2018 to 2020

National Quality Improvement Operational Plan

Disability Services in Ireland

HSE Disability Services Quality Improvement Team

Contents

1.0 Purpose	3
2.0 What is the Quality Improvement Operational Plan?	3
3.0 Background and Context	4
4.0 Disability Policy in Ireland	5
5.0 How was this Operational Plan Developed?	7
6.0 What is Quality Improvement?	16
7.0 International best practice for Disability Services	18
8.0 Framework for Classifying Operational Objectives 2018 – 2020	22
9.0 Operational Objectives 2018 – 2020	24
10.0 Implementation Plan	26
11.0 Evaluation of the Operational Plan	26
12.0 Collaborative Working	26
13.0 Key Dependencies	28
14.0 References	30
15.0 Appendices	33

National Quality Improvement Operational Plan

Disability Services in Ireland

1.0 Purpose

The purpose of this Operational Plan is to lead and support the implementation of quality improvement projects for disability services. These initiatives are evidence based and promote the values, principles, culture, structures and processes to deliver efficient and effective person-centred and outcomes-focused services that support people with disabilities to develop their potential. 85% of disability services in Ireland are delivered by voluntary agencies (Section 38, Section 39 and For Profit) and as such will play an integral part in the implementation of this Operational Plan as the main collaborators with the Health Service Executive (HSE) provided services.

2.0 What is the Quality Improvement Operational Plan?

A quality improvement (QI) Operational Plan is an approach to change. It provides a framework and tools to plan, organise, monitor, sustain, and spread the changes that data show are improvements. A Quality Improvement Operational Plan uses the science of Quality Improvement to frame its approach to improvement. This includes:

- Identified leadership, accountability, and dedicated resources;
- Choosing specific models/approaches for quality improvement (i.e. PDSA[1], Lean[2], Six Sigma[3]) to carry out repetitive and systematic processes for testing and then implementing improvements - the HSE Quality Improvement Division has endorsed the Institute of Healthcare Improvement (IHI) - Model for Improvement[4];
- Use of data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks (measurement and data and key to driving and guiding improvement);
- Focus on linkages and efficiencies in addressing outcome improvement;
- Ensuring staff members understand the metrics for success;
- Ensuring that people with disabilities, their families where appropriate, providers and support team members are involved in quality improvement activities;
- Adopting a continuous improvement process that is adaptive to change and that fits within the framework of other programmatic QI and quality assurance activities in the Social Care Division.

An Operational Plan based on quality improvement differs from an Operational Plan based on research; while research attempts to assess and address problems that will produce generalisable results, quality improvement projects usually include small samples, frequent changes in interventions, and adoption of new strategies that appear to be effective. There is a continuous programme of quality improvement, which is centred on incremental changes.

[1] PDSA – Plan, Do, Study, Act – cycle of change

[2] Lean is a quality improvement methodology that works on the key principle of creating more value for customers with fewer resources

[3] Six Stigma is a set of techniques and tools for process improvement

[4] The IHI Model of Improvement was developed by Associates in Process Improvement. It is a simple but powerful tool for accelerating improvement - http://www.ihi.org/resources/Pages/HowtoImprove

"Improvement projects are similar to implementation projects in that they require assignment of roles and tasks, coordination, and active monitoring of project progress. For implementation projects, the required changes to systems and processes are largely known in advance; thus, the primary challenge lies in defining the tasks and coordinating the activities needed for successful implementation. In contrast, for improvement projects, the current level of performance is known and a desired level of performance is specified, but the changes that will be needed to enable the organization to reach the desired level of performance are not known with surety in advance.... A common mistake is quickly offering solutions before understanding the problem in depth; achieving consensus on the objectives; incorporating the perspectives of all stakeholders; and considering a variety of alternative solutions." (DB Larson & LJ Mickelsen, 2015)[5]

3.0 Background and Context

The National Quality Improvement Operational Plan for Disability Services in Ireland, hereafter referred to as "the Operational Plan", builds on a number of policies and programmes developed in Ireland over the past 10 years including Transforming Lives which builds on the work achieved during the past few years. It has been informed by a wide range of discussions involving people with disabilities who access the services and supports as well as staff and management in services for people with disabilities that are either funded or provided by the Health Service Executive (HSE).

In 2012 the Value for Money and Policy Review of Disability Services (Department of Health) and the following National Implementation Framework (2013) provided the evidence base for a significant restructuring of disability services in Ireland. Transforming Lives is the programme to implement changes informed by the recommendations from the Value for Money and Policy Review of Disability Services. The 2015 Report on the Implementation of Transforming Lives articulates the vision of the programme "to contribute to the realisation of a society where people with disabilities are supported, as far as possible, to participate to their full potential in economic and social life, and have access to a range of quality personal social support and services to enhance their quality of life and well-being".

This Operational Plan also builds on the work of the Social Care Division/Quality Improvement Division (SCD/QID) Quality Improvement Programme. For the last 3 years this programme has advised and supported disability services to enhance their structures and processes to improve the delivery of quality and person-centred safe services to:

- Strengthen leadership and governance structures;
- Improve relevant person-centred documentation;
- Engage with staff and persons who use services;
- Progress action plans arising from regulator inspections and establish where further supports are required;
- Identify areas of good practice and innovation for sharing across the service;
- Implement improvement projects to enhance the quality and person-centeredness of services e.g. managing complaints, reducing incidents, improving person-centred plans and testing adapted clinical governance documents.

[5] DB Larson and LJ Mickelsen (2015) "Project Management for Quality Improvement in Radiology", American Journal of Roentgenology. 2015; 205: W470-W477

The Operational Plan also takes cognisance of the Department of Health's Healthy Ireland Operational Plan programme and recognises the benefits of preventative, positive support to counteract the negative effects of poor diet, lack of activity, poor physical health, lack of stimulation and stress in the general population and in particular, people with disabilities.

The Department of Health (DoH) and the Health Service Executive (HSE) approved nine outcome domains for Irish disability services in 2016. The nine outcome domains are linked to quality of life, which encompasses experiencing a meaningful life, having valued roles and connections with family, friends and community.

Supporting persons with a disability to live ordinary lives in ordinary communities is at the core of this Operational Plan.

Department of Health /HSE Nine Outcome Domains:

1. Are living in their own home in the community
2. Are exercising choice and control in their everyday lives
3. Are participating in social and civic life
4. Have meaningful personal relationships
5. Have opportunities for person development and fulfilment of aspirations
6. Have a job or other valued social roles
7. Are enjoying a good quality of life and well-being
8. Are achieving best possible health
9. Are safe, secure and free from abuse

The Operational Plan will have a direct and positive impact on these outcome domains through the improvements it will make in supporting people with disabilities to live lives of their choosing.

4.0 Disability Policy in Ireland

A significant programme of reform is underway in disability services in Ireland supported by the System Reform Group and the National Clinical/Integrated Care Programmes. This reform is aligned to and informed by the wider context and reform of the health services. In disability services the Value for Money and Policy Review of Disability Services (2012) and the National Implementation Framework (2013) provided the evidence base and case for significant restructuring of disability services.

The Vision

> *"To contribute to the realisation of a society where people with disabilities are supported, as far as possible, to participate to their full potential in economic and social life, and have access to a range of quality personal social support and services to enhance their quality of life and well-being."*

Transforming Lives' is the programme to implement the changes informed by the recommendations of the report Value for Money and Policy Review of the Disability Services in Ireland (2012). It is a programme of reform to sustainably migrate to new models of support, governed by a National Steering Group, reporting to the Minister for Disabilities and driven by six National Cross-Sector Working Groups.

Working Group 1 - Strategic Planning

- Report on the volume and nature of future needs in disability services over the next ten years.
- Progress the evaluation of policy implementation across a number of service providers.

The core principal for the reform programme is to deliver evidence based change. This involves understanding the needs by having the right tools, information and data required to make informed decisions about the future. It also involves the ability to learn from and build on what works well. Many services across the sector have demonstrated better practice in delivering person-centred supports. Developing a structured approach to piloting solutions and building better practice is essential to building a sustainable change.

Working Group 2 – Implementing Policy

- Congregated Settings
- New Directions
- Progressing Disability Services for Children and Young People (0-18's)

The development of person-centred supports is underpinned by key policy at a national level. The overarching objective is to ensure that service planning begins with user needs assessment and that services are designed to support people to participate to their full potential.

Working Group 3 – Community Involvement

- Complete the development of a Service User Participation Framework

Ensuring persons with disabilities are supported to live active engaged lives within mainstream society requires the development of appropriate networks that are integrated in local communities and within the context and provision of local community services and activity and to ensure an inclusive approach is taken to planning and policy so that persons with a disability and their family members are engaged in the process.

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Working Group 4 - Quality & Standards

- Develop a National Quality Framework for Disability Services

Developing a Quality and Outcomes Measurement Framework for adults and children will assist disability services in meeting the recognised standards of quality needed to ensure the delivery of quality, safe services that can be performance managed against key performance indicators.

Working Group 5 – Management & Information

- Provide a report on the Information System requirements for disability services in Ireland which will be enabled by appropriate IT systems.
- Development of a web based system which will act as a single point of information and advice on the disability service provision for service users, family and the community.
- Development of outcome focused key performance indicators on an annual basis.

Enabling the sector to use standard and consistent assessment tools to identify person's needs and the services required to meet them is critical to seeing services re-oriented to be person-centred. Coupled with the implementation of unique identifiers, services can be planned and monitored on the successful delivery of outcomes that directly respond to proven needs.

Working Group 6 - Governance & Accountability

- Governance and Accountability Framework for Service Arrangements
- Guidance on Strategic Alliance/ Mergers
- A National Shared Database and IT System

Developing the appropriate enabling IT systems and technology support is a key requirement to ensuring that the sector can best work together to ensure streamlined and efficient management and governance of service. Better systems for planning and delivery can ensure savings through reducing wasted costs incurred, duplicated work or ineffective data control and verification processes. Service Arrangements are a priority mechanism to enable a reconfigured governance and accountability framework.

5.0 How was this Operational Plan Developed?

The priorities for this three year Operational Plan have been informed by:

- Consultation with key stakeholders across the country to determine the key areas in need of improvement, (see 5.1)
- Collating themes arising from recommendations from national investigations and audits into disability services in Ireland, (see 5.2)
- Including key findings from national reports in to disability services in Ireland, (see 5.3)

- Using findings from reports that were commissioned by the working groups within the Transforming Lives Programme, (see 5.4)
- Identifying trends in inspections from the Regulator, Health Information and Quality Authority, (see 5.5)
- The work of the Social Care Division/Quality Improvement Programme (see 5.6)

5.1 Consultation with key stakeholders

One of the key success factors and fundamental features of a quality improvement approach to the development of an Operational Plan is the involvement of all key stakeholders. In order to inform the development of the Operational Plan, consultation workshops were planned in all nine Community Health Organisations (CHOs), as well as a separate initial workshop to listen to the voices of people who use disability services. By utilising local advocacy groups, people who live with disabilities were invited to attend this workshop.

Seven workshops were held within the CHOs. These workshops were attended by frontline staff and management working in the disability sector including HSE services, Section 38, Section 39 and For Profit organisations.

Over 120 participants attended these workshops where participants were asked to discuss three broad questions:

What are the core components of a high quality service for people living with a disability?
What are the barriers to achieving this type of service?
What are examples of good practice in Irish services for people living with a disability?

Participants discussed each question in their own group and this was followed by a whole group discussion on each topic.

The themes which emerged from these three questions were as follows:

Components of a high quality service –

Key themes emerged throughout all the workshops with a high quality service being defined as:

- person centred - responsive to persons who use services
- individualised and flexible
- accessible
- inclusive
- provided by flexible well trained and consistent staff
- good governance
- emphasis on continuous improvement - not just regulation driven

It is interesting to note that the service user consultation day, which preceded the CHO workshops, identified many of the same themes as those identified through the CHO workshop but with a very high emphasis around the relationship between staff and the residents. One person quoted - “A happy staff team is a happy house”. Well trained staff who are skilled not only in providing care to the person but can also support the person to achieve their goals was seen as critical to a high quality service.

Barriers to achieving a high quality service –

Seven themes emerged in this area:

- Resources - including lack of transport to support people to attend activities of their choice, insufficient staff to allow for more social experiences, lack of placements, aids and appliances, lack of multi-disciplinary supports and limited personal funding
- Legislation/ regulation - including lack of clarity on definition of a "designated centre" by the Regulator, conflicting legislation - recruitment needs and equality legislation at odds with one another, lack of uniformity between HSE, HIQA and national policy/legislation, RSSMAC scheme - impact on personal money
- Staffing - including high turnover, lack of training, poor skill mix, difficulties with recruitment, industrial relations etc. Persons who use services highlighted the negative issues that arose from high staff turnover, emphasising the relationship between the service user and staff member was critical to achieving good outcomes and this relationship was based on trust; they identified that when this relationship was broken due to staff members leaving, that it was very difficult to regain a trusting relationship with another staff member. "Staff are good at "care" but lacking in building independence/ social supports
- Governance and leadership including transition and planning issues
- Model of funding - year by year rather than three or five year to allow and encourage strategic planning of services- results in services unable to respond to changing needs
- Systems and processes including lack of connectivity between day and residential services, no definitions of all types of residential supports, multiple duplication and time implications of documentation and reporting of incidents/safeguarding
- Strategic planning in areas such as: positive behaviour supports, services for people with autism, primary care supports, joined up thinking and development of a national vision for disability services
- Values including a national culture of pity and charity for people with disability rather than rights based, valued social roles and empowerment, risk adverse especially since regulation commenced, lack of family awareness of rights, health based approach
- Communication, in particular hearing the voices of people who use the services, difficulties in trying to ascertain views from people with severe/profound disabilities who are not able to adequately articulate their views

Examples of Good Practice –

The final part of each workshop was given over to the participants to identify what they considered good practices in their services. A range of good practices examples were provided – 86 in total. Some of these identified significant improvements in their processes and practices whilst other examples looked at specific projects undertaken. It is the intention of the Quality Improvement team to follow up further on these examples. The team will develop a process where these projects that have been proven to improve the lives of people with disabilities will be prioritised and supported by the national team to be rolled out in other areas nationally in order to learn from each other utilising peer support. Examples of these include:

- Value based recruitment, parents on interview panels
- Active inclusive advocacy groups
- Policies in accessible formats
- Persons who use services involved in college, radio station employment, social activities such as sky diving, social farming initiatives, intensive interaction with nurse led programme
- Multiagency collaboration of hospital discharge
- Quality and safety walkabouts
- New Directions Subgroup - learning event
- Workers Co-Op
- Reflective practice
- Safeguarding through drama/peer support
- Staff team building – out of the office for a day
- Family engagement forum. Social experience in the house
- Link the transition year students, outreach programme with schools
- "Nimble spaces" where a board game was created to support persons who use services to design their environment
- Community integration - garden /landscape projects
- Let's get to work project (Pobal funding)
- Procurement of individualised support packages

5.2 Recommendations from National Investigations/Audits

The development of this Operational Plan offers an opportunity to collate the recommendations and key findings from a number of reports and investigations that have been carried out over the last few years and prioritise actions for the coming three years. The recommendations below are taken from the following reports:

- Southeast reports:
    - Conal Devine - March 2012
    - Resilience Ireland - March 2015 (no recommendations identified)
    - Conor Dignam - August 2016
- The McCoy Report - July 2016
- McDonnell & Dickinson Report on Audit of HSE services for people with intellectual disabilities and behaviours of concern - November 2016
- Case Review "Mary" - Callinan February 2017

- Molly's (not her real name) case: How Tusla and the HSE provided and coordinated supports for a child with a disability in the care of the State - Ombudsman for Children's Office January 2018

The major areas of concern identified throughout the investigations reviewed were as follows: (See Appendix I for full list of recommendations)

- Advocacy
- A need for positive behaviour supports
- Collaboration with other agencies
- Decongregation
- Documentation/Communication
- Engagement with people who use disability services
- Governance
- Human Resource, Performance Management and Supervision
- Legal Issues
- Policy Issues
- Safeguarding
- Sharing the Learning
- Staffing/Multidisciplinary Team working

5.3 Key Findings from National Reports –

The final part of each workshop was given

5.3.1 The following key findings were taken from the Intellectual Disability Section of the TILDA longitudinal report which marked wave 3 and the 10 year anniversary of IDS-TILDA[6]

A. Changing Demographics and Housing Mobility – Over the 10 year period:

- 32% (241/753 participants confirmed a change in where they were living with 167 people moving in the last three years.
- Movement within or to similar settings (lateral moves) were the most frequent moves made (64.7%).
- 1.4% of participants reported making a more community based move.
- Physical health changes were more likely to be reported as the main reason for these moves.
- A third of participants reported having a key to their own home. Of those who moved to a new residence, only 27.5% (46/167) reported having their own key.
- The majority of the participants who moved reported being happy following the move.

B. Changing Demographics and Housing Mobility – Over the 10 year period:

- Older people with intellectual disabilities continued to be more socially excluded that their counterparts in the general population; whilst those with severe-profound levels of ID and those living in institutional settings remain the most excluded across practically all measures.

[6] IDS –TILDA Health, Wellbeing and Social Inclusion: Ageing with an Intellectual Disability in Ireland. Evidence from the First Ten Years of the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing. (December 2017)

- Respondents with the most frequent family contact continued to be male, younger, with milder levels of ID and living in community settings; respondents with severe-profound ID and those living in institutional settings continued to have the least family contact.
- The vast majority of respondents had friends (92.4%), the most common type being a co-resident friend (71.8%), however a majority also reported they had friends outside their home (62%) and a similar number reported their keyworker/support staff were their friends (62.2%).
- Just over half (56.6%) reported they had a best friend and almost two-thirds (63.2%) said that their best friend was someone with an intellectual disability.
- The vast majority of older people with ID continue to engage in a broad range of social activities and most do these activities in their local communities; while the most popular organisations were "Sports, Social or Leisure Club", "Art or Music", "Advocacy Group". "Special Olympics" fell from the first to the fourth most popular between Waves 1 and 3.
- Four out of five respondents reported a sense of belonging in their local community.
- Older people with ID continue to be dependent on others for their transport, in contrast to the general older population. Overall 92.7% were driven as a passenger (just one person reported driving themselves), while just 29.4% used bus transport.
- The vast majority of respondents (96.4%) said that the day activity they described was what they wanted to do.
- Just over a quarter of respondents felt that a lack of transport facilities in their area affected their lifestyle (25.2%), and that they would like to use more public transport (26.7%).
- Half of respondents reported they had not spent any full days at home in the previous week, and a further 17% spent just one full day at home; however, 6.1% had not left the house at all in the previous week; while most who did not leave the house for at least one day had to stay at home for reasons other than their choice.

C. Physical Health – over the 10 year period

There was a noted increase in chronic health conditions between Waves 1 and 3.

- Objectively measured overweight and obesity increased from 66% in Wave 2 to 79.7% in Wave 3 and is now similar to rates reported by TILDA for the general population.
- Using waist circumference as an indicator of risk for metabolic conditions, 74.9% of participants in IDS-TILDA were at increased risk compared to 54% in the general ageing population.
- Falls remained high at 27% with 28.5% reporting > 2 falls and 12.5% reporting injurious falls.
- Polypharmacy remained high in Wave 3 at 39.5% and excessive polypharmacy at 32.7% with 47.4% of those taking 3-4 medications at Wave 2 having progressed to taking 5-9 medications (polypharmacy) at Wave 3.
- Dementia screening within the last two years rose from 14.5% in Wave 1 to 30.5% in Wave 3 overall and from 13.9% in Wave 1 to 61.4% in people with Down Syndrome.

D. Mental Health, Well-Being, Vitality and Life Events – over the 10 years

- Emotional, nervous and psychiatric conditions remained at a high prevalence, with almost 52% of participants reporting having received a doctor's diagnosis.
- Depression, anxiety, and mood disorders were the main contributors to poor mental health.
- Participants who self-reported were more likely to rate their mental and emotional health as excellent/

very good/good (92.9%) than those with join self/proxy (78.2%) or proxy only (70.8%) responses. This represented the highest self-rating of positive mental health to date across the three waves.

- Prevalence of depression, as measured using the Glasgow Depression Scale for people with a learning disability (GDS-LD), was significantly higher than that in the general population with 10% of participants reporting symptoms.
- There was no significant difference in prevalence of depression between those in institutions (11.1%) and community group homes (11.3%).
- Prevalence of anxiety, as measured using the Glasgow Anxiety Scale for people with a learning disability (GAS – LD), was similar to that in the mainstream population with 15.1% reporting symptoms. Anxiety was more frequently reported in those living in community settings than in institutions.

E. Health Care Utilisation –

- The majority of IDS-TILDA participants continued to access health services using a medical or GP card.
- There was a trend for increased health service use demonstrated by increases in emergency department admissions, GP use, outpatient appointments and hospital admissions.
- There were increases in the percentage of participants reporting accessing health screening services including prostate cancer and breast cancer checks.
- There was a much higher rate of flu vaccinations for the ID population (90.9%) compared with 47.5% for the older general population.

5.3.3 National Federation of Voluntary bodies, 2015, Next Steps - The Journey so far

Next Steps is a community of practice that provides leadership, peer-supports and shared learning in the development of high-quality, personalised (individualised) supports to people with intellectual disabilities in Ireland. It currently facilitates an inclusive learning community of 26 organisations throughout Ireland that are direct members through the National Federation of Voluntary Bodies, and has a much wider out-reach function in sharing learning and practice development throughout the ID sector.

The Next Steps community published a report on the learning gathered to date; the Journey so Far, which shared qualitative and quantitative data; learning from life-stories; and highlighted a number of key building blocks identified by the community as central to the process of developing high-quality individualised and person-centred supports. Anchoring all of these is the development of valued roles in family and community, essential to the sustainment of an included, community-focused life.

BUILDING BLOCKS FOR INDIVIDUALISED/SELF *DIRECTED SUPPORT*

5.4 Reports from the "Transforming Lives" Working Groups

A number of reports are in an advanced stage of completion and have been made available for consideration as part of consultation process in developing this Operational Plan. This included the work being done on a framework for quality improvement. Completed reports through Working Group 5, Transforming lives programmes are: Information systems for the Disability Services in Ireland, 2016 and KPI Subgroup report, 2016.

5.5 Identifying trends in regulatory inspection reports -

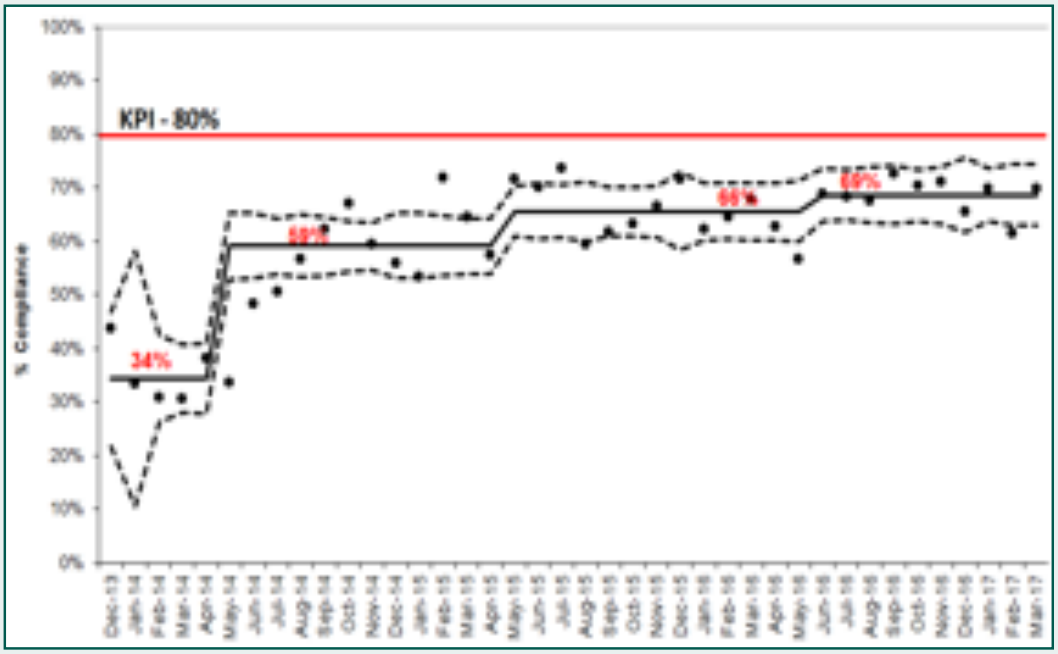
In 2012, the Health Information and Quality Authority (HIQA) which is the Irish regulator for health and social care services published the National Standards for Residential Services for Children and Adults with Disabilities. This was followed by the Department of Health's publication of the regulations with inspections commencing in November 2013. On commencement of inspections, a number of issues emerged very quickly relating to the quality of services and the buildings that services were being delivered from. Some agencies responded quicker to the regulatory requirements as they were already on a positive pathway of service improvement. Indeed significant improvements have been made with overall compliance over the last few years as evidenced by the diagram below. However, it is apparent that we need to support all services to continue on a process of continuous improvement and we need to do this through the sharing of knowledge, expertise and above all, a vision for providing the best quality of service possible to the people that we support.

Through the monitoring of HIQA reports, the areas that are consistently poor compliance are:

- Outcome 7 Health and Safety and Risk Management
- Outcome 14 Governance Leadership and Management
- Outcome 5 Social Care Needs
- Outcome 8 Safeguarding
- Outcome 17 Workforce

DIAGRAM 1

Disability Residential Centres national average HIQA compliance Dec 13 – Jan 17



- The National Service Plan target for compliance with inspected outcomes following HIQA inspections of Disability Residential Centres is 80%.
- The national average compliance has continued to make sustained improvements, from 34% in early 2014, to 59% in 2014-2015, to 66% in mid-2015, to 69% compliance from mid-2016 onwards to March 2017
- SPC[7] probability rules state that a trend can only be interpreted as a signal of improvement after 8 data points. Therefore further data is required to establish if the improvement will continue
- The national average compliance rate in HIQA

Extract from National Social Care Division - Quality Profile Q3 2017

Developing plans for improving compliance with the National Standards, with special emphasis on the five areas highlighted above will remain a priority within the three year Operational Plan.

[7] Statistical Process Control (SPC) is a method of quality control which employs statistical methods to monitor and control a process.

5.6 Social Care Division/Quality Improvement Division Programme

In March 2015, the Social Care Division /Quality Improvement Division (QID) - Quality Improvement Programme (SCDQID Programme) was established. QID and SCD - Disability Services jointly provided resources to form the interdisciplinary SCD/QID Quality Improvement Programme Team, lead by Assistant National Directors in SCD and QID. Team members combine knowledge and competencies in the areas of audit and evaluation, quality improvement, disability services, and clinical expertise.

The SCDQID Quality Improvement Team commenced a programme of work in March 2015. The purpose of the SCD/QID Quality Improvement Programme was to advise and support HSE residential services for adults with ID on enhancing structures and processes to improve the delivery of quality and person-centred services. The Programme's focus was on improvement in care, practice, service delivery, and generating the enthusiasm to make sequential improvements locally. Teams comprising of both SCD and QID staff have been aligned to CHO areas to support residential services staff.

The work carried out by this programme to date includes:

- Resource and develop cross divisional programme team
- Preliminary site visits in HSE residential services for adults with ID
- In dept support to HSE residential services for adults with ID
- Intensive programmes of support to CHO 1
- SCD/QID briefing papers – which have informed a number of national sub groups in place
- Workshops to support local service managers: PIC's/ PPIM's
- SCD/QID toolbox
- Governance and leadership documentation
- Training for staff in HSE residential services for adults with ID
- Audit tools
- Shared learning

In line with the objectives of this programme, it is now coming to a conclusion and the sustainability plan for the work of this team will be integrated into the National Quality Improvement Operational plan.

6.0 What is Quality Improvement?

Quality improvement aims at enhancing the quality of life of people with disabilities who receive services and supports. Most quality improvement models refer back to the original concepts which derived from the

work of Deming and Shewhart and refer to a four step continuous cyclical process – Plan, Do, Check/Study, Act. Quality improvement is NOT the same as quality assurance which is often aimed at compliance with minimum regulations or standards; quality improvement is visionary in nature and engages with persons who use services to ask what is important to them.

A quality improvement ethos is not restricted by a compliance-based environment and instead lifts the conversation to attain values-based best international practice as identified by people who use disability services and supports. Quality assurance preceded quality improvement and according to the Towards a Framework for Outcomes-Focussed Disability document, "undue focus on quality assurance systems, which do not include developing a quality improvement culture in services, carries the risk that staff may focus on quality assurance processes to the detriment of improving outcomes and enhancing quality of life for people with a disability." An example of this can be seen when the whole focus of an organisation is on the action plans which are required to ensure "compliance" for the regulator, at the cost of system wide innovative quality improvement initiatives. Organisations cannot "see the wood for the trees" in such circumstances and all efforts are focussed on the minutiae without due regard for the assessed needs of the person being supported by the service.

Quality improvement is a continuous process that is built-in to the quality management system of the organisation of planning, implementing, measuring outcomes and using the results to start the cycle again. Schalock et al (2015)[8] explain it as an ongoing process that occurs in organisations that have built the capacity to change and includes:

- Integrating organisation self-assessment, planning, doing, and evaluating
- Involving key stakeholders in the quality improvement process
- Incorporating multiple performance-based perspectives
- Implementing specific quality improvement strategies aligned with these perspectives

Quality improvement ensures an organisation's sustainability. Sustainability focuses on outcomes, generating knowledge, building capacity, establishing stable funding and staffing patterns and providing value-based services and supports in an effective and efficient manner. Sustainability characterizes an organisation's ability to adapt to change and provide service delivery opportunities and practices that are effective and efficient and requires that an organisation:

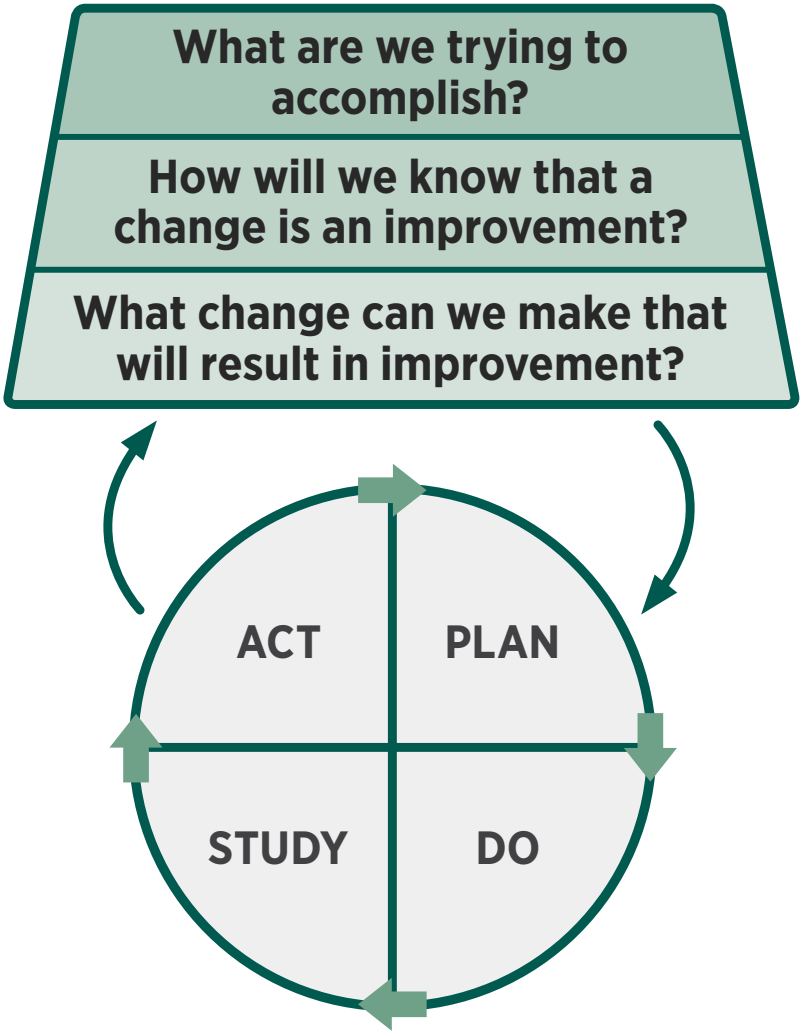
- Recognise the necessity for self-assessment, buy-in, and capacity building
- Create a structure for implementation including quality improvement teams and user-friendly, quality improvement formats/templates
- Ensure on-going support strategies such as technical assistance and supportive feedback
- Encourage learning and sharing

Evidence about successful quality improvement indicates that the way in which leaders and managers introduce change into services is important and that organisations should not underestimate the importance of involving all staff. This is a fundamental feature of a quality improvement and outcomes focused approach. An organisation-wide developing and sharing of a vision for services and supports is essential and a breaking down of traditional hierarchies so that all staff feel welcome to contribute perspectives and ideas.

The HSE uses the Institute for Healthcare Improvement (IHI) model which builds on the traditional Plan, Do, Study, Act cycle for quality improvement.

[8] Schalock, RL., Verdugo, M., Lee, T (2016) A systematic approach to an organisation's sustainability Evaluation and Program Planning.

MODEL OF IMPROVEMENT



Quality improvement approaches are underpinned by a philosophy and a set of competencies. For this reason, research indicates that quality improvement initiatives are more successful if frontline staff are supported by facilitators who have capability in quality improvement methods, approaches, tools and techniques. The HSE Improvement Knowledge and Skills Guide – Development Assessment Tool for All Staff was developed to support the ongoing learning and professional development of all staff, both clinical and non-clinical, by providing a list of improvement knowledge and skills which can help to educate, train and guide staff on how to deliver improvement in the health service. This guide is available on the HSE website under the Quality Improvement Division site.

7.0 International best practice for disability services

The United Nations Convention on the Rights of People with Disabilities (2006)

The United Nations Convention of the Rights of People with Disabilities (UNCRPD) developed values-based disability policies based on individual and organisation values and principles. Countries have adopted these is different ways – In the case of monitoring progress towards implementation of the principles and articles of the UNCRPD.

Denmark:

The Danish Institute for Human Rights developed Gold Indicators:

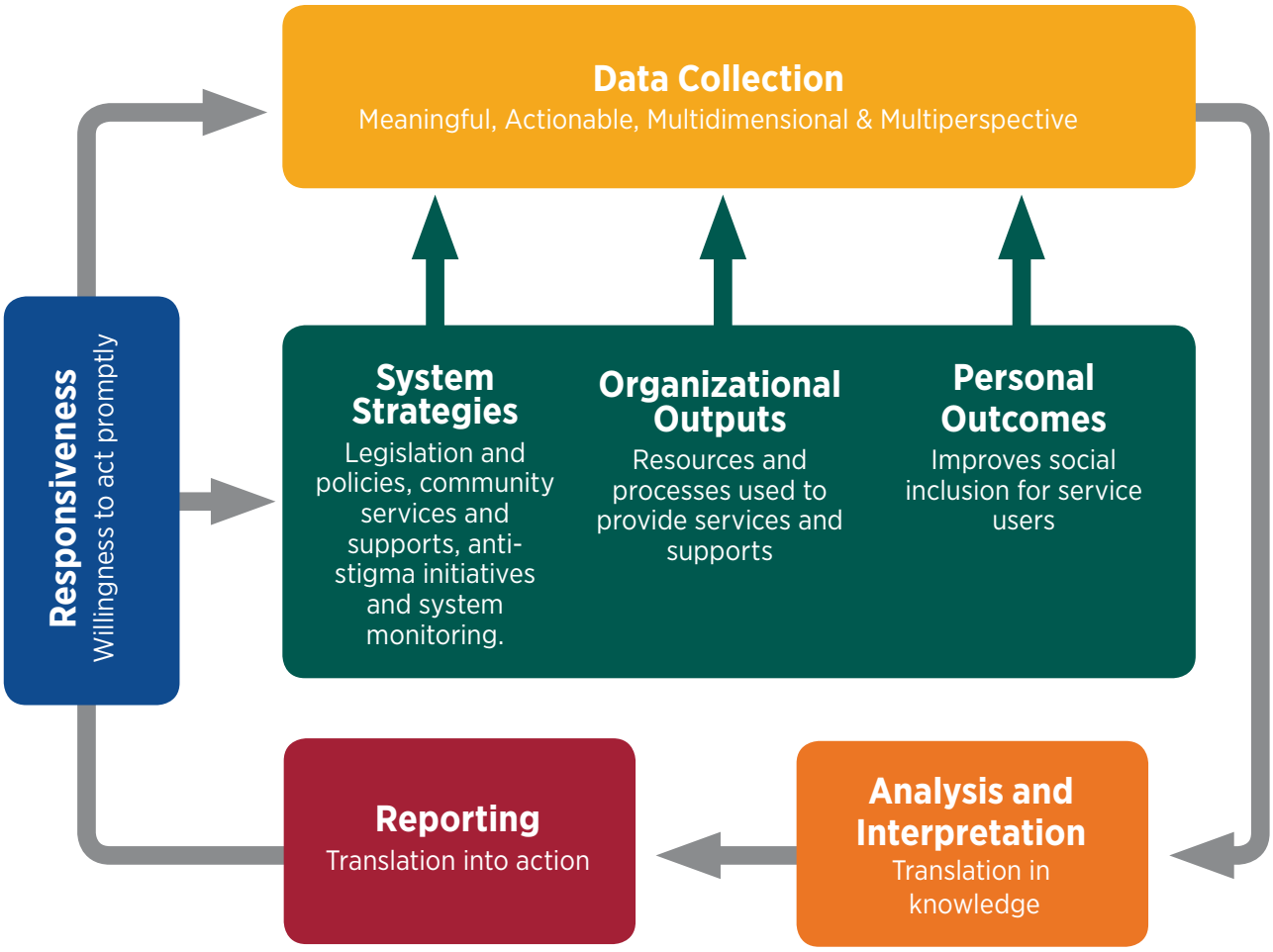
Diversity & awareness training	Percentage of persons with and without disabilities, who within the last week have experienced at least one person with a disability expressing an opinion or otherwise participating in a broadcast/ segment/interview on radio, TV or other news media
Accessibility & mobility	Percentage of persons with and without disabilities who, during the last week, have experienced problems of accessibility to public transportation such as local buses, trains, motorised vehicles, taxis, etc.
Liberty & personal integrity	Percentage of persons with and without disabilities under the age of 30 who have been detained in a prison/detention centre or a psychiatric facility
Independent living & community inclusion	Percentage of persons with and without disabilities who feel strongly or very strongly that they have influence/ control over their own lives
Education	Percentage of persons with and without disabilities under the age of 25, who leave school early and thus fall within the EU classification early school leavers
Health	Percentage of persons with and without disabilities, who state that they are in good physical and/or mental health
Employment	Percentage of persons with and without disabilities who in a selected week had at least a few hours of paid employment
Social protection	Percentage of persons with and without disabilities who, during the last three years, due to economic reasons have been prevented substantially from living what they consider a normal life
Political participation	Percentage of persons with and without disabilities who voted in the most recent general election

USA:

Definitions in the 2000 amendments to the Developmental Disabilities Act in the USA recognised the importance of individualised, personalised supports, self-determination and inclusion in defining and evaluating the quality of disability services and supports.

As discussed in Towards a Quality Framework for outcomes - based Disability Services, individualised supports enable an individual with a developmental disability to exercise self-determination and be independent, productive, integrated and included in all facets of community life. It means supports that are designed to enable such individuals to control their environment, permitting the most independent life possible; prevent placement into a more restrictive living arrangement than is necessary; and enable such individuals to live, learn, work, and enjoy life in the community.

Continuous Quality Improvement in Intellectual and Developmental Disability Services, Ontario Canada, (Cobigo et al, 2014)



FOCUS	DOMAIN	DEFINITION
PERSONAL OUTCOMES Benefits for service users	Valued social roles	Being socially included means experiencing a range of social roles within a variety of contexts. Social roles are valued when they respect the individual and the community's expectations, choices and needs
	Competency	To perform a given social role, the person has to have acquired the required skills to be competent in that role.
	Reciprocity	Complementary social roles; social roles only exist when reciprocated by others.
	Belonging	A sense of belonging is a subjective feeling of value and respect that is built from reciprocal relationships and shared experience.
	Choice	Social roles are the result of an individual's choices.
	Satisfaction	Social inclusion relies on the satisfaction of all members of the community that their social roles are valued, meaningful and respectful of choices.
ORGANIZATIONAL OUTPUTS Resources and processes used by agencies to provide services	Tangibles	Quality of physical facilities, equipment and people.
	Reliability	Ability to perform the promised service dependably and effectively.
	Responsiveness	Willingness to help consumers and provide prompt services.
	Assurance	Knowledge and courtesy of employees and their ability to convey trust and confidence.
	Empathy	Caring and individualized attention provided to consumers.
	Availability	Presence of needed services and supports.
	Affordability	Ability to procure the service and supports.
	Awareness	Degree to which the service user is aware of potential services or supports.
	Accessibility	Ability to access the services and supports (e.g. barrier - free environment)
	Extensiveness	Variety of services and supports.
	Appropriateness	Degree of correspondence between needs of the consumer and availability of relevant services or supports.
SYSTEM STRATEGIES Ways in which agencies and MCSS enhance personal outcomes and organizational outputs	Legislation and policy	Human rights discourse and legislation that protect the rights and freedoms of persons with IDD.
	Supports and services	Community - based and person - centered supports and services.
	Anti-stigma Initiatives	Efforts to eliminate social barriers and promote adequate and equitable access to public goods and services.
	System monitoring	Developing evidence of the effectiveness of actions.

Quality Improvement in IDD Services in Ontario, Canada: Domains Proposed by the Multidimensional Assessment of Providers and System (Cobigo et al, 2014)

8.0 Framework for Classifying Operational Objectives 2018 – 2020

8.1 HSE Framework for Improving Quality

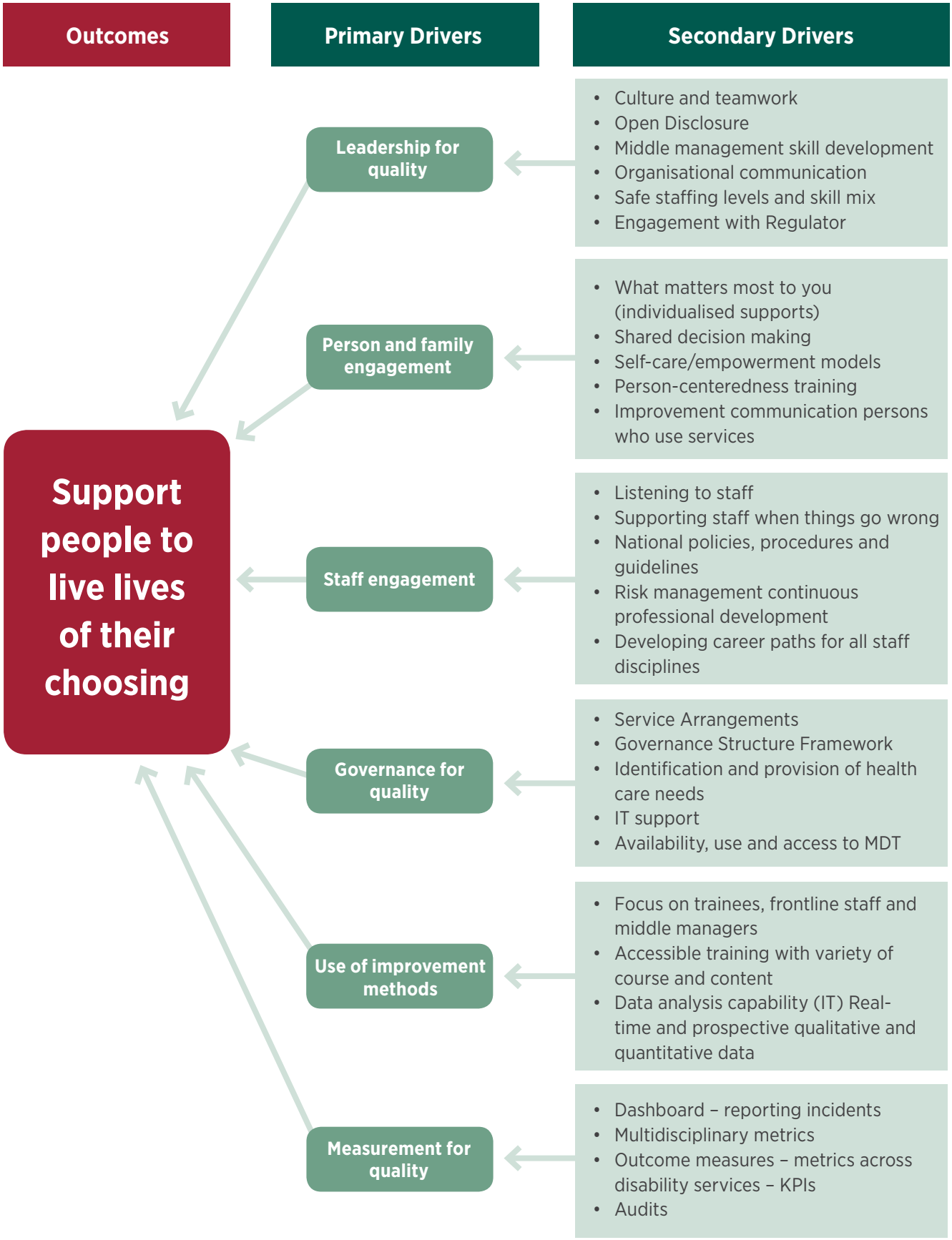
The HSE Framework for Improving Quality in services (Quality Improvement Division 2016) defines quality improvement as the combined and unceasing efforts of everyone - health-care professionals, patients and their families, researchers, commissioners, providers and educators - to make the changes that will lead to:

- Better personal outcomes
- Better experience of care
- Continued development and supporting of staff in delivering quality care

As evidenced in the following Driver Diagram, figure 2, in order to support the achievement of the vision to "support people to live ordinary lives in ordinary communities", the Quality Improvement Operational Plan will focus on the key drivers identified in the HSE Framework for Improving Quality which are:

- Leadership for Quality
- Person and Family Engagement
- Staff Engagement
- Use of Improvement Methods
- Measurement for Quality
- Governance for Quality

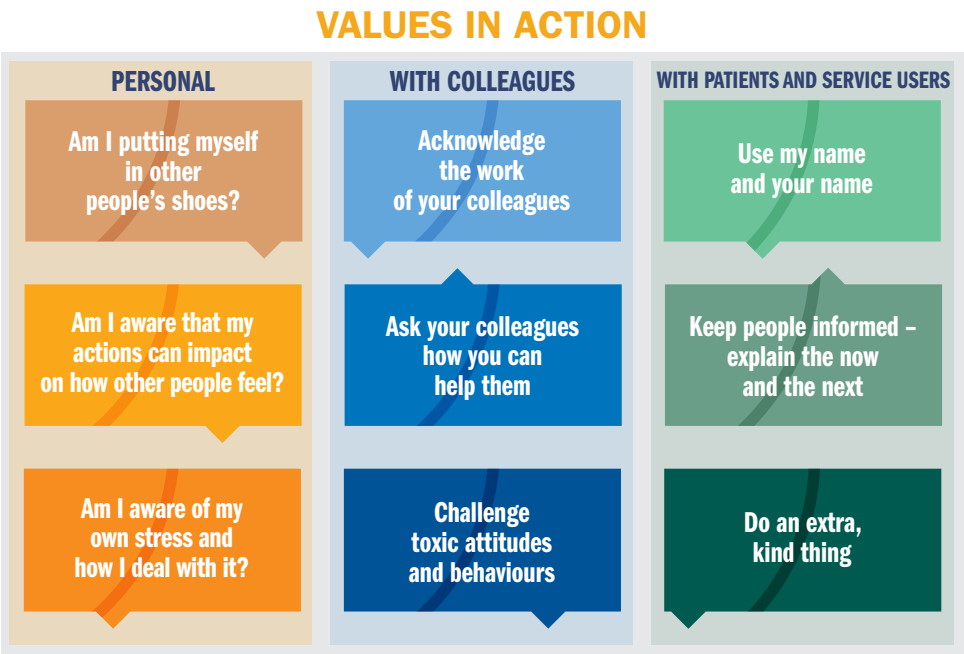
FIGURE 2: Quality improvement disability services - Driver Diagram



8.2 HSE Values in Action Programme

Values in Action is about delivering better experiences to those who use our services, and creating better workplaces for our staff. It's about building a culture in the health service that reflects our values of care, compassion, trust and learning, so that they are evident every day in every workplace. These values have been translated into the 9 behaviours that bring the values to life. Values in Action is led and supported by staff from across the health service, from all grades, roles, disciplines and backgrounds, who are working together to create a grassroots movement to spread these behaviours. **The nine behaviours are identified as:**

It is going to take all of us, working together to change our health service for the better in every setting, including Disability Services. This Operational Plan reflected these behaviours during development and will continue to reflect these behaviours throughout its implementation.



9.0 Operational Objectives 2018 – 2020

Driver -	No.	Strategic Objectives -	Due Date	Who - Disability QI Team in collaboration with
1.0 Leadership for Quality	1.1	Shared Vision: In collaboration with key stakeholders, develop a shared vision for disability services in Ireland that reflects our commitment to support people to live lives of their choosing	Q4 2020	Disability QI (DQI) Communications Team (Comms) Quality Improvement Leads in CHOs Heads of Social Care (HOSC)
	1.2	Communication: Ensure that the work conducted by the Quality Improvement team is communicated in accessible formats to all key stakeholders.	Q4 2020	DQI Comms QI Leads in CHOs Heads of Social Care (HOSC)
	1.3	Effective Engagement with the Regulators: Engage with Regulators (HIQA, NMBI, CORU, HSA etc.) to ensure opportunities for two-way communication to develop a partnership approach to Quality Improvement in Disability Services.	Q4 2020	DQI Comms

9.0 Operational Objectives 2018 – 2020 continued...

Driver -	No.	Strategic Objectives -	Due Date	Who - Disability QI Team in collaboration with
2.0 Person and Family Engagement	2.1	Effective Engagement: Create an inclusive decision-making environment for persons with a disability, families as appropriate, and recognising people as active agents capable of affecting change in their own lives to achieve their full potential.	Q4 2020	DQI Communications Team HSEland QI Leads in CHOs Heads of Social Care (HOSC
3.0 Staff Engagement	3.1	Staff Engagement: Support staff to spread a culture that reflects the values of the health and social service in Ireland – care, compassion, trust and learning and embraces the principles of empowerment, person-focused and person led approach	Q4 2020	DQI Quality Improvement Division (QID) Human Resources Planning and strategy team Safeguarding Office QI Leads in CHOs Heads of Social Care (HOSC)
4.0 Use of Improvement Tools	4.1	Use of Improvement Tools: Promote and support the rollout of accessible continuous professional development programmes to provide staff with knowledge and experience in the use of Quality Improvement Methodologies.	Q4 2020	DQI QID Social Care QPS (SCQPS)
5.0 Measurement for Quality	5.1	Measurement for Quality: Monitor progress towards implementation of the Quality Improvement Operational Plan.	Q4 2020	DQI HSE Compliance National Disability Specialists QPS National Disability Authority Academic Partners
6.0 Governance for Quality	6.1	Governance for Quality: Develop robust governance mechanisms to implement, monitor and evaluate the effectiveness of the Quality Improvement Operational Plan.	Q4 2020	DQI SCQPS NDOT HSE Compliance

10.0 Implementation Plan:

An Action Plan will be developed each year, which will identify the priority actions aligned to each Strategic Objective, the timeframe in which the action will be completed, the project lead for each action and the key stakeholders with whom we will collaborate. These actions will be prioritised with key stakeholders and will be evaluated in Quarter 4 of each year in order to inform the priority actions for the following year.

11.0 Evaluation of the Operational Plan

The Quality Improvement team will measure the effectiveness of this Operational Plan utilising international validated measurement tools such as;

- The Quality of Life Outcome Measures (QOL)
- The Quality of Life Impact of Services Tool (QOLIS)
- The National Core Indicators Tool for Outcome Measurement (NCI)
- NDIS Australia
- Personal Outcomes Measurement Tool (POMS)
- The Council on Quality and Leadership's Personal Outcomes Measurement Tool (CQL)
- CQL Basic Assumptions Tool
- CQL Person Centred Excellence Tool
- Key performance indicators
- Observation (Bigby)
- EFQM
- PQASSO
- Outcomes Based Accountability framework
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- European Quality in Social Services (EQUASS)

12.0 Collaborative Working

In order to effectively implement this Operational Plan, avoid duplication, and ensure "buy in", it is essential that the Disability Quality Improvement Team engage closely with key stakeholders across the Irish health and social care system. These include:

12.1 External to HSE:

- Disability Federation of Ireland (DFI)
- National Federation of Voluntary Bodies
- For Profit Disability Service Providers
- Not-for-Profit Disability Service Providers
- Genio
- Nursing and Midwifery Board of Ireland home (NMBI)
- Medical Council
- CORU - Regulating Health & Social Care Professionals
- Health Information and Quality Authority (HIQA)
- National Disability Authority (NDA)
- Nursing and Midwifery Board of Ireland (NMPDU)
- Department of Health (DoH)
- Department of Social Protection
- Department of the Environment (DoE)
- Inclusion Ireland
- Universities
- Unions
- Advocacy Services

12.2 HSE:

- Quality Assurance and Verification Division (QAVD)
- Quality Improvement Division (QID)
- Social Care Quality and Safety (SCQPS)
- Communications Division
- Human Resources

12.3 Disability Services Team: National Disability Specialists

- National Disability Specialists, including Children's Team
- Reform Team
- Service Improvement Team (analysis)
- Human Resources
- Finance
- Information Technology

12.4 CHO Structures:

- CHO Chief Officer
- Head of Social Care (HOSC)
- QPS Lead
- Disability GM
- Disability QI Lead and Team

13.0 Key Dependencies
13.1 Community Health Organisation (CHO) and Community Health Networks (CHN's)

This Operational Plan will also link in with the work currently underway in Primary Care as the success of the Operational Plan will be dependent on the community supports in place for people with disabilities.

13.1.1 CHO Structures

A review of Community Health Services was commissioned by the HSE Director General in May 2013. The resulting report Community Healthcare Organisations – Report & Recommendations of the Integrated Area Service Review (CHO Report), Sept 2014 provides a framework for the governance and organisation for all community healthcare services in Ireland. It identifies a new structure for the operational delivery system in community healthcare and sets out recommendations regarding the importance of developing a new integrated model of care which is responsive to the needs of local communities. The identified changes focus on service delivery, local decision making and accountability through integrated management structures, with Primary Care at the centre of how services can be delivered.

Specifically the report recommended the establishment of:

a Nine Community Healthcare Organisations (CHOs) led by Chief Officers and a CHO Management Team.

b Ninety Community Healthcare Networks (CHNs), serving an average population of 50,000 (range from 35,000 – 80,000) with each CHO having between eight and 14 CHNs

c An average of five Primary Care Teams per CHN serving an average population of 10,000

d Network Managers who will manage core primary care services within Community Healthcare Networks while ensuring effective integration of specialised services including mental health, services for older people, disability services and access to acute hospital Services.

e Improved participation from General Practitioners in Primary Care Teams through the establishment of GP lead roles on the management team for each CHO and at Community Healthcare Network level

These new structures are designed to:

- Support the decisive shift of providing care to primary care and community services from the most expensive form of treatment and care, acute hospital settings.
- Enable integration of services for a local population and provide clearer, more joined up pathways of care for persons who use services.
- Support prevention and management of chronic disease at a community level.

The establishment of the nine Community Healthcare Organisations (CHO's) with the appointment of Chief Officers and their Senior Management teams provides standardised and appropriate governance and management arrangements for the delivery of community healthcare services in Ireland. The management structure at CHO level provides for management of services at CHO level on a care group basis. This enables a standardised approach to the delivery of services in line with government policy priorities and best practice in:

- Primary Care
- Mental Health Services
- Specialist Disability Services e.g. Children's Disability Teams
- Services for Older People e.g. Home Support Services
- Palliative Care
- Social Inclusion (services for vulnerable or marginalised groups)

13.1.2 CHN Structures

Community Healthcare Networks (CHNs), as set out in the CHO Report, will be the "fundamental unit of organization for the delivery of services" in the community. They are geographically based units which will consist of an average of five multidisciplinary Primary Care Teams (PCTs) who will deliver local accessible services to an average population of 50,000 people.

CHNs will support the delivery of the maximum levels of services within local primary care services along with appropriate and clear access to specialist services for older people, people with disabilities and people with mental illness, along with clear referral pathways to acute hospitals, where required and appropriate.

CHNs will enable a proactive coordinated approach across all healthcare staff and services to systematically improve the health and wellbeing of the CHN population. CHNs will also provide the structures and processes to support the prevention and management of chronic disease at community level.

A key outcome of the development of the Community Healthcare Networks is to achieve better outcomes for people requiring services in the network, achieved through a multidisciplinary approach, particularly for supporting people with complex needs. Through multidisciplinary working and in conjunction with clear lines of communication and liaison with specialist services, the networks will be the fundamental provider of frontline services. This can only be achieved through careful planning and with investment in the skill set of the network staff through training and other supports. In addition, the development of community linkages and engagement, co-planning and joint working, in relation to health and wellbeing are critical.

13.2 Resources at National and CHO Level

In order to ensure the successful implementation of this Operational Plan, adequate resourcing of the National Quality Team will be imperative. A well- resourced Quality Improvement structure at CHO and CHN level with teams of appropriately skilled staff with competence in both disability services and quality improvement methodologies is also imperative.

14.0 References:

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- Health Service Executive (2017); Health & Wellbeing Operational Plan, https://www.hse.ie/eng/services/publications/serviceplans/serviceplan2016/oppls16/hthwebngopspls16.pdf
- Health Service Executive, (May 2013); Community Healthcare Organisations - Report and

Recommendations of the Integrated Area Service Review (CHO Report), https://www.hse.ie/eng/services/publications/corporate/choreport.html

- Health Service Executive Southeast reports:
- Conal Devine – March 2012
- Resilience Ireland – March 2015 (no recommendations identified)
- Conor Dignam – August 2016
- The McCoy Report – July 2016
- McDonnell & Dickinson Report on Audit of HSE services for people with intellectual disabilities and behaviours of concern – November 2016
- Case Review "Mary" – Callinan February 2017
- Health Information and Quality Authority, (2013); The National Standards for Residential Services for Children and Adults with Disabilities, https://www.hiqa.ie/reports-and-publications/standards?tid=51&tid_1=All&keys
- Healthcare Act 2007 – (Care and Support of residents in Designated Centred for Persons (Children and Adults) with disabilities) Regulations 2013, http://www.irishstatutebook.ie/eli/2013/si/367/made/en/print?q=367
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15.0 Appendices
15.1 Collated Recommendations from Investigations
15.2 Glossary of Terms

Appendix 1: Collated Recommendations from Investigations

Advocacy –

- Promote voluntary advocacy services and initiatives under the aegis of the National Advocacy Service (McCoy July 2016)
- A need for Positive Behaviour Support
- A National Behaviour Support Advisory Hub should be set up (McDonnell & Dickinson November 2016)
- National Leadership programme to be set up to reduce Restrictive Practices (McDonnell & Dickinson November 2016). This would be part of the work of the Hub.
- A stronger focus on implementation of Behaviour Supports (McDonnell & Dickinson November 2016). This would be part of the work of the Hub.
- Broaden the therapeutic model of behaviour support (McDonnell & Dickinson November 2016). This would be part of the work of the Hub.

Collaboration with other agencies –

- The HSE should designate a responsible officer in each CHO to ensure that there are clear and practical protocols between the HSE and other service providers in respect of the care and management of vulnerable adults with a disability. (Devine August 2012)
- There should be ongoing comprehensive documentation and exchange of adult protection concerns between the HSE and any relevant voluntary service providers to any such vulnerable adult. A national policy for the protection of vulnerable adults with a disability should underpin such a practice and ensure that there are reciprocal obligations applied to the relevant voluntary agencies. (Devine August 2012)
- Promotion of a shared awareness of intersecting policies and procedures for interagency working including the HSE Safeguarding Policy and the Tusla Aftercare Policy will facilitate a mutual understanding of roles, responsibilities and referral pathways, which would assist the management of complex cases. (Callinan Feb 2017)
- Formal arrangements to include meetings to address complex cases pertaining to people with disabilities with multi agency involvement would facilitate improved management, or shared management of specific cases. (Callinan Feb 2017)
- Address the current gap in the provision and co-ordination of supports and services to children with a diagnosed moderate to severe disability in foster care through legislative, regulatory, policy and/or budgetary means. (Ombudsman for Children's Office Jan 2018)
- Review the current supports and services being offered to Molly to ensure that she reaches her full physical, cognitive and educational potential. (Ombudsman for Children's Office Jan 2018)
- If, as proposed, Molly is moved to another care placement, ensure the necessary supports are put in place so that she experiences a stable transition from her current to her future home. (Ombudsman for Children's Office Jan 2018)
- Review the supports and services being offered to approximately 471 other children with a moderate or

severe disability in foster care in the State within 12 months. The output of this review should inform the development of the local case management model, the development of specific performance metrics and improve wider inter-agency and departmental engagement. (Ombudsman for Children's Office Jan 2018)

- Devise a respite action plan for children with a disability in the care of the State, as well as children with a disability in the community at large. (Ombudsman for Children's Office Jan 2018)

Decongregation –

- Implement a rolling programme of assessments of individual needs in all congregated settings (McCoy July 2016)
- Ring-fence resources to support people to move out of congregated settings, ensuring that the funding follows the individuals, and that personalised budgets are an option (McCoy July 2016)
- Accelerate the process of supporting people to move into community living, avoiding transitional arrangements (McCoy July 2016)
- Ensure the entitlement of people with disabilities living in designated centres to access all housing supports (McCoy July 2016)
- Focus on positive aspects of people moving to community (McDonnell & Dickinson November 2016)
- A stronger focus on individuals with lower support needs (McDonnell & Dickinson November 2016)
- Prioritise people with challenging behaviour for Decongregation (McDonnell & Dickinson November 2016)

Documentation/Communication –

- Clear and transparent record keeping should be maintained in respect of decisions and the reasons and basis for same to allow for the ready identification of the date upon which a decision was made and the reasons and basis for same. (Dignam August 2016)
- Management must ensure, as a matter of urgency that there is a robust process in place for the documented handover of cases and that the effectiveness of this is monitored (Devine August 2012)
- All staff in intellectual disabilities should receive appropriate training on file and record keeping. (Devine August 2012)
- Requirements with regard to record keeping standards are an identified deficit requiring attention. Clear guidance needs to be provided to staff in relation to good record keeping practices (Callinan February 2017)

Engagement with people who use disability services –

- Ensure that HSE disability managers engage with people with intellectual disabilities and their representatives (McCoy July 2016)

Governance –

- Terms of Reference must be drafted by the HSE to ensure, insofar as is possible, that they are clear, precise and unambiguous. (Dignam August 2016)
- Management should ensure that decisions taken at meetings for follow up by staff are actioned and that clear effective measures for dealing with non-compliance are in place. (Devine 2012)

- Make certain that structures and accountability mechanisms ensure that national policy is fully implemented at local level (McCoy July 2016)
- Place failing services into 'Special Measures' (McCoy July 2016)
- Conduct a review of the McCoy Report actions, and provide a progress report on the recommendations and deficits identified, to be reported back to the Minister with responsibility for Disability Services within 12 months of the report. (McCoy July 2017)
- Governance versus Oversight – develop a standardised Governance Structure Framework (McDonnell & Dickinson November 2016)

Human Resource, Performance Management and Supervision –

- Where issues with performance are identified, every effort will be made by the employee's immediate supervisor/manager to address any shortcomings in work standards, conduct or attendance through informal counselling without invoking the disciplinary procedure. However, when the employee's conduct does not meet the required standards despite informal counselling and support, such performances are to be dealt with under the Disciplinary Procedures.(Devine 2012)
- Management should ensure that staff working in this area has appropriate supervision, direction and support to ensure that their practice in the support and protection of adults with an intellectual disability is of a high standard. (Devine August 2012)
- Develop a bespoke leadership development and management of change programme for managers of all congregated settings (McCoy July 2016)

Legal Issues –

- Consent issues, in particular for vulnerable adults should be clarified with legislation (Devine August 2012)

Policy Issues –

- The HSE should develop a clear governance structure to be implemented by the HSE and other relevant agencies to support the placement of adults with a disability in family type settings. (Devine August 2012)
- Consideration should be given to developing a protocol around contact between service users and their families, being mindful of service users' wishes. (Devine August 2012)
- There is a requirement for consistency in respect of communication with relatives of a vulnerable adult who may not be in regular contact with that person and who may not and who may not be in a position to advise on what would be in the best interests of the vulnerable adult at the time a decision is required to be made. (Devine August 2012)
- Where there are concerns about the appropriateness or suitability of a placement this should be taken into account in determining the weight to be attached to the views of any such person having or managing control over that placement. (Devine August 2012)
- Financial clarity around closure of some facilities and transition plans for same versus money spent to maintain inappropriate facilities (McDonnell & Dickinson November 2016)

Safeguarding –

- All health and social care providers should ensure that risk assessments in adult protection services are holistic and consider all aspects of the person's life so that this will in turn form a Protection Plan which can be used to deliver effective protection and support to the service user.(Devine August 2012)
- Create, implement and roll out a National Protection Awareness programme for people with intellectual disability, and include people with intellectual disability in its design. (McCoy July 2016)
- In the review of Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures, ensure that guidance is included for the development of local adult protection and welfare procedures (McCoy July 2016)

Sharing the Learning –

- Where the HSE determines that significant learning can be achieved from particular material or a report but that same should not be published due to, for example, data protection issues or concerns in relation to an adverse impact on a criminal investigation or criminal trial, the HSE should explore and strive to extract this learning from the document to circulate it to relevant individuals or agencies in a manner which does not unduly or improperly impact on the above concerns. (Dignam August 2016)
- Develop a mechanism for promoting good practice throughout the intellectual disability sector (McCoy July 2016)

Staffing/Multidisciplinary Team working –

- Social work management need to more clearly define the role of social work professionals vis a vis both the wider social work and intellectual disability services. Reporting relationships, roles, responsibilities and accountability arrangements must be clearly defined so as to provide a clear strategic and operational context within which those professionals can deliver an effective service. (Devine August 2012) In the absence of a regulatory framework for social workers and other allied health professionals, Devine recommends that in the interim management and social work staff have regard to the provisions of Statutory Instrument 143 of 2011 "Code of Professional Conduct and Ethics for Social Workers Bylaw" as a quality benchmark to assist in the meetings standards that should reasonably be expected in respect of Social Worker and Management interventions, particularly with regards to children and vulnerable adults, in particular Provisions 8 and 9 a&b.
- Social work management, together with Intellectual Disability Management, should ensure that there is an effective case management process in place within the Disability Service which allows Social Work Professionals to prioritise cases in line with best practice and ensure service delivery is of a high standard (Devine August 2012)
- Move from a culture of a nursing and medicalised model to a culture that implements a social care model (McDonnell & Dickinson November 2016)
- Develop a core skills development programme for all staff working in disability services including autism informed practice, management of challenging behaviour etc.(McDonnell & Dickinson November 2016)
- A better understanding of change processes in resistant culture, (McDonnell & Dickinson November 2016)

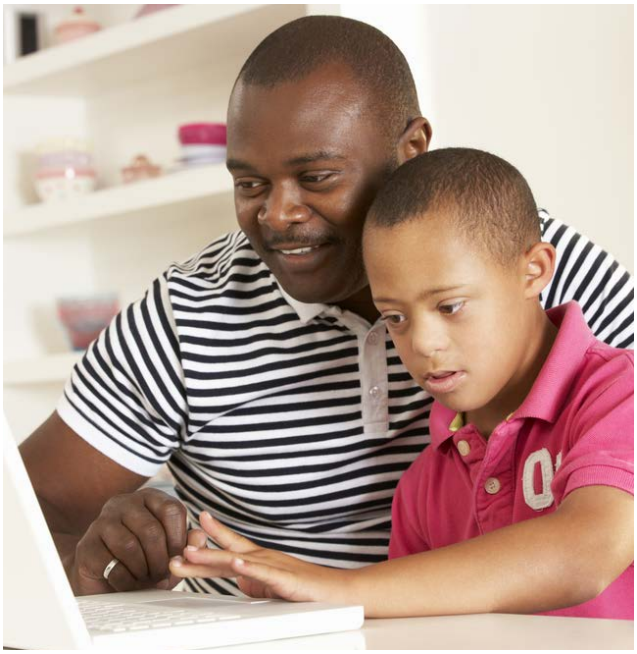
Appendix 2:
Glossary of Terms and descriptions:

CHO	Community Health Organisation
CHN	Community Health Networks
CORU	Regulatory body for Health and Social Care Professions
DOH	Department of Health
DQI	Disability Quality Improvement
HAS	Health and Safety Authority
HIQA	Health Information and Quality Authority
HOSC	Head of Social Care
HSE	Health Service Executive
ID	Intellectual Disability
IHI	Institute for Healthcare Improvement
KPI	Key performance indicator
LEAN	A quality improvement methodology that works on the key principle of creating more value for customers through better planning in the use of resources
MDT	Multi Disciplinary Team
NDOT	National Disability Operational Team
NMBI	Nursing and Midwifery Board of Ireland
PCT	Primary Care Team
PDSA	PDSA – Plan, Do, Study, Act – cycle of change
QAVD	Quality Assurance and Verification Division
QI	Quality Improvement
QID	Quality Improvement Division
RSSMAC Scheme	Residential Support Services, maintenance and accommodation contributions – Regulations in Statutory Instrument 467, 2016 and amended in 2017
SCD	Social Care Division
SCQPS	Social Care Quality and Patient Safety
Section 38	A voluntary, not for profit organisation who receives funding through section 38 of the Health Act, 2004
Section 39	A voluntary, not for profit organisation who receives funding through section 39 of the Health Act, 2004
Six Sigma	A set of techniques and tools to reduce variation in processes
SPC probability	Statistical Process Control (SPC) is a method of quality control which employs statistical methods to monitor and control a process
TUSLA	Child and Family Agency
UNCRPD	The United Nations Convention of the Rights of people with Disabilities

"We promote the values, principles, culture, structures and processes to deliver efficient and effective person-centred and outcomes-focused services that support people with disabilities to develop their potential."

For further details please contact

National Quality Improvement Office

HSE Disability Services in Ireland

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