposed									
Band 8a	-	0.50	-	-	-	0.30	0.20	-	1.00
Band 7	-	-	-	-	-	2.00	-	-	2.00
Band 6	1.00	1.5	1.00	1.00	1.00	3.00	-	-	8.50
Band 5	-	-	-	-	-	2.00	-	0.5	2.50
	1.00	2.00	1.00	1.00	1.00	7.30	0.20	0.5	14.00
Movement - (Increase)/ Decrease									
Band 8a	-	(0.50)	-	-	-	2.70	(0.20)	-	2.00
Band 7	-	-	-	-	-	(2.00)	-	-	(2.00)
Band 6	-	(0.50)	(0.50)	-	(1.00)	3.40	-	-	1.40
Band 5	-	-	-	-	-	(0.20)	-	(0.5)	(0.70)
	-	(1.00)	(0.50)	-	(1.00)	3.90	(0.20)	(0.5)	0.70

Rationales

Occupational Therapy

Reflected in this proposal is the introduction of Band 7 posts, with one professional lead at Band 8a. This provides the opportunity for appropriate professional leadership / clinical support and supervision across the Board area; this is also consistent with the arrangements within Speech and Language Therapy and Physiotherapy. The need for a better skill mix has also been addressed via an increase in Band 5 practitioners.

Prior to the redesign of Tier 4 In Patient Services, Community Occupational Therapists were expected to provide a service to four In Patient units in Glasgow. Redesign of Tier 4 Inpatient services saw the development of 2 posts therefore removing demand on Community based practitioners. Currently there are 2.5 wte posts within In Patient Services.

Activity in Aids and Adaptations will be reduced in Glasgow City through negotiation and will in turn reduce demand for this service.

Inclusion of wider grade mix development of Band 7 roles and introduction of Band 5 posts.

Redrawing of NHS Boundaries will result in South and North Lanarkshire corridors no longer drawing on South and North East Glasgow resources.

Each area will have a local Occupational Therapy resource.

New Skill mix allows clinical supervision across the NHS GGC area.

Increased delivery of identified evidence based practice such as sensory integration.

Speech and Language Therapy

Speech and Language Therapy - Registered

	wte								
	West Dumbarton wte	Renfrew wte	Inverclyde wte	East Dumbarton wte	East Renfrewshire wte	Glasgow wte	Prof Lead wte	Lan	Total wte
Current									
Band 8b	-	-	-	-	-	1.00	-	-	1.00
Band 8a	-	0.80	-	-	-	1.00	-	-	1.80
Band 7	0.92	-	0.60	-	-	3.30	-	-	4.82
Band 6	-	-	0.40	-	-	3.00	-	-	3.40
Band 5	-	-	-	-	-	-	-	-	-
	0.92	0.80	1.00	-	-	8.30	-	-	11.02
Proposed									
Band 8b	-	-	-	-	-	-	-	-	-
Band 8a	-	-	-	0.80	-	-	0.20	-	1.00
Band 7	0.40	1.00	0.60	-	1.00	3.00	-	-	6.00
Band 6	1.00	-	0.60	0.60	-	3.00	-	0.50	5.70
Band 5	-	1.00	-	-	-	1.00	-	-	2.00
	1.40	2.00	1.20	1.40	1.00	7.00	0.20	0.50	14.70
Movement - (Increase)/ Decrease									
Band 8b	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	1.00
Band 8a	0.00	0.80	0.00	(0.80)	0.00	1.00	(0.20)	0.00	0.80
Band 7	0.52	(1.00)	0.00	0.00	(1.00)	0.30	0.00	0.00	(1.18)
Band 6	(1.00)	0.00	(0.20)	(0.60)	0.00	0.00	0.00	(0.50)	(2.30)
Band 5	0.00	(1.00)	0.00	0.00	0.00	(1.00)	0.00	0.00	(2.00)
	(0.48)	(1.20)	(0.20)	(1.40)	(1.00)	1.30	(0.20)	(0.50)	(3.68)

Rationales

Speech and Language Therapy

This proposal seeks to achieve appropriate professional leadership consistent with Board wide arrangements, and a balance between effectiveness and efficiency along with a balance with staffing levels in other AHP disciplines which brings about investment in the Speech and Language Therapy workforce overall.

Given that a post graduate qualification in Dysphagia is a pre-requisite for this service, the workforce model cannot feature high numbers of Band 5 practitioners, although there is benefit in introducing Band 5 staff to assist in development of the profession for future years.

Communication difficulties affect a significant number of individuals with a learning disability, and Speech and Language Therapy staff will have greater involvement in the development of communication strategies which underpin the range of clinical interventions which will be undertaken in the future service.

At a local level, Speech and Language Therapy will be more involved in issues such as challenging behaviour and the development of positive behavioural support strategies, working closely with colleagues.

Clinical risk associated with Dysphagia management is more robustly managed within a greater critical mass of available practitioners.

Speech and Language Therapy is available in Tier 4, therefore increased provision in the community will allow more effective handover for people who require admission and more detailed planning and delivery on discharge.

Physiotherapy

	wte								
	West Dumbarton wte	Renfrew wte	Inverclyde wte	East Dumbarton wte	East Renfrewshire wte	Glasgow wte	Prof Lead wte	Lan wte	Total wte
Current									
Band 8a	-	-	-	-	-	0.83	-	-	0.83
Band 7	0.80	1.50	1.00	1.00	-	5.45	-	-	9.75
Band 6	-	-	-	-	-	-	-	-	-
Band 5	-	-	-	-	-	1.80	-	-	1.80
	0.80	1.50	1.00	1.00	-	8.08	-	-	12.38
Proposed									
Band 8a	-	-	-	-	-	0.80	0.20	-	1.00
Band 7	0.8	1.00	-	-	-	2.2	-	-	4.00
Band 6	-	-	0.80	0.80	0.80	1.3	-	0.80	4.5
Band 5	-	1.00	-	-	-	2.00	-	-	3.00
	0.80	2.00	0.80	0.80	0.80	6.30	0.20	0.80	12.50
Movement - (Increase)/ Decrease									
Band 8a	0.00	0.00	0.00	0.00	0.00	0.03	(0.20)	0.00	(0.17)
Band 7	0.00	0.50	1.00	1.00	0.00	3.25	0.00	0.00	5.75
Band 6	0.00	0.00	(0.80)	(0.80)	(0.80)	(1.30)	0.00	(0.80)	(4.50)
Band 5	0.00	(1.00)	0.00	0.00	0.00	(0.20)	0.00	0.00	(1.20)
	0.00	(0.50)	0.20	0.20	(0.80)	1.78	(0.20)	(0.80)	(0.12)

Rationales

The proposed workforce profile is reflective of the skills required to safely and effectively deliver clinical care. The profile also takes account of the need for skill mix and career progression, as well as longevity of learning disability specific skills in a cost effective manner.

The proposed model will focus on the delivery of 24 Hour postural management. This is envisaged to be the highest demand activity along with the management of long term conditions. The professional competencies are required at Band 6 which is reflective of the highest proportion of staff.

Nursing

	Nursing						Epilepsy	Lan	Complex Need	Out of Hours	Liaison (GMS)	Total	
	West Dumbarton	Renfrew	Inverclyde	East Dumbarton	East Renfrewshire	Glasgow	PDN						
Current wte	wte	wte	wte	wte	wte	wte	wte	wte		wte	wte	wte	wte
Band 8a	-	1.00	-	1.00	-	-		0.85		-			2.85
Band 7	0.60	5.00	1.00	1.00	1.00	9.80		1.00		2.00	3.00		24.40
Band 6	2.00	-	1.00	2.00	1.00	17.70						2.00	25.70
Band 5	1.00	1.00	3.00		1.00	3.60						3.00	12.60
Total Registered	3.60	7.00	5.00	4.00	3.00	31.10		1.85		2.00	3.00	5.00	65.55
Proposed wte	wte	wte	wte	wte	wte	wte	wte	wte		wte	wte	wte	wte
Band 8a								0.85					0.85
Band 7	1.00	1.00	1.00	1.00	1.00	3.00	1.00	1.00		-			10.00
Band 6	1.00	3.00	1.00	1.00	1.00	12.00	-		1.00	-		2.00	22.00
Band 5	2.00	4.00	2.00	2.00	2.00	15.00	-		1.00	-		3.5	31.50
Total Registered	4.00	8.00	4.00	4.00	4.00	30.00	1.00	1.85	2.00	-		5.5	64.35
Proposed Movement - (Increase)/Decrease													
Band 8a	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00
Band 7	(0.40)	4.00	0.00	0.00	0.00	6.80	(1.00)	0.00	0.00	2.00	3.00	0.00	14.40
Band 6	1.00	(3.00)	0.00	1.00	0.00	5.70	0.00	0.00	(1.00)	0.00	0.00	0.00	3.70
Band 5	(1.00)	(3.00)	1.00	(2.00)	(1.00)	(11.40)	0.00	0.00	(1.00)	0.00	0.00	(0.50)	(18.90)
Total	(0.40)	(1.00)	1.00	0.00	(1.00)	1.10	(1.00)	0.00	(2.00)	2.00	3.00	(0.50)	1.2

Rationales

The proposed workforce profile is reflective of the skill mix required to safely and effectively deliver nursing care. The profile also takes account of the need for skill mix and career progression, recruitment of Non Qualified Nurses and succession planning. The proposed workforce change is reflective of wider nursing workforce changes across community services as well as national professional and policy direction.

Importantly the proposed workforce reflects the nursing contribution to the developing service model, in particular, focusing on the enablement role of nursing and, where required, direct intervention. The model removes managerial costs from the Nursing budget and introduces new roles such as Practice Development roles.

Psychology

Current wte	West Dun wte	R'shire wte	I'clyde wte	East Dun wte	East Ren wte	Glasgow wte	Complex wte	Prof Lead wte	G'nance wte	Academic wte		Total wte
Band 9						0.3*		0.5	0.2			1.00
Band 8c	0.50					2.00	0.87					3.37
Band 8b						-						-
Band 8a		1.00	1.00	0.80		1.60						4.40
Band 7		1.00										1.00
Band 6												-
Band 5			0.60									0.60
Band 4												-
University										0.50		0.50
	0.50	2.00	1.60	0.80	-	4.60	0.87	-	-	0.50		10.87

Proposed wte	West Dun wte	R'shire wte	I'clyde wte	East Dun wte	East Ren wte	Glasgow wte	Complex wte	Prof Lead wte	G'nance wte	Academic wte	Lan	Total wte
Band 9						0.30		0.50	0.20			1.00
Band 8c		1.00				2.00						3.00
Band 8b												-
Band 8a	0.70	0.50	0.70	0.70	0.70	0.4						3.70
Band 7						1.00					0.4	1.40
Band 6												-
Band 5												-
Band 4												-
University										0.50		0.50
	0.70	1.50	0.70	0.70	0.70	3.70	-	0.50	0.20	0.50	0.40	9.60
Movement	(0.20)	0.50	0.90	0.10	(0.70)	0.30	0.87	0.00	(0.00)	- 0.00	0.40	1.27

**Notes : Prof Lead * This is variable dependent on clinical need across various localities
1wte Consultant Grade within T4 In patient Services is not included in these figures.
Rationales**

Each CH(C)P/Sector has a dedicated Psychologist post.

Consultant (Band 8c) cover/input for each CH(C)P/Sectors is via a system of professional / clinical supervision.

Band 8a is the “required” grade for each CH(C)P/Sector. Lower bandings are only appropriate when there are additional posts and higher grade Psychologists also in post.

A Professional lead post plus supervision system provides governance of the Psychology service across the Board area.

A “single system” is established for Psychology, whereby managers agree that resources can be moved to cover gaps in service, to ensure continuity of service, prevent growth of waiting lists etc.

Consultant cover:

Consultant cover can be achieved by the following grouping of CH(C)Ps/Sectors (based on establishing areas of roughly equivalent population):

Renfrewshire and Glasgow will provide clinical supervision to Psychologists in all other sectors.

Inverclyde & East Renfrewshire – East Renfrewshire currently has no dedicated Psychologist post; the Resource Allocation Methodology will ensure the allocation of an appropriate number of sessions.

Renfrewshire – Existing Band 8a Psychologists in post are currently undergoing re-grading to Band 8c. This is supported by the Professional lead and is appropriate to the required service/workforce model.

Glasgow: Split of Band 8c Consultant posts and Band 7 posts across Sectors to be agreed locally

Psychiatry

	West Dun	Renfrew	Inverclyde	East Dun	East Ren	Glasgow	IP	Epilepsy Clinic	Academic	Lan	CD & LC	Total
	wte	wte	wte	wte	wte	wte				wte	wte	wte
Current												
Consultant Specialty Doctor	0.70	1.40	0.70	0.40	0.70	4.10	1.00	0.10		0.30	0.40	9.80
Medical Officer (GP)				0.65		0.05						0.70
GP SLA							0.20					0.20
University							0.55					0.55
									2.00			2.00
	0.70	1.40	0.70	1.05	0.70	4.15	1.75	0.10	2.00	0.30	0.40	13.25
Proposed												
Consultant Specialty Doctor	0.70	1.40	0.70	0.40	0.70	4.30	1.00	0.10		0.30	0.40	10.00
Medical Officer (GP)				0.40		0.30						0.70
GP SLA							0.20					0.20
University							0.55					0.55
									2.00			2.00
	0.70	1.40	0.70	0.80	0.70	4.60	1.75	0.10	2.00	0.30	0.40	13.45
Movement - (Increase)/ Decrease												
Consultant Specialty Doctor						(0.20)						(0.20)
Medical Officer (GP)				0.25		(0.25)						0.00
GP SLA												
	0.00	0.00	0.00	0.25	0.00	(0.45)	0.00	0.00	0.00	0.00	0.00	(0.20)

Rationales

1. Responsibility for medical staffing allocation to Tier 3 and Tier 4 LD services across NHS GGC currently lies with the Clinical Director – the advantage of this is that staff time can be moved temporarily and allocated depending on local need (which is influenced by multiple other factors), rather than being in fixed proportions according to population size. This has been a successful way of ensuring a safe service at all times and maintaining the waiting list for psychiatric assessment at a maximum of 8 weeks across all the community teams.
2. 1 WTE Specialty Doctor post was deleted from the LD Service in 2011 and 3 Hospital Practitioner posts (1.5 WTE) were replaced by three Service Level Agreements equivalent to 0.55 WTE in 2012 as part of the re-design of the in-patient service. i.e. medical staffing has already been reduced by 2 WTE since 2011.
3. Current Medical Staffing is thought to already be at the minimum safe level and is 0.2 WTE Consultants below the Royal College Of Psychiatrists recommended level for safe services.
4. It is not anticipated that the new service model for Learning Disability Services will result in a reduced need for medical staffing. Any psychiatry time freed up by sharing mental health assessments will be required to meet the new physical health care, governance, audit, research & clinical leadership roles.
5. Reducing medical staffing further could only be achieved by removing the LD Psychiatry contribution to the Epilepsy Clinic and changing the LD Psychiatry service to a centrally based specialist mental health service that did not contribute to any Community Team Supporting Activities.
6. There is no scope to replace Consultant Posts with Specialty Doctor posts because of longstanding recruitment problems that are unlikely to change in the near future.
7. Training grade staff cannot be relied upon for service delivery as there is no guarantee of availability.

APPENDIX 6
Resource Allocation

RAM Application

	West Dunbartonshire	Renfrewshire	Inverclyde	East Dunbartonshire	East Renfrewshire	Glasgow	Central Costs	Total
Population	74,590	139,529	66,203	85,750	71,461	491,787		929,320
RAM %	8.03%	15.01%	7.12%	9.23%	7.69%	52.92%		100.00%
Current Budget								
Nursing	35,820	347,320	202,990	185,160	122,350	1,690,344	218,353	2,802,337
Occupational Therapy	15,860	61,102	22,386	41,837	0	466,502		607,687
SLT	8,880	39,504	48,033	0	0	363,218		459,635
Phsyiotherapy	12,214	42,581	42,157	0	0	406,459		503,411
Psychology	20,150	96,259	89,885	0	0	473,835		680,129
Psychiatry	39,630	152,950	26,260	0	23,480	1,329,400		1,571,720
Administation	59,080	33,600	47,330	26,400		341,930		508,340
Unregistered Nursing Staff	22,370	43,810	0	13,500	0	263,309		342,989
Unregistered AHP Staff	8,036	12,733	9,205	0	0	7,993		37,967
Artform							91,347	91,347
Others	18,350					10,430		28,780
Dietetics	21,440	8,840	7,800	0	0	175,840	(213,920)	0
Podiatry		15,010	7,400			134,860	(157,270)	0
Savings 13/14							(100,000)	(100,000)
Total In Scope Salaries Budget	261,830	853,709	503,446	266,897	145,830	5,664,120	(161,490)	7,534,342

RAM Allocation

Nursing	219,500	410,700	194,800	252,400	210,300	1,447,400	75,780	2,810,880
Occupational Therapy	47,600	89,000	42,200	54,700	45,600	313,800	16,892	609,792
SLT	36,000	67,400	32,000	41,400	34,500	237,400	20,999	469,699
Phsyiotherapy	39,400	73,800	35,000	45,300	37,800	260,000	33,598	524,898
Psychology	53,300	99,700	47,300	61,200	51,000	351,200	19,788	683,488
Psychiatry	123,100	230,300	109,300	141,500	117,900	811,700	34,500	1,568,300
Administation	39,800	74,500	35,300	45,800	38,100	262,500		496,000
Unregistered Nursing Staff	26,800	50,200	23,800	30,800	25,700	176,900		334,200

Unregistered AHP Staff	3,000	5,600	2,600	3,400	2,800	19,600		37,000
System wide costs								0
Total Available	588,500	1,101,200	522,300	676,500	563,700	3,880,500	201,557	7,534,257

Profession Profile Proposal

Nursing	159,033	310,593	159,033	159,033	159,033	1,159,119	426,068	2,531,912
Occupational Therapy	41,997	91,886	41,997	41,997	41,997	309,831	28,448	598,153
SLT	61,785	83,253	54,880	71,422	49,470	308,184	32,555	661,549
Phsyiotherapy	39,576	83,253	33,598	33,598	33,598	277,220	45,154	545,996
Psychology	40,446	112,140	40,446	40,446	40,446	275,667	152,098	701,689
Psychiatry	80,500	161,000	80,500	73,200	80,500	514,900	584,904	1,575,504
Administation	40,800	76,300	36,200	46,900	39,100	269,000		508,300
Unregistered Nursing Staff	27,500	51,500	24,400	31,600	26,400	181,500		342,900
Unregistered AHP Staff	13,800	25,800	12,200	15,900	13,200	90,900		171,800
System wide costs	85,694	160,301	76,059	98,516	82,100	565,000	(1,067,670)	0
Total Proposed	591,131	1,156,026	559,313	612,612	565,844	3,951,321	201,557	7,637,803

Amount Overallocated

Nursing	60,467	100,107	35,767	93,367	51,267	288,281	(350,288)	278,968
Occupational Therapy	5,603	(2,886)	203	12,703	3,603	3,969	(11,556)	11,639
SLT	(25,785)	(15,853)	(22,880)	(30,022)	(14,970)	(70,784)	(11,556)	(191,850)
Phsyiotherapy	(176)	(9,453)	1,402	11,702	4,202	(17,220)	(11,556)	(21,098)
Psychology	12,854	(12,440)	6,854	20,754	10,554	75,533	(132,310)	(18,201)
Psychiatry	42,600	69,300	28,800	68,300	37,400	296,800	(550,404)	(7,204)
Administation / Include Gov Facil	(1,000)	(1,800)	(900)	(1,100)	(1,000)	(6,500)	0	(12,300)
Unregistered Nursing Staff	(700)	(1,300)	(600)	(800)	(700)	(4,600)	0	(8,700)
Unregistered AHP Staff	(10,800)	(20,200)	(9,600)	(12,500)	(10,400)	(71,300)	0	(134,800)
System wide costs	(85,694)	(160,301)	(76,059)	(98,516)	(82,100)	(565,000)	1,067,670	0
Total Proposed	(2,631)	(54,826)	(37,013)	63,888	(2,144)	(70,821)	0	(103,546)

* Variance between RAM allocation and Professional Profile will be addressed locally with each Partnership