THE PERFORMANCE PARTNERSHIP LTD.

Report on the Review of the Network Disability Team Service for Kildare – West Wicklow

Provided by

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Results focused Organisation Development

Table of Contents

Sections	Pages
Executive Summary	3 - 5
Introduction –Terms of Reference	6
Methodology	6 – 7
Data Collection	8 - 9
Overview of the NDT Development Timeline	10 – 11
Review of Comparator Services	12 - 15
Main Review Findings	
Field One: Effectiveness of NDT – 2016	16 - 35
Filed Two: Organisation, Systems and Efficiency	36 - 43
Field Three: Quality Assurance and Feedback	44 - 46
Field Four: Development of Service Capability	47 - 49
Field Five: Organisation Structure and Corporate Governance	50 - 56
Appendices 1. Summary of Recommendations 2. Comparator Service Enquiry Areas 3. Stakeholder Survey Formats 4. Survey Qualitative Feedback Summaries 5. Resource Modelling Outline Framework	 58 – 68 69 – 71 72 – 88 89 – 94 95

Executive Summary of Kildare West Wicklow Network Disability Team Service Review

The review of the Kildare – West Wicklow NDT Service was conducted between June 2016 and May 2017. The objective of the review was:

- To identify what is working well in the Service
- To identify what is working less well in the Service
- To take a timeline perspective on how the Service is evolving
- To make recommendations as to how the Service may be improved

The review used a multi –method, stakeholder focused evaluation approach covering six primary strands:

- Timeline Appreciation of Service Development
- Effectiveness of the Service
- Organisation & Efficiency of the Service
- Customer Feedback and Quality
- Service Capability Development
- Governance & Accountability

The Kildare – West Wicklow NDT Service commenced in mid – 2014 and the bulk of the data collection for this service review was conducted in mid to late 2016. So effectively the service is only now entering into a consolidation phase at this point in time.

The service has made significant positive progress since its establishment in integrating staff from five different employer organisations, establishing three team locations, developing a suite of Polices & Procedures and establishing a family – centred service model in line with the PDS national framework. Since its inception, the NDT service has expanded the number of families, who have a child with a significant disability, that are receiving a specialised support service.

Significant resources have been put into increasing staff numbers within the service but the service has had difficulty providing continuity of service to families because of high levels of staff turnover and an inability to fill vacancies quickly or provide timely cover for maternity leave. In its relatively short operational history, the service has shown a high degree of responsiveness and flexibility and has demonstrated the capacity to learn and adapt its service configuration to better meet needs within the resources available to it.

From a service effectiveness perspective, the service is providing a wide range of intervention and supports within the Early Years programme. The service at this program level is delivered on a planned multi-disciplinary basis in partnership with the family and underpinned by a regular Family Service Plan [FSP]. The relevance and structure of this service is generally well regarded by families, although there are concerns about how well the individual plans are followed through on.

The feedback on the School-age programme level is much more mixed. Schools that do receive support from the NDT service rate the specific intervention supports positively but can find access difficult to organise. The collaboration between the NDT and the school system is responsive in nature and based on goodwill. Arguably this reduces the systemic opportunities to have an integrated approach to supporting the child's development across natural settings.

A substantial proportion of families [Up to 33%] indicate that their needs are not being met by the school age service. There are a number of factors at play here, the primary one being that the service tends to be more reactive in its delivery posture, responding to issues that families raise rather than providing a planned and comprehensive support process for each family. Many families need a more planned, proactive and comprehensive support and this seems to be particularly the case for families with children on the ASD spectrum and a small number of children with life-limiting physical disability issues. Many of the families with children on the ASD spectrum have been passed around services on waiting lists and have not experienced the benefits of an early intervention programme. They typically have multiple needs including a closer level of support and are often not able to specify exactly what their priority needs are. These families need a multi-disciplinary close support approach with access to a range of resources including home support/respite not all of which are within the remit of the NDT.

A challenging aspect of the service delivery context is matching resources to the level of needs and the growing demand for services as evidenced particularly in the school age service. The NDT service has had additional staffing but this has been uneven across the disciplines and so there are substantial waiting times to access the support of some disciplines. It is predictable that, on current demand trends and with the staff resources available to the service, the school age service in particular will not be able to adequately meet the support needs of all families within the service.

The service also has considerable room for improvement in terms of facilitating access to the team and improving basic communication protocols. There is no doubt but that the service is under-resourced on the administrative front, as this element has not kept pace with the growth in clinical staff numbers.

While extra clinical resources have been put into the teams, there has also been a lot of attrition as promotion opportunities have started to open up elsewhere in the health services. An unintended consequence is that there are substantial training needs arising within the teams and a deficit in clinical practise leadership. This report recommends an enhanced career structure, formal practise development systems and an injection of resources to boost in-service training of staff.

However, the service also has a fundamental weakness in its systemic management practices in that there is no formal activity tracking process and little systematic collection

of outcome data. It is not sustainable in the long term, to look for more service resources, when there is no systematic data collection process to evidence how current resources are deployed or their link to service outcomes. Two priority recommendations are that the 1] the service develop a robust activity tracking system and 2] that building on this – a resource modelling exercise is undertaken to establish the relationship between family support needs, core service activity areas and resourcing requirements.

The service also needs to put in place a formal system for collecting regular feedback from families on their experience of the service. Family access and representation should be enhanced at all levels of the service and the addition of family representation to the Steering Group is a welcome development in this regard.

The coming together of 5 provider organisations, to provide a single service has been a major task with many systems, practice and cultural challenges. Having said this, we found that there is a positive and cohesive team climate and great credit is due to the Team Managers for their contribution to building & sustaining collaboration and morale.

However, there is a legacy of tangled reporting and accountability relationships that impede both effective performance management of the teams and effective clinical supervision. In the report we make recommendations on how the management and clinical supervision systems can be configured on a more structured and sustainable basis.

Finally we recommend that the service needs to be operated and managed more deliberately as a single integrated service entity rather than as three largely self sustaining teams. In our view, this will improve the consistency & standardisation of service processes and make the best use of the available clinical resources. The review raises longer term implications on determining the best option for how the overall service is configured, resourced and led.

A set of observations on lessons learned for the wider development of policy and services nationally is presented as a separate document.

Section 1.0: Introduction –Terms of Reference

The Network Disability Team service for Kildare – West Wicklow was established in 2014 in accordance with the new government strategy on Progressing Disabilities.

The review of the Kildare –West Wicklow NDT Service was commissioned in May 2016.

The terms of reference were to review the service with stakeholder involvement in order to identify:

- What is working well
- What is not working so well and needs to be improved
- What other issues need to be addressed

Section 2.0: Methodology

The service review used the following service evaluation methodology:

Element 1: The Overall Service Evaluation Framework

The desirable criteria for a service programme are that it is effective, efficient, responsive and progressive:

- **Effective**: Does the service achieve its primary purpose and meet its objectives on a consistent basis?
- **Efficient:** Does the service deploy the resources at its disposal in a manner that generates the best volume and value of outcomes from the resources deployed?
- **Responsive:** Does the service collect information about the needs of its customers and keys stakeholders on an ongoing basis and does it adapt successfully to meet these needs?
- **Progressive:** Does the service operate systems and processes to continuously develop capability & capacity in line with best practice and emerging needs & requirements?

Element 2: Organisation Structure and Corporate Governance

The service was established as a partnership between the HSE and a number of voluntary service providing agencies. The HSE has a dual function within the NDT service as it provides staff for the service but it also provides the overall funding for the service on a direct and indirect basis. The NDT service is overseen by a Steering Group comprised of senior representatives from the participating service agencies. The review evaluates the organisation structure, governance arrangements and management accountabilities.

Element 3: A Timeline Perspective on the Service

The review takes into consideration that the service was only set up in May 2014 and it has been on a development pathway since then where programmes, staffing, systems and processes have had to be established, policies & procedures developed and service activities consolidated and stabilised. This Review is a snapshot in time on the service's developmental progression.

The full service review framework is set out in the table below:

<table>
<tr><th colspan="3">Service Review Framework</th></tr>
<tr><td>Field 1: Effectiveness</td><td rowspan="4">“A service that meets its primary objectives in an effective, accountable and efficient manner; learning from its client & staff experience and external best practise to implement continuous improvements and develop capacity to meet future needs.”</td><td>Field 2: Organisation & Efficiency</td></tr>
<tr><td>How well the service meets its objectives
How well the service works against its underpinning service model
The impact, outcomes & outputs of the service</td><td>How the service is organised
How resources are allocated & deployed
How service activity is tracked & recorded
How efficiently it uses the resources that it has</td></tr>
<tr><td>Field 4: Service Development</td><td>Field 3: Quality Assurance & Feedback</td></tr>
<tr><td>Strategic planning for the future
Development of the service model
Development of staff capability
Enhancement of systems and methods</td><td>How the service measures quality
How the service improves quality
How the Services collects feedback from its key stakeholders</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Field 5: Organisation Structure and Corporate Governance</td></tr>
<tr><td colspan="3">The review evaluates the adequacy of the organisation structure, governance arrangements and management accountabilities.</td></tr>
<tr><td colspan="3">Field 6: A Timeline Perspective on the Service</td></tr>
<tr><td colspan="3">The review takes into consideration that the service was only set up in May 2014 and it has been on a development pathway since then so this review is a snapshot in time on the service’s developmental progression.</td></tr>
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Section 3.0: Data Collection:

The following data collection methods were used in the review:

3.1: Getting the Family Perspective:

Survey with Families who use the service:

This was a postal survey run from September to November which was returned directly to the Reviewer. In total 117 families completed the postal survey. Families also had the option of completing the survey online and 28 families completed this format. So a total of 145 completed.

Family Survey Descriptors [Total number = 145]							
Breakdown by Age:			Early Years	41	School Age		104
Breakdown by Diagnostic Category:							
ASD	74	I.D.	28	P.D.	31	Other	12
Breakdown by Location:							
North Tm.	45	Mid-Tm.	54	South Tm.	41	Unknown	5
Note: Technical Point	**With a service population of 1200, this gives an error margin of +/-7.5%**						

File Review with a cohort of service users who entered the service 18 – 12 months ago

In the absence of service activity tracking data sets; we conducted a limited file review of a cohort of children across the 3 teams who had come into the service at a similar time point [N=25].

This did confirm the planned sequence of intake activities leading into the initial Family Service Plan and variable patterns of subsequent family support activities.

Note: The file review itself illustrated the lack of standardisation across the 3 teams in how service activity is tracked and recorded.

Focus Groups with Families

We held a series of Focus Groups with families to further explore the themes that were emerging from the Family Survey. These focus groups were held during the day and also in the evening to facilitate attendance. A total of 8 focus groups were held and 138 parents attended.

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3.2: Getting a School Perspective

Survey with Schools in the area

We developed and sent a post survey to all the schools in the catchment area. This survey was returned directly to the Reviewer. 56 completed surveys were returned with some schools having

more than one respondent [E.g. Principal and class teacher]. Four of the surveys returned did not know anything about the service and were blank.

3.3 Getting the Service Staff Perspective

Survey with all Staff

An online survey was made available to all staff and 54 responses were completed. The feedback from this survey informed the main enquiry areas for the subsequent staff focus groups.

Focus Groups with Staff

We held 5 semi-structured focus groups with staff in November 016 – January 017, which built on the key themes emerging from the staff survey and covered what is going well, less well and their views on how issues of concern & areas for improvement might be addressed

3.4 Getting the Service Management Perspective

Joint Interview with Team Managers

We had an initial briefing session with the 3 team managers to get an overview of the service, its development from set up in 2014, current status and prospective issues still to be addressed.

Individual Structured Interviews with the Team Managers:

We held 2 subsequent individual interviews with each team manager to get a more in depth understanding of how the main team systems and processes operate, what is going well & less well, key areas for improvement being addressed & still outstanding and their views on the team manager role.

3.5 Getting the Steering Group Overview Perspective

Survey and Individual Phone Interviews with Steering Group Members

An email survey was sent to all Steering Group members and was completed by all but one member. The survey was followed up by an individual phone interview with each respondent.

This phone interview followed up on the points that the Steering Group member made in their survey response and explored their thinking on emerging themes from the review.

3.6: Review of Activity Figures for the last 12 months

We had access to the service activity data set for the last 12 months which is sent on a regular basis to the Steering Group. [This comprises: waiting list & intake numbers, numbers of cases active in the services, numbers referred on or discharged, complaints, risks identified and staffing information]

3.7: Desk Research & Review of Comparator Services:

We conducted desk research on the Progressing Disabilities key documents trail and also reviewed other NDT policy and guidelines documents.

We visited and did a structured 0.5 day briefing session with the managers of the Mid West NDT Service.

Section 4.0: Overview of the NDT Development Timeline

The NDT service for Kildare West Wicklow was established in 2014 after a period of inter-agency planning and family & stakeholder consultation. The NDT service is a collaborative partnership between the HSE Children's Service, HSE Beech Park Service, St John of God's Children's Services, KARE, Muriosa Foundation and Enable Ireland.

The NDT Service is formed into 3 NDT teams for North, South and Mid –Kildare in three separate premises. Each team has a Team Manager and is constituted on an multi-disciplinary multi-agency basis. All teams have a core of Psychology, Social Work, Speech & Language Therapy, Occupational Therapy and Physiotherapy. There is also a Specialist Nursing and Social Care Worker element in some teams.

The NDT Service operates according to a Family centred and Bio Psycho-Social Model and follows the set –up and operational guidelines recommended by the Progressing Disabilities Implementation mechanism.

The accountability framework for the NDT Service is that the three NDT teams report in via their Team Managers to a Steering Group which is constituted of Senior Managers from the participating agencies and chaired by the HSE Disability Service Manager.

Since its inception, the NDT Service has developed Policies & Procedures and a structured standardised intake protocol. At the heart of the service is the Family Service Plan [FSP] which is an interdisciplinary planning partnership with each family to identify and address the support& development goals that are most important for the child & family. The NDT Service offers a range of interventions and supports to deliver on the FSP including parental training, guidance and support in individual and group formats, interdisciplinary assessment & guidance on development and group work with children and parents.

From our contact with families and staff; the interpretation of the Family – centred, Bio Psycho-Social model seems to be that the service focus is on facilitating the child's development through family enablement, empowerment, education and support rather than on intensive individualised therapy with each child in clinic settings.

The NDT service is split into two constituent sub- services: Early Years Service for children up to starting school and then a School Age Support Team up to eighteen [or school leaving]. Service staff are generally assigned to one of the two service areas.

At its inception, the families that were already using services from the participating agencies were allocated into one of the three teams based on geographical criteria although allowance was made for some family's wishes to remain with a team that most closely constituted their previous service. We understand that staff preferences were also taken into account in the staffing makeup of the three teams. Since the service start-up there has been a considerable growth in the staffing complement of the service.

Our View on the Service Status at the Time of the Review in 2016:

The NDT Service has made significant progress since its inception. It has largely delivered on the planned service model although this is not without its complications. It has developed a wide range of service provision and there is positive feedback on the service from families, schools and other stakeholders.

There is now a suite of Policies and Procedures in place across the service and the intake & FSP process operates in a semi – standardised manner across the three teams and the two sub-service areas [Early Years and School=Age]

The three Team Managers operate in a collaborative and complementary manner that facilitates shared approaches, problem solving, good communication and support. They also receive positive support from the HSE Manager Disability Services.

We believe that there is a high level of staff commitment and professionalism within the service which is reflected by very positive feedback from families and schools. See Appendix One Summary of survey feedback from schools and families.

However not all of the feedback on the service is positive and there are a number of unresolved issues that are legacies of the initial service set up process. We see that the NDT Service is now entering a phase of consolidation where there are a number of critical issues to be addressed including:

- The further standardisation of core activity processes within the three teams while building on the original expertise of the participating agencies
- Development of a more proactive and structured case management approach for working with families & schools at the school age team level
- Adjustment of the service model so that it adapts a more flexible approach to meet individual family needs
- Development of a single service mindset, management system and operational practises across the three teams [“We have common structure, standards, processes & share resources to deliver the best service for all”]
- Streamlining and simplification of the current complicated governance and accountability processes
- Addressing the challenges of delivering an equitable service - based on needs to all families taken into the service, within the finite resources available
- Working to develop closer partnerships with other groups and agencies so that families & children can receive an integrated set of supports that best meet their needs

Section 5.0: A Note on the Comparator Services Review:

We conducted a structured enquiry visit with the Mid Western NDT Service. The rationale for choosing this service was that:

The Mid – Western NDT Service, when one takes into account its origins, is possibly the longest established integrated multi-agency children's disability service. It is also a service where the HSE has played a central role in promoting an integrated and equitable working philosophy and model.

The main enquiry areas for the service visit are presented in Appendix 2 and to a large degree they mirror areas covered in the NDT review process.

The Learning points from the comparator review – Mid –West NDT Service

This is a more extensive service with 7 NDTs operating on a Lead Agency per team basis [The teams are centred on geographical patches]

The service is experiencing a growth in numbers of around 11% per annum and this is putting particular strain on the school age service response.

At early intervention level, the aim is to take families into the service within a 3 month waiting period. An early transdisciplinary play – based assessment is usually carried out [by a minimum of two clinicians] before the first FSP is held. The service operates a key contact clinician for each family and this role is a proactive liaison and service coordination role with the aim to provide an early route into group support & training.

At school – age, there is concern that the service is coming under increasing resource pressure. The consequence of this is that the service provision is increasingly being tilted towards the children with the most complex needs. There is a heavy emphasis on building close working relationships with the schools which includes providing training courses for teachers and SNAs. There is an effort to combine FSPs & IEPs into a single support plan. There is a strong emphasis on supporting families to work on functional goals. A number of parent training & support groups are run as well more individualised home & clinic work.

The most striking learning points from the Mid –West NDT service are the more robust Governance and Management Systems & processes.

The service has an MIS system used by all teams that captures family contact and team time-activity records.

Each local team has a Lead Agency and an effort has been made to align team member's employment contract with the Lead Agency. Not with standing this, there still appears to be some areas of ambiguity in performance management & clinical governance arrangements

The service has an overall service management structure built on two levels:

At the Operational level – there is a service management team comprising of the Team Managers [Clinical Team Managers] and the Regional Programme Lead who acts as the overall Service Coordinator. The operational management team is supported by a Clinical Advisory Team which

meets on a standing basis and reports into it on issues to do with practise development, clinical governance and risk Management.

At a Strategic level – there is a Programme Steering Group with a clear remit, terms of reference and defined operating processes. The Steering Group, in addition to Senior Managers from the participating agencies, has a wider representation including 2 Parents Representatives, 2 Educational Representatives [In an advisory role] and I Clinical Representative.

An effort has been made to formally involve parents at each level of the service.. Suggestion boxes are made readily available across the service and there are service- user forums at both early intervention and school age. The feedback from families feeds into the two family representatives on the Steering Group.

Section 6.0: The Main Review Findings

The following sections of the report set out the main findings and recommendations of the Review.

The Review section of the Report is split into five sections:

Field One: Effectiveness of the Service

Field Two: Organisation & Efficiency of the Service

Field Three: Customer Feedback and Quality

Field Four: Building Service Capability

Field Five: Governance & Accountability

Within each of these sections; the service issues are described and recommendations are made to address gaps and deficiencies**.**

A number of qualifying comments are made here about the review process and the conclusions that we draw:

- The service review is not exhaustive in its coverage as we operated mainly with the service information that was available [So for example we did not conduct a detailed analysis of activities versus resourcing as there was not sufficient base data available].
- The question may arise as to how representative our data sources were. The table below illustrates that we collected data from the following sources:

Respondent Data Sources for the Review			
Families	By Survey	145	*
	By Focus Group	138	**
	File Review	25	
Schools	By Survey	56	
Staff	By Survey	54	
	By Focus Group	52	
Managers	By Interview	A minimum of 2 interviews each	
DSM Manager	By Interview	One interview	
Steering Group	By Survey	All bar one	
	By Phone	All bar one	

* Note1: The family survey gives a 7.5% error margin at 95% confidence level for a total service population of 1200 [If we factor in that perhaps 50% of focus group attendees had not completed the survey-then composite error margin could be seen as 6%]

- Many of our recommendations may overlap with service development activities and initiatives that are already underway.

Qualitative Data from the surveys is in <u>Appendix Three</u>

Review Field One: Effectiveness of NDT Service – 2016

Effectiveness:
An effective service has a coherent Mission & Vision, clearly stated objectives and a suitably aligned operational execution that delivers intensity of relevant programming which leads to the achievement of desired outcomes for the customers of the service and its primary stakeholders.

The Service Objectives:

The aims of the NDT Service are derived from the National Progressing Disability Services for Children and Young People Programme which was established in 2010. The vision of the programme is that each and every child or young person with a disability will be supported to achieve their full potential through the implementation of an integrated service model that will allow children, whatever the nature of their disability, to be seen and supported as locally to their home and school as possible based on their needs.

The NDT Service aims can be paraphrased as to:

- Assess and support the needs of families with children with disabilities who have complex needs
- Provide equitable access to services
- Provide responsive and supportive services to help individual children & young people to meet their potential
- Empower and support families
- Provide cost effective services [See Field 2 for more commentary on this area]

Introduction to this section:

From an Effectiveness Perspective; it useful to think of the NDT services in 2 categories – The Early intervention teams and the School-age Teams as they operate in different ways. At the early intervention [EIT] stage, the expectation is that the NDT operates for most families as the primary developmental support service.

At the school age stage [SAT], the rationale of the service is that the child & family should have received a strong developmental foundation through the Early Years service and the education system is now the primary learning support service. On this basis; the required specialist supports & developmental interventions from the NDT may be more episodic and focused on a specific issue.

[Note: Our finding is that although this service rationale is logical; it does not correspond with the reality for many families at this point as a] They may have missed out on Early Years provision – this is particularly common with children with a late diagnosis on the ASD spectrum and b] the level of close collaboration between their child's school and the NDT is entirely discretionary on both sides]

How well does the service address and support complex needs?

It is difficult to answer this question in a categorical way as the service is not collecting relevant activity & outcome data in a systematic enough manner and this is a major weakness of the service.

The Family Views on Service Addressing Needs:

From the family perspective the Survey gives a level of positive affirmation in the following areas:

Feedback from the Family Survey [N= 145]				
Question Area		**Yes**	**No**	**
Working with NDT addresses the things most important to parents	EIT	62%	24%	
	SAT	44%	41%	
Family has a clear plan to address Family Service Plan [FSP] goals?	EIT	72%	14%	
	SAT	30%	50%	
The team follow up well on the FSP	EIT	43%	5%	
	SAT	24%	21%	
Key: EIT = Early years Service [1-6 years]	SAT = School Age Service [6+ years]			
** Many families did not answer specific questions on the survey and subsequent feedback in the Focus Groups suggested that some families were wary of being seen to be critical about the service.				

The family survey indicates that families in the EIT programme provide more positive feedback on the service relevance, structure and effectiveness than families in the SAT service.

Within diagnostic categories families with a child on the ASD spectrum are less likely to give the service a positive rating.

The Early Years Service:

A List of What is Going Well:

Equity of access to the services in terms of the referral process [although this doesn't necessarily carry through to equity of services provided by the individual NDT teams]

Ease of physical access to local support services – [About 75% of families, who responded to the survey, are happy with this]

The positivity of the team and the individual staff – Parents frequently cited the following terms child – centred, helpful, professional, caring, enthusiastic

Parent training programmes are rated highly by families but more so when they are matched to the individual child's current needs and followed up by one to one home visit to reinforce the key applications – this is reflected by the staff feedback which also emphasises the value of more focused training inputs and evaluated methods.

Both families and staff value the interdisciplinary approach practised by the service – seeing this as more comprehensive & integrated in delivery

The home visits are cited as very helpful by families and this is reflected by the staff also as it is seen as both a more natural setting and an aid to building rapport & good partnership working.

One to one sessions with SLT, Physio and OT are all cited as being very valuable by families and staff

The input by psychologists into Intervention and support plans for behaviour problems is highly valued but reported as very difficult to get access to.

Groups are also rated highly by parents in terms of their usefulness for general orientation to the service, covering relevant adjustment issues, imparting information, socialisation for children and networking & support between parents.

Specialist services including motor management service, orthotics, and clinical nurse specialist in autism are highly valued by families.

What is Going less Well?

<u>Excessive Waiting Times for the Service</u>

The waiting times for the service are too long both in terms of getting access into the NDT service but also in terms of the team's follow through on individual family service plans and families getting access to specific services within the NDT. Many parents cite waiting times of over 2 years before they finally got referred to the NDT.

<u>Children Falling Between Stools in Service Provision</u>

Many families have had a negative service experience where the therapy supports that they are receiving in the Primary Care service are withdrawn immediately when the child is referred to the NDT service even though there is a subsequent long waiting time before the NDT engages with the family. So in the short term, the child loses out on actual services by being referred to the NDT service.

<u>Excessive Delays in Accessing Service Supports within the NDT Service</u>

Many also reported that once they got a letter indicating acceptance into the NDT service, there was still a considerable waiting period before there was active service engagement with the family.

In addition, the timeliness of follow through on FSPs is reported as poor in many cases and access to specific disciplines is delayed due to a build up of internal waiting lists.

The service does appear to be under some demand pressure as it is taking on new families, while internal waiting list for specific services within the teams are building up. This is exacerbated by the relatively high level of staff turnover & delays in filling vacancies [See more commentary on this issue in Section - Field Two]

Lack of Equity in Service Access within the NDT Service

There is a relative lack of equity in how families can access specific services within the teams as some cases with more complex needs take a higher priority and use greater amounts of the clinical resources available. The reality is that there is a ceiling on the therapy resources available and this poses many challenges for the service while underlining the need to be sure that best use is being made of the available resources.

Perceived Lack of a Comprehensive Service Intervention Response

The actual NDT service delivery can appear to be fragmented, reactive and episodic to families when they are looking for a comprehensive service programme for their child. This is linked to the FSPs focussing on a small number of functional goals without a fuller rolling assessment of the child's status & needs. It is also linked to a lack of clear service pathways although work is being done on this area.

Some group programmes are seen by parents and staff as not being sufficiently targeted or outcome focused and there are problematic levels of non-attendances for many of the group interventions.

The level of Psychology resources available versus the demands seems a particular concern and families may be using inappropriate or suboptimal alternatives sourced privately.

The vision of a tiered primary care service, with access for the NDT to other specialist resources as required, is not working well – particular concerns being interoperability with CAMHS, access to child psychiatry in context of intellectual disability, lack of equitable access to respite services, home care workers & preschool support.

At early intervention level there are three elements that are worth more detailed comment – Alignment with the Service Model, Efficacy of the FSP Process and Equity of Provision:

1.1] **Model Coherence- Alignment with the Service Model**

The service is operating to a model that is primarily family centred and includes the bio-psychosocial and life needs paradigms which are all cited in various national NDT programme & policy documents.

In layman's terms the models emphasise the provision of supports to families using a partnership model where families are empowered to become expert in facilitating their child's development within a social and daily living context. This approach is sometimes counter- pointed against a medical – model that emphasises a more individual therapy - based intervention approach where the expert clinicians work directly with the child on a sessional basis.

There appears to be some ambiguity or lack of clarity about the way that, staff in the NDT service, have interpreted these models as some think that the model actively discourages individual therapy interventions with children in favour of skills transmission approaches that emphasise the provision of group education and training inputs to families.

The Family Survey indicates that a third of the respondents felt that the model was explained poorly to them or that they didn't understand it. In addition the qualitative comments in the family survey and focus groups indicate that many parents are not in agreement with the service model. The following points emerged strongly in both survey and focus groups:

Families have an understanding that their child's development is delayed or atypical and that there are intervention solutions that will remedy this in some way or at least help to maximise the child's potential. They see clinicians as experts in these development areas who can provide therapeutic or remedial inputs that will enhance the child's development. They are also anxious that a developmental clock is ticking and that every day without intervention is a reducing their child's

potential to make progress developmentally**. From this perspective delays in accessing the service or gaps in the continuity of the service are a major cause of concern.**

This mismatch of expectations is compounded by the Assessment of Need process which gives parents an expectation that they are going to get a full interdisciplinary intervention programme that will enhance their child's development in a multi-faceted manner. In reality although the initial Family Support Plan [FSP] process is likely to be interdisciplinary in nature; the subsequent NDT support is likely to be more focused on 1 or 2 development goals and to be less involving of all disciplines.

The use of language is important in arriving at a shared understanding of what the NDT can offer families. Many parents are not comfortable being described as the "experts" on their child and to the contrary expect that the NDT staff are the actual holders of the expert knowledge & skills that can help their child. If the parents are described as "knowing their child best", this means something different and is more valid to the families.

Some families of older children will have previous experience of early intervention services which may have been more specialised to their child's specific disability and /or may have provided more sessional therapy type services. This prior experience has set their expectations of how a service should operate and they may be less comfortable where they perceive that the primary responsibility for developmental intervention is being put in their own hands.

In some cases families perceive the service as providing generic intervention supports through group training programmes whereas they are looking for intervention supports that are clearly tailored to their individual child's context and needs. This seems to be particularly the case for some families whose child is on the ASD spectrum. This mismatch of perceptions can be exacerbated where staff, attending the FSP meeting or the training programmes, may not be familiar in advance with the individual child.

In our view; there are a number of factors that may make it more difficult for families to engage fully with the partnership & enabling model service model.

- **Family Need for Adequate Counselling:**
  Some families may not have come to terms sufficiently with the reality that their child has a disability and may need emotional & psychological support to help them get to a point **where they feel ready to engage actively with what the service is providing.**
  In this context it is not clear that the NDT service provides sufficient or equitable access to such counselling supports. Counselling may need to be provided at more than one level. So whereas team members with adequate training should be able to cover a lot of the requirement but some family members may require a more in – depth level of psychological counselling that requires specialist expertise which needs to be sourced externally.
- **Some families are operating under multiple socio-economic stressors which can erode their ability to engage fully with the service.**
- Some families have less capacity to respond to an educational & skills transmission approach that is primarily mediated through information transmission – particularly where this is done through the written word or checklist formats. This can include parents where English is not their primary language or who have a learning difficulty themselves.

The information transmission process works best when a therapist actively models what is required with the child in their natural setting and then leaves a visual record of this.

- Some families are in a situation where both parents work outside the home and so they require a more flexible service delivery from a scheduling perspective.
- A number of families with children on the ASD spectrum made the point that their child responds differently to them versus a therapist and this makes it more difficult for them to implement specific learning programmes at home

It is clear that the take –up of group interventions is poor in many cases and the above issues are all likely to be contributory factors. One rationale for group interventions is their relative efficiency in addressing many needs at the same time but if take –up is poor, as is reported in many cases in the NDT service, this rationale becomes eroded to a degree.

The feedback from the staff focus groups reinforces this point as the take up of group interventions is much higher in those families who have already had a positive engagement with team members on an individualised basis with their child. There is a clear lesson for the service here: - You must build engagement [which leads to trust] with families on an individualised basis before you offer group centred interventions and supports.

1.2] Efficacy of the Family Support Plan [FSP]:

Data from the Family Survey – Early Years Children			
Question Area	**Yes Positive**	**No Negative**	**Not Answered**
Do you have a FSP?	67%	19%	15%
Is the FSP flexible enough in the way that it responds to your needs?	53%	29%	17%
How well does working with the NDT address the things that are most important from your point of view?	62%	24%	14%
How easy is it to set initial goals for your child?	49%	29%	21%
Family has a clear plan to address FSP goals?	72%	14%	14%
Is the FSP documentation helpful?	57%	15%	29%
The team follow up well on the FSP	43%	5%	52%

The current FSP implementation in Early Years gets generally positive but mixed feedback. There is plenty of positive feedback from families about the interdisciplinary and partnership aspects of the FSP. There is also positive feedback about the practical and goal focused approach. Two out of 3 families say that working with the NDT addresses what is most important for them.

However families are finding it difficult to determine initial goals for their child [Only 49% rate this positively]. While a quarter to a third of families are struggling with aspects of the FSP such as, being clear afterwards about the specifics of the plan and finding the documentation helpful.

Moreover a plan is only as good as its execution and the main criticism of the FSP from families is the inconsistency and delays in the team following through on what has been agreed. Only 43% of respondents felt that the team followed up well on the plan and this is an issue that is reflected also in the staff feedback. Elements of the FSP may be agreed at the meeting without the availability of the required team resources to respond being clear and this can lead to delays and frustration on all sides. While families are waiting for the agreed targeted interventions specific to their child, they may be invited to various group programmes but these may not be focused on the child's specific goals and they may be run by a different set of staff

The qualitative comments from families suggest that a substantial number would prefer a more comprehensive or holistic assessment of the child's status and a matching development programme with active therapist support rather than a more stripped back focus on singular functional goals.

Some more negative fedback from families indicates that some see the FSPs as putting more staff resources into planning for the service while less are put into follow through intervention or support – they would prefer the opposite to be the case.

Another major constraint on the FSP follow through is the high turnover of staff & the delays in replacements. This breaks up the continuity of the relationship with child & family and undermines the momentum of developmental supports.

1.3] **Inequity in Service Provision:**

It is clear from the family feedback that there are major issues around equity of access to service supports once <u>the child is actually accepted into the</u> NDT service. This point is also validated by the staff feedback in the focus groups.

This is reducible to two issues – i] some families receive considerably more support and are allocated more team resources than others and ii] there is no minimum or standard amount of service support that is made available to all families.

When we explore this issue in more detail; there are a number of factors at play:

Team resources are allocated against an evaluation of complexity /priority of support required – So the service provides a fairly standard procedure for intake and initial identification of priority needs through the FSP process. However, once the initial needs are identified, the service will allocate resources to meet the identified needs on a prioritised basis. The criteria for prioritisation appear to be a combination of complexity & relative urgency of need and the judgment on this prioritisation may be made by a subgroup of the team in conjunction with the team manager or it may be done on an individual discipline basis where a list of children are referred for support. To compound this problem; some disciplines within the teams are less well resourced than others and so where complexity of needs is high; then involvement from more disciplines is likely to be required, even where these are in short supply [Psychology is an example of this].

While this type of prioritisation is understandable from a clinical perspective, it does not sit easily with families who understand that they have been referred to the NDT precisely because their child has "complex needs" [Nor of course to most families are their child's needs a relative priority].

There is also a second cause of inequity in service provision, which is the fact that the discipline-composition of the 3 teams are different and there are some expertise & skill-sets which are unique to a single team. For example the North team has a specialist nurse who has a high degree of expertise in ASD-related service delivery so families in this geographical patch can avail of specialist input and support from an early age whereas this is not available in the South Team patch. Similarly the Mid – team have a social care worker element which provide a large number of specialised group interventions including mother & baby groups and teenage ADL and socialisation skills – whereas these services are not available in the other 2 patch areas.

R1/8: Recommendations to Enhance Early Years Service:

R1. The HSE should operate a protocol whereby children receiving primary care supports do not lose these supports until the point where the NDT <u>is actively engaged</u> in service provision with the family.

R2. Put resources into fuller family engagement, after the initial intake into the service. Provide emotional and psychosocial support before providing advice & guidance on functional skills and development.

R3. Build collaborative relationships with other interested groups & agencies that may also provide support and counselling so that the NDT provides a hub function for a range of potential supports for families of young children.

R4. Explore the feasibility of enabling and training parents to act as peer supports for other parents.

R5. Move to a point where the specialist nurse and social care workers that are providing ASD Counselling and mother & baby groups are used as a service – wide resource and develop a skills transfer process in these areas to widen these relevant competencies within the teams.

R6. Improve family empowerment by doing a graduated skill transfer model whereby the therapist demonstrates the relevant skills and supports directly with the child [in the home if possible], creates a visual model and then gets the parents to practise the skill with feedback.

R7. Ensure that there is an induction and ongoing development process for new staff that covers communication, family support, enabling skills transfer& skills for effective key-working.

R8. Structure group training programmes so that all children have been seen by a clinician before attending who informs the trainers how to best match the child/family needs with the training content. Get clinicians to drop in to the training where possible to connect with families and ensure that there is a follow up home visit to reinforce the generalisation of skills learned.

The Service for School age Children [SAT]

What is Going Well?

Equity of access to the services in terms of the referral process [although this doesn't necessarily carry through to equity of services provided by the individual NDT teams]

Ease of physical access to local support services – [About 75% of families are happy with this]

The positivity of the team and the individual staff – Parents frequently cited the following terms child – centred, helpful, professional, caring, enthusiastic.

Schools feedback cites a very collegial approach, efficient, professional and caring. The prompt response useful recommendations and prompt correspondence are also cited by the schools

The schools value the specialist expertise, provision of valuable information on children and appropriate programmes- the sharing of practical resource materials and provision of practical specific tips by therapists helps with IEPs.

Schools also value receiving information about courses for parents and teachers that cover key issues of concern.

Both families and staff value the interdisciplinary approach practised by the service – seeing this as more comprehensive & integrated in delivery. The staff see the benefit in working in an interdisciplinary and collaborative mode which enhances flexible response, problem solving and skill-sharing.

The schools and families highly value where expert support is provided in a targeted and timely manner [One team is reasonably successful in dealing with formal school – based referrals within a set timeframe].

Parents find home visits very helpful for specific child centred intervention & support work.

The variety of groups that have been provided have been seen as helpful for many families and teenagers [Although some of the feedback is mixed in this area regarding relevance of the group focus to the individual child's needs]

The Sibling Camp was seen as a useful provision by both families & staff

Information sharing and pooling is working better within teams: - SMART Goals database // Group database for all groups

The provision of some specialist services including motor management and orthotics has been seen as valuable.

The teams have taken a number of initiatives that have worked well including:

- The move to the mini – team format has been helpful for knowing families and schools better and facilitating interdisciplinary case-working
- The Drop-in Clinics have worked well in providing accessible services on a responsive basis
- Setting up databases for Goal setting and Group Provision have made it easier to link resources with families
- The Waiting List Initiative team is cited as being a good example of an interdisciplinary focused response to a service problem

What is not Working Well at School –age Level?

There are some similar themes to the Early Years service but in general dissatisfaction levels are much higher in the school age service.

We have identified a number of key areas for concern at school age service level which are described in more detail below

1.4] Consolidate the NDT-School Collaboration:

Although the feedback from schools that have regular contact with the NDT service is generally positive; there are a number of areas for improvement:

Schools cite difficulties in getting access to the NDT service and it can be difficult for teachers and NDT staff to communicate by phone, given that the teachers need to be in class and the busy schedules of NDT staff. However a simple communication protocol could be set up to improve access [For example that phone contact is primarily done at a set time and day when access can be most facilitated on both sides].

Families raised frequent concerns that the feedback, when NDT staff visit their child in school, can be patchy and delayed.

The referral form for school support gets mixed feedback although it does regulate the collaboration within clear parameters. The establishment of "patch – based" mini-teams within the NDT service gives the potential for more continuity in relationships between specific schools and NDT staff.

There is a lot more information that could be shared between the team and the schools without a formal referral being necessary so that teachers and therapists are more consistent in goals and approaches. There is also the question of whether there could be a more streamlined approach between the school and NDT in terms of merging IEP and FSP meetings.

Schools would like more opportunity for support to be provided to teachers on a group basis – The provision of training or advisory sessions for groups of teachers on specific themes or techniques is seen as being of great potential benefit. There is considerable in-service training available to teachers through NCSE & Middletown, but there may be room for more collaborative training between the NDT and schools on particular topics where the NDT staff have particular expertise.

Actioning the Education and Health Working Group Recommendations:

The Education and Health Working Group of the Progressing Disability Services for Children and Young People programme sets out a framework for Collaborative Working between Education and Health Professionals. Among its key recommendations are:

- That a permanent National Education and Health Steering Group be formed to provide guidance to stakeholders in local areas in developing joint working, to monitor their progress and evaluate outcomes.
- It also recommends that local Education and Health forums be established under the umbrella of a National Education and Health Steering Group. The objective of these local

forums, which would include representatives of parents, health services and education partners, would be to facilitate networking, building relationships and sharing information.

- The Framework document also makes recommendations on strengthening collaboration through the establishment of joint policies, procedures & protocols, enhanced shared training and establishing a standard approach to supporting the child's pathway through key stages of transition in education.

All these recommended initiatives are contingent on the establishment of the National Education and Health Steering Group as the model proposed is central specification and then local roll-out. From previous experience, this means that the timeframe before local implementation will be protracted.

Nonetheless there are a number of collaboration strands that can be progressed on a more current basis.

Recommendations to Strengthen NDT – School Collaboration

While collaboration between the NDT and schools is generally good, the working relationships are responsive rather than planned in nature and so opportunities for greater service synergy for the benefit of the families and children are not being developed.

R9. Set up Local NDT –School Collaboration Forums:

At a local level, an effort should be made to set up a standing cooperation forum between schools and the NDT service. This could initially work by inviting Principals and relevant teachers to a quarterly or half – yearly forum where issues of joint concern could be discussed and worked on. You would think that this could be done perhaps at team or mini –team level initially. Some useful agenda items could include the following:

- *How to improve basic communication access between the 2 services*
- *How information on a child's development and recommended support approaches could be shared more routinely and frequently, particularly at the start of each school year. We understand that there are protocols for sharing information with schools but is there scope for the NDT to share development support information about individual children with schools on a more routine basis – this is a shared responsibility with parents but could information sharing become the norm rather than on request?*
- *Identifying where the NDT expertise might feed into in-school training for teachers and SNAs*
- *Exploring the potential for parent training programmes that would be jointly run by teachers and the NDT*
- *-Whether there is potential in some cases, to combine the IEP and FSP into a single family support plan*
- *Identify areas where standard intervention protocols might be jointly developed – For example: aspects of communication, functional skills development and behavior management*
- *Consider the feasibility of implementing the Transition Planning protocols in the Education and Health Framework report.*

R10. It is clear that the responsive nature of the current service collaboration impedes the most streamlined use of resources. A case in point is the Special Needs Assistant who is assigned to support an individual child in school – how many of these are routinely briefed by the NDT via the teacher on the best ways to support the individual child's development?

R11. A recurring theme in this report is that the NDT service makes insufficient use of generic close support workers to facilitate programmed supports for children & families. We recommend that the NDT take an initiative to see if one or two schools could be interested in developing a project to use SNAs as a more effective bridge between home and school support programmes?

R12. The onus is on the Steering Group to progress the strategic aspects of improved school – NDT collaboration. Has the National Education and Health Steering Group been established? – How can this development be expedited?

1.5] Difficulty Matching service & family expectations at School Age

Data from the Family Survey –School Age Children			
	Yes positive	No negative	No reply
How well does working with the NDT address the things that are most important from your point of view?	44%	41%	14%
How well does the team follow up on the plan?	24%	21%	56%

As in the Early Years programme, there is a mismatch between the service model and the expectations of families, but to a much greater degree. The survey indicates that 40% of families don't feel that the service addresses the things that are most important to them. Only 21% of the survey families feel that the service follows up adequately on the initial family service plan – in any service; this scale of dissatisfaction should be a cause for major concern.

The sources of dissatisfaction appear to be mainly attributable to the following factors:

The service, while still following a child centred – family enabling model, is set up in a format that primarily responds to issues that families or schools raise. So to many families; the service appears to be ad hoc, issue-specific and reactive whereas what they are looking for is greater continuity of support, a more comprehensive rolling assessment of their child's developmental status and provision of an ongoing programme of intervention and supports.

High Levels of Dissatisfaction from Families with Children on the ASD Spectrum

This seems to be particularly the case for families of school age children on the ASD spectrum who collectively seem to be the families who are expressing the greatest level of dissatisfaction with the service. Many of these families have arrived in the service at a relatively late point in the child's

development and after having been transferred from one type of service or service waiting list to another over an extended period of time. It may be that having a child on the ASD spectrum is a particularly challenging experience for families as there is such a variability of issues and support needs thrown up by the condition while there is also considerable uncertainty as to what approaches and methods work best. So on the one hand: the families may be very anxious and confused about the situation and what their actual needs are and on the other hand many NDT staff may have relatively limited expertise in appropriate interventions methods.

As a number of families expressed in the focus groups – they don't know what their needs are because they don't have a clear understanding of the child's status and therefore they don't know what support or intervention may be required or helpful. On the other hand; when communication and behaviour issues arise as common features, the service does not appear to have the appropriate expert resources to put in place timely and individualised support programmes.

Late Diagnosis of Children on the ASD Spectrum

Research in the USA indicates that between 2/5 & 3/5 of children on the ASD spectrum are not fully diagnosed until after they start school. The increasing referral rates of school age children to the NDT may be confirming this trend also. It seems to us that, new families entering the school-age service with an ASD child may need an intervention response that is more like an early intervention approach – a comprehensive multi-disciplinary assessment, a comprehensive support & intervention plan closely coordinated with the school, tailored group training and regular rolling reviews of support and intervention needs. This seems to be quite different to the responsive service model that prevails in the current NDT school age services.

If families newly entering the school age service have received an Assessment of Need; this has served to raise their expectations that they will receive a multi-disciplinary and specialist service which will address their needs on a comprehensive basis. The reality is that they receive a responsive but partial service that may only address some of their issues and needs.

As in the Early Years service, families that are new to the service respond better to the family empowerment and educational inputs if the service first builds up a meaningful relationship with them and with their child but this is less likely to happen unless they have very high complexity needs. As a result families are invited to training courses but don't feel confident that this will be sufficiently beneficial or tailored to their specific needs.

R 13: Recommendation on Enhancing the Service Pathway for School-age Children with ASD

We recommend that the NDT work with the educational sector to develop a clear service pathway for families with a child who has a late ASD diagnosis. This work would involve identifying commonalities of support needs and could usefully be done in collaboration with an external agency that has Autism-specific expertise [For example – ICAN or Scottish Autism].

This work could also be broadened out in a holistic manner encompassing wider educational, family and community integration supports, rather than concentrating solely on service areas where the NDT is currently resourced.

Topics to be considered in this design work could include the following:

- How to maximise the integration of support activities provided by different agencies
- Whether there should be a combined IFSP and IEP rather than separate intervention & support plans
- What it would take to broadened and up-skill the Special Needs Assistant role so that it could encompass a dual school & home /community support function
- This work should also encompass consideration of the issues relevant to behaviour support covered in Recommendation 19 below.

Barriers to Accessing the School-age Service

Many families have a difficulty with the concept that they need to take the lead in contacting the service and this is exacerbated where the service is not easy to access by phone or primarily works to time schedules that don't match their work – home routines..

1.6] Family's Needs to Access Other Resources

As children get older, families have a wider set of support needs and the NDT does not have direct access to some resources that would be useful for specific families – Most cited examples of other resources needed are : - out of home respite, home support, counselling for teenagers and specialist supports for challenging behaviour.

Note: It was of note that in the family survey [N= 145], not a single family gave an affirmative answer to the question

"How well has it [NDT] helped you to link your child into ordinary community activities?"

While this report is not necessarily advocating that the NDT should provide all of these services; it is in a prime position to identify needs and proactively facilitate access were these services to be available. In the case that these broader range of family supports are not available – what is the role of the NDT in highlighting the service deficiencies, making the quantum of need known and proactively advocating for the required services? – What are the respective roles of the Team Managers and Steering Group in this regard?

1.7] Inadequacies in Customer Care - Key Working within the NDC Service:

The responsive model of the school years support service is predicated on there being an effective system that links every family with the NDT service – so that families feel supported and know they have a clear and familiar contact point in the service. Generally within children's services, this should take the form of either a key Worker or a key Contact Person.

Among the useful functions of a nominated contact person are:

- it provides continuity of contact for the family

-it provides a sense of security that there is ease of access to support

- it should improve information transfer to the family in terms of both routine and tailored communication

-it should improve status update and information transfer on the family within the team

-it should be the vehicle for proactive or planned family support

Some of these useful functions will only happen if the role of the key contact person is clearly specified. The proactive role of a key contact person should be to initiate regular [minimum quarterly] contact with the family to track development and needs status, provide motivational support and advise on upcoming groups or other prospective inputs.

It is important to note that in the absence of a clear role specification; the key contact role is likely to be reactive and families will feel more isolated. A number of staff commented that they find the key worker role uncomfortable, as they feel that if contacted, families will make demands for service that they cannot meet. This highlights a difficult issue for clinicians acting as key workers where they are very aware of resource constraints and may therefore be less likely to elicit family needs that they know cannot be met in the short to medium term.

This raises the further issue of whether clinicians are being asked to take ownership for case coordination in its more proactive case- management mode as well as direct service provision. To do this effectively; requires a change of mindset where the individual clinician is aware that he/she has two distinct client responsibility areas:

- Direct & indirect targeted service provision to individual children & families

- Case coordination / liaison for a set of families, where they may not necessarily provide the primary intervention input

This means that the individual clinician has to proactively plan both types of contacts with families for the service to run effectively. It may also mean that individual clinicians need to see their contribution in the team as much wider than the delivery of direct and indirect service to children on their caseload.

The lack of a clinical services forum and the unclear reporting relationships may be constraining reflection and discussion on this key issue.

The feedback from families in both the survey and the focus groups is that the clear point of contact model is not working well, particularly at school age level:

Survey Question	Positive Answers	No	Not Answered
Do you feel there is enough continuity in the service provided?	35%	50%	15%
Do you have a clear contact person for the team?	49%	37%	14%

At the Family Focus Groups, there was consistent feedback that one of the teams was not currently operating a key contact person system.

The Focus Groups also highlighted a widespread difficulty in contacting the teams by phone. A considerable number of families recounted experiences of the main team phone not being answered and left messages not being returned in a timely manner or in some cases at all.

Taken together, these points indicate than many school age families may not actually be experiencing the service as truly family centred in its operation.

Recommendation: Strengthen the Customer Care – Case Management Ethos and Systems within the NDT:

We believe that, notwithstanding the fact that resources are constrained, there is a need to re-orientate the school years provision so that it becomes more planned and proactive in its delivery mode**.** A central part of this is the following recommendation:

R14. Ensure that there is a proactive key worker system in place at school sage:

The elements within this recommendation are that:

- *Every family has a current nominated key worker and a clear contact number/email for this person.*
- *There is specific protocol in place for the time within which a key worker should respond to a family initiated contact*
- *The role of the key worker should be clearly specified and should include a case management responsibility to proactively contact each family within a specified timeframe to check in on status and needs*
- *Staff may require a short training module on this more proactive approach to key contact*

R15. Establish Standards within the Service for Communication Responsiveness:

It is highlighted elsewhere in the report, that there is a significant shortfall in administration resources for the NDT service. As the service has grown in client population and staff numbers, the administrative resources have not been developed in parallel. Notwithstanding this, it is not satisfactory that families are experiencing the level of reported difficulty with contacting the service by phone.

R15a. In the short term, Team Managers need to work together to find a solution that ensures phone contact is responded to within a standard timeframe. It may be that part of this solution will require re- routing of calls at points when the phone is not manned in one team. In the longer term the resourcing shortfall on the administrative side needs to be addressed.

1.7] Difficulties with the FSP Process at School Age:

Data from the Family Survey –School Age Children

Question Area	Yes	No	Not Answered
Do you have a FSP?	24%	59%	16%
Is the FSP flexible enough in the way that it responds to your needs?	38%	33%	26%
How well does working with the NDT address the things that are most important from your point of view?	44%	41%	14%
Family has a clear plan to address FSP goals?	30%	50%	20%
Is the FSP documentation helpful?	47%	27%	26%
The team follow up well on the FSP	24% *	21%	55%

There are a number of issues with the FSP process:

Is the format of the FSP too cumbersome and resource – intensive? – The bulk of families appear not to be getting regular FSPs and this seems to be resource – linked. On the other hand; where FSPs are held, only 24% of families feel the follow up is adequate.

Would it make more sense to schedule FSPs less frequently and instead to assign a case coordinator who links more often with the family & proactively coordinates the inputs of other disciplines? Provision could also be made that where 2 disciplines are working with a family; then this becomes a rolling FSP and is labelled as such.

As in the Early Years service, parents are not comfortable attending FSPs where the staff do not know their child.

A lot of parents find the follow up documentation less helpful than intended and this raises questions as to whether the documentation is too text – based versus using more visual modalities likes pictures and video. In addition, there is a cohort of families where there may be other factors contributing to communication & reading difficulties such as learning difficulties or English not being the primary language.

The effective follow up to the FSP is rated poorly by parents and this is linked to shortage of required resources [Psychology & OT particularly?] but also the discontinuity from staff absences and delays in filling vacancies.

Some families do not see topic-based groups or group training programmes as being of equivalent value to the more specific individual intervention or supports that they expect to follow on from an FSP. As noted elsewhere, this factor can be mitigated by the family having a trusted point of contact with the service so that they better understand the potential value of attending a group.

1.8] Inequity in Service Delivery & Constrained Resources

The factors that underpin inequity in resource allocation at school age level are similar to those at Early Years in terms of relative complexity of needs, scarcity of specific disciplines [Psychology & OT are most frequently cited here] and discontinuity in staffing [Maternity leave & delays in vacancy filling].

There are also the differences in team make up which even constrain the teams in the provision of some core parent training programmes[For example-Early Bird training for new referrals].

As in the Early Years service; there are resources in one team that are not on another so Social Care Workers run groups for teen agers in one team but there is no equivalent provided in the other teams.

The issue of constrained resources is a reality that the teams must face up to as the school age service has such a long time span [12 years] – that numbers looking for a service are liable to grow on an incremental basis while discharges on an age expiry basis are not liable to match the intake pressure.

1.9] **Scheduling & logistics that are family & school - friendly**

Schools and parents also report significant difficulties in both accessing the NDT by phone and aligning time schedules of teachers or parents and NDT staff. Some parents wonder why they can't see the NDT staff in the school with the teacher in the child's normal school hours. Parents have particular difficulty removing their child from school to attend groups for the same reason.

1.10] Working Collaboratively with other Specialist Services

There seems to be a significant difficulty for the teams in working seamlessly with other specialist services – the most frequently cited being CAMHS and Behaviour Support Specialists [Dietician is also mentioned by staff & families].

While a good number of staff in the NDT service have come from the Beech Park service; there is no specialist behavior support sub-team or dedicated staff within the service. There are and will be children in the service who would benefit from the expertise of a mental health service or child psychiatrist. However there seems to be rigidity within the HSE where, once a child is allocated to a specialist service, other services are reluctant to provide support even on a shared care basis.

As children get older, families have a wider set of support needs and the NDT does not have direct access to some resources that would be useful for specific families – Most mentioned are respite, home support and counselling for teenagers.

<u>Recommendations for School Age Service -2</u>

R16. Consider stretching out the FSP process to a 2 - 3 year cycle perhaps linked to transition points in the child's life [At ages 6,9,12 & 17].

> *In between assign a case coordinator to each open case with a clear brief to proactively contact the family within a set timeframe [For example – once a quarter] and to ensure that the family always has a current "roadmap" of the support plan for the family over the next 12 months.*

Consider the feasibility of operating a "paired support worker process whereby 2 members of the team liaise with the family each calendar year- the case coordinator and another member of the team providing some targeted or responsive intervention and support.

In some cases could the NDT case coordinator attend the child's IEP meeting and dovetail the family support required?

R16. Team members need to take shared responsibility for working in a resource-constrained environment by working in a flexible and resource – efficient manner.

There are some current positive emerging examples of this.

- *While a clinician may be providing targeted interventions and supports to allocated cases & group programmes; they could also spend a portion of each day on case management & liaison work.*
- *Is it possible to explore ways to develop a more frequent but less time intensive contact process with families?*

R17. The service needs to further strengthen partnership relationships with other groups & agencies in the geographical area so that family & child needs can be met on a shared or complementary basis.

R18. A protocol for closer collaboration with CAMHS, TUSLA and other specialist services should be brokered and where the required services are simply not made available, an unmet needs record for every case should be sent to senior management in the CHO.

R19. Further exploration is required as to how the service meets the needs of families where the child exhibits behaviour that is severely challenging. We understand that work has been done on developing Policy & Procedures in this area but there does not appear to be the dedicated expertise available to cope with the emerging demands in this area [Close home support & counselling, respite care as well as intervention advice].

An internal scoping exercise should be feasible to establish the full scale of the needs in this area.

We understand that a proposal on this issue has been prepared by the Team Managers for submission to the Steering Group.

1.11] Better Integration with the Motor Management Service

The Motor Management Service is a specialist service that operates within one of the NDT premises and provides access to children & families from the three teams. It provides an accessible and valuable specialist support to a subset of the families using the NDT service. There is room for greater integration between this service and the overall Physiotherapy provision within the NDT service as a whole. In particular there is scope to improve family supports by rotating junior Physio staff through this service to build their awareness & skills. There is also room for improvement in

joint case management where the NDT physio retains the ongoing family support link but with greater communication with the MM Service. The MM Service has developed a paper on the potential for a more effective and seamless service for families [February 017]

Recommendation: Improve Collaboration between NDT and MM Service

R20. Run a workshop between the Motor Management Service, Team Managers and Physiotherapists to identify enhanced collaboration practises.

Determine what channels should be activated to review the wider issues in the MM discussion document

1.12] Facilitating Service Information & Communication by Development of a Web Presence

We believe that the service is relying on outmoded forms of communication to get its message across to its customers and the wider public.

R21: Recommendation- Develop a Web Presence for the Service

Set up a website for the NDT Service that sets out its mission, values, operating model and contact points.

- *The model needs to be simply and persuasively explained to positively manage expectations-perhaps with case examples*
- *This might be a project that could be facilitated by a student placement working in conjunction with the participating agencies own website supports.*
- *Ensure that plain English is the standard for all content*
- *Have a website committee within the service to provide ongoing impetus for this communication modality*

Review Field 2: Organisation, Systems and Efficiency

An effective service deploys its resources to achieve a reasonable balance between maximisation of impact and equity of access. Core activities are tracked against resources used and outcomes achieved.

The service has significant weaknesses in its resource planning & deployment, information management and administrative processes

2.1] Service- level Performance Management and Activity Tracking Systems:

For a service to be effective; it must be able to collect and evaluate activity information in an accurate, accessible, consistent and consolidated manner.

At the point in time of the review, there was no coherent and standardised system in place for service activity tracking and reporting.

The service data set that is consolidated for the Steering Group is minimalist in the extreme and while it gives a sense of trends in service intake, waiting list and discharges, it does not give any indication of what the service is providing to the families or how service resources are allocated against activity areas.

It does provide information on risk management and complaints but this is the practice of "management by exception" and is clearly not sufficient from an accountability and oversight perspective.

At the moment, it is necessary to do individual file reviews to build up a picture of what is happening for families and even here, files and activity recording are not done on a standard format across the three teams.

Only one of the three teams operates an IT- enabled filing and record system. However staff report that this system can be cumbersome to use and maintain in a currently updated status.

As a consequence of this:

- It is difficult to establish exactly who is doing what in terms of service activity
- It is unclear what proportions of clinician's or discipline's time is going towards different service activity areas [For example group versus individual work, assessment versus interventions, education versus therapy]
- It may not be possible to ascertain the number of clinician hours available each month
- It is not possible to make tangible links between service activities and service outcomes
- It is not possible to establish levels of service efficiency
- It is difficult to make the case for additional resources

This not to say that individual clinicians don't keep records of their activity area, interactions with clients and caseload; but the point is that this information is neither standardised in format nor collected in a manner that allows it to be consolidated into an overall picture of what the service is doing.

R22: <u>**Recommendation: Establish an Activity Tracking System**</u>

The service should establish a standard activity tracking and consolidation framework that will give a clear picture of what the service is actually doing.

This framework should collect & consolidate activity data at individual clinician, team and discipline levels on a regular probably monthly basis.

The teams and their managers can already describe what they are doing so the task is to specify and codify this knowledge, develop workable recoding templates and then use IT systems to consolidate the data for reporting and evaluation purposes.
Staff should be involved in the working up of this system and it should be possible to have a working model within 3 months although this may not be IT-enabled initially.

We recommend that an initial collection of activity information be piloted for a month across the three teams with a view to identifying the most useful data set to be tracked on an ongoing basis.

We understand that there is an intention to introduce a national IT support system for the NDT service but to our knowledge; there is no working off the shelf model in situ at present so this may be a case of who takes the initiative first.

R23*:* **Recommendation: Consolidate Information Management and Performance Tracking**

The overall service should have a Business Management function that encompasses responsibility for the following areas:

- *Development, implementation and maintenance of a KPI reporting system that consolidates activity data for each team and the service as a whole including a summary dashboard report on a periodic basis. Such a dashboard summary could include elements such as :*

  Monthly number of service contacts with families by type & by discipline

  Numbers of education/training groups run, numbers attending and percentage attending versus invited

  Number of FSPs completed per month & associated valued outcomes achieved

  Number of team hours deployed versus capacity ceiling [What percentage of the overall team hours are unavailable each month]

- *Specification and acquisition of a standard MIS system across the entire service. This may take a number of years to implement as there is a suggestion that the current MIS used for the Limerick NDT Service might become the national template but my understanding is that it is not an off the shelf system..*

- *Provide medium to long term demand forecasting [3-5 years out] through the collection of data on population, forecast incidence rates of certain diagnostic categories, disability databases and the predicted movement and needs of age cohorts of service users.*

2.2] Matching Demand and Service Resources

The feedback from families [and to a lesser extent staff] indicates that there is a significant concern that the service does not have adequate resources to meet the levels of current and prospective demand. We estimate that at least a third of families, who have school age children, are not receiving the level or type of service contact that they think they need. The feedback from service staff is also that a significant number of families are not receiving the level of service that they need because their needs are not seen as being of sufficient relative priority within the demands that the teams are working with. This mirrors the feedback from the NDT service in the Midwest where waiting lists and waiting times are beginning to get out of proportion for the school age service.

It is clear that as a relatively recent service, the NDT will experience a growth in numbers referred at school age for a number of years to come as a]it is becoming clear that many children with atypical conditions are not picked up until this point and b] there is potentially a 12 year “service lifespan” for families whose children enter the school age service at six.

The table below illustrates the trends in service population over a 12 month period

The Service Population Trends over 12 months [Q1 – Q4 of 2016]									
Q1					Q4				
	EY	SAT	Total	Wait – List		EY	SAT	Total	Wait – List
North	81	235	316	30		90	248	338	29
Mid	99	297	396	52		73	326	399	63
South	93	290	383	31		94	346	440	31
	273	822	1095	103		257	920	1177	123
Growth rate of Early years Service from Q1-Q4 = - 16 or a 6% fall									
Growth rate of School years Service from Q1-Q4 = 98 or 12% increase									
Overall increase in Service numbers = 82 or 7.5% increase									
Waiting List trend from Q1 – Q4 = 20 or 19% increase									

R 24.Conduct a Resource Modelling Exercise

A priority issue in the school age service is to best match the resources available with the scale of need. It is likely that the demand for services at this age will continue to grow in the absence of other support services and because parents are liable to need formal transition planning support at key points in the child’s life cycle.

A resource modelling exercise is required to anticipate likely demand levels and to scope these against the current NDT Service model and available resources. This exercise will help to inform decision – making about both the current service activity-resourcing configuration and also the prospective needs for future resourcing of the service.

An indicative model for a resource modelling approach is set out in <u>Appendix 4</u>

Note: It is possible that the service will not be able to provide a support – intervention service that meets all family needs & expectations within the resources available to it. This will mean that the service may need to develop options for providing a different type of service:

- Working more closely with other involved agencies to provide an umbrella service that meets more needs on a shared basis. This might involve shared care arrangements with Primary Care or other services.
- Defining the services that it provides in a more limited and targeted manner, which means either limiting the services it offers, limiting the families it provides the service to or a combination of both
- Determine on what basis a case remains open in SAT and consider redirecting the children of lowest priority back to Primary Care

2.3] Improve Administrative Support Systems

The administrative support for the 3 teams appears to be deployed on an ad hoc and historical basis without any reference to the growth in activity levels and without a consistent standard set of administrative priority tasks & duties having been specified across the 3 teams.

So there is not only a significant shortfall in administrative support but also a lack of role clarity & consistent expectations of what the priority focus of the current roles should be.

The clinicians on the teams report that they spend an inordinate amount of time on routine administrative tasks including appointment scheduling, preparation and posting of routine correspondence, preparation of course materials and documenting FSP outcomes – this is both an opportunity cost and a poor use of an expensive resource.

There also appears to be a lack of standardisation for activity recording and report writing within each discipline across the teams and home agencies

We recommend that administrative resources be enhanced by a minimum of 0.5 wte across each of the the 3 teams but Recommendation 25 below should be implemented prior to this, to ensure that the new resources are deployed to best effect.

Recommendation: Specify Administrative Support Activity and Enhance Resources

R25. Define a standard administrative support function across the three teams which will encompass comprehensive specification of activities, roles, duties and a performance management template

R26. Based on the outputs from Recommendation 25: put in place a resourcing plan to enhance the administrative resources available to the teams by a minimum of 0.5 wte per team.

2.4] Use Technology to Enhance Logistics & Information Management

While the current level of administrative support is inadequate; it is also clear that not enough use is being made of advances in technology to facilitate case recording, activity scheduling and skills enablement of parents.

Recommendation; Set up an Internal Working Group on Technology Enablement

R27. The service should set up a small standing working group comprised of clinicians and administrative staff to develop and pilot the application of digital technology to facilitate service delivery.

Examples of areas for investigation would include:

- *Use of Apps for appointment scheduling and reminders*
- *Use of phone and mobile device technology to film interventions with children so that families have a visual model to follow*
- *Use of Skype or other variants to facilitate "check – ins" with families*
- *Use of voice recognition software to facilitate clinician report writing [What do legal firms do in this space now?]*
- *Touch screen formats for recording clinician activities*

There has to be some useful working models elsewhere so the group should do a search for what is being used for similar applications elsewhere.

[Note: We understand that there are current IT procedural parameters that operate within the HSE but the overriding principle should be to test how new approaches can improve services and this is where the inter –agency partnership should offer the potential for greater creativity]

2.5] Fixing the Resource Envelope for the Service- Specify a Dedicated Budget for the Service:

At present the NDT service does not have an identifiable budget as such, although there is clearly an agreed number of staff hours allocated to it by each of the participating agencies. In addition the premises and materials [with the exception of the equipment aids & appliances budget] are clearly allocated and in two cases these are clearly allocated to the NDT service alone. So the bulk of the current service expenditure is clearly identifiable but not consolidated as a managerial accountability for the NDT service. There are a number of consequences to this situation:

- The team managers of the NDT service have little discretionary authority into how current resources can be reconfigured to meet changing needs
- There is no access to service development resources from a capacity building perspective [For example staff training which is a critical area of concern at present – see commentary under Fields 3 & 4 below]
- There is no capacity to plug short term resourcing gaps caused by maternity leave or staff turnover – and these gaps are a major source of poor service quality from a family perspective.
- There is no incentive for team managers to be entrepreneurial in building up partnerships with other agencies or seeking to widen the resource base from other sources

Recommendation: Specify an Operational Budget for the Service

R28. We recommend that a proper service budget be established by, in the first instance, pulling together the dedicated resourcing elements from each agency under a single consolidated budget.

R29. We further recommend that the service makes a determination in principle that resources freed up on a temporary basis through extended leave or staff turnover will be immediately used to source cover by setting up a temporary staffing pool which is fully vetted.

R30. We also recommend that the service look to develop partnering arrangements with other agencies and voluntary groups so that opportunities for resource sharing and voluntary inputs can be maximised.

2.6] The Current Staffing of the Service:

The service has had considerable resources put into it since its inception. The current staffing profile is summarised in the table below:

NDT Service Staffing Summary as of June 2016 [*}								
	wte total	**Principal**	**Senior**	**Staff Grade**	Posts vacant [**}	Ratio Snr /Staff Grade	% Full time	% Senior Full time
Psychology	11.2		2.3	8.9	0.5	1 to 4	45%	0
Social Work	9.3	0.4	2.8	6.1	-	1 to 2	43%	36%
OT	19.9		8.9	11	2.5	1 to 1.25	85%	67%
SLT	19.8	0.6 + 0.6	6.6	12	2.8	1 to 2	72%	60%
PHYSIO	10.5		5.5	5	2.7	1 to 1	57%	36%
CNS	1.9		1.9			-	100%	
Social Care	1			1		-	100%	
	72.6	1.6	28	44	8.5 [12%}			
[*] Information supplied by Team Managers excludes Team Mgrs & Admin posts				[**} Posts vacant as of June 016]				

The following observations can be made on the current staffing profile:

- Although recent recruitment has been mainly at Staff grade, the overall balance between Senior & Staff grades seems reasonable.
- However there is a high proportion of staff working in a part-time capacity, this being particularly the case in Social Work, Psychology and Physio.
- This could be problematic in Psychology where there is no full time Senior grade post. Social Work and Physio also have only about a third of their Senior complement in fulltime roles.
- Only two disciplines have a Head of Discipline role [Social Work & SLT] albeit these are also part-time roles. However the Heads of Discipline do not operate in a formal discipline leadership capacity across the service albeit that they may be giving strong leadership by example.
- As already noted, the expert practitioner role in nursing is not represented across all 3 teams and neither is the Social Care Worker role.

2.6a] Unintended Consequences of the Staffing – Up Model:

As noted above; the current resourcing –up model has primarily focused on recruiting personnel at Staff or Basic grade level. This has a number of unintended consequences for the service:

- The filling of service development posts at basic practitioner grade means that the level of expertise in the team is diluted and this means that more complex or risk –profiled cases are allocated disproportionately to a small number of personnel across the 3 teams.
- A higher proportion of basic grade posts has a knock – on in- service training requirement which includes a comprehensive and structured in – house induction, training and up-skilling process which is resource intensive but critical for service quality – the service has not been meeting these requirements adequately.
- The basic grade practitioners require a high level of supervision and this has been difficult to formalise adequately within the teams although some progress has been made in this area.
- By the nature of the posts, basic grades tend to be career mobile and so they are difficult to retain particularly when the careers market is opening up in the health services and when the NDT service itself does not appear to be structured for career progression.

The impact on families of this high staff turnover is adverse in a number of ways; primarily in terms of the gaps in their service where a therapist leaves and there is a delay in replacing them. Other adverse impacts are in the discontinuity of the support being provided which involves clinicians repeating the familiarisation & information gathering process with the child & family. Families may also feel that they are at a loss of the expertise that comes when clinicians have more experience. Finally the delivery of more complex support & interventions may not be feasible for junior clinicians, which puts undue stress on the rest of the system.

Recommendation: Work towards a fully developed career structure within the overall service

R31. Over time, the overall service should have a Single leadership role for each discipline. In the shorter term, this may be possible to implement for Social Work and Speech & Language Therapy.

R32. In the meantime, there is another recommendation under Review Field3 below that the Senior roles take a fuller role in practise development

2.7] Long Lead Time to Fill Vacancies:

There are unacceptably long lead times for the filling of vacancies within the service. There is considerable fragmentation & inefficiency in recruitment and selection processes compounded by variations in systems & practices within the different participating agencies.

R33. We understand that some progress is being made in trying to consolidate and streamline the recruitment processes across the agencies. We also believe that consideration should be given to developing a temporary staff pool so that ongoing therapy support could be sustained when vacancies arise.

2.8] Operating the NDT Service as a Single Service

As noted already, there are inconsistencies in the staffing resources and expertise available within each team and this has a knock – on consequence in terms of access for the families using the service. We believe that more can be done in the following areas:

Recommendation Adopt a Single Service Approach to Provision

R34. Develop a single annual family training schedule for the entire service: This could improve opportunities for families to attend by having greater frequency of courses and both day & evening provision. Ensure that staff with specialist training skills [Such as Earlybird Training certification] are used as a service wide resource.

R35. Use the Social Care Worker to provide Mother and Baby groups across the service

R36. Use the Clinical Nurse Specialist as a service –wider resource for counselling and behaviour management support

Review Field Three: Quality Assurance and Feedback

An effective service tracks customer feedback on a regular basis, quality assures its core activities and promotes continuous improvement as part of its ethos.

What is Going Well:

Policies and Procedures have been developed to cover most aspects of the service. It has taken some time to finish the most contentious and complex of these [Children First - Safeguarding & Challenging behaviour- Behaviors of Concern] but these are now reaching completion.

There has been good progress made in participative process mapping some of the main service pathways.

A number of the Disciplines now work in cross team groups to look at service delivery & quality issues.

What is Going Less Well:

3.1] Lack of a Formal Family Feedback System

The first and clearest point is that the service does not have a systematic process in place to collect feedback from its primary customers- so it is effectively operating in the dark about how well it is meeting needs from a customer perspective.

Of course, there are opportunities and points of feedback such as after family consultations or when groups or training programmes are run but even here the data is neither collected nor consolidated in a systematic enough fashion.

The team managers also log complaints and the frequency of complaints is part of the standard data set that is reviewed periodically by the Steering Group. However the feedback from the parent survey indicates that 75% of respondents did not know how to make a complaint & in many cases there was a reluctance expressed about making a complaint for fear of adversely affecting the level of service to the child.

<u>Recommendation: Implement a formal family feedback system</u>

R37. Implement a formal customer feedback system, where family feedback is collected in a structured format on a rolling basis [Suggest quarterly]. It may be necessary to make some of this feedback in a non-identifiable format.

At a minimum the rolling feedback process should collect information on the following areas:

- What are the families finding positive and helpful about the service?
- What are the families less happy or actually dissatisfied about the service?
-Are there areas of significant unmet need for the family?

A separate point is made later on in the report under Governance about the need to have formal family representation on the Steering Group.

3.2] Developing a formal quality assurance system & processes

While good work has been done on process mapping the main service pathways; the service does not have a formal quality system and so single quality issues are addressed on an ad hoc basis.

Given that the service has been constituted from separate services that provided expertise in ASD, intellectual disability and physical disability; then it is arguable that there should be centralised expertise within the service for each of these main areas. This expertise should be codified for wider dissemination across the service [assessment & guidance methods & templates, educational materials and up to date research]. Formal practise development groups for ASD, Intellectual Disability and Physical Disability could greatly facilitate this process.

Recommendation: Develop a more formalised quality assurance process for the service

R38. The service should develop a formal quality assurance system that covers all of its main activity areas and incorporates a continuous improvement process.

> *It may be that there are elements of a viable system within some of the contributing organisations [Personal Outcome Measures, EFQM] and it should not be necessary to have to start this work from scratch*.

Recommendation: Develop Practise Development Groups for each of the main diagnostic groups

R39. Practise Development subgroups should be established for the main diagnostic categories and also for each discipline

3.3] Develop the role of the Senior Grade within the Disciplines

In our view, the role of Senior grades in the disciplines is under – developed. They should have a formal role in providing added value elements such as Practise Leadership, induction support, quality assurance & clinical supervision for less experienced staff. While this is happening to some degree, it does not appear to be formalised as a core role requirement.

Recommendation

R40. The role of Senior grades, within the Disciplines, should be extended to include contribution in the areas of Practise Development, Quality assurance and Clinical Supervision.

> *[Note: This may require that the current service resources are supplemented to ensure the current active caseloads continue to be serviced]*

3.4] Consolidate the Clinical Supervision Process within the Service

Staff within the NDT service, have a lot of confusion about their accountability, reporting and quality assurance relationships. A staff member may relate to their NDT Team Manager for their allocation of work and yet may report on their attendance, leave and performance to their original host organisation.

There are a variety of clinical supervision arrangements operating across the NDT service and there is a need to arrive at a more consistent and standardised practice.

Recommendation: Take Clinical Supervision internal to the NDT Service

R41. The norm should be that Staff grades receive their clinical supervision from a Senior grade within the overall NDT service. In the longer term the build up to a full grade structure within the disciplines should make this possible and also make this the case for the Senior grades. In the interim we recommend that a Head of Discipline from one of the participating organisations who has a relevant back ground in children's services should take on the clinical supervision role for all Seniors within the service.

3.5] Enhance Interdisciplinary Representation at the Steering Group

There is a degree of remoteness between the practise development role of senior clinicians and the strategy setting role of the Steering Group for the NDT Service.

Recommendation Enhance Communication between Clinicians and Steering Group

R42. Once the practise development role of senior clinicians is consolidated, consideration should be given to providing access on the Steering Group to a practise development representatives from the service so that they can make a regular input on quality assurance and service development strategy.

Review Field Four: Development of Service Capability

An effective service learns from its experience, refines & develops its practise on an ongoing

basis and develops capability to meet current and anticipated future service needs.

What is going well:

A comprehensive training needs analysis was conducted in 2014/15, however this has not been followed through on with training delivery.

There is a Journal Club operating to share practise updates and research but this is not service-wide.

Multidisciplinary and Interdisciplinary working has led to skill-sharing and enhanced cross-discipline service delivery.

Speech and Language Therapists have regular cross team practise meetings.

What is going less well:

The feedback from the manager's interviews, staff survey & focus groups indicates that there are a number of areas of concern in this field.

4.1] No Coherent Training Plan for the Service

There was a lot of good work done on training early in the team's development but this has not been sustained.

At present; there is no coherent service – wide approach to implement training and development and this is linked to other factors such as focus on staff as team members versus service resources, the lack of an overall service budget and lack of clinical leadership roles

Given the large proportion of newly qualified staff coming into the service; then staff training should be an ongoing high priority. While there is an awareness of this at Team Manager level, resourcing constraints are hampering systematic progress in this area – [basically it is a case of the individual staff depending on their host organisation to make training resources available or not and there are major inconsistencies in this regard]

It is clear that that there are a number of clearly identified training areas at two levels:

- Level1 is standard training on core service areas that should be provided on an interdisciplinary basis [Some examples emerging from the staff feedback are Running effective FSPs, Communication with families, Policies & procedures, Activity tracking & report writing]
- Level 2 is more specialised training that is required for specific service activities or by particular disciplines [For example Early Bird training or Behaviour Management]

Recommendation: Develop a Systematic Staff Training Programme

R43. Revisit the Training Needs Analysis exercise done 2 years ago and update it with a simple survey of all staff to identify short, medium and long term training goals under a minimum of 3 headings:

a. *<u>Generic service training areas</u> – such as Service Model, Policy & Procedures Updates, Customer care, Freedom of Information, Effective FSP Process, Caseload Management and so on*
b. *<u>Delivery – specific training</u> such as Early Bird, Marte Meo, Hannon & so on*
c. *<u>Discipline specific training</u> such as Behavior Management*

<u>R44. In the short term; address the three priority training needs of the overall service –</u>

The Team Managers have jointly identified the following three priority training needs across the service- <u>Stepping Stones, Early Bird and Brief Encounters</u>

R45. Develop a register of current expertise and skills within the service and use this to identify potential resources to deliver training internally.

R46. There should be a standard induction process for the Service including a basic knowledge & training curriculum- the bulk of which should be delivered by internal staff. This type of induction could be run largely on a whole service basis with some additional team – specific inputs.

R47. All team members should have an annual Personal Development Plan [PDP] which is integrated with their supervisory & performance management process

<u>Recommendation: Develop an ASD –Specific Training Framework</u>

R48 Consider the feasibility of implementing an ASD specific training programme along the lines of the National Training Framework for Autism Spectrum Disorders in Scotland. This framework has been developed and updated in conjunction with a range of stakeholders and includes a number of assessment templates and sources of training provision.

4.2] Lack of Consolidation of Expertise /Knowledge Management

There is a limited amount of knowledge management & knowledge transfer across the service although there are Islands of good practise such as the service –wide SLT group and the journal club.

Given that the service originated in the amalgamation of three specialist disability services [ASD, Intellectual and Physical Disability]; then it is important that the service can build on these diverse backgrounds by developing a system whereby this distinctive expertise, knowledge and skill- sets are transmitted and shared across the entire service in a structured manner. While a certain amount of this may have been done at the initiation of the NDT service; there does not appear to be any ongoing structured system or process to share specialist expertise of the primary diagnostic categories across the staff group.

<u>Recommendation- Structure a Knowledge Management & Transfer System</u>

R49. See recommendation39 & 40 in the previous section for the relevant commentary on this area.

Practise Development subgroups should be established for the main diagnostic categories and Senior clinicians in the disciplines should be asked to play a leadership role in this work. This should lead to the codification of best practise approaches which can then be disseminated within the service.

4.3] No Consultative Forum for Service Development Planning

The service is so busy addressing current demand levels that it doesn't have an adequate consultative planning process for future needs. This is an area that requires a more structured planning process but with adequate consultation from staff and other stakeholders.

Recommendation: Set Up a Service Planning and Quality Forum

R50. Set up a strategic service and practise development working group comprised of Team Managers & senior representatives from each discipline. The following areas could be Included in its brief:

- *Practise Development coordination*
- *Networking with other services*
- *Liaison with Third level bodies & Centres of Excellence*
- *Long term planning for needs*

Field Five: Organisation Structure and Corporate Governance

The service was established as a partnership between the HSE and a number of voluntary service providing agencies. The HSE has a dual function within the NDT service as it provides staff for the service but also provides the overall funding for the service on a direct and indirect basis. The NDT service is overseen by a Steering Group comprised of senior representatives from the partnering agencies

5.1] Fragmented Nature of the Formal Accountability Systems

In our view and as already noted in the report, the initial partnership arrangements for establishing the integrated NDT service, are not robust enough to provide consistent and stable accountability systems for the staff working within the service.

From a staff member perspective; they may have up to 3 accountability relationships:

- to their host service organisation line manager for "performance management" purposes
- to a senior clinician in their own or a different organisation for clinical supervision
- to the NDT Team Manager for compliance with the Policies & Procedures of the NDT

From the NDT Team Manager perspective; there is a lack of clarity about their role in areas such as:

- Although they are ultimately responsible for intake and discharge, it is unclear whether they have the designated authority to allocate cases to specific disciplines or clinicians
- Although they are responsible for service quality and dealing with complaints, it is not clear that they have the authority to intervene directly where individual staff performance is unsatisfactory
- Although they are responsible for running a responsive service; they do not have any budget holding or resource management authority that would enable them to deploy resources flexibly to meet changing needs

From the Heads of Discipline in the host organisations perspective; there are constraints in areas such as:

- They may have only remote access to performance information about the individual clinician rather than "line of sight" which is clearly preferable
- For new staff at Basic Grade level, they have a responsibility to sign off on "fitness to practise" but again they do not have direct access to the requisite data to do so
- As senior clinicians practising in a different service area [Adult rather than child], they may lose touch with key practise developments in the child & family area and be less qualified to offer practise development guidance
- As resource managers for clinical services in their host organisation; they may have competing priorities when it comes to resource allocation and staff deployment

The current situation as outlined above is invidious to all concerned and creates uncertainty and an overreliance on goodwill from all parties. It is sub optimal as a performance management practise with ambiguity on authority parameters and the line of sight principle. It contains the potential for risk from a quality assurance perspective.

There are options to reduce the level of ambiguity and lack of line of sight for performance management and clinical supervision which are set out below:

Recommendations on the Accountability Management Process within the Teams

R51. Consolidate the Role and Authority of the Team Manager

All performance management functions outside of clinical supervision for staff working in the NDT teams should be delegated fully to the Team Managers by the respective host organisations.
This would mean that the Team Managers carry full delegated authority to performance manage the following areas:- attendance & time-keeping, leave, allocation of duties including but not limited to case allocation, standards of behaviour and compliance with service Policies & Procedures.

NB: This will need to be done through a formal process of memorandum of agreement signed off by all the relevant parties.

R52. Streamline the Clinical Supervision Process

All Staff grades should have their clinical supervision provided by Senior grades within the overall NDT service
Where there is a Principal or Head of Department level role within the NDT service; this role should provide clinical supervision and practise leadership for the Senior grades within the service
The service should work towards having a Leadership role for each discipline within the service but in the interim clinical supervision for Senior roles should be provided either by an identified Head of Department/Clinical Lead in one of the host organisations who has a background in children's services or through negotiation by a similar level role in an adjacent children's NDT service.

5.2] Strengthen the Reporting Process for the Teams and the Team Managers

At present, the three Team Managers have a reporting relationship in to the Disability Services Manager[DSM] . However the accountability functions of this reporting line are not clear. The DSM meets with the Team Managers and they provide certain information about the activity of their teams and outstanding service issues. The DSM provides support, advice and encouragement. Certain case management and resourcing issues for the teams, may be discussed, problem solved and /or taken on by the DSM for escalation up the HSE system.

The Three Team Managers attend the Steering Group in a non-voting capacity and the DSM chairs this group, so in principle there is good linkage between the operation of the teams and the oversight group.

These reporting lines have served reasonably well from an information transmission and support perspective. However at this point in the service's evolution, we think that a move towards a more formal reporting and accountability framework for the service is warranted.

In our view, there are two missing elements in the accountability structure:

1. A single Operational Service with a Service Management Team

In our view, the NDT needs to move towards operating more clearly as a single service entity which pools its resources and operates in as standardised and integrated a manner as possible across the three teams.

- This means a standardised approach to taking in new referrals, operating key worker/key contact system, case recording processes, type of family support groups etc.
- This means operating clinical supervision coherently across teams
- Ultimately this means the service having a single boundaried budget

In order for this to happen; there needs to be a Service Management Team and preferably a single point of accountability for the operating service as it reports into the Steering Group.

Indicative functions of a Service Management Team are set out below:

Functions of the Service Management Team
To be accountable for the achievement by the NDTs of the service objectives set by the Steering Group and the national PDS programme To develop and achieve an annual operating plan for the overall NDT Service To collect and evaluate core service activity data on a quarterly basis To collect, evaluate and report on service user feedback and client outcome data on an annual basis To ensure that resources are accessed, deployed and coordinated across the entire service to achieve the beneficial outcomes for service users in an efficient manner To ensure that core service standards are set and achieved for the main activity areas of the service To ensure that there are consistent quality assurance processes operating across the service To ensure that there is an ongoing programme of staff development To ensure that there is an ongoing process for service and practice development To ensure that all stakeholders are involved in an annual service planning, evaluation and review cycle

A service management team could be comprised of the Team Managers, the HSE DSM or another management representative from the HSE, an administrative role with a business management function and representation from the clinical staff.

R52: Recommendation: Consider moving towards a Formal Single Service Management Model

The participating agencies should consider how to consolidate the formal operational management accountability structure and process for the NDT service so that it operates in a more standardised and integrated manner-– a single operational management structure for the entire integrated service is worth consideration.

As it stands, the three Team Leader posts operate at a single team accountability level and as a result intake and core activity processes vary. The service does not therefore operate a systemic management process which manages the NDT service as an integrated entity that operates to a

standardised service model & process and maximises the use of its resources for the service as a whole. It may be that the management structure needs to be reconfigured with a single overall service manager role that a number of individual team managers report into.

R 53. Clear Performance Accountability for the Team Managers

In our view, there is not currently a full performance management relationship between the Team Managers and a single accountable person at a higher level.

This type of accountability relationship would entail that each Team Manager has a clear set of objectives, performance measures and service outcomes that they are responsible for achieving and reporting on to a single accountable person at a higher management level.

R53: As part of this management structure process, a clear performance management accountability line should be established for the individual Team Managers.

5.3] The Role & Contribution of the Steering Group

The Steering Group is comprised of Senior Managers from the participating organisations and is chaired by the HSE Disability Services Manager. The Steering Group meets periodically with the Team Managers in attendance. A standard report-in template is provided by the three Team Managers to the Steering Group

The Steering Group has had a chequered history in terms of attendance and full delivery of effective oversight management. The feedback that we have received indicates that the Steering Group has taken on a more proactive stance in the last year with a clear agenda & working process and a more regular meeting schedule.

There is still an ongoing anomaly whereby one of the participating agencies does not make a contribution at Steering Group level.

Clarify the Functions of the Steering Group

As a reference point; the Steering Group for the Mid-West NDT Service has the following Terms of Reference:

The primary functions of the Steering Committee are to:

- Ensure that high standards of governance are maintained in the conduct of the business of the Teams.
- Define annual and longer term objectives and agree plans to achieve them
- Ensure that the structures and policies for service delivery are developed with the primary goal of achieving best possible outcomes for children and their families.
- To set the strategic direction for the Teams in line with National Policy and also as informed by the Programme Lead and Management Team.
- Oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary.
- Ensure there is effective dialogue between the teams and service users with regard to planning and performance, so that services are responsive, and in line with national policy.
- Ratify changes to regional policies, procedures and guidelines within the framework of relevant legislation and national policies.
- Provide an Annual Report to the ISA/CHO Manager of the Service's activities, challenges, developments and plans within 4 months of the end of the previous year.

[Source: Organisational Structure for Mid – West Children's Disability Services [MWCDS]

The Kildare/West Wicklow Steering Group fulfils some but not all of these functions at present. It appears to be weaker on the aspects of:

- Setting strategic direction and longer term objectives for the service
- Monitoring performance against objectives and ensuring that corrective action is taken
- Ensuring effective dialogue between the service and its consumers to ensure responsiveness and appropriate representation

In addition, it appears that one of the participating organisations has opted out of full participation in the service oversight process

5.4] Family Representation in Service Planning and Review

The PDS approach puts "family – centredness" as a core value at the heart of the service ethos and delivery model. However there are currently no formal structures in place for involving or consulting families in a systematic manner on how the service is planned and run. [Note: at the time of writing this report, efforts were underway to co-opt family representation onto the Steering Group.]

We believe that there should a rolling formal family consultation process across the service which could build on the formal family feedback process recommended in recommendation 34. It would make sense to have a formal family consultation process for each team and then a mechanism for consolidating this consultation at the overall service level with a representative feed –in of family views through this into the Family representatives on the Service Steering Group. It might be useful to get some advice or facilitation input from a reputable advocacy group to develop a set of effective processes in this area**.**

5.5] Broaden Representation on the Steering Group

It was noted earlier in this report that formal coordination at a management level between the education system and the NDT service is weak. The Midwest service has co-opted two school representatives with non – voting rights onto the Service Steering Group.

It might also be considered whether it would be useful to have a representative from the Primary Care Service on the Steering Group to facilitate better joint working between the two services.

We noted earlier in this review that it would be useful to have a Clinical Representative at the Service Steering Group once formal clinical practice development & representation structures have been established at an operational level.

R54: Recommendation – Broaden the Representation on the Service Steering Group.

Consideration should be given to widening the representation on the Service Steering Group to include family, education, clinical and possibly primary care representation. Not all representatives need have voting rights.

R55: Recommendation- The Steering Group take a more proactive role in the strategic direction and oversight performance management of the service

1. *In our view, the Steering Group needs to accept primary accountability for determining the future strategic direction for the service which includes deciding - what is the most appropriate service configuration to meet the aspirations of the stakeholders, within the spirit of the Progressing Disabilities policy framework.*

2. *Determining what type and level of service will be offered to school-age children within the resources available to the service and then ensuring that all stakeholders are clear on this and that the service is managed optimally within these parameters*

3. *There needs to be adequate family representation on the Steering Group but the objectivity and impartiality required of this role should be emphasised*

4. *Ensuring that clear workable collaboration & cooperation protocols are agreed with the primary care and specialist services including CAMHS*

5. *Determining how a full career development and practise leadership structure for the service can be achieved or putting in place a viable alternative from within the wider resources of the participating agencies*

6. *Determining what role the Steering Group has in advocating for or developing the wider wrap - around service supports that are needed for families with the most complex needs*

7. *Defining a set of performance measures for the service that actually track core activities, resource deployments and service outcomes*

5.6] Taking the Long Term View: Moving from a Service Configuration based on Goodwill and Ad - hoc Accountability Relationships to a Seamless Integrated Service

In our view the current service governance is suboptimal due to the level of drifting accountability for performance & quality, lack of strong clinical leadership and unclear strategic direction.

While there is a clear national strategy and policy framework underpinning the establishment of the service, this is not currently supported by the basic building blocks of an effective delivery system:

- Boundaried resources managed by the service managers
- Specific service objectives & outcomes that are measured
- A clear performance accountability system based on line of sight
- Strong clinical leadership and practise development
- Adequate feedback from and representation of service users

There is a strong case that a Lead Agency approach would help to address these issues and put the service governance & accountability relationships on a sounder footing. One option is to nominate a lead agency for each team/geographical patch – however our view is that this will not address the

need to deliver an integrated and standardised service to the full catchment area within the resources available.

R56: Recommendation: Consider a Transition to a Lead Agency Configuration

It is our view, that the most effective way to deliver the focused, accountable and integrated service that is required is to move over time to a single Lead Agency format for the entire service.

In such a model a service level agreement would define the necessary parameters, standards and working arrangements in each of the above areas.

However careful consideration and consultation between stakeholders on this option is a pre-requisite to this becoming an action point.

The transition to a Lead Agency format would need to be managed so that the best of the current practises and expertise are subsumed within the new service arrangements and it will take time and mature cooperation by all parties to ensure that this happens in a manner that seen as effective by all stakeholders.

Section Six: Lessons Learnt and Emerging Issues for National Policy & Provision

This section is available as a separate document

Appendix One: Summary of Recommendations

A List of the Service Review Recommendations

Review Field One: Effectiveness of NDT Service – 2016

R1/8: Recommendations to Enhance Early Years Service:

R1. The HSE should operate a protocol whereby children receiving primary care supports do not lose these supports until the point where the NDT is actively engaged in service provision with the family.

R2. Put resources into fuller family engagement, after the initial intake into the service. Provide emotional and psychosocial support before providing advice & guidance on functional skills and development.

R3. Build collaborative relationships with other interested groups & agencies that may also provide support and counselling so that the NDT provides a hub function for a range of potential supports for families of young children.

R4. Explore the feasibility of enabling and training parents to act as peer supports for other parents.

R5. Move to a point where the specialist nurse and social care workers that are providing ASD Counselling and mother & baby groups are used as a service – wide resource and develop a skills transfer process in these areas to widen these relevant competencies within the teams.

R6. Improve family empowerment by doing a graduated skill transfer model whereby the therapist demonstrates the relevant skills and supports directly with the child [in the home if possible], creates a visual model and then gets the parents to practise the skill with feedback.

R7. Ensure that there is an induction and ongoing development process for new staff that covers communication, family support, enabling skills transfer& skills for effective key-working.

R8. Structure group training programmes so that all children have been seen by a clinician before attending who informs the trainers how to best match the child/family needs with the training content. Get clinicians to drop in to the training where possible to connect with families and ensure that there is a follow up home visit to reinforce the generalisation of skills learned.

R9. Set up Local NDT –School Collaboration Forums:

At a local level, an effort should be made to set up a standing cooperation forum between schools and the NDT service. This could initially work by inviting Principals and relevant teachers to a quarterly or half – yearly forum where issues of joint concern could be discussed and worked on. You would think that this could be done perhaps at team or mini –team level initially. Some useful agenda items could include the following:

- *How to improve basic communication access between the 2 services*
- *How information on a child's development and recommended support approaches could be shared more routinely and frequently, particularly at the start of each school year. We understand that there are protocols for sharing information with schools but is there scope for the NDT to share development support information about individual children with schools on a more routine basis – this is a shared responsibility with parents but could information sharing become the norm rather than on request?*
- *Identifying where the NDT expertise might feed into in-school training for teachers and SNAs*
- *Exploring the potential for parent training programmes that would be jointly run by teachers and the NDT*
- *-Whether there is potential in some cases, to combine the IEP and FSP into a single family support plan*
- *Identify areas where standard intervention protocols might be jointly developed – For example: aspects of communication, functional skills development and behavior management*
- *Consider the feasibility of implementing the Transition Planning protocols in the Education and Health Framework report.*

R10. It is clear that the responsive nature of the current service collaboration impedes the most streamlined use of resources. A case in point is the Special Needs Assistant who is assigned to support an individual child in school – how many of these are routinely briefed by the NDT via the teacher on the best ways to support the individual child's development?

R11. Further than this; A recurring theme in this report is that the NDT service makes insufficient use of generic close support workers to facilitate programmed supports for children & families. We recommend that the NDT take an initiative to see if one or two schools could be interested in developing a project to use SNAs as a more effective bridge between home and school support programmes?

R12. The onus is on the Steering Group to progress the strategic aspects of improved school – NDT collaboration. Has the National Education and Health Steering Group been established? – How can this development be expedited?

R 13: Recommendation on Enhancing the Service Pathway for School-age Children with ASD

We recommend that the NDT work with the educational sector to develop a clear service pathway for families with a child who has a late ASD diagnosis. This work would involve identifying commonalities of support needs and could usefully be done in collaboration with an external agency that has Autism-specific expertise [For example – ICAN or Scottish Autism].

This work could also be broadened out in a holistic manner encompassing wider educational, family and community integration supports, rather than concentrating solely on service areas where the NDT is currently resourced.

Topics to be considered in this design work could include the following:

- How to maximise the integration of support activities provided by different agencies

- Whether there should be a combined IFSP and IEP rather than separate intervention & support plans
- What it would take to broadened and up-skill the Special Needs Assistant role so that it could encompass a dual school & home /community support function
- This work should also encompass consideration of the issues relevant to behaviour support covered in Recommendation 19 below.

Recommendation: Strengthen the Customer Care – Case Management Ethos and Systems within the NDT:

R14. Ensure that there is a proactive key worker system in place at school sage:

The elements within this recommendation are that:

- *Every family has a current nominated key worker and a clear contact number/email for this person.*
- *There is specific protocol in place for the time within which a key worker should respond to a family initiated contact*
- *The role of the key worker should be clearly specified and should include a case management responsibility to proactively contact each family within a specified timeframe to check in on status and needs*
- *Staff may require a short training module on this more proactive approach to key contact*

R15. Establish Standards within the Service for Communication Responsiveness:

It is highlighted elsewhere in the report, that there is a significant shortfall in administration resources for the NDT service. As the service has grown in client population and staff numbers, the administrative resources have not been developed in parallel. Notwithstanding this, it is not satisfactory that families are experiencing the level of reported difficulty with contacting the service by phone.

R15a. In the short term, Team Managers need to work together to find a solution that ensures phone contact is responded to within a standard timeframe. It may be that part of this solution will require re- routing of calls at points when the phone is not manned in one team. In the longer term the resourcing shortfall on the administrative side needs to be addressed.

Recommendations for School Age Service -2

R16. Consider stretching out the FSP process to a 2 - 3 year cycle perhaps linked to transition points in the child's life [At ages 6,9,12 & 17].

> *In between assign a case coordinator to each open case with a clear brief to proactively contact the family within a set timeframe [For example – once a quarter] and to ensure that the family always has a current "roadmap" of the support plan for the family over the next 12 months.*

Consider the feasibility of operating a "paired support worker process whereby 2 members of the team liaise with the family each calendar year- the case coordinator and another member of the team providing some targeted or responsive intervention and support.

In some cases could the NDT case coordinator attend the child's IEP meeting and dovetail the family support required?

R16. Team members need to take shared responsibility for working in a resource-constrained environment by working in a flexible and resource – efficient manner.

There are some current positive emerging examples of this.

- *While a clinician may be providing targeted interventions and supports to allocated cases & group programmes; they could also spend a portion of each day on case management & liaison work.*
- *Is it possible to explore ways to develop a more frequent but less time intensive contact process with families?*

R17. The service needs to further strengthen partnership relationships with other groups & agencies in the geographical area so that family & child needs can be met on a shared or complementary basis.

R18. A protocol for closer collaboration with CAMHS, TUSLA and other specialist services should be brokered and where the required services are simply not made available, an unmet needs record for every case should be sent to senior management in the CHO.

R19. Further exploration is required as to how the service meets the needs of families where the child exhibits behaviour that is severely challenging. We understand that work has been done on developing Policy & Procedures in this area but there does not appear to be the dedicated expertise available to cope with the emerging demands in this area [Close home support & counselling, respite care as well as intervention advice].

An internal scoping exercise should be feasible to establish the full scale of the needs in this area.

We understand that a proposal on this issue has been prepared by the Team Managers for submission to the Steering Group.

Recommendation: Improve Collaboration between NDT and MM Service

R20. Run a workshop between the Motor Management Service, Team Managers and Physiotherapists to identify enhanced collaboration practises.

Determine what channels should be activated to review the wider issues in the MM discussion document

R21: Recommendation- Develop a Web Presence for the Service

Set up a website for the NDT Service that sets out its mission, values, operating model and contact points.

- *The model needs to be simply and persuasively explained to positively manage expectations- perhaps with case examples*
- *This might be a project that could be facilitated by a student placement working in conjunction with the participating agencies own website supports.*
- *Ensure that plain English is the standard for all content*
- *Have a website committee within the service to provide ongoing impetus for this communication modality*

Review Field 2: Organisation, Systems and Efficiency

R22: **Recommendation: Establish an Activity Tracking System**

The service should establish a standard activity tracking and consolidation framework that will give a clear picture of what the service is actually doing.

This framework should collect & consolidate activity data at individual clinician, team and discipline levels on a regular probably monthly basis.

The teams and their managers can already describe what they are doing so the task is to specify and codify this knowledge, develop workable recoding templates and then use IT systems to consolidate the data for reporting and evaluation purposes.
Staff should be involved in the working up of this system and it should be possible to have a working model within 3 months although this may not be IT-enabled initially.

We recommend that an initial collection of activity information be piloted for a month across the three teams with a view to identifying the most useful data set to be tracked on an ongoing basis.

We understand that there is an intention to introduce a national IT support system for the NDT service but to our knowledge; there is no working off the shelf model in situ at present so this may be a case of who takes the initiative first.

R23*:* **Recommendation: Consolidate Information Management and Performance Tracking**

The overall service should have a Business Management function that encompasses responsibility for the following areas:

- *Development, implementation and maintenance of a KPI reporting system that consolidates activity data for each team and the service as a whole including a summary dashboard report on a periodic basis. Such a dashboard summary could include elements such as :*

Monthly number of service contacts with families by type & by discipline

Numbers of education/training groups run, numbers attending and percentage attending versus invited

Number of FSPs completed per month & associated valued outcomes achieved

Number of team hours deployed versus capacity ceiling [What percentage of the overall team hours are unavailable each month]

- *Specification and acquisition of a standard MIS system across the entire service. This may take a number of years to implement as there is a suggestion that the current MIS used for the Limerick NDT Service might become the national template but my understanding is that it is not an off the shelf system..*

- *Provide medium to long term demand forecasting [3-5 years out] through the collection of data on population, forecast incidence rates of certain diagnostic categories, disability databases and the predicted movement and needs of age cohorts of service users.*

R 24.Conduct a Resource Modelling Exercise

- *A priority issue in the school age service is to best match the resources available with the scale of need. It is likely that the demand for services at this age will continue to grow in the absence of other support services and because parents are liable to need formal transition planning support at key points in the child's life cycle.*
- *A resource modelling exercise is required to anticipate likely demand levels and to scope these against the current NDT Service model and available resources. This exercise will help to inform decision – making about both the current service activity-resourcing configuration and also the prospective needs for future resourcing of the service.*

Recommendation 25 & 26: Specify Administrative Support Activity and Enhance Resources

- *R25. Define a standard administrative support function across the three teams which will encompass comprehensive specification of activities, roles, duties and a performance management template*
- *R26. Based on the outputs from Recommendation 25, put in place a resourcing plan to enhance the administrative resources available to the teams by a minimum of 0.5 wte per team.*

Recommendation; Set up an Internal Working Group on Technology Enablement

R27. The service should set up a small standing working group comprised of clinicians and administrative staff to develop and pilot the application of digital technology to facilitate service delivery.

Examples of areas for investigation would include:

- *Use of Apps for appointment scheduling and reminders*

- *Use of phone and mobile device technology to film interventions with children so that families have a visual model to follow*
- *Use of Skype or other variants to facilitate "check – ins" with families*
- *Use of voice recognition software to facilitate clinician report writing [What do legal firms do in this space now?]*
- *Touch screen formats for recording clinician activities*

There has to be some useful working models elsewhere so the group should do a search for what is being used for similar applications elsewhere.

<u>Recommendation 28-30: Specify an Operational Budget for the Service</u>

R28. We recommend that a proper service budget be established by, in the first instance, pulling together the dedicated resourcing elements from each agency under a single consolidated budget.

R29. We further recommend that the service makes a determination in principle that resources freed up on a temporary basis through extended leave or staff turnover will be immediately used to source cover by setting up a temporary staffing pool which is fully vetted.

R30. We also recommend that the service look to develop partnering arrangements with other agencies and voluntary groups so that opportunities for resource sharing and voluntary inputs can be maximised.

<u>Recommendation: Work towards a fully developed career structure within the overall service</u>

R31. Over time, the overall service should have a Single leadership role for each discipline. In the shorter term, this may be possible to implement for Social Work and Speech & Language Therapy.

R32. In the meantime, there is another recommendation under Review Field3 below that the Senior roles take a fuller role in practise development

R33. We understand that some progress is being made in trying to consolidate and streamline the recruitment processes across the agencies. We also believe that consideration should be given to developing a temporary staff pool so that ongoing therapy support could be sustained when vacancies arise.

Recommendation 34- 36: Adopt a Single Service Approach to Provision

R34. Develop a single annual family training schedule for the entire service: This could improve opportunities for families to attend by having greater frequency of courses and both day & evening provision. Ensure that staff with specialist training skills [Such as Earlybird Training certification], are used as a service wide resource.

R35. Use the Social Care Worker to provide Mother and Baby groups across the service

R36. Use the Clinical Nurse Specialist as a service –wider resource for counselling and behaviour management support

Review Field Three: Quality Assurance and Feedback

Recommendation: Implement a formal family feedback system

R37. Implement a formal customer feedback system, where family feedback is collected in a structured format on a rolling basis [Suggest quarterly]. It may be necessary to make some of this feedback in a non-identifiable format.

At a minimum the rolling feedback process should collect information on the following areas:

- *What are the families finding positive and helpful about the service?*
- *What are the families less happy or actually dissatisfied about the service?*
- *Are there areas of significant unmet need for the family?*

Recommendation: Develop a more formalised quality assurance process for the service

R38. The service should develop a formal quality assurance system that covers all of its main activity areas and incorporates a continuous improvement process.

It may be that there are elements of a viable system within some of the contributing organisations [Personal Outcome Measures, EFQM] and it should not be necessary to have to start this work from scratch.

Recommendation: Develop Practise Development Groups for each of the main diagnostic groups

R39. Practise Development subgroups should be established for the main diagnostic categories and also for each discipline

Recommendation: Develop the role of the Senior Grade within the Disciplines

R40. The role of Senior Grades, within the Disciplines, should be extended to include contribution in the areas of Practise Development, Quality assurance and Clinical Supervision.

[Note: This may require that the current service resources are supplemented to ensure the current active caseloads continue to be serviced]

Recommendation: Take Clinical Supervision internal to the NDT Service

R41. The norm should be that Staff grades receive their clinical supervision from a Senior grade within the overall NDT service. In the longer term the build up to a full grade structure within the disciplines should make this possible and also make this the case for the Senior grades. In the interim we recommend that a Head of Discipline from one of the participating organisations who has a relevant back ground in children's services should take on the clinical supervision role for all Senior Grades within the service.

Recommendation Enhance Communication between Clinicians and Steering Group

R42. Once the practise development role of senior clinicians is consolidated, consideration should be given to providing access on the Steering Group to a practise development representatives from the service so that they can make a regular input on quality assurance and service development strategy.

Review Field Four: Development of Service Capability

<u>Recommendation: Develop a Systematic Staff Training Programme</u>

R43. Revisit the Training Needs Analysis exercise done 2 years ago and update it with a simple survey of all staff to identify short, medium and long term training goals under a minimum of 3 headings:

d. <u>Generic service training areas</u> – such as Service Model, Policy & Procedures Updates, Customer care, Freedom of Information, Effective FSP Process, Caseload Management and so on
e. <u>Delivery – specific training</u> such as Early Bird, Marte Meo, Hannon & so on
f. <u>Discipline specific training</u> such as Behavior Management

<u>R44. In the short term; address the three priority training needs of the overall service –</u>

The Team Managers have jointly identified the following three priority training needs across the service- <u>Stepping Stones, Early Bird and Brief Encounters</u>

R45. Develop a register of current expertise and skills within the service and use this to identify potential resources to deliver training internally.

R46. There should be a standard induction process for the Service including a basic knowledge & training curriculum- the bulk of which should be delivered by internal staff. This type of induction could be run largely on a whole service basis with some additional team – specific inputs.

R47. All team members should have an annual Personal Development Plan [PDP] which is integrated with their supervisory & performance management process

<u>Recommendation: Develop an ASD –Specific Training Framework</u>

R48 Consider the feasibility of implementing an ASD specific training programme along the lines of the National Training Framework for Autism Spectrum Disorders in Scotland.

Recommendation- Structure a Knowledge Management & Transfer System

R49. See recommendation39 & 40 in the previous section for the relevant commentary on this area. Practise Development subgroups should be established for the main diagnostic categories and Senior clinicians in the disciplines should be asked to play a leadership role in this work. This should lead to the codification of best practise approaches which can then be disseminated within the service.

Recommendation: Set Up a Service Planning and Quality Forum

R50. Set up a strategic service and practise development working group comprised of Team Managers & senior representatives from each discipline. The following areas could be Included in its brief:

- *Practise Development coordination*
- *Networking with other services*
- *Liaison with Third level bodies & Centres of Excellence*
- *Long term planning for needs*

Field Five: Organisation Structure and Corporate Governance

Recommendations on the Accountability Management Process within the Teams

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This would mean that the Team Managers carry full delegated authority to performance manage the following areas:- attendance & time-keeping, leave, allocation of duties including but not limited to case allocation, standards of behaviour and compliance with service Policies & Procedures.

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Head of Department/Clinical Lead in one of the host organisations who has a background in children's services or through negotiation by a similar level role in an adjacent children's NDT service.

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It may be that the management structure needs to be reconfigured with a single overall service manager role that individual team managers report into.

R 53. Clear Performance Accountability for the Team Managers

R53: As part of this management structure process, a clear performance management accountability line should be established for the individual Team Managers.

R54: Recommendation – Broaden the Representation on the Service Steering Group.

Consideration should be given to widening the representation on the Service Steering Group to include family, education, clinical and possibly primary care representation. Not all representatives need have voting rights.

R55: Recommendation- The Steering Group take a more proactive role in the strategic direction and oversight performance management of the service

8. *In our view, the Steering Group needs to accept primary accountability for determining the future strategic direction for the service which includes deciding - what is the most appropriate service configuration to meet the aspirations of the stakeholders, within the spirit of the Progressing Disabilities policy framework.*

9. *Determining what type and level of service will be offered to school-age children within the resources available to the service and then ensuring that all stakeholders are clear on this and that the service is managed optimally within these parameters*

10. *There needs to be adequate family representation on the Steering Group but the objectivity and impartiality required of this role should be emphasised*

11. *Ensuring that clear workable collaboration & cooperation protocols are agreed with the primary care and specialist services including CAMHS*

12. *Determining how a full career development and practise leadership structure for the service can be achieved or putting in place a viable alternative from within the wider resources of the participating agencies*

13. *Determining what role the Steering Group has in advocating for or developing the wider wrap - around service supports that are needed for families with the most complex needs*

14. *Defining a set of performance measures for the service that actually track core activities, resource deployments and service outcomes*

R56: Recommendation: Consider a Transition to a Lead Agency Configuration

It is our view, that the most effective way to deliver the focused, accountable and integrated service that is required is to move over time to a single Lead Agency format for the entire service.

In such a model a service level agreement would define the necessary parameters, standards and working arrangements in each of the above areas.

However careful consideration and consultation between stakeholders on this option is a pre-requisite to this becoming an action point.

Appendix Two: The Comparator Service Enquiry Areas

1] Enquiry Area for Midwest Progressing Disabilities Services

Objectives and Operating Model

1. 1What is the operating model for the NDTs and has this evolved over the lifetime of the integrated service model?

- Rationale for the model [& any data on evidence base in research]
- Key elements of the model
- Acceptance by stakeholders of the model [including staff]

1.2 How does the core operating activity of the teams match or align with the model?

- What are the core services offered and main activities of team members?
- What is the rough proportion or time – split across these
- Do the services offered /provided change much on transition to school age services?
- Are there any obvious or emerging trends in how service activities map onto particular diagnostic groups/categories?
- Is there a clear admissions and discharge rationale & system

1.3 Are there clear boundaries around the service?

- Is it clear what is in and out of the service delivery?
- Do people like special needs assistants/preschool support workers have a role in the teams?
- Does the service use home teachers?
- What about respite services for families?
- How do links work with specialist services external to NDT?

Tracking and Resource Deployment

2.1 What are the main ways that you track & measure the service delivery?

- How do you track /measure outcomes [family & child results]
- How do you track /measure service activities and outputs [activities & deliverables]
- What type of IT/MIS systems or packs helps you best with this?

2.2 Is there a particular organisation structure and staffing deployment model that you work?

- A clear organisation structure for the entire service
- A clear structure within delivery teams
- A number of levels of work /grades within disciplines within the service as a whole and within delivery teams – is this by custom & practise/ by clear plan & rationale/by combination etc
- Is there some form of implicit or explicit modelling of staffing numbers versus population being served and expected levels of particular types of needs/diagnostic categories

[Expected population disability levels/ referral trends/waiting list trends and caseloads trends]

- If you have it could I get a rough ratio of staff numbers versus demand levels?
- How do you cope with predictable levels of staff absences [maternity/staff turnover]- any ways that you cover for this or backfill quickly?
- How you allocate resources against needs
- What activity data you track and collect – how you categorise this?

Quality Assurance and Reporting Accountabilities etc

- Are accountabilities clear for staff and managers in terms of operational performance management [Who gives you work, what you generally do, your attendance & annual leave, office & operational support systems etc]
- and
- Are accountabilities clear in terms of clinical governance [QA within delivery teams and QA for individuals from each discipline?]
- How does the service approach quality assurance and quality improvement from an overall service perspective
- Do Service Managers & team leads have comprehensive role descriptions – how have these evolved over time?
- How does the service get feedback from families/referral agents/collaborating services?

How the Service Grows in Capability & Expertise

- How does the service learn as it goes?
- How has it evolved in the way that it works – did any processes or structures help with this?
- How does the service share expertise and grow capabilities internally?
- What level of training do you find is required and possible?
- Do you have any service research projects ongoing?

Building Identity and Pride

What has worked well here and any less helpful issues?

Appendix 3: Survey Formats

A. Family Survey

Survey of Family Views on the Network Disability Team Service Kildare-West Wicklow

<table>
<tr><td colspan="9">General Information</td></tr>
<tr><td>Which Team do you get support from?</td><td colspan="3">North - Clane</td><td colspan="3">Mid - Naas</td><td colspan="2">South - Monasterevin</td></tr>
<tr><td>What is your child’s primary disability</td><td>Autism Spectrum</td><td></td><td>Learning Disability</td><td></td><td>Physical disability</td><td></td><td>Other</td><td></td></tr>
<tr><td>What age is your child</td><td colspan="8"></td></tr>
<tr><td>When did you start with the NDT Service?</td><td>2016</td><td></td><td>2015</td><td></td><td>2014</td><td></td><td colspan="2"></td></tr>
<tr><td colspan="9"></td></tr>
<tr><td colspan="9">Section 1: Your General Impression of the Service:

Please comment below about your general view of the service that you have received from the Network Disability Team [NDT]</td></tr>
<tr><td>What works well in the services that you have received from the NDT?</td><td colspan="8"></td></tr>
<tr><td>What works less well in the services that you have received from the NDT?</td><td colspan="8"></td></tr>
<tr><td colspan="9">Section 2: Your views on aspects of the Service</td></tr>
<tr><td colspan="9">Instructions

Please answer the following questions about the service that you have received by doing 2 steps:</td></tr>
<tr><td colspan="5">Step 1] You score each question on a scale from 1 to 5
<table><tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr></table></td><td colspan="4">Step 2] Please add any comments about each question under this column all the way down the survey</td></tr>
</table>

Where: **1**:: = **Very poor** **3: = Acceptable** **5: = Excellent**		
1. Once you were put on the waiting list **-** How long did it take to get an initial contact with the team?	**1** | **2** | **3** | **4** | **5**	
2. How well was the NDT service explained to you?	**1** | **2** | **3** | **4** | **5**	
3. Do you have a preference for clinic or home-based appointments?		
3a How do you rate access and facilities at your NDT centre?	**1** | **2** | **3** | **4** | **5**	
2.1: How the FSP [Family Support Plan] system works:		
4. Do you have a Family Support Plan [FSP]?		
5. How easy did you find it to set initial goals for your child?	**1** | **2** | **3** | **4** | **5**	
6. Did you feel that you had a clear plan of how to achieve these goals	**1** | **2** | **3** | **4** | **5**	
7. How well did the team follow up on the plan?		
8. How clear are you about the different roles that team members play?	**1** | **2** | **3** | **4** | **5**	

9. Do you have a clear contact person for the team – how well does that work?		
10. Is the FSP system flexible enough in the way that it responds to your needs?	**1** **2** **3** **4** **5**	
11. Are you comfortable with the number of individuals present during FSP meetings?	**1** **2** **3** **4** **5**	
12. Do you find these meetings helpful for expressing any worries or concerns that you have?	**1** **2** **3** **4** **5**	
13. Is the documentation you receive following IFSP meetings helpful?	**1** **2** **3** **4** **5**	
14. Is the FSP system flexible enough in the way that it responds to your needs?	**1** **2** **3** **4** **5**	
2.2: The Ongoing Intervention & Support Service:		
How well do the main supports that the NDT offers work for you? – Rate the list below and comment		
15. Providing general information and advice	**1** **2** **3** **4** **5**	
16. Providing training and other workshops for parents [E.g.: Hannon training, Stepping Stones etc]	**1** **2** **3** **4** **5**	
17. Providing group sessions for your child	**1** **2** **3** **4** **5**	

18. Providing one to one interventions with your child	1 | 2 | 3 | 4 | 5	
19. Providing specialist clinical supports E.G. Orthotics, seating clinics etc]	1 | 2 | 3 | 4 | 5	
20. How well are your needs for broader family support being met?	1 | 2 | 3 | 4 | 5	
21. How well does working with the NDT address the things that are most important from your point of view?	1 | 2 | 3 | 4 | 5	
22. How well does it help in linking you with other families with similar issues & concerns?	1 | 2 | 3 | 4 | 5	
23. How well has it helped you to link your child into ordinary community activities [E.g.: Play grounds, Sports clubs etc.]?	1 | 2 | 3 | 4 | 5	
24. Do you feel there is enough continuity in the support being provided	1 | 2 | 3 | 4 | 5	
Section 3: Support with Transitions		
25. How much support and advice did you get about your child moving into preschool?	1 | 2 | 3 | 4 | 5	
.26. Does your child attend : • A local community preschool? • A special preschool • Both types of preschool	**Y Local Preschool** **Y Special Preschool**	

	Both **None**	
27. Which type of schooling does your child attend? Note: SNA = Special Needs Assistant	Ordinary class with SNA Special class with SNA Special school other	
28. How much support and advice did you get about your child moving into primary school	**1** | **2** | **3** | **4** | **5**	
29. How much support and advice did you get about your child moving into secondary school	**1** | **2** | **3** | **4** | **5**	
30. How happy are you with the support that the NDT provides to your school-age child?	**1** | **2** | **3** | **4** | **5**	
31. How happy are you with the support that the NDT provides as your child prepares to move on to adult support services?	**1** | **2** | **3** | **4** | **5**	
Section 4 Your changing needs:		
32. What would you like **more** of from the service?		
33. What would you like l**ess** of?		
34. Is there a type of support that you		

don't currently get, which you would like to start receiving? What is it?		
35. Do you use other services or supports outside of the NDT? If yes; please describe these briefly	**Yes** **No**	
Section 5: How well are you being heard:		
36. Apart from this survey; Have you been formally asked to evaluate or comment on the quality of the service that you are receiving?	**Yes** **No**	
37. How well does the service respond to your feedback about the service?	**1** | **2** | **3** | **4** | **5**	
38. How easy is it for you to get referred on for advice about your child from a specialist outside the team?	**1** | **2** | **3** | **4** | **5**	
39. Do you know how to make a complaint about the service?	**Yes** **No**	
40. Does the service respond quickly enough to a crisis?	**1** | **2** | **3** | **4** | **5**	
Please add any other comments that you wish to make about the service below:		

B] School Survey

Network Disability Team Review – Kildare West Wicklow 2016

Stakeholder Survey – Schools

Version P: To be completed by the Principal

Name & Address of School					
Type of Provision	Please tick relevant boxes below				
Mainstream School		Special Class		Special School	
Name of Principal					
Contact Details	Can one of our review team contact you by phone for further exploration of your views?				

Confidentiality Note:

Your feedback will be aggregated into a summary picture of feedback from the school sector and will not be identified directly.

However; If you would like your specific feedback to be shared directly with the Network Disability Team please tick the box below

Yes please share my feedback directly with the NDT also	

Please give us your feedback on how you have experienced working with the new Network Disability Team over the last 2 years [The NDT commenced in May 2014]

Please type your answers directly into the survey form below.

Section 1: Your Expectations of the Service										
1. What were your expectations and understanding of how the NDT Service would operate?										
2. How clear are you on the services the NDT offers? Did you receive information	**1-**				**5**					**10+**

about this? How clear is the information?										
3. How easy is it to access the NDT service? Please comment on your experience in this regard	**1-**				**5**					**10+**
Section 2: How Well the Service Works with your School										
4. What is working well in your view? [Please give examples]										
5. What characterises your very best collaboration with the NDT so far? What positive feedback would you give to the NDT service at this point?										
6. What is not working so well?										
Section 3: Specific Aspects of the Service										
7. In your view; what works best in giving families clear and consistent advice from school and NDT?										
8. How would you rate the support that is provided to your pupils & teachers from the NDT on the following criteria										
Timeliness of Response	**1-**				**5**					**10+**
Usefulness of advice	**1-**				**5**					**10+**
Practicality of advice	**1-**				**5**					**10+**

9. What works best in terms of knowledge/skills transfer from the NDT to your staff & vice versa]?	**1-** | | | | **5** | | | | | **10+**
Section 4: Final Thoughts on Support from NDT	
10. If you could change 1- 2 things about the way the NDT works with you – what would they be	
Please add any other feedback here	
Thanks for your cooperation with this review	
©TPP	

C Staff Survey:

Network Disability Team Review – Kildare West Wicklow 2016

Staff Survey – NDT Member Version

[DR Draft3]

<table>
<tr><td colspan="3">Which Team are you in?</td><td colspan="6"></td></tr>
<tr><td colspan="3">Age group you work with</td><td colspan="2">Early Years</td><td></td><td>School age</td><td colspan="2"></td></tr>
<tr><td colspan="3">Who is your employing organisation?
[Or previous service]</td><td colspan="6"></td></tr>
<tr><td colspan="3">What discipline are you</td><td colspan="6">Please tick relevant boxes below</td></tr>
<tr><td>OT</td><td>CNS</td><td>Social Work</td><td>Physio</td><td>Psychology</td><td>SLT</td><td>SC Worker</td><td>Admin</td><td>Other</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3">Contact Details</td><td colspan="6">Can one of our review team contact you by phone for further exploration of your views? – please give a number here</td></tr>
</table>

Confidentiality Note:

Your feedback will be aggregated into a summary picture of feedback from the NDT Members and will not be identified directly.

However; If you would your specific feedback to be shared directly with the Network Disability Team please tick the box below

Yes please share my feedback directly with the NDT also	

Please give us your feedback on how you have experienced working in the new Network Disability Team over the last 2 years.

Note: We will be using the feedback in this survey to help structure a second more interactive focus group phase with all NDT staff, so this is part of the enquiry process not an end in itself

Please type your answers directly into the survey form below.

Please return this survey to Dermot Rush at the following:

dermot@the performancepartnership.ie

or by post to

Dermot Rush – TPP

24 Woodlands Park

Moycullen

Co Galway

The Survey Enquiry Areas

<table>
<tr><th colspan="11">Section 1: Overview of views on NDT</th></tr>
<tr><td>1. What were your expectations and understanding of how the NDT Service would operate?</td><td colspan="10"></td></tr>
<tr><td>2. What is working well in your view?
[Feel free to give examples]</td><td colspan="10"></td></tr>
<tr><td>3. What characterises your very best work with the NDT so far?</td><td colspan="10"></td></tr>
<tr><td>4. What is not working so well?</td><td colspan="10"></td></tr>
<tr><th colspan="11">Section2: Compare & contrast NDT to the previous service that you worked in:</th></tr>
<tr><td>5. Compared to your previous service configuration and role – what is different in how you work in the NDT?

5a: What is new and what do you think about this?

5b What is most positive – what do you think about this?

5c: What do you miss from your previous way of working and what do you think about this?</td><td colspan="10"></td></tr>
<tr><th colspan="11">Sect.3: Service Objectives & Service Model – rate 1[-] to 10[+] & <u>include comment</u></th></tr>
<tr><td>6. How clear are you on the</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
</table>

Question										
objectives of the NDT Service – please summarise in <3 lines										
6a How well is the service meeting these objectives – 6B. How do you know? & 6C. Why do you think this is so?	**1-**				**5**					**10+**
7. How clear are you on the Working Model for the NDT service? 7a What research evidence is the model based on? 7b Are there other factors influencing the service model- what is their rationale?	**1-**				**5**					**10+**
8. How well is the service operating to this working model? 8a. Which elements are working best – what helps this? 8b.Which elements are working least well – what are the constraints?	**1-**				**5**					**10+**
Sect 4: Rating Current Core Service Activities – rate 1[-] to 10[+] & include comment										
9. How well the referral to NDT service works?	**1-**				**5**					**10+**
10. How well the Intake process works?	**1-**				**5**					**10+**
11. The clarity and usefulness of the initial information provided to families about the service?	**1-**				**5**					**10+**

12. How well does the IFSP process work	1- | | | | 5 | | | | | 10+
13. How well you deliver in following through on the IFSP as a team?	1- | | | | 5 | | | | | 10+
14. How well does the Key Worker system work?	1- | | | | 5 | | | | | 10+
15. How well does the Key Contact Person system work?	1- | | | | 5 | | | | | 10+
16. How well do Training & Workshops for families work?	1- | | | | 5 | | | | | 10+
17 How well do Groups for children work?	1- | | | | 5 | | | | | 10+
18 Of the range of interventions and advice that the staff of NDT provide to families What works best in your view –how?	
19. Of the range of interventions and advice that the staff of NDT provide to families What works least well in your view- why?	
Section 5: Facilitating key Transitions	
20. Facilitating planning & transition to pre-school	1- | | | | 5 | | | | | 10+
21. Providing support to pre-school staff	1- | | | | 5 | | | | | 10+

22. Facilitating planning & transition to school	**1-**				**5**					**10+**
23. Providing support to schools about a specific child	**1-**				**5**					**10+**
24. Facilitating preparation for post-school transition	**1-**				**5**					**10+**
Section 6: Effectiveness of intervention with diagnostic categories										
25. In your view; what does the NDT do best for Families with child on ASD spectrum?										
26. In your view; what does the NDT do least well for Families with child on ASD spectrum?										
27. In your view; what does the NDT do best for Families with child with Intellectual Disability?										
28. In your view; what does the NDT do least well for Families with child with Intellectual Disability?										
29. In your view; what does the NDT do best for Families with child with Physical / Sensory Disability?										
30. In your view; what does the NDT do least well for Families with child with Physical/Sensory Disability?										
Section 7: What would you do differently?										

<table>
<tr><td>31. If you had up to 3 choices what would you change about the service model and core activities carried out by NDT staff?</td><td colspan="10"></td></tr>
<tr><td colspan="11">Section 8: Deployment of Resources</td></tr>
<tr><td>32. Are you clear about how team resources are deployed to meet service needs?</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
<tr><td>33. Are you clear how the team tracks the efficiency with which it uses staff resources?</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
<tr><td>34. Have you any views on how the team could work more efficiently?</td><td colspan="10"></td></tr>
<tr><td colspan="11">Section 9: Quality Assurance and Feedback</td></tr>
<tr><td>35. What system or process does the team use to collect feedback from families & children?</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
<tr><td>36. Have you any views on how to enhance the feedback process from families?</td><td colspan="10"></td></tr>
<tr><td>37. Are you clear how the team or each discipline sets quality standards for each main core activity area?</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
<tr><td>38. Who is primarily involved in setting and improving these quality standards?</td><td colspan="10"></td></tr>
<tr><td>39. How are these quality standards tracked and measured?</td><td colspan="10"></td></tr>
<tr><td>40. How clear is the</td><td>1-</td><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td><td></td><td>10+</td></tr>
</table>

professional/ clinical supervision process within the overall NDT?	
41. How effective in your view is the professional/clinical supervision process? 42 Please comment on the frequency of formal supervision that you receive	1- | | | | 5 | | | | | 10+ never | annual | 6-monthly | Bi-monthly | monthly
43 Have you any views on how the professional /clinical supervision process could be enhanced?	
Section 10: Ongoing Development of Service Capability	
44. How well is the process for staff to update and develop their skills & knowledge working?	1- | | | | 5 | | | | | 10+
45 In your view what training has worked best so far and why?	
46. In your view, what training & development has worked least well and why?	
47. What training areas/needs are cross discipline?	
48. What training areas/needs are discipline-specific?	
49. Are there subject matter experts in & across the teams who could provide internal training & development?	
50. Is there a clear	1- | | | | 5 | | | | | 10+

system/process for knowledge management /transfer within the team?										
51. Is there a clear system/process for reviewing and improving the team's working model & core activities?										
Section11: Management Structures & Governance										
52. How clear are you on the role of your NDT Team Manager?	**1-**				**5**					**10+**
53. How clear are you on the role of your employing agency Line Manager?	**1-**				**5**					**10+**
54. How clear are you on the role of your Clinical Supervisor?	**1-**				**5**					**10+**
55. Have you any views on how reporting and professional supervisory relationships could be simplified or work more effectively?	**1-**				**5**					**10+**
56. How clear are you on the role of the Steering Group?	**1-**				**5**					**10+**
57. In your view, how effective is the line of communication with the Steering Group?	**1-**				**5**					**10+**
Thank you for putting the time into completing this survey - please add any final views & comments in the section below										
Please add any other feedback here										
Thanks for your cooperation Please <u>return the survey to</u> dermot@theperformancepartnership.i										
©TPP										

Appendix 3 a]– Summary Picture from Surveys Qualitative Data

1] Feedback from School Survey

My understanding is that the NDT is a family based service. With the agreement of parents, schools can consult with NDT for advice/programmes relating to SLT, OT behaviour issues, psychology, & psychiatry. NDT staff will work directly with the children in schools of requested by parent

We had some experience and found them great / Good we have service now - school visits, specialist team have so much valuable information on children and appropriate programmes

Very collegial, efficient, professional and caring - clear access, prompt response, useful recommendations /Prompt correspondence. Very efficient and professional

NDT have helped our finished students progress into suitable courses. These students may have disabilities and NDT have linked them into further education

Information from OT and SLT generally good: I received visits from SLT and OT regarding children in special needs class I teach who were already assessed

OTs give reports and recommendations. S/L therapists give feedback also and give recommendations and offer resources

Visits from specialist team excellent

I was aware of psychologist's role to assess and provide support / Clinical psychologist and HSCL/SEN coordinator visited home of student together to meet parents and complete an assessment. Excellent intervention by clinical psychologist worked really well.

I receive a lot of valuable information about courses for parents and teachers that I can pass on. The courses are usually in a wide range of venues and focused on key issues of concern

when access is received we can get good meetings but these are usually insisted upon by school so that relevant information s given to all parties. However: unless schools push this wouldn't happen

Good services provided to students on NDT list. It can be challenging to make a new referral and to see exactly demarcation line between CAMHS /NDT referral appropriateness

In case of child with disability in my class agency seems very helpful to mother

Practical resource materials work well for work that therapists are doing with children that I can continue / Offering practical specific tips to teachers to help with IEPs

What Schools / Teachers Would Like More of.

I would like a booklet explaining all the services provided, the names or people involved in each area explaining how we further use their services / clarity re referral guidelines; Clarity re waiting lists, Clarity re services of a child and adolescent psychiatrist and NDT

Having teachers, SEN/HSCL coordinator ,SNA/Resource teacher, parents and NDT staff present at EP meetings/clarity on what is to be achieved by school and NDT (This is now what happens with NEPS-team(parent, school and NEPS) meet and plan short/long term action)

School and NDT need to meet more rather than NDT and parents. School and NDT are coming from different perspectives and giving parents conflicting information/In the case of students in my class, parental knowledge is limited so advice should be given via teachers and group meeting as information sent home directly may be lost or misunderstood

SLT and OT interventions would be very greatly appreciated and very much needed / It would be beneficial if some of our students with Dyspraxia could avail of OT or any computer typing courses

Good services provided to students on NDT list. It can be challenging to make a new referral and to see exactly demarcation line between CAMHS /NDT referral appropriateness

While initial appts for drop in psychologist or OT services are good the wait time for follow up is criminal given the difference these services can make during the short time before these children grow up. 6mths is an incredibly long time in a child's life and development.

I assumed support would be similar to previous levels of support

Yes, I received letters. I was invited to meetings which I could not attend as they were during the school day and no sub cover was provided

NDT responds to contact from teachers but this response is usually during school hours when teachers are in class and unable to come to the phone / Responses from NDT to teachers are often phone calls when teachers cannot leave class. very little direct intervention for children

Offer workshop practical for teachers to help with managing the specific learning needs of children in our schools/ the recommendations/info given in one child's report could be given in a group format to whole class as all children in moderate class have similar needs

Continuity of therapist perhaps OT SLTS should be allocated to a school and not a particular pupil. The high level of change in staff is frustrating and it is often hard to know who to contact in the different department

2] Feedback from Families through the Postal Survey

Positive Feedback

Wonderful professional caring people: He has received more interventions in the last 2 years than his whole life before. [Autism]

My family works very close with SLT. We attended Hannon course & it was very helpful. Only recently we started seeing occupational therapist. It's good to hear advice about ways you should help your child to improve. [Down's Syndrome]

Having a stable team is great, though that has changed slightly this summer. There is nothing worse than therapists changing continuously. FSP meetings are a good way refreshing everyone, if things are getting slack & always making needs known. Clinic & home visits work as family can be seen in natural environment as well as formal. NDT is very good at contacting & co-ordinating outside services which would otherwise be very difficult. [LD]

Group activities run by OT and social care have made input feel more like a club or social event than an appointment or "work session". Meeting other kids (especially the same ones consistently) and their parents has been great socially too, as has the input with sports promotion. [Physical Disability]

I feel everybody tries to do their very best for you but I do feel they are under pressure and resources have gone down. Each person tries to give 100% in what area they are involved in. Training courses are always very well run. A lot of work goes into them and they are always looking for feedback and what would improve the services. [Autism]

The NDT building itself is a wonderful purpose built facility. 2. The Hydrotherapy pool. 3. The supply of equipment for our son has been excellent to date. 4. Physio & Occupational Therapists have been brilliant. Physio and OT have been great for our son and they are open to options for new equipment etc. They are available for advice and see our son frequently when required. [Physical disability]

Increased access to hydrotherapy pool has been great. Parent training sessions to date have been excellent e.g. triple P. Routine orthotic slots valuable. There is Increased awareness and ability of therapists to cope/advise re children with ASD, since Enable Ireland became NDT. Dedicated therapists but under resourced. [Autism/Learning & Physical Disability]

Team (especially - nurse) seemed very helpful on first meeting. The key worker is a great way to keep us at ease when we need support and advice. Haven't got any of the pre-school visit yet as our daughter is only starting in September but we are looking forward to that as the team will be working with her teachers as well as us parents

Location, Facilities and team are great. The 'class' and activities based therapy are really benefiting her and she loves it. Being able to also plan around her needs in a holistic sense was really impressive. [Autism]

Key Issues, Perceptions and Concerns from Family Survey

The ball is very much in my court so if I get lax or too busy or just forgetful, the service my child receives slows down or stops. I feel that a phone call from key worker every 6 months would help to keep me on target or can let the team know something & just haven't got round to. I have no problem with parents taking responsibility but I worry if we drop the ball our child will be forgotten.

Family expectations of the Service are very different from the Service's /Model of Service

Not clear or comprehensive enough follow up either on initial assessment of needs/FSP, from training courses or from Therapist interventions & advice

Lack of a clear plan versus episodic service / Lack of regular reviews to assess progress

Appointments or group session dates not working

Difficult or cumbersome trying to sort appointments out /getting phone access

Group sessions not effective enough or age appropriate in some cases

Lack of prioritization or sense of urgency

Reduction of contact & service from previous service

Lack of coordination with School

Too many changes in staff or absences- difficult to maintain rapport/familiarity with child & family

3] Feedback Summary from Staff Survey

What is Going Well

Teamwork and collaboration across Disciplines

Interdisciplinary working model / Liaison and joint problem solving between Disciplines when concerns arise about family & child arise

Clinicians being open and flexible to different approaches

The inclusive one service approach for all types of need

Joint goal setting

Intensive family training programmes

Home – based work with individual children & families

Family getting service relatively near their home & school

Rapport with and empowering families

Specialist clinics

Key Worker system coordinating support for family

2 Week response time to school – based issues & needs

The interdisciplinary team around the child

Viewing the service more holistically

Summer camps & sibling support

The SLT Coordination and collaboration across the 3 teams including common quality assurance process

Family support and community involvement support [Intellectual disability]

Home visits and home support [Intellectual disability]

Wrap around support for children with autism

Great learning experience for Basic Grade Therapists

Waiting List Initiative Team

Developing SMART Goals database

Using expertise to develop & mentor other colleague

What is not working so well:

Demand levels versus limited staff numbers

Lack of staff training [Even for core training programmes]

Some disciplines working in isolation a lot

Spreading to meet demand versus Quality of service provided

Lack of clear service pathways and Unequal access

Lack of consistency & clarity about how the service model works in practise

Poor attendance at groups and DNAs

Lack of support & timely response from Steering Group

Need to do more structured assessment early on after child is referred

Lack of emotional support for families & Lack of respite care for families

Administrative support and IT system particularly for FSPs

Uneven quality assurance and evidence –base for some parent training programmes – no structured evaluation

Lack of consistent follow up after training programmes due to other demands

Mixed views on caseload management training

Impact of high staff turnover & delays in getting replacements

Request for Support system with schools is cumbersome

Lack of clarity about on intake, discharge & waiting lists systems

Lack of a seamless coordination with other services [Eg: CAMHS]

Lack of Seniors

Reporting relationships and professional governance

Delays in finalising certain service policies [Lone Working/Child Protection]

Need more 1:1 home visits & developmental programmes [Intellectual Disability]

Need more consistent approach across teams/more assessment and individual plans [Autism]

Managing family expectations/Lack of Physios/Lack of sensory expertise [Physical Disability]

Appendix 4: Elements of a Service Resource Modelling Framework

Element A: Service Activity – Resource Profiling

Describe the typical Activity Conditions that the Service operates

High Intensity Support Needs Service Pathway /Medium Intensity Support Needs Service Pathway/ Low Intensity Support Needs Service Pathway

Model these pathways over an indicative 12 month period in terms of activities, time and staff resources allocated

Model the proportionate allocation of children to the pathways

Element B: Capacity Modelling Staff Resources

Conduct Staff Activity Tracking Exercise / Model staff time availability & constraints

Element C: Demand Forecasting

Model service population trends and forecasts/Model proportionality of service support needs intensity / Aggregate scale of support needs