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### **Emerald Article: Deinstitutionalisation and Community Services in Greater Glasgow**

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# *Deinstitutionalisation and Community Services in Greater Glasgow*

## ABSTRACT

*Knowledge of what makes for quality in adult learning disabilities services does not cascade directly down into grassroots practice. It is instead severely filtered and variously diluted through layers of national policy, local strategy and administrative complexity. In the current difficult climate, quality is not obtained without exposure to the strains and stresses inherent in the dynamics of the health and welfare bureaucracies and their attempts at partnership. Following a largely chronological and descriptive account of attempts to change and develop services in the Greater Glasgow area in the mid-1990s, consideration is given to the effect of these 'filters' in the context of the Greater Glasgow Joint Learning Disability Project.*

### **John Dalrymple**

SUPPORT FOR ORDINARY LIVING, MOTHERWELL (FORMERLY PROJECT MANAGER, GREATER GLASGOW JOINT LEARNING DISABILITY PROJECT)

## INTRODUCTION

While there has been a consistent United Kingdom emphasis on the need to shift learning disability services away from policies of segregation and health care dominance towards a model of ordinary living in community settings with the emphasis on social care, there has in Scotland been a much more conservative and slower-moving interpretation of this trend. During the 1980s, when plans were being made to phase out, almost totally, hospital provision for adults with learning disability in England and Wales, new learning disability hospitals were actually being opened in Scotland, and the speed of retraction in existing Scottish hospitals has been much slower.

Nonetheless, in the early 1990s things began to change, for two reasons. The first was a short period when the Scottish Office threatened with monetary penalties those health boards which did not produce

plans to reduce significantly the number of their long-stay hospital beds. The second was the introduction of the *NHS and Community Care Act*, with its double emphasis on the development of community-based social and health care services which enable people to live in their own homes, and the transfer from long-stay hospitals of people whose needs can best be met in a community care setting.

Strategies for the development of a new style of learning disability service began to emerge in various parts of Scotland, typically proposing significant resettlement programmes for hospitals such as:

- Royal Scottish National Hospital, Larbert (in the Forth Valley Health Board area)
- Gogarburn Hospital, Edinburgh (Lothian Health Board area)
- Lynbank Hospital, Dunfermline (Fife Health Board area)
- Merchiston Hospital, Renfrewshire (Argyll & Clyde Health Board area)
- Birkwood Hospital, Lesmahagaow (Lanarkshire Health Board area)
- Arrol Park and Strathlea Hospitals (Ayrshire and Arran Health Board area)

- Crighton Hospital, Dumfries (Dumfries and Galloway Health Board area).

The plans developed in Greater Glasgow (with implications for Lennox Castle Hospital) formed part of this larger national picture.

In addition to developing these strategies with local authorities through joint community care plans, health boards were encouraged by the Scottish Office to submit bridging finance applications to assist with their implementation. Lothian Health Board had been successful at an earlier stage in securing bridging finance and the permission of the Secretary of State to close Gogarburn Hospital, and Fife Health Board had made similar progress in relation to Lynbank Hospital. Beyond that point, however, it was only the Greater Glasgow plan which was to receive this type of financial support from the Scottish Office, resulting in considerable uncertainty over the future of services in other areas, whose applications had in effect been rejected.

## THE GREATER GLASGOW JOINT LEARNING DISABILITY PROJECT

In the summer of 1995, Greater Glasgow Health Board, the social work department of Strathclyde Regional Council and the Greater Glasgow Community and Mental Health NHS Trust agreed to collaborate in the creation of a joint learning disability project. The joint community care plan proposed a very significant shift in the balance of care, the health board had made formal application for the closure of Lennox Castle Hospital, and application had also been made for bridging finance. The project had as its aim the creation of comprehensive, competent and locally-based community services for adults with learning disability in the Greater Glasgow area.

A project manager was appointed in 1995 in the social work department of Strathclyde Regional Council to manage the project. An assessment team already existed at Lennox Castle, and to this a commissioning team was added. The project manager chaired a joint learning disability project team made up of middle-level managers in the social

work department, health board and NHS trust. This reported to an inter-agency project management group (a sub-group of the Greater Glasgow Joint Planning Group) comprising officers of the regional council, the health board, the NHS trust, Scottish Homes, Glasgow City Housing and Strathkelvin District Council.

The structure of the project was that the assessment team focused on individuals in hospital, working with them and with ward staff to identify their needs, while the commissioning team found suitable community services. Once services were set up, it was envisaged that they would be supported, to the extent necessary, by specialist community health staff. The project team handled inter-agency relations as well as project planning.

As a result of training and consultancy work arranged for the assessment team, some of the assessment tools which had been in use were abandoned in favour of a person-centred approach to individual assessment and service planning known as Essential Lifestyles Planning. In addition to being a significant development in the policy and practice of the team, this had the effect of providing an important team-building exercise, giving all members of the team a shared sense of the task and its importance in shaping the future of the people they were working with. This developmental work also resulted in increased speed and volume of completed assessment work.

The major initial task of the commissioning team was to develop the range of social care agencies able and willing to participate in the project and to provide the types of service required. Following advertisement in the national press in May 1995 seeking enquiries from agencies interested in participating in the programme, team members undertook visits to agencies in various parts of Britain, seeking to evaluate the quality of service such agencies might be able to bring to the development of community learning disability services in the Greater Glasgow area. The team arranged a providers conference which took place in Glasgow in September 1995. This was important in attracting more providers to the local area and in engaging some of the existing local providers in a new way. It was accompanied,

however, by negative and mischievously-inspired media attention (focusing on hospital closure) which seriously hampered the work of the project in many ways over the following months.

Those agencies which sustained an interest in participating in the project submitted draft proposals, and a list of preferred provider agencies for the project was drawn up and later approved by Glasgow City Council Social Work Committee. This piece of work resulted in the recruitment of a range of new providers, some of them innovative in their approach.

In addition to engaging with the providers of social care, the commissioning team was involved with various aspects of the housing agenda. The difficulties in procuring the type and quantity of housing required are discussed below, but the team was also engaged with the related issues of the need (or otherwise) to have properties registered, and the willingness (or otherwise) of housing agencies to provide householders with full tenancies. Some progress was made in asserting the rights of individuals to proper security of tenure, and in raising awareness of the inappropriateness of much of the registration process to the development of high-quality domestic-scale services. This type of developmental work necessarily ran in parallel with the practical business of commissioning services for people leaving hospital.

## IMPLEMENTATION

### Policy and organisational context

The creation of the joint learning disability project was followed by a period of uncertainty when no decisions were forthcoming from the Scottish Office regarding the applications for hospital closure and bridging finance. It was not until March 1996 that the Scottish Office announced a bridging finance award of some £30m towards the entire community care plan for Greater Glasgow, with some £12m of this being predicated against the learning disability developments. The award was made available for the period of the community care plan (1995–98), and was accompanied by a statement that the longer-term future of the strategy and the hospital would be reviewed towards the end of that period. This

meant, in effect, that the decision on the future of the hospital had been postponed; it did not mean that the hospital would close, or that the hospital would not, in the longer run, close. The effect of the announcement was to release sufficient funding for a significant programme of hospital resettlement in the twenty-five months then remaining until March 1998.

Following hard on the heels of the bridging finance announcement came the implementation of the re-organisation of local government. This had the effect of creating in the Greater Glasgow area six social work authorities where previously there had been one. These new unitary authorities combined the responsibilities of the local housing authorities, previously held by the second-tier district councils which had also disappeared on 1 April 1998.

In addition to the short-term problems of discontinuity created by the considerable changes of personnel in key roles in local authorities, the effect of these changes was to create a situation in which no single local social work or housing authority was in a position to take an overview of the joint planning agenda for Greater Glasgow as a whole. In view of the significant social work and housing objectives associated with the joint community care plan, this placed considerable onus on the joint planning structures for Greater Glasgow to assume a strategic responsibility for this work.

Another effect was to introduce radical complications into the commissioning of social care services for people being discharged from hospital. A whole set of new cross-boundary issues now had to be negotiated in seeking to resettle people from Lennox Castle Hospital into the various communities of Greater Glasgow. The social work staff employed in the hospital to fulfil this task were, at length, and with two exceptions, ‘disaggregated’ to Glasgow City Council, despite the fact that they were now based in a hospital in East Dunbartonshire. The East Dunbartonshire Council had, in fact, argued that all staff should be ‘disaggregated’ to it, in view of the location of the staff base, but in other quarters the view was taken that staff should go to Glasgow City because of the scale of the council’s share of the services to be developed.

## Housing

As the work of the project developed it became clear that a fresh and radical approach was required in connection with the housing needed. A large range of local authority housing providers and housing associations registered with Scottish Homes (the Scottish equivalent of the Housing Corporation) liaised with social work and health regarding the objectives of the community care plan through a variety of joint forums, but for many months there was no discernible capacity actually to procure the housing required.

Eventually, the conclusion was reached that it was necessary to have the capacity to operate across the whole of the housing market and not simply within the narrow segment of the market represented by the housing associations and the local authorities. A co-ordinated and focused approach to the task of housing procurement was required. Whereas there existed the capacity and authority to commission social care, there was no parallel capacity or authority to commission the housing required to complement this social care. This housing commissioning capacity – characterised by clear authority, sound knowledge, proper links to the commissioning team and access to capital for house purchase and adaptation – had to be created. In the event, it took much agitation from the joint project team for the larger part of 1996 before, in October of that year, the Home Link team came into being, created through the secondment of one member of staff from each of Scottish Homes and the housing departments of Glasgow City and East Dunbartonshire Councils.

The team was in due course successful in obtaining local authority and housing association tenancies. Using a limited amount of capital made available by the health board (no capital funding was available as part of the bridging finance settlement), it completed required adaptations on such properties, and assisted the housing associations to purchase properties on the open market. A small number of people were also assisted to purchase their own accommodation. This co-ordination of housing procurement contributed greatly to the acceleration of the resettlement programme.

There were also a number of issues of principle which, for much of the period of the project, were the subject of discussion between the local authorities and housing agencies, often without any clear prospect of resolution. These included:

- the advantages to be gained from the separation of housing and support
- the rights of people with learning disability to full security of tenure in their accommodation
- the impact on the above factors of the application of registration guidelines.

## Hospital resettlement programme

At the outset of the programme, Lennox Castle Hospital (situated in the small town of Lennoxton, some 12 miles to the north of Glasgow) was the largest learning disability hospital in Scotland. It offers a service to people from the Greater Glasgow area, and its residents include people with origins in and links to all parts of Scotland, from Dumfries and Galloway to the Highlands.

The hospital resettlement programme which emerged from the bridging finance award envisaged as many as 291 Greater Glasgow people being discharged from hospital to community care services, with 261 people being discharged from Lennox Castle Hospital, and a further 30 Greater Glasgow people being discharged from other Scottish learning disability hospitals. A further 30–40 non-Greater Glasgow residents of Lennox Castle were also caught up in these resettlement plans.

Throughout the first six months of 1997 there were many discussions between newly-appointed health board and unitary local authority senior managers, aimed at reviewing the financial assumptions which had underpinned the strategy and plan when drawn up initially by Greater Glasgow Health Board and Strathclyde Regional Council in 1995, and reducing the amount of ‘new money’ to be found through resource transfer. When these came to a conclusion, these managers had agreed that the services being developed through the hospital resettlement programme should be provided at an average unit cost some £3,000 lower than that

originally agreed. In the event, given the relatively late stage at which this significant diminution of resources was decided upon, these new cost objectives proved persistently difficult to achieve. The number of Greater Glasgow residents associated with the plan was also reduced at this time from 291 to 251.

### **Progress made by March 1998**

To begin with, the pace of hospital discharge was very slow. It took some time before any real momentum became apparent. There were a number of reasons for this, including:

- inexperience of this specific type of work on the part of all those involved in the assessment and commissioning of social care services
- the length of time taken in the early part of the programme to complete community care assessments
- the consequent delay in the commissioning of social care services
- the lack of any systematic capacity to commission the housing required to complement the new social care arrangements, until this was specifically rectified in October 1996.

While around 300 people were involved in the programme, fewer than 50 people had been discharged from hospital by the end of the second financial year (March 1997). It had by then been decided that the programme should extend until March 1999 rather than March 1998, and certainly by the end of the following financial year (March 1998) sufficient momentum had been established to allow some 160 people to have been discharged in total, and for the upper site at Lennox Castle Hospital (containing some of the oldest and poorest accommodation) to have been closed.

### **Hospital staff**

Staff working in the hospital were in general terms concerned with the implications of the strategy for their future employment, implying, as it did, a major policy shift away from hospital services towards community services, and a significant geographical

shift away from Lennoxtown towards the various communities within Greater Glasgow.

The bridging finance award identified financial resources to be used to help staff make the transition from their present employment in the health service to employment in the social care sphere. The re-orientation required to assist this transition was considerable, and involved the personnel issues of career development, future terms and conditions and travel to work on the one hand, and the professional training aspects of skill, attitude, and language on the other. Only very limited success was achieved, however, in assisting hospital staff to make the necessary transition.

## **THE FILTERING OF GOOD PRACTICE AND APPROPRIATE SERVICE DELIVERY**

Given the above account of the 'project', most of what follows provides an examination of the various policy-related planning, administrative and organisational 'filters' apparent in its implementation.

### **National policy**

Some have argued locally that Scotland has benefited from its more cautious approach and has managed to avoid what are perceived to have been the worst excesses of too speedy an approach to the dismantling of hospital systems elsewhere.

While there may be some modicum of truth in this argument, it cannot be claimed that this was a result of a conscious policy framework. More apparent in the Scottish context for many years has been a national policy vacuum, which has encouraged Scottish health boards and Scottish local authorities to maintain the status quo. Thus, while certain aspects of UK community care policy support changes which should lead to greater quality in learning disability services (at least in respect of the type and location of the accommodation people live in), there has been in Scotland no framework of national policy which would support what is known to make for better outcomes for people. The effect of this is to create a sense of extreme relativism in discussions which take place at a national level in

Scotland. With no national strategy to guide local planning, and no clear statement about what quality services might look like, each learning disability strategy, buried deep within each generalised community care plan, is as good and as valid as the next, whatever the degree of variation.

In addition to a national policy vacuum, there has also been an absence of any strategic initiative from the Scottish Office. This is a significant factor on account of the high level of interdependence of the various plans in various parts of the country, because of the volume of cross-boundary 'traffic' which had arisen for historical reasons. Thus, while the majority of Lennox Castle Hospital services were purchased by Greater Glasgow Health Board for Greater Glasgow people, most other Scottish health boards also purchased services there, some in considerable numbers. Again, while Greater Glasgow Health Board purchased most of its hospital-based learning disability services from Lennox Castle, it also purchased some 25% of its total hospital services from hospitals and trusts outwith its area.

With such a tangled historical and institutional web, it is simply not possible to make a coherent shift to localised community care services of the style and quality which legislation and professional practice dictate, without a more consistent quality of strategic assistance than has ever been apparent from the Scottish Office.

### **Local strategy**

From the outset it became evident that the development of community services and the run-down of hospital provision, rather than being viewed as two sides of the same coin held together in creative tension, were seen instead as two distinct activities with little to bind them together.

The over-riding priority was in reality the hospital discharge programme, with its much more immediately identifiable targets and measurable outcomes. It was this hospital discharge programme which had money allocated to it, target numbers of people to discharge and timescales attached for the closure of wards. This was the primary focus of activity for the health board and the NHS trust. In

contrast, the development of community services was an altogether vaguer activity undertaken by a completely different group of people (employed by social work) – or by several different groups of people as time passed – with little or no money to spend and few targets to meet. In practice, it fell to the project team to articulate and co-ordinate two separate agendas.

### **Interface between national policy and local strategy**

The initial applications for permission to close the hospital, and for the accompanying bridging finance, were in effect received into the national policy void described earlier. With no quality yardsticks to measure their appropriateness, they were instead evaluated by quite different criteria: the local and political and economic implications of losing the large number of jobs associated with the hospital, the popularity of the proposals among the relatives of people living in the hospital and their perceived popularity in the wider community. The outcome was a prolonged period of political delay and foot-shuffling.

### **Administrative complexity**

The period of project implementation described here (1995–98) bridged the period when the system of Scottish two-tier local government (1975–96) gave way to a new system of unitary local authorities (1996–present).

This meant not only that the hospital resettlement programme latterly required to be mediated through six different and determinedly independent local authority structures, but also that, either by design or by default, six new local authority learning disability strategies began to emerge as the environments within which the resettlement programme had to take root. The picture was further complicated by the fact that four of the six local authorities were not fully coterminous with Greater Glasgow Health Board, but had instead part of their geographical area within that of another health board. These new, and for the most part relatively small, local authorities were thus having to engage in two parallel sets of joint planning and joint working arrangements with health boards.

It is a measure of the instability of the structures surrounding the project that, for reasons of local government reform and departmental restructuring, social work provided the project management group with five different chairs during the 36-month period described here.

There also existed within local authority social work systems a number of issues of 'division of labour' which added to the complexity and discontinuity. No single person had responsibility for the continuous process of assessment and commissioning from start to finish, for any one individual. Thus the assessment and commissioning teams faced the continuing challenge of working out the nature of their collaboration in order to ensure that the work was as seamless as possible. In a similar way, the assessment team required to work out how best it could collaborate with ward-based nursing, and other hospital, staff. The team also faced difficulties in reaching an understanding with community-based social work staff over 'care management' for people after their discharge from hospital.

The complexity of local government administrative arrangements was mirrored by similar complexity in health service matters. An extensive range of cross-boundary issues came to the fore. In their wake, these out-of-area health service complexities trailed further local authority debates and disputes regarding ownership, 'ordinary residence' and funding. Matters were not rendered any less complex by the fact that, whereas Greater Glasgow Health Board had included all its funded hospital beds in its bridging finance application, other boards making similar applications around the same time tended to include only the beds they funded in hospitals in their geographical area.

Change, instability and complexity on this scale greatly increased the number of people who, even for a short time, held some form of responsibility for the implementation of strategy and for the progress of the discharge programme. They also greatly increased the number of such people who had little understanding of the quality agenda in learning disability services, and little commitment to it. Obviously this in turn weakened the level of cohesion and consensus regarding the way forward.

## Dynamics of bureaucratic partnerships

The dynamics of the partnerships between the various public bureaucracies have at least three themes: money, time and trust. Before looking at each of these in turn, some observations on the nature of the partnership itself:

- It involved primarily Greater Glasgow Health Board, the NHS trust and the six local authorities which came into being in 1996 within the Greater Glasgow Health Board area (although, as described above, many other local authorities and health boards were also involved at a secondary level).
- The local authority aspect had two dimensions: social work and housing. Thus, one health board was engaged in an enterprise with six social work departments and six housing departments (though as time passed some of the social work and housing departments merged with each other in the structures of the unitary authorities).
- It was concerned not just with learning disability but with the totality of community care. There was a tendency therefore to generalise from one care group to another and to import assumptions from elsewhere into discussions about learning disability.
- It was less a marriage of hearts and minds intent on pursuing quality outcomes for people with learning disability, than a marriage suited to the convenience of writing and implementing the community care plan, and doing deals over the public finances.

## Money

The subject matter for most of the discussions which took place within the partnership was money. There were very real reasons for this, rooted in the financial difficulties being experienced by health board and local authorities alike as central government continued to limit public spending on the so-called 'priority services'. It is nonetheless disturbing that concern with matters of finance should have come to dominate, to the exclusion of almost all else, the deliberations of senior managers and practitioners;



disturbing, also, that it should become the focus for much inter-agency conflict and mistrust.

The extent to which discussions about money form the major dynamic of the bureaucratic partnership detracts dramatically from any enduring concern with quality outcomes for people with disabilities. Instead of being a means – albeit an essential one – of achieving important outcomes with and on behalf of people with disabilities, the management of money assumes an over-riding priority which at times relegates concern with quality to a place of relative unimportance. In this environment, for instance, it becomes quite possible for some to argue the legitimacy of the widespread use of largescale nursing home and residential care home provision for many people leaving hospital, partly because these are the services primarily on offer for many people in other community care client groups, but mainly because the unit cost-savings for such placements are so significant. In these arguments, what is known about the quality of such services is largely ignored, viewed as irrelevant, or at best regarded as of secondary importance.

### *Time*

Timelines were an important, though confused, feature of the resettlement programme from the outset. The original plan and bridging finance application were related to the period 1995–2001 and were associated with the plan to close Lennox Castle Hospital. When permission to close the hospital was withheld in 1996, bridging finance was at the same time made available for the period 1995–98 to permit a partial closure of the hospital.

While an emphasis on timescales helps ensure the work actually gets done, people leave hospital and there is not an endless round of procrastination, it also carries a negative sense and effect. Together with the ‘spend less’ imperative comes the refrain of ‘hurry up’.

### *Trust*

The emphasis on spending less money and taking less time occurred in a context where there was already precious little trust between the main partners. Trust breaks down for two main reasons:

either agencies have differing short-term aims and objectives concerning how the project should proceed, or they have conflicting longer-term visions for the service. These differences of view and conflicts of opinion exist not only between agencies but also between officers in the same agency.

Thus, for much of the time the emphasis for some people was on getting wards closed, or getting part of the hospital closed, as quickly as possible at the lowest possible cost, while for others the emphasis was on the commissioning of new community services. These emerged as two quite distinct sets of concerns and competing short-term priorities, although they clearly impinged on each other. Even within the ranks of those with responsibility for commissioning community care services would emerge a tension between those concerned to achieve this in a manner consistent with the original aims of the strategy and those concerned simply to achieve the creation of the targeted number of community places within the constraints of time and money.

The chances of creating a truly unified, high-quality, community-based learning disability service for the future were largely dependent on the extent to which the service was conceived, designed and managed as a single entity, with the different partner agencies working in true collaboration. Yet the potential for the fuller development of genuine joint purchasing by the health board and the local authorities was never grasped.

One of the main ongoing tensions within the project team was the co-existence in the one group of those with a responsibility for developing and purchasing new learning disability services – the local authority and Greater Glasgow Health Board – and one of the main providers of learning disability services in the area – the NHS trust. While this arrangement was essential for the efficient and harmonious implementation of the hospital resettlement programme, it led to a variety of circumstances in which it was necessary for the local authority and the health board to protect their shared interests as purchasers, and for the NHS trust to protect its interests as a provider of services. The tensions which arose as a result were inevitable.

More significant in some ways were the conflicts which arose over the future of health services for adults with learning disability, given that Lennox Castle Hospital was reducing in size or perhaps closing. Unlike the situation in England and Wales, there has to date in Scotland been no acceptance of the role of NHS trusts as social care providers. Whereas NHS trusts in England and Wales have been able to diversify into the provision of social care services as hospitals have closed, trusts in Scotland, with limited and short-lived exceptions, have been denied this opportunity.

The result is to place a much greater focus on inter-agency discussions over the number of NHS continuing care beds which should remain in the system, and, more difficult still, on discussions regarding the identification of people whose characteristics are such that they should remain in continuing NHS care. A battleground develops around people with challenging behaviour, people with very significant physical disabilities and people with additional mental illnesses in particular. How many of these people should be retained within the revamped health service, living in health care accommodation? And how should they be identified?

In the context of constant anxieties over time and money, it hardly needs emphasising that conflict and mistrust of this kind do not assist a clear-sighted and consistent focus on quality outcomes for people with disabilities. The need, additionally, to manage the long-running hostility to the process from local politicians and representatives of relatives and staff served further to distract personnel from focusing on the key issues.

### **The management of resources**

In the main, two broad sets of resources must be managed to produce new community services for people either leaving hospital or already living in community settings: those associated with the provision of social and health care services, and those associated with the provision of housing.

#### ***Social and health care service resources***

Through the resettlement programme, it was possible to discard some of the more bureaucratic approaches

to these tasks and to introduce highly individualised, person-centred futures planning. In most instances these were translated into the commissioning of new services which were, typically, truly domestic in scale, and where the provision of care and support was separated from the provision of housing. Funding being transferred from the health service to the local authorities, supplemented by additional local authority funding, was available to develop services in this way.

For people not leaving hospital, but requiring perhaps to leave the family home, or to return to the home area from, say, a residential child care placement, or simply to have their existing community care service reconfigured, the prospects were much more limited, largely because no parallel funding sources were available. The approach to assessment and commissioning for such people was much more akin to the rationing of scarce resources than a true attempt to tap into the needs, hopes and wishes of individual men and women and their families. Thus 'places' or 'vacancies' would (when available) be allocated in existing residential services of various types and configurations – both locally and in many out-of-area locations. (It was apparent, paradoxically, that significant financial resources could often be hurriedly secured for out-of-area placements when, in general, funding for people not leaving hospital was severely limited.)

The implementation of the hospital resettlement programme certainly did lead to a significantly broader base of social care providers active in the provision of services in the Greater Glasgow area. While agencies new to the area were commissioned mainly to provide services for people leaving hospital, they did, as time passed, begin to receive a small number of referrals from staff working with people not in hospital, and were in some instances able to develop services for such people.

This pattern, of new services provided mainly for people leaving hospital through an increasing number of independent sector social care agencies, developed in a context where there had been little previous commitment to the notion of active care management for adults with learning disability. For people leaving hospital, the historic assumption had

for many years been that social work staff based in the hospital would in some way retain care management responsibility for an indefinite period. Adults with learning disability already living in community settings rarely merited the allocation of care management staff, in a broader social work service dominated by the priorities of children and older people. There was even an assumption in some quarters that the care management task could quite appropriately be left to the social care agencies to fulfil. The sheer momentum of the discharge programme in its later stages began to effect a change in this situation, as more community-based local authority resources began to be released.

The whole service system continued to suffer, however, from a generic infrastructure which was either dominated by other priorities perceived to be more pressing (social work community care teams) or poorly informed about the needs of people with learning disability (general practitioners and associated health care workers). The specialist infrastructure, on the other hand, remained either extremely institutional in nature (local authority day services) or excessively dominated by health care practitioners (community learning disability teams). This latter circumstance meant that the most specialist and dedicated underpinning of the social care system for these men and women was provided by the health service, and yet the mechanisms for liaison and joint working between the professionals involved remained hopelessly weak and were characterised by mutual incomprehension and suspicion.

### ***Housing***

By definition, almost everyone leaving hospital as part of the resettlement programme faced the issue of long-term homelessness. Yet there was at the outset no mechanism for ensuring that this situation was rectified as a matter of priority. This was partly the result of changing assumptions about the extent to which community care housing and support should be the responsibility of separate parts of the system, and about the balance of reliance on purpose-built 'special needs' housing as opposed to more mainstream housing options. But it was also

the result of the absence of any agreed commissioning authority for housing to parallel that which existed for social and health care.

The creation of the Home Link team rectified many of these problems, and its success was significant. It must be noted, however, that the activities of this housing team were confined, at least formally, to homelessness faced by people leaving hospital (and included the needs of people leaving psychiatric hospital). The housing needs of adults with learning disability living in the parental home or in inappropriate residential accommodation remained outwith its scope.

### **Service delivery**

Some elements of quality, therefore, emerged intact in the actual delivery of service for people leaving hospital. The coalescence of innovative assessment, commissioning and housing practice resulted in some very significantly disabled people moving to services characterised by high levels of individualisation, personal ownership and security of tenure. There were also high levels of expressed satisfaction with those services on the part of the people themselves and many of their relatives who had initially been sceptical. It was also possible to develop some new, non-institutional day services for many of those leaving hospital. A much broader range of community-based options had become available through the increased number of agencies which had become active as a result of the programme.

On the other hand, service commissioners and service providers allocated insufficient time and attention to the task of working together to ensure that the agencies – old and new – were able to develop their competence fully in the face of rapid growth and many new challenges.

More generally, most of the positive outcomes were restricted to people leaving hospital and were not available to others. In addition, there was little evidence of any enduring mending of the basic fault lines in the community service infrastructure.

## CONCLUSION

In this account, many factors appear to militate against the endurance of quality in the development of services:

- an absence of national policy
- the ambivalent, uninterested stance of central government towards local strategy development and implementation
- a constantly changing and unhelpfully complex set of local government and health authority administrative arrangements within which local strategy struggles to survive and remain coherent
- reliance on a shaky set of partnerships among large public bureaucracies driven by separate and often conflicting sets of interests
- professional preoccupation with issues of time and money at the expense of detailed attention to good practice
- an over-emphasis on hospital resettlement to the neglect of general service development.

In the *Book of Lennox Castle*, written in 1936 to mark the opening of the institution, the medical superintendent wrote:

*'The vagaries of the defective are many and often militate against his progress. Patience and perseverance are the virtues required at all times and seasons in those who supervise the mentally defective, and in no other branch of medicine or nursing can one imagine to be so greatly necessary that charitable quality, THE MAKING OF ALLOWANCES'.*

An alternative analysis suggests that, both now and then, it is the many vagaries of public administration and professional practice which more effectively impede the progress of people with learning disabilities towards lives of greater purpose and fulfilment, and that it is these men and women whose patience and charitable impulses are continually tested to the limit.

The story, of course, continues. On 30th November 1998, the Secretary of State for Scotland approved Greater Glasgow Health Board's renewed application for permission to close Lennox Castle Hospital. The following day, the Scottish Office launched, by way of a one-day conference, a national review of learning disability services, with a remit 'to submit to ministers by December 1999 a strategic framework for the development of social and health care for adults and children with learning disabilities...'. In addition, it seems that final agreement is about to be reached regarding the allocation of bridging finance to assist with the large number of people, drawn from all over Scotland, living in the Royal Scottish National Hospital near Falkirk.

The manner in which these separate, though related, processes are implemented and concluded will carry significant implications for the life prospects of present and future generations of Scottish men, women and children with learning disability. It can only be hoped that, on this occasion, the opportunity to embrace policies which will assist people with learning disabilities to take their rightful place as equal citizens in the mainstream of Scottish life will be understood, and seized with imagination and enthusiasm.