

'It's a good thing we're doing, we just need to be better at it'. Forensic intellectual disability nursing experiences of Transforming Care: A multi-perspectival interpretive phenomenological analysis

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Abstract

Background: Concerns have been expressed regarding the impact of Transforming Care (TC) an English deinstitutionalisation mandate, on forensic services. With nursing staff positioned as significant in delivering TC; this research explored nursing experiences.

Method: Nine face-to-face semi-structured interviews were completed with nursing staff working in either inpatient or community forensic teams. Multi-perspectival interpretive phenomenological analysis was used to explore participants' experiences. Interviews were analysed independently, prior to a mini meta-synthesis.

Results: Participants from the inpatient group experienced TC as a threat, which resulted in consistency of perspective and practice. Participants from the community group viewed TC as a worthwhile challenge, which presented opportunity. The community infrastructure was experienced as inadequate by both groups, with the needs of people in forensic services needing more consideration, leading to widespread frustration.

Conclusions: The blanket approach of TC may not be suitable for this population, with those leading TC perceived as naïve.

KEYWORDS

forensic intellectual disability, multi-perspectival IPA, nursing, Transforming Care

1 | INTRODUCTION

1.1 | Transforming Care

The broadcast of the Panorama TV documentary featuring Winterbourne View (BBC, 2011) highlighted abusive practice towards people with an intellectual disability and/or autistic

spectrum disorder in an inpatient service located in southern England. Criminal convictions for staff members followed (Hill, 2012), as did national condemnation (Morris, 2011) which led to political pressure and a subsequent inquiry into the care at this service (Flynn & Citarella, 2012). The resulting enquiry revealed deficiencies in safeguarding practice, commissioning of care and service regulation with people detained in questionable out of

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area placements. In light of these concerns, the ethos of care for these groups shifted significantly. Commitment to this change was detailed in the concordat of action published by the Department of Health in England (DOH, 2012). This concordat committed NHS services in England to a programme of deinstitutionalisation, to increase provision of community-based placements, and repatriate individuals to their home region from out of area placements. These changes were collated under the banner of Transforming Care (TC). Progress of TC was not as rapid as anticipated, requiring a re-commitment through the plan 'Building the right support' (NHS England, 2015a). Within this plan; fast-track sites were selected to pilot the reduction in inpatient beds, with all NHS services in these sites provided with deinstitutionalisation targets. Alongside the mandated reductions; other changes associated with TC have included the introduction of care and treatment review meetings (CTR; NHS England, 2017) to ensure a timely discharge into community services, and emphasis on integrated working between inpatient and community services.

Despite the intentions of TC, it has been beset by difficulties. For example, the community infrastructure necessary to support the planned level of deinstitutionalisation does not seem to exist. This was captured in the study by Washington et al., (2019) who retrospectively reviewed the admission and discharge rates of an intellectual disability admission and treatment unit. Their analysis indicated that in 51% of the admissions there were delayed community transitions; with 83% of these delays reflecting a lack of community-based provision. In addition, Barnoux (2019) reflected on the difficulties incumbent on community intellectual disability teams in dealing with an increasingly complex population. These include an absence of good practice guidelines, lack of adequate supervision, excessive caseloads and poor staffing numbers. Further issues highlighted by Taylor et al., (2017) include the lack of preparedness and training within community teams to manage an influx of complex adults from inpatient services.

1.2 | Forensic intellectual disability services

All services for people with an intellectual disability and/or autism were required to follow the mandated changes indicated in TC, including forensic services. The primary function of forensic intellectual disability services in England is to prevent, manage and reduce offending behaviour (NHS England, 2015b). Offending behaviour or forensic needs are difficult to define but broadly are present if a person is arrested and charged with a crime (Jaydeokar & Barnes, 2010). Current English provision for those with an intellectual disability and offending needs has been summarised by the Royal College of Psychiatrists (2013) who note provision of high, medium, and low security inpatient forensic beds, separate from the prison service. The mandate of inpatient forensic intellectual disability provision is to provide detainment and treatment when an individual's behaviour and risk mean that they cannot be managed in the community (Hickman et al., 2018). Alternatively, individuals with forensic needs

may work with specialist community forensic teams, which provide assessment and treatment to those people with forensic needs living in the community.

Forensic intellectual disability teams offer benefits to those adults requiring forensic services including adapted treatment approaches and resources (Taylor et al., 2005). In addition, these teams often incorporate the input of various professional groups, usually classified as multi-disciplinary (MDT) input. Amongst those professions involved in the MDT approach and at the centre of this research project are nursing staff. Prior to this research project, no empirical research had been undertaken to explore the effect of TC on forensic intellectual disability services; however, opinion pieces published by experts in the field (Taylor, 2019; Taylor et al., 2017) highlighted risks including expedited discharges, truncated treatment and a community infrastructure unable to support the necessary changes.

1.3 | Nursing staff in forensic intellectual disability services

The role of nursing staff within forensic intellectual disability services often involves liaison and negotiation between fellow professionals working within probation, the prison service and generic mental health services (Lovell et al., 2014). Historically, nursing staff working in forensic intellectual disability services have received little attention in terms of research. Prior to TC, the scant evidence available indicated that nursing staff's experiences were marked by complexity (Lovell & Bailey, 2017), development of communication and risk management skills (Lovell et al., 2014), and maintenance of resilience (Lee & Kiemle, 2015).

Unfortunately, nursing staff in forensic intellectual disability services have had limited opportunities to access reflection and support (Jackson, 2014) despite the taxing emotional experiences and impact of their work (Lee & Kiemle, 2015). The trend of limited research focuses on nursing staff working in intellectual disability services has continued during the period of TC. In the context of limited formal research exploring the impact of TC on forensic intellectual disability services, this research aimed to address this absence. Given nursing staff's experiences of the forensic population as different to their non-forensic peers (Dalgarno & Riordan, 2014) it appeared appropriate to consider the experiences of those working in forensic intellectual disability services in their own right.

1.4 | Aim

The primary aim of this research was to explore the experiences of inpatient and community based forensic intellectual disability nursing staff working with this distinct population during TC, compare their experiences, and identify areas of similarity, change, and evolution.

2 | METHOD

2.1 | Research method

Qualitative methods enable the exploration of people within their contextual world (Larkin et al., 2006) and seek to understand the meaning that people assign to their experiences (Creswell & Poth, 2018). Interpretive phenomenological analysis (IPA), which focuses on how people make sense of their lived experiences (Smith et al., 2009), was selected as the method of analysis. IPA was selected as it was expected to provide the richest understanding of staffs' experiences, following its aim of exploring objects and events holding significance for people. Additionally, IPA embraces the bearing of culture and social meaning (Smith et al., 2009), with both playing roles in the narratives surrounding TC.

As the research question aimed to explore two groups' experiences, the research design was broadened beyond a single sample IPA design, which would typically explore a sole homogenous group's experiences of an object or event (Smith et al., 2009). As a result; a multi-perspectival IPA design was selected. The aim of a multi-perspectival IPA design is to explore more than one group's experiences of a phenomenon, whilst retaining a commitment to the components of an IPA design. The metaphor used by Larkin et al., (2018, p.5) to describe a multi-perspectival IPA design of related groups is that it enables the exploration of their experiences 'surfing the same wave'. As referenced by Larkin et al., (2018) the traditional IPA design can be self-limiting and one dimensional, whereas multi-perspectival designs can lead to the development of more detailed and multifaceted accounts (Smith et al., 2009).

2.2 | Sample and recruitment

The guiding principle for participant recruitment is that the sample should grant access to the object or event under exploration (Smith et al., 2009); in this project TC and forensic intellectual disability services. Inclusion and exclusion criteria were established to ensure that the sample comprised nursing staff working in forensic intellectual disability services within a fast-track site who had experiences of TC. In order to uphold the inclusion and exclusion criteria a purposive sampling strategy was adopted, to ensure that participants with the desired experiences and characteristics were

recruited. Participant inclusion and exclusion criteria are included in Table 1.

Smith et al., (2009) suggest that the appropriate sample size for an IPA study should ensure enough data for analysis, without the sample becoming overwhelming for detailed analysis. They suggest between three and six participants can satisfy this recommendation, with issues of data saturation not relevant to IPA. Therefore, a maximum sample size of ten was set for this study and split between the two groups of nursing staff (community and inpatient).

All participants were sampled from one NHS trust based in a fast-track site in England. This is a mental health trust providing a variety of services including forensic services. This trust hosts a variety of community-based and inpatient forensic intellectual disability services, ranging from community homes through to low and medium secure inpatient forensic intellectual disability services. There was no single research site, with all forensic intellectual disability services in this trust invited to partake in the study. The lead researcher worked in the same NHS trust, but not within forensic services and had no prior relationship with any of the participants who were invited to participate.

Potential participants in these target services ($n = 43$) were sent a total of three electronic invitations to participate in the study by service managers who acted as gatekeepers. Participants were invited to contact the researcher if they wished to participate in the project and fulfilled the inclusion/exclusion criteria. Data collection occurred over a period of 4 weeks.

There were nine responses to the invitations. Nine participants, comprised of four inpatient staff members and five community staff, all of whom were registered as learning disability nurses met the study criteria and took part in the project. The characteristics of the sample are provided in Table 2. No other details have been provided, to maintain confidentiality.

2.3 | Procedure

Semi-structured face-to-face interviews were completed with each participant. This is widely regarded as the exemplary method of data collection in an IPA study (Smith et al., 2009), as they offer a degree of flexibility and responsiveness (Smith & Osborn, 2015). Each semi-structured interview was guided by an interview schedule. In line with Smith's (1995) recommendations, the interview schedule was refined over several drafts. Questions were redrafted

TABLE 1 Participant inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Current RNLD registered qualified nurse working within inpatient or community forensic intellectual disability services	Alternative non-nursing profession such as occupational therapy
Employed in nursing role from 2015 onwards (as this is the year that the 'building the right support' document was published)	Job role does not involve direct care provision to service users
Able to communicate verbally using the English language	Registered RNLD nursing staff member covering shifts on target sites (not permanently placed on a study target site)
Aged 18 years or over	-

TABLE 2 Participant demographic overview including gender, role and working environment

Pseudonym	Gender	Working environment	Duration working in forensic services
Bill	Male	Inpatient	5 years
Barbara	Female	Community	15 years
Sean	Male	Community	6 years
Sheila	Female	Inpatient	5 years
Jessica	Female	Inpatient	6 years
Ken	Male	Community	5 years
Joan	Female	Community	13 years
Frank	Male	Community	8 years
Sasha	Female	Inpatient	8 years

to become less leading, but to be clear to a participant what was being asked. Questions on the interview schedule were open, and technical language was avoided to minimise confusion (Smith & Osborn, 2015). Questions were designed following consultation of

the issues related to TC obtained via systematic review of literature such as that written by Taylor et al., (2017) and Clifford et al., (2018). Prompts were included in the schedule; if clarity or rephrasing were required (Smith et al., 2009). All semi-structured interviews were audio recorded using an audio dictation device.

All interviews took place in a private room, at a time convenient to each participant and were completed by the primary researcher (NH) only. The primary researcher had previous experience of high level qualitative research interviews. The researcher completed all transcription using audio files in order to retain closeness and breed familiarity with the data.

As in all IPA research, the analysis stage of this project focused on several key processes (Smith et al., 2009) including; moving from the particular to shared, shifting from the descriptive to the interpretive, and a commitment to understanding the participant's point of view. The commitment to understanding the participant's point of view was a key focus in the analysis stage given the need to consider two groups' experiences, increasing the complexity of analysis. The analysis process is detailed in Table 3.

TABLE 3 Research method, modelled after the process conducted by Rostill-Brookes et al., (2011) and Shaw et al., (2016)

Phase number	Phase description	Focus	Phase overview
One	Reading and re-reading transcripts	Single participant transcript	Entering the participant's world through immersion in the data, achieved through re-reading a transcript several times in order to provide insight into rapport, interview flow and overall tone.
Two	Initial noting	Single participant transcript	Similar to a free textual analysis, a transcript was read through and commented upon. Comments focused on describing what a participant had said, the use of language by participants and interpretive comments. This started the process of shifting the analysis from the descriptive to the interpretive level.
Three	Developing emergent themes	Single participant transcript	Establishing connections, patterns, and links between initial notes. The aim of this phase was to capture what was crucial during different parts of a transcript, often in a synergy of the researcher's interpretations and participant's experiences.
Four	Identifying connections across emergent themes	Single participant transcript	Utilising different methods to organise the emergent themes into a structure or representation that highlights the most relevant and significant themes that contribute to answering the research question. This was achieved materially using physical materials that could be manipulated to reach an emergent structure for a transcript.
Five	Repeating for the next case	Within Group (inpatient or community)	Moving on, repeating steps one to four, but considering the next case in its own terms, bracketing off any fore-structures from the previous case, to allow new themes to emerge from the data. An independent audit was completed at this stage.
Six	Exploring patterns and divergences between groups—'mini-meta synthesis'	Between Group (inpatient and community groups)	Looking for patterns, divergences, and relationships across cases, interpreting and potentially relabelling themes to present the connections between cases and the group as a whole—with a focus on considering the relationship between the groups. Conducted with the assistance of other researchers involved in the project.

In keeping with the recommendations from the Larkin et al., (2018) review paper, the participant groups were analysed separately, prior to comparison to identify areas of divergence and convergence. The analysis stage was modelled after the approach completed by Shaw et al., (2016) and Rostill-Brookes et al., (2011). Analysis was completed case by case on one group of participants, clustering themes, and then repeated for the other participant group. Following this, themes were compared across groups prior to generating an interpretive understanding of the groups' experiences and their relationship to each other. This ensured that analysis adhered to the idiographic requirement of moving from one group's experiences to consider the shared experiences between the groups.

Recommendations from Larkin et al., (2018) were used to guide the analysis of the participant groups, through a mini-meta synthesis (analysis phase six). Larkin et al., (2018) suggest considering areas of consensus or conceptual overlap, where groups may share experiences, conflicting experiences where groups differ in their perspectives and the related context, and reciprocal concepts which support each other.

Sensitivity to context was maintained via the close attention paid to participants' accounts and the researcher's initial interpretations of these. The interviewer's initial thoughts and impressions were documented following each interview, to capture the context of this meaning-making, with these initial notes considered during analysis. The use of a reflexive diary was an important aspect of the project, drawing attention to pre-conceived ideas which might otherwise bias interpretation. For example, the reflexive diary was used to attune more to participants' experiences when analysis was at risk of becoming disconnected from the participant experience and overly interpretive. An independent audit was completed on the project by a researcher with a background in qualitative research methods. The independent researcher completed blind coding on two transcripts, comparing their coding with the researcher's. Following this, the independent researcher compared this coding against the resultant subordinate and superordinate themes for each group. Credibility of the study was enhanced via participant validation, with all participants reflecting that analysis was an accurate and resonant representation.

2.4 | Ethics

Ethical clearance was granted by the Health Research Authority and the host NHS trust. It was made clear that participation was voluntary and that declining participation would in no way have any detrimental impact. Written consent was gained from all participants. Participants were signposted via the debrief materials to a confidential employee wellbeing service provided by the host NHS trust if they experienced any post-participation distress. No participant distress was reported or detected during interviews or participant validation.

3 | RESULTS

Participants from both groups appeared engaged within the interviews, with areas of convergence and divergence noted between them. Due to the need for brevity, core themes have been selected for presentation, which illustrate the key observations from the analysis. Quotes have been selected by the primary researcher (NH) to represent overall participant experiences and were included via consensus with the other researchers Figure 1.

3.1 | Convergence

Participants observed that TC had an impact on the timing of discharges. Some participants from the inpatient group reflected that discharges had been rushed, including Jessica:

...it's almost like let's move them out because they're suitable, even if they're not quite ready.

(Jessica, 122–123)

There was a sense of pressure and unease connoted from Jessica's experiences, of striving towards discharge even if this was counter to the readiness of patients. An undertone of frustration was noted, with patients deemed 'suitable' by individuals outside of the direct care team. These experiences were paralleled by participants in the community group:

...sometimes you do think is that patient really ready?

(Frank, 33–34)

Frank and other participants shared their experiences of the discharge process, where targets and deadlines appear to have been prioritised over the needs and care of patients:

...sometimes some of the decisions that are potentially being made maybe are not necessarily in the patient's best interest or it's not necessarily what's best for the patient.

(Ken, 12–14)

Participants from both groups expressed their anxieties and unease at the influence of TC in this regard. It seemed that TC was experienced as a pressure and force, separate from care teams and their understanding of their patients. A sobering connection was the impact on risk, with inpatient nursing staff expressing fears that once patients had been discharged they could reoffend, with tragic consequences:

...why would you in a sense, usher somebody out of the door that is, still poses a big risk to the public?

(Sheila, 43–44)

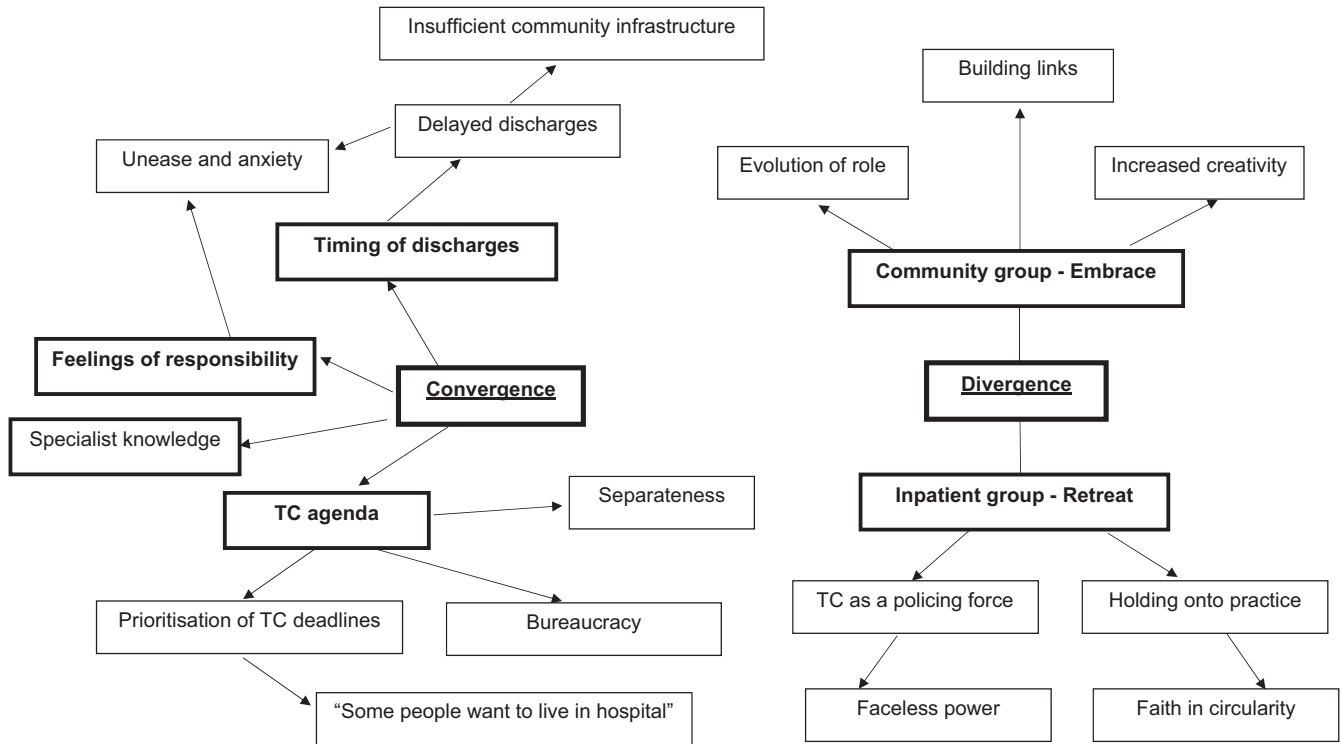


FIGURE 1 Thematic overview

The fear and responsibility associated with public protection was also reflected by participants in the community group:

...it's alright other people saying well we've done everything we can and we've got risk assessments... you still feel a lot of the pressure to protect the public.

(Frank, 72–73)

A sense of frustration was connoted from these experiences. Participants appeared to hold specialist knowledge in relation to forensic services and the associated risks, which the professionals and processes associated with TC were unable to access. Participants framed themselves as being forced by TC into these premature discharges which was uncomfortable, given the potential for grave repercussions. TC was experienced as inflexible, compelling participants to make decisions counter to patient need and the underlying ethos of TC itself. Representatives of TC were characterised as separated and naïve to the reality of forensic intellectual disability services and protected from the consequences. This was epitomised by Sheila who when asked what feedback she would provide to those leading TC responded:

[Laughs] In a nutshell, would you want them living next door to you?

(Sheila, 265)

The previous interview excerpt captures Sheila's transition beyond frustration to indignation.

In addition to expedited discharges, participants in both groups shared experiences of delayed discharges, often linked to systems and processes delaying progress, with a sense of bureaucracy permeating TC. This was eloquently exemplified by Sasha:

...by the time the first e-mail gets from one person to where it's supposed to be at six months have gone by..

(Sasha, 364–365)

Similar experiences were also described by participants in the community group:

I've been in meetings where three months later I'm sat in the same meeting again and there's no further progress.

(Sean, 136–137)

Patient discharges from inpatient services were not only delayed by bureaucracy but by limitations in the community infrastructure. Participants in both the inpatient and community groups expressed frustration that there were insufficient community placements for people to be discharged to upon leaving inpatient forensic services, with packages referring to specialist forensic community placements or non-forensic community placements.

But there isn't many places to go. Or you have to get a whole new care provision.

(Barbara, 188)

Frustration and 'stuckness' permeated these experiences, with participants experiencing the demands to discharge patients, but with limited options to achieve the mandated targets of TC.

There isn't the packages out there to manage people. All the people I work with need an independent package. There's not even the physical buildings, let alone the staffing that needs to go with it, and all the policies and procedures that they need to get in place before these people go. Services all over the country are closing beds.

(Jessica, 81–84)

An additional barrier to discharges from inpatient forensic services expressed by both participant groups was patient resistance to discharge. There were several factors which appeared to elicit this, with participants noting that patients linked the prospect of discharge to a loss of attachments, belonging, and security, prompting experiences of anxiety and fear, as detailed by Bill:

So when they're leaving here, they're leaving everything. Security, they're leaving all the people they know...

(Bill, 253–254)

This was also noted by participants in the community group, including Joan:

You know, some people just don't want to be out of hospital.

(Joan, 203–204)

Resistance to discharge also appeared to be prompted by patients' experiences of the difference between the inpatient and community 'worlds'. Participants reflected that patients had often spent a significant amount of time in inpatient services and that the community had subsequently changed in the interim, contributing to a sense of disconnection and subsequent anxiety:

The whole of society has changed in 10 years. So the expectations of what you're going to. How they're going to be supported. It's not there anymore.

(Bill, 45–47)

So how...what are we expecting them to manufacture a society for some people which is not in [pause] keeping with the real world?

(Sean, 69–71)

et al., (2018). In this way, the main point of divergence between the groups was understood as the community group 'riding the wave' of TC, whilst the inpatient group were crushed by it.

The community group embraced the changes incumbent with TC. They described an evolution in their role, identity and practice. Frank exemplified this, as he noted that community staff were approaching their practice with a renewed sense of creativity:

It's about using the resources more that are already out there than probably what we've done in the past.

(Frank, 270–271)

Community group participants reflected that TC had provided them with an opportunity to shift perceptions of their identity. This was conceptualised as a bridging role between inpatient services and the community, focused on developing links and co-working:

...recently within the new team we've actually been looking and trying to start new links with police, probation, social care and the secondary care teams.

(Barbara, 22–24)

The community group built links and this helped to alleviate historic confusion over their role and afford them more influence and the ability to advise on issues related to discharge:

You get more of a say on placements. It's not the nurses' role, but certainly we go in now and can advise what placement and what areas will be suitable. And I think that's listened to a lot more to be honest.

(Frank, 114–116)

Prior to TC, participants described how colleagues were unclear regarding the focus of their role, seeming to hold negative views of them taking patients out for meals and nothing more. However, Frank described a turn in the tide, with more influence afforded to the community group. Therefore, there were tangible benefits experienced by the community group.

However, the inpatient group experienced TC as a threatening watchful force. TC was associated with experiences of anxiety within the inpatient group, as exemplified by Bill:

I feel like they police the CPA process.

(Bill, 171)

Language used by the inpatient participants connoted a sense of separateness and faceless power associated with TC. The inpatient participants' response to this was characterised as a focus on maintenance of practice, and a retreat into a 'coping position' that services will remain the same despite TC.

3.2 | Divergence

In attempting to summarise the divergent experiences between the groups, it is useful to draw upon the wave metaphor from Larkin

I: Do you think other people's job roles have changed following Transforming Care? Sasha: I would say on the ward...not that much.

(Sasha, 194)

Manifestation of faith in the permanence of inpatient services was captured through descriptions of a circularity of deinstitutionalisation. Previous attempts at deinstitutionalisation were referenced, with participants reflecting that TC would be impermanent, that inpatient services would be 'upscaled' again, and their roles would be needed:

So I don't know whether we'll go full circle. Maybe in a couple of years' time we'll be back with all these beds open. And being in institutions again or whether [pause] other than that I don't know. We may go full circle [pause].

(Jessica, 323–325)

An interesting perspective on this issue is the question of whether this sense of impermanence stopped staff engaging fully with TC, thus contributing to its perception as a failure.

4 | DISCUSSION

This was a novel empirical research project exploring an issue of contemporary significance at a national level. This discussion focuses on selected findings from the research. In considering the experiences of both inpatient and community staff groups, TC was viewed as a pressure, with its broad application across the population affected representing a 'one size fits all' approach. The participants in this study demonstrated specialist knowledge of working within forensic services. This contributed to feelings of detachment from the 'top down' mandates issued within TC, with representatives of TC characterised as naïve of forensic services. Whilst similar themes regarding specialist knowledge have been previously identified in nursing staff working in these services (Dalgarno & Riordan, 2014; Lovell et al., 2014), resistance to service change has also been identified in forensic services, namely in the study by Astbury et al., (2011) who noted a group of inpatient nursing staff attempted to maintain consistency of practice in the context of institutional change. The implication being that a 'one size fits all' approach is unsuited to the unique needs of people with an intellectual disability and offending needs, a point reflected in opinion pieces (Alexander et al., 2015) and reinforced by the hesitation of communities to welcome these people back upon leaving inpatient care (Taylor et al., 2017). The experiences of the participants in this research indicated that those leading TC seemed detached from this reality.

Corroboration between both groups adds strength to the premise that the community is ill-prepared to provide the infrastructure required in order to fulfil the targets set by TC. Whilst previous research has also highlighted this issue in assessment and treatment units (Evans, 2018; Washington et al., 2019), this is the first research

project to suggest similar difficulties within forensic intellectual disability services. It is possible that this is another indication of the failure of the 'one size fits all' approach adopted by TC in the context of the additional needs and risks presented by the forensic population. The evidence indicates that this limited infrastructure seems to impede progress, with societal awareness growing of the slow pace of TC relative to the original concordat of action (Cave, 2018) and TC labelled a failure by media outlets (Phillips, 2019).

The bureaucracy experienced by the participants in this study could be viewed as a response to the limitations of the community and an inability to sustain progress. In this way; the meetings and delays referenced by the participants may service as a method of delaying transitions in order to create a hiatus and allow more time for community provision to be improved, bearing some similarity to the suggestion proposed by Sinclair (2018). Sinclair (2018) proposed the idea of a bed reduction hiatus, in order for the community infrastructure to be established. Patient resistance to discharge as indicated by both participant groups has been evidenced in other research, namely that conducted by Head et al., (2018), which referenced a loss of attachments and limited connections to the community for people with an intellectual disability discharged from inpatient services. Consideration of the context to resistance to discharge is also required; referencing the views of the community and members of the public. Alongside the aforementioned public hesitation (Taylor et al., 2017), research has indicated outright negative views of people with an intellectual disability and offending behaviour from the general public (Stears & Duff, 2018). With this group already marginalised, vulnerable, and being integrated into a potentially hostile community, this study has contributed reflections on the applicability and the ethical soundness of the broad drive for community provision mandated by TC to this group.

The main point of divergence between the inpatient and community participant groups was in the manifestation of their responses to TC. These divergent responses mirror some of those from other research, including the study by Astbury et al., (2011), which found one group of staff in inpatient services which attempted to maintain consistency in light of institutional change. The participants' references in the current study to maintain consistency of practice seemed to be linked to the impact of TC on inpatient services, with them being reduced and 'cut' by the faceless force of TC. The inpatient group's faith in circularity bore similarity to the Bion's basic assumption pairing (Stokes, 1994). As Stokes (1994) describes this assumption: '...there is a conviction that the coming season will be more agreeable....' (Stokes, 1994, p. 21–22). The faith in circularity expressed by the participants that usage of inpatient services would increase may have served to stave off the anxiety at the prospect of further inpatient bed closures and their services and roles becoming obsolete. In comparison, the community group embraced the changes and consequences resultant from TC. This mirrored the research completed by Astbury et al., (2011) and may have been driven by fulfilment of the desire for additional training and support (Chester & Henriksen, 2014) following from the changes incurred by TC.

4.1 | Strengths and limitations

A strength of this empirical research project is that it has contributed to a contemporary issue, which has received minimal formal research focus. There are advantages to utilising a multi-perspectival IPA design, including the inherent triangulation between different group's experiences. This triangulation implies that themes can appear more trustworthy and consequently hold more weight. The use of an audit process also contributed to the trustworthiness of the results. In considering the idiographic nature of IPA research, the findings and analysis from this research relate to the nine participants who formed the sample. Whilst this approach facilitated an in-depth analysis of these experiences, it was not striving for a level of generalisability to other experiences of TC. It should also be noted that given the focus on a single host NHS trust, the sample was limited to discussing their experiences within this trust and its particular approach at delivering the changes directed by TC. Given the existence of 48 other Transforming Care partnerships (NHS England, 2015a), there are other experiences within these partnerships that may differ to the experiences of the participants in this study.

5 | CONCLUSIONS

The limitations of the community infrastructure were reflected by both participant groups, confirming the fears of clinicians working in the field and contributing to the narrative that TC has led to stunted change for patients. This caused widespread frustration for the nursing staff. Their specialist knowledge of forensic intellectual disability services and their experiences of patient resistance to discharge into the community raised some interesting ethical considerations regarding the ongoing application of TC to intellectual disability services, and the appropriateness of a blanket policy being applied to a population experienced as markedly different to that intended by this national agenda. It is hoped that this research will be used to contribute to discussion regarding the ongoing application of TC, with the findings highlighting several issues of consideration for forensic services and NHS England.

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