DRAFT REPORT

TO: PROGRAMME MANAGER, COMMUNITY CARE

FROM: STRATEGY TASK GROUP

ON: PHYSICAL AND SENSORY HANDICAP

MAY, 1995

REPORT OF TASK GROUP ON PHYSICAL AND SENSORY HANDICAP

A Task group was appointed by the Programme Manager, Community Care, Eastern Health Board, and held its first meeting on 22nd February, 1995.

Terms of reference:
The formulation of a four year action plan with detailed costings in line with the Health Strategy's document (Shaping a healthier future) recommendation for persons with physical and sensory handicap.

Definition: the following definition of 'physical and sensory handicap' was accepted:- Any limitation, congenital or acquired, of a person's physical or sensory ability which affects his daily activity and work by reducing his social contribution, his employment prospects or his ability to use public services.

Members of the Working Party
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ACKNOWLEDGEMENTS

Thanks are due to all members of the task group who contributed in an energetic and enthusiastic fashion.

Special thanks to Dr Eibhlin Connolly and Dr Heidi Pelly who shared the secretarial duties and to Ms Caroline Murphy and Ms Teresa Purdue who typed the document.

Ailis Quinlan,
Chairperson.

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CHAPTER ONE

INTRODUCTION

The problems faced by persons with disabilities have been highlighted in recent years in a number of reports and publications including:

Towards a Full Life (Department of Health)
Disability, Exclusion and Poverty (N.R.B.)
Shut up at Home - A Survey of Respite Care Facilities by D.F.I. (1994)
and People First (Irish Wheelchair Association, 1994).

These problems include:-

- poverty
- unemployment
- lack of awareness by society
- lack of social outlets
- segregation in housing, education and training.

Addressing these problems by such measures as improving transport and access to public buildings, increasing employment levels, providing suitable housing, and promoting the social integration of the disabled will require a multi-sectoral approach. The Eastern Health Board has welcomed the measures proposed to address these issues in government reports including a the policy agreement - a Government of Renewal (1994), and the Report of the Special Education Review Group (December, 1993) and Shaping a Healthier Future - a strategy for effective programme for health care in the 1990s (1994).

This report is concerned with the health issues of the physically and sensory handicapped. The Health Strategy states that the emphasis in future development of services for this group will be on providing extra facilities on the basis of locally assessed need.

A Review Group established by the Minister for Health is currently examining the health service needs of people with a physical or sensory disability and will report shortly. Subject to the recommendations of the Review Group, the focus in service development over the next four years, as outlined by the Health Strategy, will be:-

- To provide extra facilities for day care, respite care, home care and personal support services, and residential care/independent living.

- To provide additional residential facilities for the young chronic sick.

- To improve the organisation and co-ordination of services.

- To build up information on the service needs of clients - this will be facilitated by the establishment of a national database on physical handicap.

- To employ additional occupational therapists, speech therapists and physiotherapists.

- To improve the counselling and psychological support services for people with disabilities and their families.

- To improve vocational training standards and facilities with a view to greater economic integration of people with a disability in society.

- To address the funding base for voluntary bodies who provide services and support to persons with a physical/sensory disability.

- To improve the availability of technical aids and appliances.

The implications for the Eastern Health Board of these targets are reviewed in this report. In addition, the group would like to stress the importance of preventive health services, to reduce the incidence of physical and sensory handicap, such as antenatal care, neonatal care and genetic counselling, although these services are not specifically addressed in this report.

CHAPTER TWO

HOME CARE AND PERSONAL SUPPORT

The provision of adequate care at home, including personal support is pivotal to the establishment of an effective service for people with physical handicap. A survey of 4,000 members of the Irish Wheelchair Association undertaken in 1994 showed that 67.7% of those surveyed required help with toileting, dressing and eating, while 37.9% required help with shopping. Within the present Community Care Services these needs should be met through a multidisciplinary team approach of Public Health Nurses, Physiotherapists and Occupational Therapist working closely with home-helps and care attendants. Co-Ordination and co-operation between the statutory and voluntary service is essential to both efficiency and effectiveness in meeting the needs of the disabled persons. **We recommend that a team approach to service provision for the physically handicapped in their own homes be piloted in one community care area.** Based on the experience of the District Care Units for the elderly we recommend the following:

1. The appointment of a Team Leader with particular responsibility for the development and co-ordination of services for the physically disabled.

2. The recruitment and training of care attendants/home helps to work with the disabled. Conditions of employment for this grade of staff who will be accountable to the team leader must include availability between the hours of 8.30 a.m. to 9.30 p.m.

The development of an assessment tool is necessary to provide an equitable service not only within Community Care Areas but also throughout the Health Board. This tool should provide accurate information on the health and social needs of each disabled person. The provision of home care can then be planned accordingly.

In addition to the team and essential to the service is the provision of essential appliances and equipment.

<u>Respite Care</u>

The provision of both pre-planned and emergency respite care must be a structured part of the home-care service, if maintenance of disabled persons at home is to be facilitated.

Forms of Respite Care:

- Residential care.
- Care at home by trained carers e.g. home-helps, care attendants.
- Day Centre care.
- Combined Day Centre and home care.

In deciding the type of respite care most appropriate to the needs of the disabled person the following must be assessed.

Needs of the Disabled Person:

- Dependency level assessment to decide level of care required.

- Feasibility of attending a Day Centre and coping with home-help/care attendant assistance for the periods he/she is not in the Day Centre.

- Ability to cope with home care only e.g. home help/care attendant to provide personal care, house care and shopping three times each day. Night sitter/sleeper as needs.

Needs of the Carer:-

- Preferred time of care - daytime, night-time etc.
- Preferred place of care.
- Length of respite period required - short day-time/night-time breaks or longer periods to allow carer take holidays.

Resources required:

Home Care: - Home -help/care attendant granted on an hourly basis as indicated by needs assessment.

- Night sitter/sleeper may be required on occasion.

Day Centre: These should be day activity centres caring for people with severe disabilities who are not able for open employment or sheltered work.

Combined Day Centre and Home Care:

Care Attendant on an hourly basis to help with breakfast, personal care and household duties.

Evening Care: Care Attendant on hourly basis to help with tea, toileting and preparation for bed.
Where a night sitter is required to remain the whole night, a Care Attendant may not be required for the breakfast period as these duties would be undertaken as part of night duty.

TRAINING AND RECRUITMENT NEEDS: (per Community Care Area).

Team Leader - 1 W.T.E.

Home-help/Care Attendants - 1 W.T.E. per 3 disabled persons.

Physiotherapists

Occupational Therapists.

Recruitment and training of Care Attendants must be undertaken to the same standard as pertains to the staff of the District Care Units for the elderly.

CHAPTER THREE

DAY CARE CENTRES FOR THE PHYSICALLY AND SENSORY HANDICAPPED

Over the last decade with the change in health policy from institutional care to community care, day centres have become an increasingly important service for the physically handicapped. To date, there is no formalised agreement as to the services which should be offered by day centres or the criteria which should be met in the evaluation of these centres [1].

At present, there is an uneven distribution of day care facilities throughout the community care areas in the Eastern Health Board(see table).

Table: Location of Day Centres by Places Offered, May 1990

Location of day centre in CCA:	No of centres	Places offered
1.Dun Laoghaire	1	63
2 Dublin South-East	2	81
3.Dublin South Central	0	0
4.Dublin South West	3	40
5.Dublin West	0	0
6.Dublin North-West	0	0
7.Dublin North Central	2	182
8.Dublin North	2	67
9.Co.Kildare	1	76
10.Co Wicklow	1	48
TOTAL	13	557

Source:NRB 1991[1]

In addition to the above, the development funds 1993/94 provided assistance towards the capital cost of a development at Firhouse, Tallaght to cater for the Dublin South West and West Areas. This centre will become operational late 1995 and will develop to full capacity in 1996.

Recommended Improvements to Services within Existing Resources

The existing day centres are funded by the Board at a level varying up to 80% of agreed expenditure, fund raising making up a a part of most centres' costs. The effort on the part of the voluntary organisations in this regard must be recognised. **A review of existing day centre provision in terms of funding, client group, usage, transport and staffing levels is indicated.**

Transport:

Transport is considered a vital component of any day care service for people with disabilities, since many clients have limited mobility. It is also a significant part of day centre costs. It is essential that transport facilities be appropriate to client needs i.e. of short duration and comfortable. It is important, therefore, that the location of day centres be planned as centrally as possible to the catchment areas they are supposed to service. **Existing transport services, provided by different agencies, should be examined with a view to rationalisation and co-ordination.**

Unmet Need in the Community - Additional Resources Required

In addressing the unmet need for day services, several dimensions of need should be taken into account;

- the number of people in the community who are not currently attending a day centre and would benefit from attendance. Some of these people are already on day centre waiting lists. Others are at home and are likely to be in contact with members of the community care team in connection with their disability;

- the extent to which current clients require a higher level service.

A survey for the NRB report of 1991,"Day Centres for People with Physical Disabilities - Current Provision and Service Requirements", which was co-funded by the NRB and Eastern Health Board, found that at that time there were 659 persons on a waiting list for day centres, while 120 existing clients required a higher level of service. This is a very conservative estimate and a systematic approach to needs identification is likely to result in a higher level of unmet need. **A realistic assessment of overall need is estimated at 30 centres strategically located providing for up to 30 places,with each person given an opportunity to attend at least 2-3 days per week.**

To meet the need for additional places, the group recommends that **priority should be given to the development of new day centres in areas which currently have no centres, ie.,Dublin West (Clondalkin) and Dublin North West (Blanchardstown).**

Day Activity Centres - Health Professional Staffing Requirement

The health professional's role in a day centre is based on maximising and maintaining the individual's level of function in daily living skills, mobility, communications vocational and recreational skills. **Therefore, adequate resources in terms of space and equipment should be available to maximise the therapeutic effect of intervention by the therapist.** It is recommended that health professionals be consulted in the planning and development of day activity centres, and they should have representation on the management committee of day activity centres.

Speech Therapy

Approximately 40% of children and adults with a physical disability have a communication disorder. At present there is no adult service available in many community care areas due to lack of resources. The Irish Association of Speech and Language Therapists recommends a maximum caseload of 1 therapist per 50/60 adults with a physical handicap. **In a centre catering for 25 adults, a therapist would need to be employed for approximately 3 sessions per week to cater for that centre.** The eventual establishment of 30 day centres in the Eastern Health Board would require the services of 10 additional speech therapists, with a short-term requirement of an additional 3 whole-time equivalents (W.T.E.) in the Board's area if one day centre per community care is established as an initial measure. In addition, an equipment budget of approximately £5,500 per centre would be required to provide the appropriate treatment tools.

Occupational Therapy

The occupational therapist has been identified as a suitably qualified person who should be involved in the running of a day activity centre, to provide the professional input necessary to clients and staff[2] [3].

It is recommended that there should be one W.T.E. occupational therapist for every 25 day centre places[4] if acting in a managerial capacity.

Physiotherapy

While flexibility with regard to the level of staffing in a day centre is expected, the staff should ideally include an Occupational Therapist or a Physiotherapist. The ADSCP and Mersey Working Party in the United Kingdom recommended an overall physiotherapy staffing ratio of one therapist per 60 disabled persons in the community depending on level of need.(i.e. 0.5.W.T.E. per day centre)[5]. Accordingly **we recommend that a Physiotherapist/Occupational Therapist should be employed for 5 sessions per week.**

References

[1] Day Centres for People with Physical Disability: Current provision and service requirements Eastern Health Board Area. NRB October 1991.

[2] Workshop Standards. National Rehabilitation Board 1987

[3] Eastern Health Board Community Care submission to P.E.S.P, 1991.

[4] Community Occupational Therapy - Future Needs and Numbers. British Association of Occupational Therapists.,1984

[5] Stock J., Seccombe S. Understanding Physiotherapy Staffing Levels. I.M.S. Report No 226/ Institute of Manpower Studies and Association of Chartered Physiotherapists in Management, 1992.

CHAPTER FOUR

SENSORY DISABILITY

Speech and Language Therapy (SLT) Service

"The major role of the Speech and Language therapist is in maximising the interpersonal communication of clients"[1]

The role of the SLT includes the assessment , diagnosis, management and prevention of disorders of communication. Time must also be allocated to training and education, administrative duties, research and professional development.

The number of therapists currently based in the community care programme is approximately 58. Waiting lists for SLT assessment are extremely lengthy in many community care areas, with some clients waiting up to 18 months for assessment. There are many gaps in the service, e.g.;

- There is no adult service available in some community care areas.
- The service to clients with a mental handicap varies from area to area depending on available resources and the existence of voluntary agencies.
- The service to clients with a specific language impairment is inadequate.

The effectiveness of the service is limited by:-

-the number of therapist employed
-lack of suitable accommodation
-inadequate clerical support
-lack of data base on clients with speech/language difficulty
-limited access to psychological and psychiatric services
-difficulties in obtaining audiological assessments

The group endorses the recommendation for the development of SLT services as proposed in the recent Eastern Health Board Report 'Speech and Language Therapy - The Way Forward"[2]

Additional SLT appointments should be allocated according to local demographic profiles and needs, rather than on the basis of staff to population ratios.

Audiology Service

The strategy document highlights the importance of identifying health problems in children at the earliest possible stage. The implementation of many recommendations made in a report written by the Directors of Community Care & Medical Officers of Health in the Eastern Health Board [3] would ensure provision of cost effective service.

The early identification, assessment and management of hearing impairment in infants and young children is of the utmost importance. In the infant, the aim is to facilitate the development of normal speech and language. In the older child, deafness must be diagnosed and treated in order to avoid learning difficulties. It is thought that many of the social, psychological and economic sequelae of deafness in adulthood can be prevented if the hearing disability is detected and treated in childhood.

Hearing problems in children are relatively common, affecting 2-4% of school going children. Most have a mild or moderate hearing deficit but 1 in 1000 have an average loss of 50.d.b. or greater in their better hearing ear. Screening for hearing in the Eastern Health Board is generally carried out as part of the routine developmental examination in the pre-school child, and as part of the routine medical examination in the school child.

Pre-School Testing:-

A questionnaire which was sent to all Community Care areas within the Eastern Health Board for the purposes of the above report, established that distraction testing was carried out at 6 - 9 months, representing from 22 - 62% of Audiometric tests within the areas. However, in only two areas was the test regularly performed by two people working together which is a necessary requirement for the test.

School Screening:-

All areas undertake routine audiometric screening in schools but there is a wide variation in the frequency of testing. The percentage of failure at the initial testing varied widely throughout the Eastern Health Board. In some centres less than 5% failed the initial test. This figure is probably too low and there may be a high corresponding false negative rate. On the other hand, a failure rate at initial screening should be in the order of 15%.(4) Most areas repeated screening of initial failures a procedure which is accepted practice. Those who failed the second screening test were referred to a variety of sources including Sr Lydia in Cabra, the N.R.B. and Consultant E.N.T. surgeons. There was variation in the E.N.T. waiting lists in each area.

A sound proofed room is available for infant or school screening in only one community care area.

Recommendations:-

Training Needs:-

Five designated Area Medical Officers (i.e., 1 per 250,000 pop) should undertake further training in audiology. This would enable them to act as a source for secondary referral from a certain catchment area which would in turn reduce the number of unnecessary referrals to E.N.T. clinics, and thus reduce the length of waiting time. These Area Medical Officers would also facilitate inservice training for Area Medical Officers and Public Health Nurses.

Training of the specialist A.M.O.'s would encompass the following
a) Medical Module, anatomy and physiology of auditory mechanism and disorders, medical and audiologic diagnostic techniques and medical management.
b) Education module, speech and language development consequence of hearing impairment class room accoustics and amplification.
c) Oral rehabilitation module, hearing aid evaluation and audiologic counselling.

Dr Cecily O'Donovan, N.R.B. is currently examining the possibility of establishing such a course at University College Dublin.

Induction training for Public Health Nurses:-
This would involve a full weeks course at the NRB to include theory and practice.

Refresher training for Public Health Nurses:-
This would involve a one day course every two years.
Approximately 20 would attend each course.
Therefore, 7 training days per year would provide inservice training for approximately half of the Public Health Nurse complement in the Eastern Health Board.

Dr Cecily O'Donovan is currently costing the above courses.

Sound Proof Facilities:-

New Health Centres are currently being planned in most of the existing Community Care Areas. The only sound proofed room available to community care at present is sited in the Carnegie Building. **If four extra sound proofed rooms were to be built in strategic locations throughout the Eastern Health Board in the new health centres, this would greatly facilitate and enhance audiologic testing.**

COMMUNICATION AIDS/TOUCH TALKERS

The group notes the increasing number of applications to the Board for specialised communication aids which are among the more expensive appliances being sought from the Board. It is difficult to quantify the future costs to the Board for these aids as applications are likely to increase. Present costs are in the region of £0.40 per annum.

References

1. ."Dligid Eatanga Aimsir" (Time to Speak) A review of Speech and Language Therapy Services. Irish Association of Speech and Language Therapist, 1993.

2. Speech & Language Therapy - The Way Forward, Eastern Health Board, 1994.

3. Review of Audiology Services in Eastern Health Board, Committee of D.C.C.'s & M.O.H.,1989.

4. Commission of European Communities; Health Services Research (1988). Early detection of vision, hearing and language disorders in childhood. Van Der Lem.

CHAPTER FIVE

MEDICAL AND SURGICAL APPLIANCES

It is recognised that the supply of appropriate medical/technical appliances can enhance the qualify of life and independence of people with physical and sensory disabilities.

However current financial resources are not sufficient to meet either the existing demand or cater for increasing requirements in the future.

In 1994 the Board's allocation for medical and surgical appliances was £3.2 million. In the course of the year in excess of 20,000 applications for appliances were approved at a cost of £3.4 million. In addition there was a waiting list to an approximate value of £.4 million at year end.

The increasing demands and costs in this service arise from a combination of many factors including:-

(i) Increased life expectancy allied with improved medical outcomes.

(ii) The shift in emphasis in primary care from an institutional setting to care in the community. This has resulted in a greater number of highly dependant physically disabled people living at home. The success of the District Care Units in reducing hospital admissions and in facilitating earlier discharges illustrates this trend.

(iii) Innovations and developments, particularly in the area of micro electronics has greatly increased the range, sophistication and expense of appliances available.

(iv) The increased employment of Occupational Therapists and Physiotherapists working in the community.

(v) Increased public awareness, fostered in part by the volunatry organisations working on behalf of the disabled.

(vi) The introduction of safety legislation has resulted in a heightened awareness, particularly amongst medical professionals, of the risks associated with manual handling.

In attempting to formulate solutions to the difficulties in the area of supply and cost two areas require examination.

(a) Utilisation of Existing Resources.
(b) Securing Additional Resources.

The existing seating assessment services at Central Remedial Clinic (CRC) and at Cerebral Palsy Ireland (CPI) cater for children and young adults. The present arrangements for other groups, including adults with neurological problems, persons with multiple handicaps, and the elderly, whereby staff borrow equipment from suppliers for each individual case is both unsatisfactory and time consuming.

The Appliances Review Committee has recommended the establishment of an appliance assessment centre. In order to advance this recommendation and to test its effectiveness and the cost implications **a seating assessment clinic should be run as a pilot project for a six month period.** The results should be independently evaluated on completion.

Range of equipment - there are variations from area to area in the range of equipment supplied. In order to reduce perceived inequities **every effort should be made to standardise, in so far as possible, the range of appliances normally supplied by the Board. This** task should be undertaken by the Appliance Review Committee.

Purchasing arrangements - the introduction of **contract purchasing** for a limited range of items has proven to be very successful and **should be extended to the greatest degree possible.** Priority should be given to contracting for equipment servicing e.g. powered wheelchairs, suction machines etc.

Tracking of Appliances - allied to the proposed extension of contract purchasing arrangements, **the suppliers should be required to brand and date code all equipment.** This would facilitate tracking and identification of equipment and allow for the planned obsolescence of low cost appliances with limited life-spans.

Deposit Scheme - in order to encourage the return of unwanted equipment, **consideration should be given to the introduction of a refundable deposit scheme.** The operation of similar schemes in some Dublin hospitals and in some Health Boards should be examined before setting it up.

Recycling of Appliances - due to the on going difficulties experienced with the existing Recycling Store, urgent **consideration should be given to the contracting out of its operation.** If taken over by a group in the rehabilitation/training area it is likely that ESF could be availed of.

All new appliances should be evaluated by the Appliance Review Committee prior to issue by the Board. The evaluation should have regard both to effectiveness and to likely cost implications.The procedure would assist in the standardisation of equipment supplied and would also enable the Board to seek additional funding in respect of specific service developments.

CHAPTER SIX

DEVELOPMENT OF HEALTH PROFESSIONAL SERVICES

Psychology Services

Psychology can make a valuable contribution in the area of physical and sensory handicap. In relation to adults with physical and sensory handicaps, there is a need for very substantial psychological input at the level of assessment and the provision of therapeutic support to facilitate emotional adjustment. This may be a particular need in the case of those with acquired handicap.

Children in special schools will generally have their psychological/emotional needs met in those settings. However, children attending ordinary schools and their families may require considerable support.

The current level of psychological support to this group is quite fragmented and varies considerably both by area and disability. There is a need for greater co-ordination between statutory and voluntary organisations, and consideration should be given to the setting up of a pilot scheme to examine how this could be achieved.

Social Work Services

Traditionally, social workers in community care have not played a major role in providing services to those with physical or sensory disability,.and these services are largely provided by other agencies. The needs of the physically and sensory handicapped in this regard should be evaluated to identify if there are any other gaps in service provision.

Speech & Language Therapy Services

See chapter on sensory disability

Community Occupational Therapy Services

"Occupational Therapy (OT) is the treatment of physical and psychiatric conditions through specific selected activities in order to help people reach their maximum level of function in all aspects of daily life" (World Federation of Occupational Therapists). The role of the OT in the community is to assess the client's needs in relation to his full participation in the community. The service offers assessment and training in the activities of daily living, wheelchair and seating assessment, advice on safety and patient handling to clients and their carers, and advice on adapting the client's environment.

Community OT services are very stretched. At present, the Community Care Programme employs 25 W.T.E. occupational therapists. In 1993, 2,135 persons with a physical/sensory disability (in the 8 Dublin Community Care areas) were referred to the community OT service. 788 of these were still on the waiting lists on 31st December,1993.

Persons with physical and sensory disabilities not being offered sufficient service at present include:

- persons with progressive neurological conditions
- young adults needing to increase their independent living skills
- children attending mainstream schools
- persons attending day centres
- persons with dual handicap

Community Physiotherapy Services

The aims of community physiotherapy (PT) for adults with physical and sensory needs are:-

- to minimise disability and empower the individual and carer to take responsibility for his/her own well being.
- to maintain the individual in maximum functional independence for as long as possible
- to prevent hospitalisation and facilitate earlier discharge

This service offers assessment, therapy, appliance review, training in manual handling and safety education for carers and other staff, health promotion and referral to other agencies/centres where appropriate.

The Eastern Health Board currently employs 7 senior and 13 sessional community based physiotherapists. The number of adults with physical/sensory needs referred to the community PT service in 1994 was approximately 820. In general, only patients with acute needs are referred, therefore only a limited number of adults with these needs have access to the existing service.

Future Development of Community OT and Community PT Services

The number of individuals with physical and/or sensory disability is increasing for a number of reasons:-

- increased life expectancy
- reduced infant mortality rate
- increased survival with certain conditions e.g.,strokes and accidents.

The emphasis in recent years on the provision of care in the community, and the need to promote more cost-effective use of acute hospital services by preventing hospital admissions and facilitating earlier hospital discharges, has led to an increased demand for community physiotherapy and community occupational services

As outlined above, the existing community occupational therapy and community physiotherapy services are unable to cope with present demands. **The group recommends that further development of these services should be a priority, to meet increasing needs and to enhance the quality of life of clients in the community.**

Suggested staffing ratios to date for these professions have been based on broad population ratios rather than detailed needs assessment research.

The British Association of Occupational Therapists in 1984 [1] recommended the employment of one community physiotherapist per 20,000 general population. Bearing in mind that approximately one third of all referrals to the Community OT service are from clients with physical and sensory disability, this guideline would indicate that **an additional 15 W.T.E. community OT posts are required for this aspect of the service in the Eastern Health Board Area.**

The ADSCP guidelines for physiotherapy staffing ratios in the United Kingdom (1980) recommend a ratio of one therapist per 60 physically disabled in the population depending on level of need, and a general population ratio of 1 community therapist: 25,000 population [2]. These guidelines are difficult to translate exactly to the Eastern Health Board, as some physiotherapy services in the community are provided by voluntary organisations and private practitioners. However, it is evident that present provision of physiotherapy services is inadequate, and the group recommends that t**here should be a planned increase in community physiotherapy staffing levels, with the appointment of 10 additional W.T.E. in the first instance.**

Two Review Groups have recently been established by the Board to examine the provision of community Occupational Therapy and community Physiotherapy services, and to identify current and future needs. The recommendations of these review groups with regard to future staffing requirements are awaited. Pending these recommendations, the group recommends that **allocation of new staff should be decided in so far as possible on the basis of objective locally determined needs,within population ratios rather than across the Board.**

General Recommendations

It is recognised that many of the recommendations in this report refer to the need for additional professional staff - community physiotherapists, occupational therapists and speech therapists. To ensure that this expensive resource is used to the best possible advantage, **the provision of adequate accommodation, equipment and clerical and other supports is essential.**

The need for adequate clerical support for additional health professional staff is emphasised. As a minimum, **the group recommends the allocation of one Grade II Clerical Officer in each area to service the requirements of the occupational therapy, physiotherapy and speech and language therapy services.**

The delivery of community physiotherapy services,.community occupational therapy services and community speech and language therapy services should be planned and co-ordinated across all community care areas.

There is a need for improved liaison between these health professionals in the community and their professional colleagues in the hospital and voluntary sectors.

Ongoing professional training and education is essential to the maintenance of professional skills and **should be facilitated** and encouraged in the development of these services.

Appropriate training in management skills should be provided to all health professionals involved in managing services.

Resources and time should be committed to ongoing research in the areas of service review and outcome measurement to ensure that services are effective and efficient and cater adequately for local needs, to ensure best professional practice and to increase consumer satisfaction.

References

1. Community Occupational Therapy - Future Needs and Numbers. British Association of Occupational Therapists,1984.

2. Stock I., Seccombe S. Understanding Physiotherapy Staffing Levels.IMS Report No.226. Institute of Manpower Studies and Association of Chartered Physiotherapists in Management, 1991.

CHAPTER SEVEN

ORGANISATION AND CO-ORDINATION OF SERVICES

Data Base

An accurate, up-to-date and easily accessible database is a pre-requisite for the planning and delivery of effective services in a cost-efficient manner. Existing registers are frequently out of date, and reflect in the main service uptake rather than established areas of need. The Departmental Review Group on Services for Persons with Physical and Sensory Disability is due to report shortly, and it is expected that the establishment of a national data-base will be identified as a priority.

The responsibility for the administration of the Disabled Person's Maintenance Allowance (DPMA) will shortly transfer from the Health Boards to the Department of Social Welfare. DPMA records have traditionally been a valuable source of information on the needs and service uptake/requirements of the local population with physical and sensory disabilities. It would be desirable to maintain a link between this database and community care services.

Liaison with Voluntary Agencies

The allocation for services for persons with a physical or sensory disability in the Financial and Service Plans - 1995 of the Community Care Programme, includes £0.700m, for the development of additional services for this group during 1995. Substantial grant aid is paid by the Board to a wide range of voluntary organisations which provide services to persons with physical or sensory disability.
In 1994, the Community Care Programme allocated £5.6m approximately to this sector. Services provided by voluntary organisations include day activation centres, transport, clubs and social services, advice, vocational training, placement and employment services, social work support, psychological support, aids and appliances, library services and interpreting services.

The significant contribution by voluntary organisations to services for persons with physical and sensory disability must be recognised. In view of the increasing demand for health care at all levels, and the scarcity of resources, equity, efficiency and comprehensiveness of service provision is essential. To obtain the maximum benefit within existing resources will necessitate greater liaison and co-operation between the Health Board and Voluntary Organisations. This may be facilitated by the formation of partnerships between key agencies involved in providing services, thus avoiding duplication of some services at the expense of others. **The group recommends that there should be more co-ordination and control of voluntary agencies providing services directly to the public.** With this in mind, **we recommend that Health Board Personnel should be included on the Management team of the major voluntary organisations.** A further option which should be explored is **the establishment of a contract system for agreed services based on client needs.**

Inter-Sectoral Liaison

Concerns were expressed to the group that the current liaison between the General Hospital Programme and Community Care Programmes in respect of the care of clients with physical and sensory disability is inadequate. Of particular concern was the difficulty in responding at short notice to the discharge from hospital of clients requiring specialised treatment and appliances. In line with the recommendations of the Kennedy Report [1], the group recommends **that there should be increased liaison between all Health Board Programmes in regard of the provision of services to clients with a physical or sensory disability,** to facilitate the provision of a more cost-effective, comprehensive and consumer-friendly service.

References

1. Kennedy et al. Dublin Hospitals Initiative Group, Brunswick Press, Dublin 1991.

CHAPTER EIGHT.

CONCLUSIONS AND RECOMMENDATIONS

Home Care & Personal Support

1996 - We recommend that a team approach to service provision for the physically handicapped in their own home be piloted in one community care area.

The provision of both pre-planned and emergency respite care must be a structured part of the home-care service, if maintenance of disabled persons at home is to be facilitated.

Recruitment and training of Care Attendants to provide personal support to the physically handicapped must be undertaken to the same standard as pertains to the staff of the District Care Units for the elderly.

Day Care Centres for the Physically and Sensory Handicapped.

A review of existing day centre provision in terms of funding, client group, usage, transport and staffing levels is indicated.

A realistic assessment of overall need is estimated at 30 centres strategically located providing for up to 30 places, with each person given an opportunity to attend at least 2-3 days per week. This will not be possible within the given time frame.

1995 - Priority should be given to the development of new day centres in areas which currently have no centres, i.e., Dublin West (Clondalkin) and Dublin North West (Blanchardstown).

It is recommended that there should be one W.T.E. occupational therapist for every 25 day centre places if acting in a managerial capacity.

In a centre catering for 25 adults we could recommend the appointment of

- Speech Therapist 3 sessions per week
- Physiotherapist/Occupational Therapist. 5 sessions per week

Adequate resources in terms of space and equipment should be available to maximise the therapeutic effect of intervention of speech therapists, occupational therapists and physiotherapists appointed to Day Centres.

Transport is considered a vital component of any day care service. Existing transport services, provided by different agencies should be examined with a view to rationalisation and co-ordination.

Sensory Disability

The group endorses the recommendation for the development of Speech & Language Therapy services as proposed in the recent Eastern Health Board Report 'Speech and Language Therapy - The Way Forward"[2]
Additional SLT appointments should be allocated according to local demographic profiles and needs, rather than on the basis of staff to population ratios.

1996 - Five designated Area Medical Officers (i.e., 1 per 250,000 pop) should undertake further training in audiology.

1995 - Public Health Nurses should receive induction training and regular refresher training in audiology.

1995 - 1997 Four extra sound proofed rooms should be built in strategic locations throughout the Eastern Health Board in new Health Centres, to facilitate and enhance audiologic testing.

Medical & Surgical Appliances

1995 - We recommend that a seating assessment clinic should be run as a pilot project for a six month period.

1995 - 1997 Every effort should be made to standardise, in so far as possible, the range of appliances normally supplied by the Board. Contract Purchasing should be extended to the greatest degree possible. The Suppliers should be required to brand and date code all equipment. All new appliances should be evaluated by the Appliance Review Committee prior to issue by the Board.

Consideration should be given to the introduction of a refundable deposit scheme.

Consideration should be given to the contracting out of the operation of the recycling store. All new appliances should be evaluated by the Appliance Review Committee prior to issue by the Board.

Development of Health professional Services

The existing community occupational therapy and community physiotherapy services are unable to cope with present demands. The group recommends that further development of these services should be a priority, to meet increasing needs and to enhance the quality of life of clients in the community.

1995 - 1997 An additional 15 W.T.E. community OT posts are required for clients with physical and sensory disability in the Eastern Health Board.

1995 - 1997 There should be planned increase in community physiotherapy staffing levels, with the appointment of 10 additional W.T.E. in the first instance.

Allocation of new staff should be decided in so far as possible on the basis of objective locally determined needs, rather than on crude population ratios.

The provision of adequate accommodation, equipment and clerical and other supports is essential.

1996 - The group recommends the allocation of one Grade II Officer in each area to service the requirements of the Occupational Therapy, Physiotherapy and Speech and Language Therapy services.

There is a need for improved liaison between health professionals in the community and their professional colleagues in the hospital and voluntary sectors. Ongoing professional training and education should be facilitated. Appropriate training in management skills should be provided to all health professionals involved in managing services.

Resources and time should be committed to ongoing research in the areas of service review and outcome measurement.

Organisation & Co-Ordination of Services

An accurate, up-to-date and easily accessible database is a pre-requisite for the planning and delivery of effective services in a cost-efficient manner.

The group recommends that there should be more co-ordination and direction of voluntary agencies providing services which are grant aided by the Board. Health Board Personnel should be included on the Management team of the major voluntary organisations. The establishment of a contract system for agreed services to clients with a physical or sensory disability should be considered.

There should be increased liaison between all Health Board Programmes in regard of the provision of services to clients with a physical or sensory disability.

Appendix 1

SERVICES FOR PEOPLE WITH PHYSICAL/SENSORY HANDICAP

PLANNED IMPLEMENTATION AND COSTS OF PROPOSED DEVELOPMENTS TO 1997

N. B.

Direct employment proposals are included in chapters 2, 4, 6 and 7 which will have considerable accommodation needs and will not be met in the existing premises.

The additional accommodation costs are not included in the costings.

Chapter		Service - Planned Implementation	1995	1996	1997	Total
2	**Home Care/ Personal Support** Provision of multi-disciplinary team	1 Team Leader] 10 Home Help/Care Attendants] .5 Physiotherapist] .5 Occupational Therapist] One 'team' for up to 30 persons. One team to commence in late 1995/early 1996 and subject to a satisfactory outcome of evaluation - 4 teams to commence in mid 1996 and a further 5 at 1/1/97. 10 'teams' by 1997. Costs including pay (and premium payments), training, P.R.S.I., travel, admin and office overheads - £.170 per team per annum.	£.030	£.340	£1.170	£1.540

Chapter		Service - Planned Implementation	1995	1996	1997	Total
3	**Day Centres**					
	- enhancement of para medical services, as required, in existing services.	Speech, Occupational and Physio Therapists (8 sessions per week) for existing centres based on a number of 25 where centre hasn't already such services.				
		Approx. costs £.0004 per week x ?5 centres	-	£.100	£.100	£.200
	- provision of additional centres					
	Capital Cost	- purpose built centre, equipment, fittings and furniture and specialist transport				
		2 centres in each year 1996 and 1997.				
		The Programmeto continue until there are a total of 30 centres functioning (including existing centres).	Capital	(£1.000)	(£1.000)	(£2.000)
		If suitable premises become available which could be adapted the development Programme could be accelerated.				
	Revenue Costs	1 Supervisor/Manager/ Administrator]	-	£.100	£.300	£.400
		1 Occupational Therapist]		(both to	2 full year	
		.5 or sessional Physiotherapist]		operate for 1/2	2 x 1/2 year	
		3 *attendants (male & female)]		year)		
		2 Drivers]				
		(P/T or F/T if duties combined with*)]				
		P/T cook & P/T cleaner]				
		Other sessionals (arts & crafts teacher hairdressing etc....)]				

Chapter		Service - Planned Implementation	1995	1996	1997	Total
4	**Sensory Disabilities**					
	- Speech Therapists	- Employment of additional therapists - 20 each year in 1996 & 1997	-	£.400	£.800	£1.200
	- Aids	- Provision of communication aids	-	£.040	£.040	£.080
	- Audiology	- Provision of facilities, equipment and training for audiology services.				
5	**Medical & Surgical Appliances**	- To respond to increasing needs	-	£.400	£..400	£.800
		- Provision of assessment & seating clinic		(£.030)	-	(£.030)
		- Establishment costs				
		- Running costs incl. transport	-			
6	**Development of Health Professional Services**					
	- Occupational Ther.	- 15 additional				
		- 10 in 1996 & 5 in 1997	-	£.200	£.300	£.500
	- Physiotherapists	- 10 additional				
		10 in 1996	-	£.200	£.200	£.400
	- Clerical Support	- 10 Grade II in 1996		£.120	£.120	£.240
		Costings include PRSI, travel, office overheads	-			
7	**Organisation & Co-ordination of services**					
	Data Base	Establish & maintain data base 1 Grade III officer in each area and 1 GradeV Co-ordinator in H.Q. to commence in 1996	-	£0.170	£0.170	£0.340
		Total (Capital)	-	**(£1.200)**	**(£1.000)**	**(£2.200)**
		Revenue	**£.030**	**£2.130**	**£3.660**	**£5.820**

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