

**National Team Development Programme**

**Children’s Disability Network Teams**

**Date: 04/10/2019**

**National Team Development Programme**

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## **Abbreviations**

FCP: Family Centred Practice

CDNM: Children’s Disability Network Manager

CDNT: Children’s Disability Network Team

LETD: Learning Education and Talent Development

LIG: Local Implementation Group

NCPOG: National Children’s Programme Oversight Group

OCFF: Outcomes for Children and their Families Framework, an Outcomes Focused Performance Management and Accountability Framework for Children’s Disability Network Teams

PDS: Progressing Disability Services for Children and Young People

QA: Quality Assurance

QQI: Quality and Qualifications Ireland

## **definitions**

Child/children: refers to babies, children and young people from birth to 18 years.

Family: refers to the full range of close personal relationships involved in the care-giving of children, including parents, foster parents and the wider family.

Parent: refers to parents, legal guardians and carers, including other members of the family and foster carers who care for the child.

Team: refers to all members of the Children’s Disability Network Team including the manager, administration, health and social care professionals.

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## **Working Group terms of reference**

1. Define the core deliverables of Children’s Disability Network Teams (CDNTs) based on the needs of children and families accessing the teams
2. Define competencies required by CDNTs to achieve those core deliverables
3. Define training and team development required to develop those competencies within CDNTs
4. Identify training and material resources available within the HSE and Voluntary Organizations, and where required, identify externally to meet the training requirements, cost neutral where possible
5. Identify how various training can be accessed e.g. intra and inter CDNTs, online resources, training face to face at CHO, regional or national and/or via webinar, webinair, recording local training event for sharing nationally
6. Identify a process to quality assure the recommended training resources where not already certified
7. Recommend a phased team development programme for CDNMs and CDNTs, with timelines for completion, including
   * Induction
   * On-going training programme
8. Develop a national Standard Procedure for CDNT development, incorporating outputs of the above objectives.

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## **The working group**

Dr Cathal Morgan, Head of Operations – HSE Disabilities extends his sincere thanks to each of the members of the National Team Development Programme Working Group for their dedicated time and expertise given to bringing this proposal to the table. This exemplifies the level of commitment by staff working at all levels within Disability Services across the country to continuously improve how we support children and young people with disabilities and their families to achieve their desired outcomes.

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# Introduction

Health services for children and young people with a disability or development delay have developed inconsistently across the country over the last 100+ years, mostly for specific types of disability. This has resulted in varying gaps with some children gaining appropriate access to high quality services whilst others have little or no service, based on access criteria of service providers. *Progressing Disability Services for Children and Young People Programme (PDS)* was launched in 2011 to

* provide equity of access to services based on need, not where the child or young person lives or goes to school, or the nature of their disability
* work collaboratively with the parents/carers and Education to optimise outcomes for children and young people within existing resources.

This requires reconfiguration of disability service staff who work with children with specific types of disabilities e.g. physical, sensory, intellectual or Autism, into Children’s Disability Network Teams to provide for all children with complex need as a result of their disability.

The PDS programme is now at a pivotal place with imminent filling of the new Children’s Disability Network Manager (CDNMs) posts to lead existing and remaining Children’s Disability Network Teams (CDNTs) to be set up. To achieve these two ambitious objectives, a National Team Development Programme is critical at this point to support all CDNMs and CDNTs (comprising staff of several different organisations with different areas of expertise) in gaining a common understanding of PDS principles and how they translate into family centred practice delivered by interdisciplinary practicing teams.

# Programme purpose

The purpose of this Programme is to

* Drive a consistent foundation and understanding of the PDS family centred model for all managers and staff of existing and newly forming CDNTs from the beginning
* Support CDNMs and CDNTs with the seismic change required to move to this model and
* Establish the CDNM Forum as a *community of practice* to support team development.

# Programme oBJECTIVES

1. To define the critical components of a National Team Development Programme comprising
   1. CDNM Development Programme, including PDS Induction and on-going development for CDNMs who will lead teams in implementing and sustaining new models of practice consistent with PDS principles across the country
   2. CDNT Development Programme for all teams led by the new CDNMs, including PDS Induction and on-going Team Development Programme to support consistent implementation of sustainable models of service in line with PDS principles nationally
2. To secure required resources for delivery of specific components by external providers where not available within health services
3. To deliver the National CDNM Development Programme
4. To support CDNMs in the delivery of the national CDNT Development Programme.

# Summary RECOMMENDATIONS

A composite of the minimal required training by newly forming teams under PDS was gathered across all CHOs by the National Children’s Programme Oversight Group (NCPOG) in 2016, capturing the experience of CDNTs as a guide for remaining services to reconfigure. It comprised mainly mandatory and clinical training courses and was used as a basis for this initiative.

In preparation for commencement of the National Team Development Programme Working group, an exploratory discussion was held with all managers of existing CDNTs in January 2019, focusing on the competencies and related training required by CDNTs to deliver on the PDS principles. A number of recommendations were put forward which over the 5 months of the National Team Development Working Group to date, were endorsed firmly and further developed by the group as critical success factors to the sustainability of the PDS model of services and supports nationally as follows:

**Recommendation 1: A nationally consistent Team Development Programme** ensuring a strong, common foundation by all managers and teams from the outset.

**Recommendation 2: A Tiered, Prioritized Approach**

**Tier 1**: to include

* Team Development, commencing in the 6 months Pre-Reconfiguration Phase
* understanding the PDS principles, including Family Centred Practice (FCP), interdisciplinary working and key working to develop a ‘new’ way of working from the beginning of the team coming together
* Change management practices
* Team Performance, tying in with interdisciplinary practice and new ways of working

**Tier 2:**

Clinical Skills development: This is traditionally where most teams have exclusively focused initially at the detriment of Tier 1 as the critical foundation for PDS.

**Recommendation 3: A phased Team Development Programme**

1. ***Pre-Reconfiguration Phase***: commencing at least 6 months before the CDNT start date. Team Development content here is deemed critical and essential from aspects of risk management and safety, management of change (for families and for staff) to a family centred practice model, and competency and skill set development.
2. ***Early Post Reconfiguration Phase:*** the first nine months after the CDNT start date. Team Development content here is considered to be urgent and important with a continued focus on the development and bedding down of a child and family centred practice model .
3. ***Post Reconfiguration Phase:*** is the period from 9 months after team set up to 3 years and team development and related training identified here is deemed critical to sustainability of the new ways of working in line with the PDS model of service (See 5.3 for more detail).

**Recommendation 4: CDNT staff be released for critical cross/upskilling/training days in the 6 months Pre-Reconfigured Phase** by soon to be peer CDNT members in regards to working with children with disabilities whom they have no previous experience in. This is critical for the safe transition to and early experience in the CDNT for all children and young people with disabilities.

**Recommendation 5: Value staffs’ competencies, knowledge and skills**, releasing them to train other staff, building confidence in their own competencies. This, in turn, enhances team morale and spread of good practice, fosters an environment of creativity amongst CDNTs and ensures optimal use of human resources in alignment with the HSE’s People Strategy of valuing its staff.

# Programme BUSINESS CASE

## 5.1 drivers FOR NATIONAL TEAM DEVELOPMENT PROGRAMME

### policy background

***Committee on the Future of Healthcare - Sláintecare Report*** (Oireachtas 2017) states

“*clinical governance as a component of total governance of health service organisations through which they are responsible and accountable for:*

* *Continuously improving the quality of their services*
* *Safeguarding health standards of care*
* *Ensuring best clinical outcomes for patient care”*.

One of its eight principles is “*The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued*”.

Goal 4 of the **HSE’s Corporate Plan 2015-2017** is to

“*Engage, develop and value our workforce to deliver the best possible care and services to their people who depend on them*”.

The People Vision of the ***HSE’s People Strategy 2015-2018*** is “*Enabling all staff to perform to the best of their ability delivering service excellence”. It holds as a value that “We will support and encourage our workforce to achieve their full potential*”.

In the ***HSE People Strategy 2019-2024 draft***, HSE CEO, Paul Reid states “*as public services, we have a responsibility to make the best use of the resources available to us… Our staff are our biggest resource - together we must deliver on the ambition set out in the People Strategy 2019-2024 in order to ensure ‘we have the right people, with the right skills, in the right place, and at the right time delivering safer better healthcare*”.

The ***Outcomes for Children and their Families Framework (2013)*** will apply to all CDNT staff in terms of what they can be held accountable for and its purpose is:

* To maintain a focus on desired outcomes for the individual child and the family…
* To ensure a standardised outcomes-focused approach to the delivery of services and supports for each child and their family in accordance with their needs and priorities;

This National Team Development Programme aims to support all (HSE and HSE funded) staff of CDNTs to deliver on each of the above commitments.

### evidence SUPORTING TEAM TRAINING AND BUILDING FOR cdntS

The *Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5-18* (HSE 2009) endorsed interdisciplinary team working as the most effective way to provide services for children with disabilities and their families. This reflects the evidence that inter-professional team-based working can improve service delivery and outcomes for those who require a health intervention (Suter et al, 2012). In general, inter-professional team working has been shown to result in better treatment quality (O’Leary et al 20112), better outcomes (Lemieux-Charles and McGuire, 2006)and improved patient safety (Sorbero et al, 2008), higher job satisfaction and staff well-being (Korner, 2010) and lower levels of staff burn out (Deneckere et al, 2013), costs savings and reduced staff turnover (Grumbach and Bodenheimer (2004), Xyrichis and Ream (2008), Zwarensen, Goldman and Reeves (2009)).

The National Reference Groupreport identified the ‘core minimum requirements for team working’ as the establishment of a clear vision, clarity on roles and responsibilities, leadership, team meetings and communications (HSE 2009). Again, this reflects the evidence that for teams to be effective, certain conditions need to be in place (Körner et al, 2009). The literature shows that many of the potential benefits of team working do not necessarily happen just because teams are formed. For example, the *Effectiveness of Health Care Teams in the National Health Service (NHS)*report (Borrill et al, 1999) on the benefits of team work found that

* Health care teams were more effective and innovative across virtually all domains of functioning **the clearer the team’s objectives** and the **higher the level** of
* Participation in the team
* Commitment to quality
* Support of innovation
* Those working in teams had better mental health than those working in looser groups or working individually. The benefits appeared to be due to:
* Greater role clarity
* Better peer support (ibid)

The literature is clear that **inter-professional** team working has significant potential benefits for those who use services, for staff and for organisations but that these benefits will only be realised where staff operate in well- functioning teams. The literature suggests that efforts to establish team-based working arrangements which don’t establish team cohesion and develop shared team values are unlikely to produce improved outcomes.

Despite the fact that inter-professional team-working is seen as a core competency of effective working in the health sector, **initial health professional training programmes typically do not provide training in “working in teams and in developing team-related skills**” (Institute of Medicine (US), Greiner and Knebel, 2003). Recognising the importance of health professionals working in teams, some jurisdictions have developed competency frameworks around inter-professional team based working. Canada has developed a *National Inter-professional Competency Framework,* which sets out the competencies required to work as part of an inter-professional team (CIHC, 2010). These competencies for inter-professional team working are

* Understanding one’s own role, the roles of those in other professions, and using this knowledge appropriately to establish and meet patients’ goals
* Integrating and valuing, as a partner, the input, and the engagement of patients and families in designing and implementing care
* Understanding the principles of team dynamics and group processes to enable effective inter-professional team collaboration
* Understanding and applying leadership principles that support a collaborative practice model
* Communicating with other professionals in a collaborative, responsive responsible manner
* Actively engaging self and others in positively and constructively addressing inter-professional conflict (ibid):

Given the evidence supports that there are potential benefits for those who use services, for staff and for organisations from well-functioning teams a literature has emerged around measuring the effectiveness of health care teams (Buljac-Samardzic et al 2010) and a smaller body of literature exists which examines what interventions are associated with improvements in inter-professional team functioning. A 2009 systematic review of peer reviewed studies of interventions (training; the development of tools, such as, checklists and goal sheets; changes to the organisation context to facilitate team-based working) to improve inter-professional team effectiveness showed that there were studies which showed a positive association between all of the intervention types and team effectiveness (ibid). However, the studies with highest quality evidence quality related to the impact of various forms of team training on improved team effectiveness (ibid).

Salas et al (2008) examined the evidence of team training and team building on health care teams. They defined team building as a team intervention consisting of four components: goal‐setting, interpersonal relations, role clarification and problem solving. They cite an analysis of 20 studies demonstrating that team building had a moderate effect on team outcomes. Also, that team building interventions were most effective when a team’s performance was measured with affective outcomes i.e., measures of trust, confidence in team members, attitudes and process outcomes i.e., coordination, communication, adaptability (Klein et al 2009). Salas et al define team training as ‘a set of tools and methods that form an instructional strategy, which provide team members with the opportunity to practice skills and receive feedback in a rich learning environment’.

Salas et al cite a comprehensive meta‐analytic review of team training strategies, which looked at all types of team training (excluding team building). This meta‐analysis included 41 studies, which represented over 2,500 teams (Klein et al, 2008). The results indicated that team training was effective for improving team outcomes. The meta-analysis showed that “moderate to large effect sizes were calculated for cognitive, affective, process, and performance outcomes, and team training had a moderate and positive effect on team functioning” (Salas et al, 2008).

In summary, the research evidence suggests that team development, comprising of both team training and team building, has the capacity to contribute to the realisation of the significant potential benefits of team-based working in Children’s Disability Network Teams.

### varying practices nationally

The LIG Review Programme of 2015 and 2016 demonstrated significant variance in practice, most significantly in reconfigured CDNTs. The National Children’s Programme Oversight Group membership echoes this as areas strive in isolation to interpret the PDS principles and how they translate into the required new ways of working (for most clinicians) for an authentic child and family centred service. For example, in some cases, staff have not moved from unidisciplinary to interdisciplinary practice, critical to a family centred service model and yet, these teams may report their service model as being family centred.

### INCREASING DEMANDS, COMPLEXITIY OF NEED AND CARER EXPECTATIONS

CDNTs are experiencing ever increasing demands for their services, reporting up to 100% increase in rate of referrals over the past 3 years.

The profile of children and young people accessing CDNTs has changed substantially over the past decade. More children with significant disabilities and medical comorbidities resulting in more complex healthcare needs are surviving and surviving longer. CDNTs are reporting up to 80% of their caseloads to have an ASD diagnosis or presentation. Responding to these changing needs through continuous monitoring and development of required skills and competencies in our teams is vital.

As with the general public, carers are better informed and expect more from services at a time when demand and complexity is increasing. This puts additional pressure and stress on frontline staff working with children and families and on their managers responsible for that service provision.

### FINITE RESOURCES

Children’s Disability Services is not a demand led service and the staff resource allocated to the provision of children’s health and social care services is finite. An evidence based Team Development programme at this pivotal time will assist in optimizing health outcomes for children with disabilities and their families with the finite staff resources available.

### Significant Change Programme of PDS

Staff in pre-reconfigured disability services typically work exclusively with children with specific types of disability e.g. physical, sensory or intellectual disability or autism. Under PDS, all staff will reconfigure into CDNTs to provide services for all children with complex needs as a result of their disability. Whilst they have a high level of skill with one cohort of children e.g. those with autism, they may have little or no experience working with others e.g. those with physical disability. Whilst the Expression of Preference process in forming CDNTs will provide optimal skill mix across CDNTs with available resources, there will inevitably be gaps in competencies and levels of required experience to provide for this full spectrum of needs. Staff awaiting reconfiguration are anxious about meeting the needs of children they have no experience with and are keen to use opportunities to develop the knowledge and skills they know they lack. Parents are asking how staff in the new teams will meet their child’s particular needs, similar to that experienced in their current service aimed at their child’s type of need.

In addition, the move from current highly varied, mostly unidisciplinary, practice models to a nationally consistent understanding and approach to implementation of family centred practice in line with the PDS principles and that staff and parents support, will be a seismic change for both staff and families. The proposed Team Development Programme will provide a solid foundation to achieving this key objective, key to the sustainability of PDS in the longterm, in line with international best practice.

## PROGRAMME Scope

### CDNM and CDNT development Programmes

The Team Development Programme encompasses both a standardized national PDS induction and early development programme for CDNMs as incoming leaders of the CDNTs followed by a CDNT PDS induction and early development programme to be led by CDNMs with external support where not available within the HSE and HSE funded agencies.

### Programme limits

This national Team Development programme excludes:

1. Employer Organisation mandatory induction which remains the responsibility of the employer.
2. Lead Agency site specific induction which will be the responsibility of each Lead Agency.
3. Whilst the Working Group proposes a 3 phased Team Development programme, this document focuses on the first two: ***Pre-Reconfiguration*** and ***Early Post Reconfiguration Phases*** (see 5.3 for further detail)
4. HSE’s Manager Training Courses e.g. First time Managers as it is recognised that the full cohort of CDNMs will have different competencies, knowledge and experience. The current programmes are listed in the Team Development Portfolio (Link to HSELand PDS)
5. Staff Clinical Training: as this will be based on regular CDNT analysis of strengths and gaps, and training prioritised within available resources. To support this process, a comprehensive collation of training programmes informed by staff both pre-reconfigured and in CDNTs and managers has been built into the Team Development Portfolio.

## PROGRAMME BENEFITS

### CONSISTENT UNDERSTANDING OF FAMILY CENTRED PRACTICE

Filling of the CDNM posts and reconfiguration of the final CDNTs in 2020 provides an opportune time for the National Team Development Programme to drive a common understanding of Family Centred Practice as the cornerstone of PDS.

### Support achievement of PDS Objective: Equity of Access

A core objective of PDS is that children with a disability or development delay will have equity of access to services and supports regardless of what diagnosis they have, where they live or where they go to school. In providing CDNTs with a solid understanding of PDS core principles, model of service and national policies, including the National Access Policy, the Team Development Programme will enable all teams across the country to achieve equity of access and consistency in the model of service delivery across the country.

### Sustainability of PDS

The Team Development Programme will be underpinned by the establishment of the CDNM Forum as a *community of practice.* The forum will build on the foundation work of the National Team Development Programme deliverying Phase 3 (Post Reconfiguration from 9 months to 5 years post CDNT set up), providing a central point for sharing and driving consistent implementation of family centred practice models, problem solving, monitoring practice against core principles of PDS, and leading implementation of *Outcomes for Children and their Families, a Performance Management and Accountability System for CDNTs*.

### RESpeCTING AND VALUING STAFF

Priority 2 of the ***HSE’s People Strategy 2019 -2024*** (2019) states a meaningful and safe work culture exists where staff are engaged, feel valued, are emotionally connected, provide services they are proud of and are support to take responsibility for their own health and wellbeing. This National Team Development Programme funded by the HSE supports this priority.

### Value for Money

This National Team Development Programme promotes the effective, efficient use of resources through identification of

* existing training and expertise sharing within health services and
* external, evidence based, PDS aligned, training where required and not available within, as a national resource for CDNTs.

### SHARING & SPREADING GOOD PRACTICES MODELS NATIONALLY

This approach of a unified, standardized National Team Development Programme promotes the sharing and spreading of good practice models across all teams, a key objective of the National PDS Conference in 2017 and again in 2019.

Establishing a connection between the community of practice for CDNMs through the CDNM Forum and the CDNTs will provide for ongoing sharing of information, new ideas and experiences in children’s disability services.

## risks of not implementing a NATIONAL team development programme

### Risk for Children accessing a CDNT

* Risk of adverse effect: Loss of continuity of good quality service provision leading to reduced outcomes for the child and family progression
* Variable levels of specific competencies in teams with potential gaps due to lack of awareness of new developments in practice
* Lack of a common understanding of the core deliverables for a CDNT including family centred practice and the measurement of outcomes for children and their families
* Inconsistency of approach to service delivery in CDNTs across the country leading to inequities i.e. a challenge to the sustainability of PDS.

### 5.4.2 Risk for CDNT Staff

* Loss of confidence due to lack of skills
* Burn out, leaving for other services

### 5.4.3 Risk for hse and voluntary agencies

* Loss of confidence in the service amongst families leading to reputational damage
* Decisions on requirements for staff training by CDNMs on an individual and ad hoc basis, leading to inefficient use of resources
* Decreased attraction for Disability Services as employer of choice

# CDNT DEVELOPMENT PROGRAMME

## phased CDNT Development programme

The Working Group proposes a 3 staged Team Development Programme

* + 1. ***Pre-Reconfiguration Phase:*** the six months (minimum) lead in period to the actual day that staff commence as a CDNT (National Guidance on Reconfiguration under PDS 2014) is required for safe, effective reconfiguration planning and implementation, including preparing families and staff. Competency development and training prioritized for completion in this phase is considered critical and essential.
    2. ***Early Post Reconfiguration Phase:*** the first nine monthsfrom commencement of the CDNT. Competency development and related training prioritized here is considered urgent and important for completion once the team has been set up.
    3. ***Post Reconfiguration Phase:*** is the period from 9 months after team set up to 3 years and team development and related training identified here is deemed critical to sustainability of the new ways of working in line with the PDS model of service (**See Figure 1**).



**Fig. 1: National Team Development Programme – Proposed 3 Phases**

## 6.2 Core deliverables, competencies & training required by CDNTs

The Working Group used a process to determine the training requirements for CDNTs by starting with the twelve PDS principles and identifying the core deliverables for CDNTs under each principle.

The core competencies for the team were then derived from the deliverables along with the appropriate training required to ensure these competencies were developed and maintained. This process can be followed in **Table 1** below.

It is recommended that CDNMs use this table with their CDNTs in the Pre and Early Post Reconfiguration Phases to

1. support team development, in particular, in reaching a common team understanding of PDS principles and how they must inform development of the team’s model of service and supports, and
2. form part of the Strengths and Needs Analysis process (see 5.3) in identifying the competency gaps within the team and prioritising how they will be bridged.

|  |  |  |  |
| --- | --- | --- | --- |
| **PDS Principles and Core Deliverables for CDNTs**  **&**  **Required Competencies and Training to achieve the Core Deliverables** | | | |
| **Principle** | **Core deliverables**  **What will the team deliver?** | **Competencies**  **How will the team deliver this? What knowledge and skills are needed?** | **Training categories**  **(see link for full portfolio)** |
| **Bio-psychosocial model** | As far as is appropriate, teams will deliver a holistic service, taking account of the biological, social and psychological aspects of a child’s and their family’s life.  A service that works in partnership with families and the wider community to support and develop services and activities that achieve desired outcomes. | The team understands the bio-psychosocial model, and regularly reviews and reflects on their understanding and interpretation of the model  The team functions in line with the bio-psychosocial model  The team engages in family centred practice  The team integrates and works in partnership with the wider community e.g. local services, community groups | * Informing families * Children First * Network induction * PDS programme * Family centred practice * Communication with families/other stakeholders * PPPGs * Interdisciplinary team working * ASD diagnostic ax * Cognitive/developmental ax * Communication support * 24 hour postural mgt * Family support & progs. * Sensory integration * Sensory motor dev. * AT and AAC * Fine motor * FEDS/dysphagia/oral motor * Housing & adaptation * Specific medical * Motor mgt. * Neurodevelopmental interventions * Behaviour and emotional supports * ASD specific parent support * Working with a child with ASD |
| **Equity of access** | Access to services is according to the National Policy on Access to Services for Children with Disability or Developmental Delay 2016 (NAP), based on the complexity of the child’s needs rather than on diagnosis.  Prioritisation of referrals is according to the National Policy on Prioritisation of Referrals to CDNTs  Discharges and transfers is according to the National Policy on Discharge and Transfer from CDNTs | In depth knowledge and understanding of the NAP, including the purpose and operation of the ICSF, the National Policy on Prioritisation of Referrals for CDNTs and the National Policy on Discharge and Transfer for CDNTs  Members of the team who decide on referrals have the competencies in clinical reasoning required to make decisions on the most appropriate service to meet the child’s needs.  Working with other services e.g. mental health, Primary Care, Tusla to provide clear and integrated pathways including joint working | * Network induction * PDS programme * PPPGs * CDNM training * Admin staff training * Communication with families and other stakeholders |
| **Accessibility** | The service is delivered in an accessible environment.  The service provides information for families on services, community resources and children’s needs in a variety of accessible formats. | The knowledge and understanding to provide accessible services and appropriate environment taking into account the varying needs of the children and families and maximising the outcomes of intervention.  Provision of written information using Plain English as in HSE/NALA guidelines  Recognising the need for varying Communication with families and other stakeholders support for children and families and how to access alternatives | * Network induction * PDS programme * PPPGs * CDNM training * Admin staff training * Communication with families and other stakeholders * 24 hour postural mgt. * AT and AAC * Housing and adaptation |
| **Family Centred Practice** | The team will provide a service based on the priorities of the family for their child, through an IFSP.  Families are empowered through capacity building at universal, targeted and direct support levels in a timely manner  The team supports families to advocate on behalf of their child  The team delivers services in line with the Informing Families guidelines  Families are supported to identify and avail of the natural supports in their family and community | Knowledge and competency in delivering family centred practice.  Communication with families and other stakeholders skills, including listening,  negotiating and resolving conflict  Interpersonal skills  The skills to deliver universal, targeted and direct supports.  Understanding, knowledge and compliance with Informing Families guidelines    The skills to develop an effective IFSP  Setting goals with families | * Informing families * Children First * Network induction * PDS programme * Family centred practice * Communication with families and other stakeholders * PPPGs * Interdisciplinary team working * Multi-cultural training * CDNM training * Admin staff training * Family support & progs. * Housing & adaptation * Behaviour & emotional supports * ASD specific parent supports * Working with a child with ASD |
| **Interdisciplinary Team** | Services are team-based rather than individual discipline based.  The team shares information, decision-making and goal-setting.  The team operates in line with the Policy Framework for CDNTs.  The team has frequent opportunities for collaboration and Communication with families and other stakeholders and joint working | Understanding of interdisciplinary team working, including shared decision making, reflection, joint goal setting and intervention, service planning and service development  Effective Communication with families and other stakeholders  Interpersonal skills  Leadership for managers  Workload management  Flexibility and adaptability  Knowledge and understanding of others’ roles and responsibilities | * Lead agency training * Network induction * PDS programme * Family centred practice * Communication with families and other stakeholders * PPPGs * Interdisciplinary team working * CDNM training * Admin staff training * Family support & progs. * ASD diag.ax * Cognitive ax * Communication support * 24 hour postural mgt. * Sensory integration * Sensory motor dev. * AT and AAC * Fine motor * FEDS/dysphagia/oral motor * Specific medical * Motor mgt. * Neurodevelopmental interventions * Behavioural. & emotional support * ASD specific parent support * Working with a child with ASD |
| **Accountability** | The team delivers the service in line with the documented governance structure with clear lines of responsibility and reporting relationships.  The team will collect data in compliance with legislation and national guidelines.  The team will monitor and review performance to achieve national and area level KPIs.  Accountability is embedded in the culture of the team, the responsibility of all involved in service delivery, supported by written policies and procedures.  The team completes the CDNT Self Audit annually. | Understanding of responsibilities  Understanding relevant legislation, duties and obligations  Understanding what data must be collected  Assessing and managing risk | * Children First * Manual handling * Fire training * Network induction * PDS programme * Communication with families and other stakeholders * PPPGs * Multi-cultural training * CDNM training * Admin staff training * Family support & progs. * ASD diagnostic ax * Cognitive/developmental ax * Communication support * 24 hour postural mgt * Family support & progs. * Sensory integration * Sensory motor dev. * AT and AAC * Fine motor * FEDS/dysphagia/oral motor * Housing & adaptation * Specific medical * Motor mgt. * Neurodevelopmental interventions * Behaviour and emotional supports * ASD specific parent support * Working with a child with ASD |
| **Inclusion** | The team supports the inclusion of children in their community  The team supports the maximisation of children’s independence.  The team facilitates each child’s participation in home, school and community.  The team works in partnership with schools to promote maximum inclusion | Skills in empowering families in promoting their child’s independence  Knowledge of community resources and facilities  Building good relationships with the community  Empowering families to encourage their child’s participation in mainstream activities  Knowledge of services provided by DES, NCSE and DCYA | * Informing families * Behaviour & emotional supports * Family support & progs. * Family centred practice * Network induction * PDS programme * Communication with families and other stakeholders * PPPGs |
| **Early Identification and Referral** | The team provides a clear pathway to services which is easily understood by parents and other referrers.  The team provides assistance for those who come in contact with children of all ages to make appropriate referrals.  The team responds efficiently to referrals | Understanding and compliance with NAP  Provision of written and verbal information for those who have concerns about children to make appropriate referrals | * Network induction * PDS programme * Admin staff training * PPPGs * Communication with families and other stakeholders * ASD diagnostic ax * Cognitive/developmental ax * Communication support * 24 hour postural mgt. * Sensory integration * Sensory motor dev. * AT and AAC * Fine motor * FEDS/dysphagia/oral motor * Specific medical * Motor mgt. * Neurodevelopmental interventions * Behaviour and emotional support * ASD specific parent support |
| **Clinical Governance and Evidence Based Practice** | The team members comply with quality and safety standards, lines of accountability, performance management structure with clinical supervision and their professional codes of practice.  The team members ensure that they keep up to date with on-going research that informs new practices and to continuously develop their professional knowledge and skills.  The team identifies and accesses specialist supports for training, consultation and direct intervention in areas of exceptional complexity as per Guidance on Specialist Supports 2016.  The team conducts a regular audit of practice and competencies | Understanding and compliance with team’s clinical supervision policy  Understanding and compliance with Performance Management policy  Understanding and compliance with quality systems in place  Knowledge and understanding of compliance with professional registration  Assessment of children who have the full range of complex needs and their families  Intervention with children who have the full range of complex needs and their families  Knowledge of specialist supports, when and how to access them.    Enhancement of service delivery through audit of practice and competencies and team review | * Children First * Informing families * Network induction * PDS programme * PPPGs * CDNM training * ASD diagnostic ax * Cognitive/developmental ax * Communication support * 24 hour postural mgt. * Sensory integration * Sensory motor dev. * AT and AAC * Fine motor * FEDS/dysphagia/oral motor * Specific medical * Motor mgt. * Neurodevelopmental interventions * Behaviour and emotional support * ASD specific parent support |
| **Cultural Competence** | The team recognises each family’s unique cultural differences and diversity  The service takes into account people’s different beliefs, behaviour and needs | Knowledge, attitudes and skills to understand and appreciate cultural differences, including the varying cultural norms of child development and rearing practices | * Network induction * PDS programme * PPPGs * CDNM training * Multi-cultural training * Communication with families and other stakeholders * Family support and progs. |
| **Staff are valued and respected** | The team operates a mutually respectful environment between themselves and with families.  Team members comply with dignity and respect at work policies.  Team members are supported by management and governance structures. | Understanding and compliance with dignity and respect in the workplace policies and codes of conduct.  Knowledge and understanding of other team members’ roles and responsibilities  Self-awareness and how behaviour and attitudes impact others  Management of change  Resilience  Flexibility  Workload management  Time management  Conflict resolution  Awareness of cultural differences  Awareness to promote a culture of health and wellbeing within the team | * Mandatory training * Lead agency induction * Network induction * PDS prog. * Team development * Interdisciplinary team working * PPPGs * CDNM training * Admin staff training * Communication with families and other stakeholders * Multi-cultural training |
| **Evaluation of Outcomes** | The team operates a standardised national outcomes-focused approach (OCFF) to the delivery of services and supports for each child and their family in accordance with their needs and priorities | Goal setting with families  Developing and working with IFSPs  Recording and collecting data on outcomes for children and families  Making returns for local, CHO and national management  Enhancement and improvement of service through reflection on outcomes for children and families | * Network induction * PDS programme * PPPGs * CDNM training * Family centred practice * Interdisciplinary team working * Communication with families and other stakeholders |

**Table 1: PDS Principles, Core Deliverables and required Competencies and Training to achieve the PDS Core Deliverables**

## 6.3 Training prioritised based on CDNT Strengths & Needs Analysis

The CDNM should complete a Strengths and Needs Analysis with the team against the required competencies on a regular basis to identify any critical gaps and, where they arise, the training required to address this. This measure is a means to ensuring all CDNT members have the knowledge and skills to undertake their work effectively and competently. A Strengths and Needs Analysis will enable CDNMs to direct finite resources into areas where they will contribute the most to bridging critical competency gaps and to CDNT development and performance to support them in implementation of the PDS framework, a key component in ensuring the delivery of a quality services.

Training should not be viewed in isolation by individual staff but as a key element in the overall implementation of the PDS framework by the team, which is monitored and evaluated to ensure continuous improvement. The CDNM and the team in deciding on training requirements and how many team members should complete any particular training, must consider:

* The current needs of children and families in their Network, including considerations of demography, geography and current service demands
* Staffing and disciplines currently on the team
* Existing staff competencies and whether they are sufficient to meet the current needs

A comprehensive Team Development Portfolio has been developed in excel as a resource for CDNMs and their teams which clearly lays components of induction, ongoing team development and clinical training, linked back to specific competencies, core deliverables and principles of PDS, where they are available within health services, on HSELand and external providers. It captures all known training and their links back to deliverables of the principles of PDS (link).

The named external training courses should not be regarded as a list of required training but as alternatives for managers and the team to consider when a gap is identified within the team. For instance, a number of parenting programmes are listed but the team should decide which of these the most appropriate programme to meet their needs is.

The training and clinical categories section is concerned with specific areas of competency which can be supported by sharing of knowledge within the team, across teams within the network, by mentoring and by external training courses. Each of the 17 sections names a particular area of expertise and support for children and their families, and a variety of related training opportunities to address this area.

## CDNT Development programme Structure

The CDNT Development Programme is divided into

1. CDNMs (Managers) Development Programme, including PDS Induction
2. CDNTs (Staff) Development Programme, including PDS Induction

This recognises that whilst the CDNM is a critical player on the CDNT, CDNMs will have additional specific training needs as leaders of their CDNTs.

### content of **Managers** Development programme

The commencement of 87 CDNMs in this new role simultaneously is recognised as a unique opportunity to ‘start as we mean to go on’, i.e. before individuals bring with them old ways of working, we take this time to gain a collective understanding of the PDS Programme, principles and authentic child and family centred practice from the start. It is a new beginning for PDS! To this end, the working group proposes the CDNM Development Programme of Phases 1 and 2 are front loaded to be delivered 1 day a week over 5 consecutive weeks on commencement in the role (see **table 2** below on page 28).

In the eventuality that all CDNMs do not commence within a 4 week period, this CDNM programme should be delivered in 2 batches, potentially January and March of 2020. Care must be taken to ensure a mix of experience including existing managers of reconfigured teams, backgrounds, agencies, disciplines and geographical locations in each group. This programme must be mandatory for all CDNMs. Each new manager should confirm their availability on agreement of their start date.

On commencement in their new role, all CDNMs will be provided with an electronic *Essential Pre Team Development Programme Reading Pack* to be read in advance of Day 1: PDS induction. A hard copy will be provided on day 1.

A standardised PowerPoint presentation will be developed for the programme which CDNMs will, in turn, use as relevant in delivering their CDNT Development Programme (see 6.2 below)

**Managers Programme:**

**Phase 1: Pre-Reconfiguration of CDNT**

**Day 1: PDS Induction** along with the substantial *Pre Team Development Programme Reading Pack* will provide a comprehensive foundation on key components of the PDS Framework document as well as an invaluable resource for each manager’s preparation and induction of incoming staff to their CDNTs, particularly in the 6 months pre-reconfiguration phase.

**Day 2: Workshop on Family Centred Practice (FCP)**: FCP is the tenet of PDS and the objective of this national CDNM Workshop is to ensure amongst all CDNMs a shared understanding of FCP and the significant change in practice required by staff of CDNTs. CDNMs, as the leaders of this change nationally, need to develop this common understanding together in order to support each other in leading this change in a consistent way across all 138 teams nationally.

It is proposed that this workshop be developed by the Team Development Programme Working Group in partnership with an existing Midwest Team Manager and Midwest Project Team currently piloting an initiative on FCP. The benefits of a reconfigured team manager leading this workshop and incorporating the learning, successes and ongoing challenges of the seismic change to a family centred service for CDNTs in the Midwest initiative will provide that lived experience for each CDNM, regardless of their background and experience to date.

**Day 3: Inaugural CDNM Forum/Workshop** will comprise

1. a half day change management workshop to be delivered by a HSE Learning Education Training Development (LETD)/Organisation Development (OD) collaboration as a shortened version of a 2 day programme being finalised for all managers who will be involved in roll out of new HSE Regional Integrated Community Organisations (RICOs) and
2. a half day workshop on CHO PDS Implementation Plans, progress against targets, challenges and plans for addressing same to be facilitated by the Team Development Programme Working Group.

**Day 4: CDNM Development Day:** including resilience and solution focused interventions training identified by existing managers of reconfigured teams as an excellent return on investment to support managers on development of management and resilience strategies for them and their teams. This day will include a focus on communication strategies, conflict management and coaching and supervision of multidisciplinary teams, a new experience for many CDNMs.

**Day 5: Workshop on Implementation of the National Access Policy (NAP)** is deemed critical for the CDNMs to complete together, to reach a common understanding of the policy and what is required to implement it appropriately. The workshop will include reviews of anonymised referrals in multidisciplinary groups and use of the NAP Decision Support Tool in supporting identification of the most appropriate service for each child. This will support CDNMs in consistent implementation of the NAP to drive the PDS key objective, equity of access.

**Phase 2: Early Post Reconfiguration** (first 9 months of CDNT in operation)

**Day 6: CDNM Training** as Facilitators of Resilience and Solution Focused Approaches to enable them to support their staff in remaining resilient under rising pressures (see 4.1.4 – 4.1.6). CDNTs and managers who completed this training have confirmed it as excellent value for money in optimising team functioning, and achieving team objectives and sustainability.

**Phase 3: Post Reconfiguration** (from 9 months to 3 years of CDNT in operation)

**Outcomes for Children and their Families:** Training to support consistent approach to implementation of OCFF nationally will be developed by the CDNM Forum in collaboration with the National OCFF Implementation Subgroup of NCPOG.

### content of **staff** Development programme

The proposed 2 day training programme for CDNTs must be delivered in Phase 1 Pre-reconfiguration, commencing a minimum of six months prior to the CDNT’s intended start date. This is critical according to CDNTs already reconfigured.

**Staffs’ Programme:**

**Phase 1: Pre-Reconfiguration of CDNT**

**Day 1: PDS Induction** will be delivered by each CDNM for all CDNTs in their remit. It will provide a comprehensive foundation on key components of the PDS Framework document and together with the *Essential Pre Team Development Programme Reading Pack*, it will be an invaluable resource for CDNTs in the first three years of development.

**Day 2: Workshop on Family Centred Practice (FCP):** it is proposed that, as for the CDNMs Day 2, this ‘starter’ 1 day workshop on FCP for staff of CDNTs be developed by the National Team Development Programme Working Group with an existing Midwest Team Manager and Project Team piloting an initiative on FCP. Options for delivery of this workshop in the 8 remaining CHOs would be explored to ensure optimal access to this key learning, critical for developing FCP in each CDNT. A number of staff from each CDNT participating in this CHO based workshop will be an additional resource to support CDNMs in driving the required systems and process changes as well as hearts and minds at CDNT level to develop an authentic family centred service.

**Additional Competency Development/Skills Sharing Days** will be identified and arranged by each CDNM, based on the EOP process where staff will identify their competencies, knowledge and experience working with various cohorts of children with disabilities and their gaps in working with the full spectrum of needs as required of a CDNT and a Strengths and Needs Analysis completed by the CDNM with their incoming CDNT. Reconfigured teams stress the importance of ‘Pre-reconfiguration Team Development Days’ where soon to be CDNT members come together to share skills, supports, knowledge and training to address those gaps in advance of the CDNT commencing service. This will be CDNT specific based on the combined strengths and development needs of the staff.

**Phase 3: Post Reconfiguration** (from 9 months to 3 years of CDNT in operation)

**Resilience Training & Solution Focused Interventions Workshops:** Team Development work led by CDNMs, including strategies for sustaining teams

**Outcomes for Children and their Families Training** led by CDNMs & informed by National OCFF Implementation Working Group.

# rESOURCES REQUIRED beyond that available within Health Services

It is acknowledged that a National Team Development Programme requires an amount of ‘time off the floor’ which incurs indirect costs. The evidence and learning from the 54 CDNTs on which this proposal is based demonstrates why this programme is required as a minimally safe level and content for roll out of the 87 CDNM posts and final CDNTs, and to commence the development of consistent services nationally aligned to PDS core principles and sustain them into the foreseeable future. The direct costs of the National Team Development Programme are outlined as estimates in **Table 3** (page 29) while final external programme proposals and quotes for Resilience Training & Solutions Focused Interventions are being scoped.

|  |  |
| --- | --- |
| **Breakdown of Phased National Team Development Programme** | |
| **Children’s Disability Network Managers** | **Children’s Disability Network Teams** |
| **Phase 1 – Pre-Reconfiguration**  (6 months minimum pre commencement of CDNT ) | **Phase 1 – Pre-Reconfiguration**  (6 months minimum pre commencement of CDNT ) |
| **Day 1:**  **PDS Induction** nationally standardised & delivered by NCPOG | **Day 1:**  **PDS Induction nationally** standardised and delivered by the CDNMs |
| **Day 2: Workshop on Family Centred Practice**  developed by NCPOG in partnership with and delivered by an existing reconfigured team manager and Midwest Project Team. | **Day 2: Workshop on Family Centred Practice x 8 CHOs**  developed by NCPOG in partnership with and delivered by an existing reconfigured team manager and Midwest Project Team. |
| **Day 3: Inaugural CDNM Forum**:   1. **Change Management Workshop** developed by LETD/OD with NCPOG &   **2. PDS Implementation Plans Workshop** | **Required Pre-Reconfiguration Training Days:**  **Critical Competency Development/Skills Sharing Days** as identified by CDNMs with their incoming staff through   * Expression of Preference Process and * Strengths & Needs Analysis of the CDNT   being established. |
| **Day 4: Resilience Training & Solution Focused Intervention**  to include communication, conflict management, coaching and supervision of multidisciplinary teams. |
| **Day 5: Workshop on Implementation of National Access Policy** |
| **Phase 2 – Early Post Reconfiguration Combined**  (first 9 months of CDNT in operation) | **Phase 2 – Early Post Reconfiguration Combined**  (first 9 months of CDNT in operation) |
| **Day 6: CDNM Training as Facilitator of Resilience & Solution Focused Interventions** | **Critical Competency Development/Skills Sharing Days** continue to address gaps identified in Phase 1. |
| **Phase 3:** Nine months – 3 years Post Reconfiguration | **Phase 3:** Nine months – 3 years Post Reconfiguration |
| **Outcomes for Children and their Families:** Training to support consistent approach to implementation of OCFF nationally will be informed by the National OCFF Implementation Working Group. | **Resilience & Solution Focused Interventions:** CDNM led skills and strategy development  **Outcomes for Children and their Families:** Training, led by CDNMs & informed by National OCFF Implementation Working Group. |

**Table 2: Breakdown of Phased Team Development Programme**

# Quality Assurance Process for ORGANICALLY DEVELOPED PROGRAMMES

The inaugural National PDS Conference *Working with Children and their Families* in 2017 showcased so many examples of home grown, evidence based programmes, based on identified needs of children with disabilities and their families. Some were based on internationally accredited training programmes, contextualized for the Irish setting. The Working Group sought to explore a quality assurance pathway for such programmes in recognition of the excellent developments by front line staff and to encourage more of this practice. This is not an essential prerequisite for staff delivering such programmes.

One optional quality assurance pathway identified by Dr Louise Doyle, General Manager, Leadership Education and Talent Development HSE, for programmes developed by CDNT staff is described below.

**Internal HSE National Programme Review Group**

1: Set up a National programme Review Group to provide governance for the programme and its development.

2: Develop the business case for the programme

3: Develop a curriculum document for the programme.

4: Develop the programme materials

5: Review and signed off the programme materials.

6: Develop the evaluation process for the programme which is agreed and included as part of the curriculum document.

**Schedule of National Programme Review Group:**

* The programme group meets a number of times in the year to review how the delivery of the programme is progressing and to review evaluations.
* Agendas and minutes of these meetings are maintained.
* Any changes to the programme content need to be proposed at these meetings and agreed.

**Standardisation of Approach:**

* All programme facilitators to use the agreed national programme agreed content so that all participants receive a consistent experience.
* If required, a session for facilitators is organised to ensure all are  familiar with the programme before delivery starts.

**Accreditation through professional bodies**

* Once these courses have been reviewed by the National Programme Review Group, then they can be submitted to each discipline body for sign off for CPD credits.

**Seek Accreditation through QQI (Quality and Qualification Ireland)**

For an internal programme that meets the standards of the National Programme Review Group, the programme can be sent to QQI for review and to be awarded with a QQI level of accreditation. This process would follow rigorous reviews to meet the standards of QQI.

QQI has developed Core QA Guidelines for use by all providers of higher and further education and training including organisations like ourselves in the HSE.

All providers will have regard to the QQI Core QA guidelines when developing their internal quality assurance procedures. The guidelines do not however prescribe the manner in which providers must implement those procedures. HSE LETD is in consultations with QQI to further investigate what this quality assurance process might entail and how it would be applicable to the various different courses in the area of Disability Services in the HSE.

# CDNM Forum AS A COMMUNITY OF PRACTICE

The Working Group commends that the CDNM Forum, set up as a community of practice under this National Team Development Programme, continue as a formal structure to continue to

* drive implementation of PDS in a consistent manner nationally
* support on-going team development and performance management,
* lead the implementation of the OCFF across their networks
* provide a forum for shared practice developments, identification of challenges and standardised approaches to resolution where appropriate
* develop national policies and
* inform and advise HSE National Disabilities as required..

# appendices

## RECOMMENDATIONS OUTSIDE THE WORKING GROUP’S TERMS OF REFERENCE

|  |  |  |
| --- | --- | --- |
| **No.** | **Item** | **For** |
| **1** | Consider recording parent staff/ member enlightening dual perspective presented at Conference 2017 as part of FCP training for CDNMs and CDNTs | Team Development WG |
| **2** | * After initial mandatory training by employer, CDNT staff complete update mandatory training as a team under Lead Agency responsibility   + Training to be delivered by employing agency vs Lead Agency to be specified in the Interagency Agreement Template | Interagency Agreement Template |
| **3** | CHO Reps gather good practice models/policies/guidelines/pathways from existing CDNTs :   * Family Centred Practice * Interdisciplinary Practice | NCPOG |
| **4** | **National PPPGs Prioritization** for CDNTs in early phase of team development. | NCPOG |
| **5** | **National PDS Information Leaflet** for staff to have readily available verbally and in writing for families/other stakeholders on the PDS model and supporting evidence | NCPOG |
| **6** | **PBS: National Guidance and Stepped Approach/Pathway**  similar to KWW ***Listening & Responding to Behaviours of Concern*** for roll out nationally | CDNM Forum |
| **7** | **CDNM Pre Course Approval Questionnaire** for CDNT member e.g. is this programme in line with PDS principles | CDNM Forum |
| **8** | **Report Writing** **Guidance and Template** should be developed in collaboration with HODs/ Professional Bodies/Disabilities Group, taking Conference 2017 Presenter learning on board and ensuring format and content meet SU/parent/family/professional need | CDNM Forum |
| **9** | **National Key Worker Guidance** | CDNM Forum |

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