



Policy Guideline and Procedure

Policy Title: National policy on prioritisation of referrals to Children’s Disability Network Teams

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1.0 Policy Statement

This policy is developed by the Prioritisation Working Group convened under the 'Progressing Disability Services for Children and Young People' programme.

1.1 Terms of Reference of the Working Group

To advise on a national policy for all Children's Disability Network Teams (CDNTs) on prioritisation of referrals for assessment and intervention, taking into account both the child's and the family's needs.

Outside the Terms of Reference

- Prioritisation for individual caseloads
- Management of individual caseloads
- Ongoing reappraisal of needs when children are in service

1.2 Objectives of the Progressing Disability Services for Children and Young People programme

- One clear pathway to services for all children with disabilities according to need
- Effective teams working in partnership with parents
- Resources used to the greatest benefit for all children and families
- Health and education working together to support children achieve their potential

1.3 The principles of the programme in relation to prioritisation of referrals are as follows:

- ❖ Equity of access to services according to needs rather than to diagnosis
- ❖ Family centred services
- ❖ Evidence based best practice
- ❖ Services accountable for outcomes for children and their families
- ❖ Consistency in service delivery across the country

1.4 Relevant policies and programme guidance documents

- National Policy on Access to Services for Children and Young People with Disability or Developmental Delay 2016

- National Policy on Discharge/Closure and Transfer from Children's Disability Network Teams 2016
- Interim Standards for Children's Disability Network Teams 2015

2.0 Policy Purpose

This policy provides a national consistent and equitable method of prioritising referrals for CDNTs. It does not apply to individual clinical caseloads which will be managed on an individual discipline basis according to professional and clinical guidelines.

3.0 Scope of the Policy

This policy applies to management and staff in all Children's Disability Network Teams.

4.0 Roles and Responsibility

It is the responsibility of each CHO and governance group for children's disability services to oversee the implementation of this policy at management and team level and to monitor its operation.

5.0 Procedure

5.1 Model of Service

The model of service for all CDNTs is family-centred and based on the needs of the child. This includes universal, targeted and specialised supports and interventions, as appropriate to the individual child and family. It is based on the objectives of empowering and supporting parents and others who are with the child on a daily basis to facilitate the child's developmental needs. The service therefore should include introduction to service meetings, information sessions and courses for parents and other relevant people in the child's life, as well as group-based and individual interventions.

It must be acknowledged that services are at all times resource dependent and as such there may be occasions when a child is on a waiting list to access services. This waiting list will at all times be monitored and reviewed, but it is dependent on

parents and referrers ensuring that the team/person monitoring the waiting list is kept informed of any changes in needs/circumstances for the child/family.

Access to information sessions and parent courses, as appropriate, should be offered to families as soon as possible following referral, regardless of the child's place on the waiting list. As well as giving parents valuable information, this access will support them to manage their concerns and link them with other parents.

5.2 Referral

The appropriate service for each child (Primary Care or CDNT) is decided according to the complexity of the child's needs on the basis of referral information (see National Policy on Access to Services for children with Disability or Developmental Delay). Therefore this policy on prioritisation of referrals applies to children whose needs have already been determined as complex and who will access the CDNT.

CDNTs can only make decisions on prioritisation based on the information they receive on referral. Referrers have a duty of care to ensure accurate detailed and relevant information is provided. Lack of relevant information provided by the referrer may lead to unnecessary delay in the processing of the referral.

The Team Manager must take the role of reviewing referrals and, where clinically relevant, requesting further information/clarification, or alternatively assign this role to a team member(s).

The National Referral Forms to Children's Services and Additional Information Forms include questions which will assist in identifying needs for urgent assessment and/or intervention and those which are non-urgent.

From the time of receipt of a referral, the service has a duty of care towards the child. If the child is placed on a waiting list for services their situation and needs must be monitored every six months, for instance by a key worker making contact with the family. If on contact it is established that there is a significant

change regarding any of the issues in the list under urgent referrals below, the child's status should be reviewed.

5.3 Categories of referral

There will be two categories of referral - urgent and non-urgent.

Urgent referrals

Urgent referrals are those with one or more of the following issues:

- ❖ Equipment/pressure care breakdown
- ❖ Family in crisis
- ❖ Critical transition stage where intervention/assessment is essential for continuity of a service
- ❖ Choking/aspiration Feeding Eating Drinking and Swallowing issue (if this service is available from the team)
- ❖ Critical rehabilitation required post discharge from an acute hospital service following acquired brain or spinal injury
- ❖ Presentations and behaviours which may lead to:
 - Significant risk to health or safety of the child
 - Significant risk to health or safety of others
 - Very severe loss in quality of life or daily functioning of child
 - School placement breakdown
- ❖ A combination of significant and multiple child and family vulnerabilities likely to lead to severe deterioration in the child's wellbeing and disability related problems
- ❖ A child who has been on the waiting list for services for a year

When information on a referral indicates there might be concerns of an urgent nature the Team Manager or a member of the team may need to make contact with the parent or referrer to obtain more information.

Some children and their families on referral may be deemed to need an immediate emergency response from the CDNT. Others may need a response as soon as possible. The response to urgent needs should be determined on an individual basis informed by clinical judgement.

The response to an urgent referral may be by one or more disciplines for a specific intervention as appropriate to address the child's and family's needs (e.g.

replacement of equipment). The child will remain on the non-urgent list for all other interventions/team based interventions as appropriate to their identified needs.

Non-urgent referrals

All non-urgent referrals will be taken into the service by date of receipt of referral.

Transfers and re-referrals

If a child's service is transferred between CDNTs, either due to change of address or to a move from Early Intervention Team to School Age Team, the new team must take the date of the original referral to a CDNT as the date he/she was referred, not the date of transfer.

If a child is re-referred subsequent to discharge from a CDNT the team must take the date of the original referral to the team as the date he/she was referred, not the date of re-referral.

5.4 Protocol for managing urgent issues and emergencies

Each CDNT must have a protocol for the management of urgent and emergency issues. This should include:-

- Clear information on how to respond immediately to whoever is providing the information
- How to ensure the responsibility for action is appropriately assigned
- How to communicate effectively with all members of staff who need the information
- A guide to the possible response for a particular urgent need including the supports by the team indicated and/or an onward referral. Examples:-
 - School placement breakdown.....Team psychology and/or a referral to EWB/SENO/NEPS
 - Housing crisis.....Team social work support and/or referral to local city/county council
 - Self-harm or injury to others.....Team psychologist/behaviour support and/or referral to school support/CAMHS/Tusla/Gardai

- Palliative Care..... Team OT/Physiotherapist for equipment and positioning and/or services and referral to supports for life limiting conditions

5.5 Protocol for management of the waiting list

Each CDNT must have a protocol for the management of the waiting list in relation to: -

- ◆ Responsibility for contact with the family every 6 months to review needs
- ◆ Response to an urgent need that the team have been informed about or that has been identified by a member of the team including procedure for informing relevant staff member(s)
- ◆ Information for families on the waiting list procedure, the determination of urgent needs, the child's place on the waiting list according to date of referral, and that they will be contacted regularly while their child is on the waiting list
- ◆ Managing the waiting timeframe through the best use of the available resources. This may include measures such as providing access to group sessions for a specific purpose, the closure of intervention for a specified length of time by an individual team member once an outcome has been achieved, or the discharge of a child from an individual discipline list when intervention is no longer required.

6.0 Implementation Plan

This policy will be implemented in conjunction with the National Policy on Access to Services for Children with Disability or Developmental Delay in all Children's Disability Network Teams.

7.0 Evaluation

The operation of this policy must be reviewed and evaluated at a national and at CHO level for effectiveness and consistency within one year of commencement of implementation and thereafter at a minimum of every two years.