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**QUALITY HERE, THERE AND EVERYWHERE.
THE APPLICATION OF A MULTI-DIMENSIONAL LEARNING TOOL
TO
LEARNING DISABILITY HEALTH SERVICES**

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Abstract

The following paper examines the applicability of Maxwell's (1984) Multi-dimensional Quality Evaluation model to community learning disability health services. The model defines seven dimensions against which the quality of any given service can be measured. Effectiveness, Efficiency, Economy, Equity, Access to Services, Appropriateness and Social Acceptability.

A number of examples in relation to community learning disability services are given and discussed.

Introduction

Interest in evaluating the quality of a health services and the way such services impact on an individual's quality of life dates back to Florence Nightingale (Maxwell, 1984) and continues to be central to health professionals. The evaluation of quality in services for individuals with a learning disability largely arose from the principle of normalisation (Nirje, 1969, Wolfensberger, 1972) and the resultant White Paper 'Better Services for the Mentally Handicapped' (1971). This led to a move from large, long-stay institutions to the provision of a variety of community-based services for individuals with a learning disability.

Early researchers assumed that community care policies would themselves lead to an increased quality of life for learning disabled people, to the extent that they took a lack of re-institutionalisation as the main criteria for increased quality of life (Novak & Heal, Eyman et al, 1984). Clinician concern with quality of life later developed such that health care quality was defined in terms of broad categories of individual functioning (Perry & Felce, 1994, Cullen et al, 1996) or systems change. Most recent work has acknowledged that some aspects of service quality can only be judged by the consumer (Dagnan et al, 1993) and the emphasis has shifted to client and carer satisfaction with the services delivered by health professionals. (Murray et al, 1998, Witts & Gibson, 1997, Dagnan et al, 1994). However a number of other stakeholders also exist in learning disability services, whose criteria of a quality service may differ in emphasis from those of clinicians and each other.

Local health boards have the responsibility of ensuring that resources are allocated to best meet the identified needs of the local population at the lowest cost (Parry, 1992). Similarly local Health Trust Managers operate under equal pressures to allocate resources in the most equitable, efficient and effective manner possible. On the other hand agencies such as advocacy and other support and pressure groups, families, carers and individuals with a learning disability work to ensure that the services available are not only effective, but accessible, ethically sound and equally available to all who need them.

Thus different stakeholders in a service have legitimate cause to focus on different indices of quality for that service, with the requirements and interest of clinician, client, service planners and policy makers all potentially differing (Parry, 1992).

As Maxwell (1984) highlights such tensions between stakeholders makes it increasingly unlikely that one discrete measure of quality will meet the requirements of all those concerned. He argues that what is required is the development of an over-arching model which encompasses the needs of all interested parties. Maxwell (1984) outlines seven dimensions against which the quality of any given service can be measured. These are: - Effectiveness, Efficiency, Economy, Equity, Access to Services, Appropriateness and Social Acceptability. The present paper examines the applicability of Maxwell's (1984) model to examining the quality of learning disability health services.

Defining the Dimensions

Table 1 below illustrates the six dimensions identified by Maxwell (1984) as key quality performance indications with some examples of their possible application to a learning disability health service.

1. **Clinical Effectiveness**

This dimension focuses on the area which is arguably of most relevance to the health clinicians, and where much research has been carried out. Clinical effectiveness measures the extent to which a service achieves what it sets out to do. For professionals working in the field of learning disabilities such goals may be complex, varied and differ for each professional group. Thus goals may range from for example reducing a client's challenging behaviour, to improving mobility to developing a communication system. While a great deal of research exists regarding the efficacy of specific interventions (Allen et al, 1997) and service approaches within the field of learning disabilities, (Lowe et al, 1996) the task of a local service is to draw on professional expertise in defining team priorities and evaluating the extent to which they have been achieved. Thus a team may determine that there is a need to develop pro-active screening services for individuals with Down Syndrome in relation to Alzheimer's Disease, or a protocol in relation to challenging behaviour, depending on the needs of the local population.

Efficiency

Efficiency measures the relationship between the resources allocated and the work done (actively). This dimension is arguably of greatest interest to those involved in service planning and resource allocation. The nature of the work of community learning disability teams means that some professionals may spend a large proportion of their time working with carers or families rather than the client themselves (Murray et al, 1998). In addition because the services are by definition, community, a great deal of time may be spent in travelling, particularly if the area covered is rural. Both of these factors give rise to possible measures of efficiency.

1. Training provided: While the relationship between training and the effectiveness of others at carrying out procedures is not always straightforward (Allen et al, 1997) a realistic expectation may be that time spent in training staff groups would lead to a reduction in the individual indirect contacts required, for example, to explain behavioural principles. Group staff training may therefore lead to a more efficient service, than one which only responded to individual staff needs.
2. Travel: A measure of the number of miles per contact travelled by team members may identify a further means of increasing efficiency. A high number of miles for each contact may indicate the need for changing the method of service provision for example from home visits to clinic-based work, to reduce travel.
3. Skill mix of team members to demands on the Service: A comparison of the skill-mix and professional composition of the team with national standards (Cooper & Bailey, 1998) would give an indication if a local service differed, and if so, if the existing composition resulted in the most efficient use of resources in relation to local needs.

Economy

This dimension examines the relationship between the resources which have been allocated and the needs to be addressed. In the context of community learning disability teams this is most simply expressed by the investment in funding for the population served.

Equity

This dimension measures the extent to which a service is available to all people who fall within its remit. The principles of normalisation (Wolfensberger, 1972) and subsequent work (Tyne & O'Brien, 1981) has emphasised the right of individuals with a learning disability to have access to services and conditions of everyday life, which are valued and as close as possible to those experienced by people without learning disabilities. The need for Equity within learning disability services also exists. Potential measures of this dimension may be an examination of therapist input to different geographical areas, other services (e.g Adult Resource Centres) or client groups in relation to perceived or identified need.

Access

This measures the ease with which clients can utilise a service. One of the most commonly used measures of access is waiting times. Clearly a service with long waiting times is more difficult to access. However other important barriers to easy access to health services for learning disabled people have been identified, particularly in relation to primary health care (Lawrie, 1995). Factors such as health information which is not available to or understandable by individuals with a learning disability, a lack of registers for learning disabled clients and waiting areas which are unsuitable for clients with challenging behaviour all present barriers to easy access.

Appropriateness

This dimension measures the ability of a service to meet the needs of a given population.

In respect of people with learning disabilities recent research has indicated that there continues to exist large areas of unmet health care needs in this group (Martin et al, 1997, Paxton & Taylor, 1998) and also that people with learning disabilities experience a greater number of health problems than the general population (Department of Health, 1995, Thornton, 1997).

There is a requirement for learning disability services to constantly respond to such identified areas of objective need to ensure the service continues to be appropriate for the client population. Thus there has been an emphasis on closer liaison between primary health care teams and specialist learning disability services (Martin, 1997) and the development of health screening programmes (Paxton & Taylor, 1998) in an attempt to improve health care for learning disabled people. This is also increasingly being measured by client, carer and referrer satisfaction with services (Murray et al, 1998, Witts & Gibson, 1997, Lowe, 1992). An additional area for examination is that of complaints. While some authors have found that individuals with a learning disability are reluctant to complain (Foote & Rose, 1993) recent research has indicated that individuals may be willing to complain if the aspect of the service is of sufficient importance to them (Murray et al, 1998, McKenzie & Murray, 1998).

Social Acceptability

As noted previously one main impetus for the change in philosophy and policy regarding the care of individuals with a learning disability was the recognition that services needed to be more humane and socially acceptable. This again led to an emphasis on both client and referrer satisfaction surveys (Murray et al, 1998, Witts & Gibson, 1997) and social validation studies (McKenzie & Murray, 1998) in relation to learning disability services. In addition there has been an increasing emphasis on the moral and legal requirement to use non-restrictive and non-aversive therapeutic approaches (La Vigna & Donnellon, 1986). Measures of social acceptability should therefore examine the extent to which consumers and society generally find the service morally valid.

A further indicator of social acceptability is the job satisfaction of the health professionals themselves. A number of studies have found that high levels of absenteeism and burn-out exist in staff who work with clients with a learning disability who also exhibit challenging behaviour (Hastings & Remington, 1994). Staff who experience high levels of aggression or other socially inappropriate behaviour without organisational support and adequate de-briefing procedures may deem the service to be socially unacceptable and accordingly vote with their feet.

Discussion

Maxwell's (1984) model offers a transparent and practical solution to balancing health professionals' assessment of client needs with those of the different stakeholders, including the client themselves. It incorporates many areas which are already routinely measured by a service, but allows for flexibility responsiveness and ongoing development of the service to meet local needs and priorities. While each of the dimensions discussed above gives a discrete measure of the quality of that aspect of the service, it also interacts with the others in an informative and dynamic way. Thus, at a simple level if a new de-briefing procedure is introduced following violent incidents, this may impact on staff's perception of job satisfaction (Social Acceptability) and lead to a reduction in absences (Efficiency), allowing waiting-times to be reduced (Access). However, the interactive nature of the dimensions may mean that the identified goal on one may be at odds with the goals of another, making simultaneous improvement on all difficult (Parry, 1992). This difficulty aside, the model provides a means for

comparison within the one service or if adopted more widely, between learning disability health services.

DIMENSION	CLUES	METHOD	SCORE	TARGET/ EXPECTATION	REVIEW PERIOD
Effectiveness	Education and Training Development of pro-active services e.g Challenging Behaviour, Down Syndrome and Dementia	Information to Team Secretary. Team to choose two per year as priority and develop and evaluate protocol	Average no of days/Whole Time Equivalent Achieved/not achieved	Agreed No of Days - 6 Days per team member/year e.g two per year (if target not met - note reason why)	Annual Annual
Efficiency	Staff Absences Travel Indirect contacts Training provided Skill mix with demands	i.e. Days 'lost' per year as a percentage Number of miles per contact Team spreadsheet Total hours provided per year Feedback from those trained Proportion of trained/untrained staff No of each professional in team as ratio	Percentage Number Number/month Hours/month Ratio Ratio	e.g 4 Days/year/person Based on geography of area e.g 30 hours/month As per national profiles	Annual Annual 6 months Annual Annual
Economy	Cost per head of population	Cost information from Trust Manager	Number		Annual
Equity	Comparison of services in different areas	No of contacts per e.g Adult Resource Centres/geographical areas	Ratio	Proportion of time spent relates to identified need	Annual

	Comparison of Services in Geographical Areas	Compare Total number of Referrals in each and	Ratio	Proportion relates to need	Annual
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		waiting time			
Access	Waiting times	Note monthly waiting times	Number	Identify requirements to reduce waiting times	6 Monthly
Appropriateness	Referrer Satisfaction	Questionnaire	Questionnaire response	Highlight and address areas of dissatisfaction	Annual
	GP Satisfaction	“ “	“ “	“ “	“ “
	Complaints	As per Complaints procedure	Details of complaint		“ “
	Areas of deficit in Service/Team highlighted by objective indicators of need	e.g Empty posts. Link to areas prioritised for development of pro-active services	Number/profession 2/year	Fill empty posts Develop identified services	“ “ “ “
Social Acceptability	Client/carer/GP Satisfaction	As Above			
	Complaints	As Above			
	Job Satisfaction (Team Members)	Job turn-over/profession/year Absences/profession/year Anonymous questionnaire	number Number Score		Annual “ “ “ “

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