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Community services and transforming care: reflections and considerations

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Community services and transforming care

Community services and transforming care: reflections and considerations

Abstract

Purpose - The purpose of this paper is to consider the existing evidence base regarding community services for people with learning disabilities in the context of Transforming Care (TC).

Design/methodology/approach – Reflections and commentary on the provision of community services for people with learning disabilities following Washington *et al.*'s article on admissions and discharges from assessment and treatment units in England.

Findings – The existing evidence base pertaining to Community Learning Disability Teams in the UK is dated, sparse, and methodologically weak. A greater focus on researching community services for people with learning disabilities is needed in order to inform best practice guidelines.

Originality/Value – The success of the Transforming Care Agenda is contingent on the provision of high quality community services. However, the focus has been on discharging individuals from hospital, rather than the support available to them once they leave.

Keywords Community Services, Community Learning Disability Teams, Transforming Care, Learning Disability, Autism, Intellectual Disability

Paper type – Viewpoint.

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2
3 The article by Washington *et al.* in the current issue, which evaluated whether
4 two regional intellectual disability Assessment and Treatment Units (AandT) in England
5 were meeting the recommended length of stay in line with the Transforming Care
6 Agenda (TC), is interesting and topical. The findings suggest that whilst average length
7 of stay in the two units for people with ID and/or autism appeared to be greatly reduced
8 (i.e., 5 months) compared to data from 2015 (i.e., 51 months; National Audit Office,
9 2015), discharge rates remained significantly below the recommended targets. Further,
10 Washington *et al.* report a significant proportion of the admissions over the three year
11 period were preventable (i.e., 27%) and over half experienced delayed discharge (i.e.,
12 51%), with inadequate community service provision cited as the primary reason in both
13 instances.
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30 Washington *et al.* are not alone in highlighting the role of inadequate community
31 services in the poor progress of TC. Indeed, similar comments were echoed in an earlier
32 TLDR commentary (Sinclair, 2018) and more recently in a series of damning media
33 reports similar to those seen in the aftermath of the Winterbourne View scandal (Ford,
34 2018; Kelso, 2018). Further, recent census figures from the Assuring Transformation
35 dataset report that 28% of the 2,315 individuals with learning disabilities in hospital
36 were deemed to not need inpatient care according to their care plan, with poor health
37 and social care funding and a lack of community service provision cited as the primary
38 reasons for delayed discharge (NHS Digital, 2018). Together, these findings highlight
39 that the success of the TC Agenda is inextricably linked to the growth and development
40 of high quality community services for people with learning disabilities discharged from
41 hospital. Yet, existing research appears to struggle in terms of empirically evidencing
42 best practice among community services. In order to prevent unnecessary hospital
43 admissions and avoid delayed discharges, we need to focus on evaluating and improving
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Community services and transforming care

community service provision in the UK – something which the academic community appears to be neglecting.

Community Services in the UK for People with Learning Disabilities

Community services in the UK are delivered in a variety of settings such as homes, schools, clinics, and community centres (NHS Providers, 2018). The services offered are diverse in nature, including physical health, mental health, and social care (NHS Providers, 2018). The large majority of their activities pertain to long-term condition nursing (e.g., diabetes), planned community services (e.g., physiotherapy), children's services (e.g., school nurses), health and wellbeing services (e.g., family planning), general practitioner teams, and specialist adult community services (e.g., mental health (NHS Providers, 2018). Existing within the specialist community services are Community Learning Disability Teams (CLDTs), their role being to provide dedicated support to individuals with learning disabilities living in the community, including those who have been discharged from hospital. Of course many of the people who are discharged will receive direct support from residential care/supported living providers whose services will be commissioned and funded by local authority and/or local health commissioners. For the purposes of the current commentary, however, the focus will be on CLDTs.

CLDTs can be traced back to the 1970s, emerging as a result of de-institutionalisation and the move to community based services for people with learning disabilities (DoH, 1971; Mountain, 1998). However, it was more recent government initiatives such as *Valuing People* (DoH, 2001), *Valuing People Now* (DoH, 2009), *Transforming Care* (DoH, 2012), the *Care Act* (DoH, 2014), and *Building the Right Support* (BRS; Houlden, 2015) that increasingly placed the spotlight on CLDTs. These

Community services and transforming care

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2
3 policies advocate that CLDTs should reside within local authorities and act as the first
4
5 point of specialist contact for people with learning disabilities living in the community,
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7 enabling and supporting them to live ordinary and meaningful lives (Department of
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9 Health, 2007; NHS England, LGA, and ADASS, 2015).
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13 However, despite a coherent policy directive, existing research regarding the
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15 roles of CLDTs is comparatively scant and under-developed. Early research identified
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17 the role of CLDTs as a combination of coordinating, providing, and monitoring services
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19 for people with learning disabilities (Brown and Wistow, 1990; Mansell, 1990). In a
20
21 later literature review, Slevin *et al.* (2008) concluded that CLDTs were responsible for
22
23 providing highly specialist treatment (i.e., for challenging behaviour, mental health
24
25 problems and complex health needs) (Hassiotis *et al.*, 2000; Roy *et al.*, 2000),
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27 supporting professionals in primary healthcare settings to meet individuals' needs,
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29 liaising with local providers to coordinate services, facilitating access to healthcare
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31 services, and providing educational and advisory support to individuals and those
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33 supporting them. However, there has been no known comprehensive empirical
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35 evaluation to date examining the roles and responsibilities of CLDTs, thus further
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37 indicating our understanding of the internal mechanisms of these teams is extremely
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39 limited (Clare *et al.*, 2017).
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47 There appears to be little consensus within existing research regarding the
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49 structure, size, or composition of CLDTs in the UK (Walker *et al.*, 2003). Considerable
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51 variability in team sizes has been reported (i.e., 2-11 members of staff) (Plank, 1982)
52
53 and membership may typically include community learning disability nurses, social
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55 workers, consultant psychiatrists, clinical psychologists, occupational therapists,
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57 physiotherapists, speech therapists, and general practitioners (Cooper and Bonham,
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3 1987; O'Hara and Sperlinger, 1997; Slevin *et al.*, 2008). However, research indicates the
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5 multi-disciplinary/multi-agency approach is lacking in practice, with CLDTs composed
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7 predominantly of social workers and community learning disability nurses with little
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9 input from other professions (Slevin *et al.*, 2007; Boahen, 2016; Cooper and Bailey,
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11 1998; McKenzie *et al.*, 2000). Further, a robust empirical evaluation is needed as much
12
13 of the literature is descriptive, lacking in quantitative data focusing on organisational
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15 structures and professional practice (Boahen, 2016).
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21 Research pertaining to the performance of CLDTs (Walker *et al.*, 2003) or the
22
23 nature of service utilisation by people with IDD (Spiller *et al.*, 2007) is equally limited.
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25 Early studies suggested CLDTs were highly effective and deemed invaluable for people
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27 with learning disabilities and their families (Aylott and Toocaram, 1996; Brown and
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29 Wistow, 1990; McGrath, 1991; McGrath and Humphries, 1990; Slevin *et al.*, 2007).
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31 However, more recent empirical work by Walker *et al.* (2003) and Slevin *et al.* (2008) in
32
33 the UK reported CLDTs lacked in consistency across regions in terms of structure,
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35 management, caseload, and discharge procedures, with little evidence that a multi-
36
37 disciplinary team was more effective compared to a uni-disciplinary team. Needless to
38
39 say, research evaluating the cost-effectiveness of CLDTs is urgently needed, particularly
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41 against the backdrop of increasing austerity measures in the UK economic climate, yet
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43 there have been few efforts to date to do so.
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50 However, there has been a small body of research devoted to identifying barriers
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52 to the success of CLDTs. Poor staffing, excessive caseload levels, inadequate staff
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54 training, ineffective teamwork, and stringent eligibility criteria have all been reported to
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56 negatively impact the effectiveness of CLDTs (Messent, 2003; Pimental and Ryan, 1996;
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58 Slevin *et al.*, 2007; Walker *et al.*, 2003). These barriers are likely to adversely impact the
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Community services and transforming care

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3 amount of time staff can dedicate to service users (Walker *et al.*, 2003), appropriate case
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5 prioritisation (Todd and Caffrey, 2002), the ability to meet more complex needs of
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7 service users (McKenzie *et al.*, 2000; Slevin *et al.*, 2008), the provision of rapid high
8
9 quality services for all service users (Clare *et al.*, 2017; McInnis *et al.*, 2012), and the
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11 improvement of services in line with government directives (Messent, 2003). As a
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13 consequence, CLDTs have reported increasing role rigidity, low morale, diminished
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15 personal well-being, and increasingly bureaucratic working practices (Clare *et al.*, 2017;
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17 Farrington *et al.*, 2015; Millward and Jeffries, 2001; Slevin *et al.*, 2008). Whilst this small
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19 body of research is undoubtedly extremely useful, in the absence of recent, larger-scale
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21 research, we have no way of knowing the extent to which CLDTs today are experiencing
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23 and/or overcoming these barriers or indeed any other unidentified barriers.
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29 **Best Practice Guidelines for CLDTs**

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33 Given the paucity of existing research pertaining to CLDTs, recommendations for
34
35 best practice are equally scant. Much of the literature suggests CLDTs need to be clear
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37 and transparent in their roles, responsibilities, and service coordination at all levels
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39 (Hudson, 1995). A multi-disciplinary, multi-agency approach appears to be preferred,
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41 where the teams are locally accessible, cohesive, supportive of their members, effective
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43 in their performance, and adopt a person centred approach to care planning with
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45 service user involvement (Clare *et al.*, 2017; Hudson, 1995; McKenzie *et al.*, 2000; Slevin
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47 *et al.*, 2008). Practical suggestions include the provision of specialist clinical psychology
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49 and psychiatry services for those with complex needs (e.g., mental health problems,
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51 challenging behaviour, contact with the criminal justice system), accessible information
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53 packs, a keyworker system, clear eligibility criteria, small caseloads (i.e., 10-15 service
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users), the capacity to deliver intensive support (e.g., through daily visits), and out of hours operation (Hudson, 1995; McKenzie *et al.*, 2000; Shepherd, 1998).

Summary

The progress and success of TC is contingent on the growth of high quality, specialised community service provision for people with learning disabilities. Where community provision is poor, discharges from inpatient settings are invariably hindered. However, beyond clear and direct policy guidelines, the best practice evidence base for CLDTs is dated, sparse, and methodologically limited. Worryingly, despite government policy initiatives, there has been no known comprehensive national evaluation of CLDT provision in the UK. This dearth of research serves to highlight a poor understanding of how to implement and run a high quality CLDT in terms of role, structure, composition, cost, and performance. Unless significant efforts are made to establish a robust evidence base to inform good practice in this area, the complete success of the TC Agenda seems unlikely.

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