Staff Competencies and Skills Mix for a Community-Based Model of Disability Services

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# Executive Summary

This paper set out to explore if and how competencies and skill-mix of staff working in disability services will need to change and adapt to meet the needs of persons with disabilities in a reconfigured, community-based, model of person centred disability service delivery. Disability services in Ireland are undergoing a significant change process. These changes are being driven by key legislation and policies that are working together to enable and support persons with disabilities live more independently and have more choice and control in their lives. This includes the movement of people with disabilities out of congregated settings to dispersed housing in local communities, and the development of comprehensive services and supports under New Directions (Health Service Executive (HSE), 2011, HSE, 2012, Department of Health, 2012). These changes have relevance to the skill-mix and competencies of staff. Staff will require a different set of skills to promote independent living and deliver a person-centred approach.

This paper shows how a competency framework can help staff to successfully navigate the shift to community-based working. It can assist in recruiting, retaining and developing a workforce ready to work in this new environment. A companion paper to this document, ‘A Review of Competency Frameworks for Disability Services’ found that a number of disability focused competency frameworks exist, including Ireland. This paper uses that information to present a rationale as to why a competency framework specific to staff working in community-based disability services in Ireland would be useful**. A key recommendation of this paper is to develop a specific competency framework for community-based disability services in Ireland.** While the work in this paper and the companion paper present useful background information and make several suggestions as to how to develop and implement a competency framework, the development of a framework was beyond the scope of this research work.

Some of the new skills that are required for the new model of disability services are outlined, such as connecting with the community and with natural supports, and supporting with personalized budgets and assistive technology. The paper also examined potential changes to the roles of the main salaried staff. It is anticipated that there will be some role enhancement, role enlargement, role substitution, and role delegation in the context of new models of service. The paper discusses these and other skills management strategies and outlines the opportunities, challenges and costs that may be associated with these changes. However, the mechanisms through which these changes will happen, how the challenges will be overcome, and whether the end result will lead to a better outcome for people with disabilities are as yet unanswered.

The report finds that there are mixed views among stakeholders on whether minimum staffing levels should be prescribed for disability services. No evidence or examples were found of the optimal numbers of staff, rostering arrangements and skill-mix required to support people with varying levels of disability to live lives with meaning in the community. Developing such scenarios in an Irish context may be helpful.

This paper was written primarily as a desk exercise and there has not yet been substantive engagement with disability stakeholders. It is important therefore, that as a next step there is wider consultation with stakeholder to gauge the appetite for developing a national competency framework for disability services and to explore some of the research questions arising around new skills and skill-mix. Specific further research areas identified that could be advanced by the National Disability Authority are proposed as follows:

* Document and share best practice in overcoming challenges involving staff transitioning from institutions to working in the community or for staff in day services transiting their role.
* Document the actual role changes that are occurring and the challenges and opportunities that they provide, particularly from the perspective of management.
* More work would be required to review the full range of competency frameworks used in Ireland, and to conduct an extensive consultation and validation process with relevant stakeholders.
* Develop and share sample rosters and staff skill-mix for good quality community houses (e.g. those with a good HIQA report) for different profiles and configurations of people using services

# Introduction

The purpose of this paper is to explore if and how competencies and skill-mix of staff working in disability services will need to change and adapt to meet the needs of people with disabilities in a reconfigured community-based model of disability service delivery. Historically, competencies and skills were derived from a medical model of service delivery and focused on the care of people with disabilities. More recently, a social model of disability service delivery has emerged requiring staff to focus more on person-centred supports and assisting the person with a disability to live a life of their choosing. The social model of disability maintains that disability is caused by the way society is organised, rather than by a person’s impairment or difference. The social model tries to remove barriers that restrict choices for people with a disability. This can lead to more independence and equality for people with disabilities with choice and control over their own lives.

The paper examines the existing skill-mix of staff and considers how skills need to evolve and adapt to ensure that people with a disability are supported to live a fulfilling life. It uses a review of competency frameworks, presented in an accompanying document, to explore whether a competency framework for community-based disability staff in Ireland would be desirable and feasible (National Disability Authority (NDA), 2018). This report reviews what the barriers and opportunities are to achieve this and looks at some experience from other countries. It also makes suggestions for how to develop a competency framework and how to achieve different staff skill sets.

The scope of this report is the competencies and skill-mix of staff working both in community-based residential units (or supporting individuals living independently) and in day services for people with disabilities. They mainly apply to frontline staff[[1]](#footnote-1), but also to supervisors and managers, and competencies required for professional registration and qualifications were also examined. In Ireland, frontline staff largely include nurses,[[2]](#footnote-2) personal carers/assistants, and social care workers. While the focus is not on staff working in institutional residential settings, the findings of this report may be relevant as more staff transition to working in the community and to a more person-centred way of working. Although the focus is on staff employed by statutory or voluntary organizations, the competencies and issues regarding skill-mix are also likely to apply to staff who are employed directly by the person with a disability e.g. through a personalised budgeting arrangement or through the private sector.

A companion paper to this report has been prepared which reviews 16 disability focussed competency frameworks from Ireland and elsewhere (NDA, 2018). This document will provide a foundation should a competency framework be developed in the future for community-based disability services in Ireland. While the work in this paper and the companion paper present useful background information and make several suggestions as to how to develop and implement a competency framework, the development of such a framework was beyond the scope of this work.

This report is presented in six chapters starting with this introduction. In chapter two the context surrounding the reform of disability services in Ireland is outlined including some research on how staff skills and competencies are essential for good practices and good outcomes for people with disabilities. Chapter three discusses what competency frameworks are, the findings from the review of competency frameworks in the companion document, a description of how competencies can lead to improved service delivery and some recommendations for the introduction of a disability focused competency framework in Ireland. Chapter four discusses the skills of existing staff working in disability services, the new skills required, and whether new staff or new skills for existing staff are required. Chapter five discusses some of the cost implications of improving competencies and skill-mix and chapter six looks at some human resource strategies to achieve competencies and skill-mix within the constraints of existing service delivery modalities.

A summary of this paper has been shared with Working Group one of the Transforming Lives[[3]](#footnote-3) programme of disability services in Ireland. This group, under the theme of strategic planning are examining ‘Person-centred models of service and supports’. Therefore, it was useful for them to have information on what new and adapted staff competencies and skill-mix would be required for a person-centred model of support. The NDA also used an earlier version of this report to inform its submission to the Department of Health for their Health Service Capacity Review and advised that it could inform development of a national competency framework.

# Context

Disability services in Ireland are undergoing a significant change process. These changes are being driven by some key legislation and policy documents including:

* Transforming Lives – Value for Money and Policy Review of Disability Services in Ireland (Department of Health, 2012)
* Time to Move on from Congregated Settings: A Strategy for Community Inclusion (HSE, 2011)
* New Directions– Review of HSE Day Services and Implementation Plan for people with disabilities (HSE, 2012)
* [Progressing Disability Services for Children and Young People 0-18 years](http://www.hse.ie/eng/services/list/4/disability/progressingservices/)[[4]](#footnote-4)
* A Vision for Change: Report of the Expert Group on Mental Health Policy (Department of Health and Children, 2006)
* Assisted Decision Making (Capacity) Act, 2015
* Task force on Personalised Budgets[[5]](#footnote-5)
* Ratification by Ireland of the United Nations Convention on the Rights of People with Disability in April 2018[[6]](#footnote-6)

Some of the key changes underway include:

* The movement of people with disabilities from living in congregated settings to living in dispersed housing in local communities with individualised support designed to meet individual need. Increasingly, some people with disabilities are making a further transition to living alone.
* The development of services and supports that can respond to the unique and diverse individual needs through a person-centred approach.
* The development of decision supports whereby decisions are no longer taken in the best interest of the person but the person is supported to make decisions for themselves in accordance with their own will and preferences.

These changes have relevance to the skill-mix and competencies of staff. Skills required to promote independent living are different to those required to care for people with a disability in a congregated setting. Staff are key to the successful implementation of a person-centred approach and require a complex mixture of skills and expertise (Keogh, 2009) [[7]](#footnote-7). The changes have particularly relevance for staff who have worked in institutions for a long period with set and clearly defined roles. There is likely to be a significant shift in staff expectations, work patterns, and type of work between the old ways of working in an institution or day service and working to provide person-centred support in the community. In research exploring living arrangement options for people with intellectual disabilities, Tatlow-Golden et al, (2014) found that institutional practices can migrate to community settings following decongregation and that staff often prioritise caring over active support and social inclusion.

In community homes that have good quality outcomes, research has shown that staff in these homes do not have a sense of ‘otherness’, that is, an ‘us and them’ attitude. For example, there is no separation between staff and client areas such as no staff area or staff toilet (Bigby et al, 2012 and 2015). The good quality homes were found to have staff that saw their role as doing things with residents rather than for them. Francis et al (2014) found that knowledgeable staff who interacted constructively with residents and had high expectations for them positively influenced quality of life.

There is evidence, however, that some staff who are currently responsible for supporting people with disabilities to develop and implement person-centred plans have an insufficient understanding of the process and what it should attain (Fitzsimons D, 2012). Many of the skills required for in-depth and person-centred support for people with severe and profound intellectual disability have been found to be beyond the training received by most frontline staff (Clement and Bigby 2010). The poor quality of many person-centred plans has been shown through research conducted by the NDA (2015). This has led to the development by the NDA (ongoing) of a national framework for person-centred planning, to be implemented by the HSE in order to support disability services to consistently achieve good practice, and therefore support the achievement of positive outcomes for people who use these services. The HSE also has an ongoing national programme to enable cultures of person-centredness.[[8]](#footnote-8)

The Health Information and Quality Authority (HIQA) have responsibility for inspection of residential services for people with disabilities (2013). There is a specific standard and regulation relating to workforce. In a NDA review of inspection reports of these residential services a number of issues in relation to workforce arose including: (NDA, 2015)

* the competency of the individuals managing the designated centre, in particular the Person in Charge
* insufficient staffing levels or inadequate rostering
* competencies and skills required to deliver quality residential services in line with standards
* inadequate staff training
* requirements for particular professionals, such as, nursing staff
* the attitude of and the approach taken by the management team

Actions taken by service providers to address non-compliance around workforce issues included reviewing roster and staffing levels, conducting risk assessments of staff levels and mixes, seeking to recruit new staff or arrange for additional agency staff, identifying training gaps and arranging training. This finding indicates that providers will need to invest more in the area of recruitment, selection, and training to ensure that an appropriate number of staff with relevant skill-mix are available to support residents. A competency framework would likely assist in the recruitment of staff and the identification of skills gaps.

The NDA, at the request of the Department of Health, developed an outcomes framework for measurement of the new model of person-centred disability services (NDA 2016). During the drafting of these outcomes the NDA engaged in consultation with people with intellectual, physical and sensory disabilities. While in general they agreed with the proposed outcomes they suggested also listing the supports required to achieve the outcomes. These all related to staffing competency and skill-mix and included:

* having the right staff to give good supports
* being involved in choosing the staff that support you
* having staff with the right skills and attitudes
* having staff that know you well and understand you
* having assistance with communication where that is needed
* advocacy support

In a NDA report that explored the use of natural community supports in promoting independent living among adults with disabilities in Ireland, people with disabilities talked about wanting more freedom, fewer policies and rules, and allowing positive risk-taking (Weafer, 2010).

Having the right staff with the right attitudes is important to help people with disabilities to live fulfilling lives. However, this may be somewhat limited by the competencies and skill-mix of people available for hire. Staff competencies need to be promoted that empower staff to adopt new practices and approaches such as encouraging positive risk-taking.

# Staff competencies for reconfigured disability services

A worker is judged to be competent when they have the ability to do a job properly. A ‘competency framework’ is a standardized structure that sets out and defines clearly each individual competency.[[9]](#footnote-9) These are usually in the form of skills statements that are specific observable actions that can be demonstrated by the worker.

Although many disability service providers have their own competency frameworks, there is limited information about how well they are embedded throughout their systems and there is no unifying competency framework that exists across organisations. There is currently no national competency framework for disability services in Ireland.

In a companion document to this report, a desk review of a number of disability focussed competency frameworks was undertaken (NDA, 2018). Sixteen competency frameworks were selected for review (10 for frontline staff, three for professional qualification/registration, and three for the management/ organisational level) – See Table 2 in Appendix. The competencies were grouped into 25 broad competency areas. The top 20 of these, and the frequency with which they occurred, can be seen in Table 1

Table 1: Frequency of broad competency areas among 16 competency frameworks[[10]](#footnote-10)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No.** | **Broad competency area** | **Total**  **(n=16)** | **No.** | **Broad competency area** | **Total**  **(n=16)** |
| 1 | Communication | 11 (69%) | 11 | Quality | 7 (44%) |
| 2 | Person-centred practice | 10 (63%) | 12 | Empowerment and advocacy | 7 (44%) |
| 3 | Professionalism and ethics | 10 (63%) | 13 | Safety | 6 (38%) |
| 4 | Planning and organization | 10 (63%) | 14 | Resilience, positive attitude and openness to change | 6 (38%) |
| 5 | Evaluation, observation and assessment | 9  (56%) | 15 | Cultural | 5 (31%) |
| 6 | Community inclusion and networking | 9  (56%) | 16 | Crisis prevention and intervention | 4 (25%) |
| 7 | Education, training and self-development | 9  (56%) | 17 | Respect dignity and privacy | 3 (19%) |
| 8 | Community living skills and supports | 8  (50%) | 18 | Innovation, creativity and problem solving | 3 (19%) |
| 9 | Specific clinical support | 7  (44%) | 19 | Staff management | 3 (19%) |
| 10 | Health and Wellness | 7  (44%) | 20 | Leadership | 3 (19%) |

It was anticipated that the competency frameworks reviewed may not yet have embraced a social model of disability service delivery. However, in the top 10 competency areas, ‘Person-Centred Practice’, ‘Community Inclusion and Networking’, and ‘Community Living Skills and Supports’, all featured. The analysis showed that there was some variation across the three areas reviewed. The competencies relating more directly to a social model of care did not feature in the three frameworks reviewed for professional registration/qualification. This is worrying as the sector increasingly moves towards a person-centred approach. More work is required to align training competencies with competencies for frontline staff.

Some competencies did not feature at all such as those relating to assistive technology. This could be included under the innovation competency but, disappointingly, only three frameworks included this competency. Other competencies may need to evolve as working practices change such as a competency for managers around managing remote workers. There is a competency on being open to change (‘Resilience, Positive Attitude and Openness to Change’). However, while this may be adequate for frontline staff, it may not go far enough for managers, and a specific change management competency may be required for the Irish setting. Unsurprisingly 100% of the qualification/registration frameworks included a competency in ‘Professionalism and Ethics’ although only 40% of the frontline workers’ competency frameworks included this. As expected, the ‘Staff Management’ and ‘Leadership’ competencies were only included in the supervisor/manager competency frameworks, although it could be argued that a leadership competency should apply to all staff and not just managers.

Although the ‘Communications’ competency was the most frequently occurring, in none of the competency frameworks reviewed was sign language mentioned. It will important that an adequate number of staff have this skill. In addition to this, skills around augmentative communication methods are also necessary.

The change in mind-set required for successful community-based and person-centred working can require adjustment for some staff and a competency framework can help to navigate this shift successfully. If developed and implemented properly, a competency framework can go some way towards attracting and retaining workers and result in a better quality service by assisting with the following (An Bord Altranais, 2005, The Lewin Group, 2014, Department of Developmental Disability Neuropsychiatry, 2016):

* Provide organisations with a way to define in behavioural terms what it is that people have to do to produce the results that the organisation desires in a way that is keeping with its culture and values
* Allow employees to know what they need to be productive
* Identify training needs by identifying skill and competency gaps more efficiently
* Develop or update training curricula and training programs
* Inform public policy and employer policy with regard to training requirements and capacity building
* Recruit and select new staff more effectively
* Evaluate performance more effectively
* Make change management processes work more efficiently
* Support performance management and personal development processes
* Manage promotion and succession
* Improve the quality of service that a person with an intellectual disability receives

With the recent ratification by the Irish Government of the United Nations Convention on the Rights of People with Disability[[11]](#footnote-11) the introduction of a common competency framework for the disability workforce would demonstrate commitment to improving the lives of people with disability. **The NDA recommends the development of a competency framework for the full range of staff working in community-based disability services to streamline and improve the performance of frontline staff.** This framework would also be relevant to disability staff who continue to work in institutions and begin the process of transforming that workforce.

The existing disability focused competency frameworks, with their accompanying skills statements, reviewed in the companion report, provides the groundwork for developing an Irish competency framework. More work would be required to review the full range of competency frameworks used in Ireland, and to conduct an extensive consultation and validation process with relevant stakeholders. As competencies can be quite broad and generic, the development of clear and measurable skills statements for each competency is essential. At the local level, these can then be made more specific for certain job roles. It is recommended that a separate competency framework be developed for supervisory and management staff. This should be aligned to the frontline staff competency framework as much as possible with the main differences being present in the skill statements. The NDA recommends linking the competencies and skills statements of any national competency framework to the outcomes for people with disability (DOH, 2016). They should also be linked to the quality framework for disability services currently being developed and the national framework for workforce planning (DOH, 2017)

Once developed, a mechanism must be agreed for embedding the competencies throughout the disability services from recruitment and performance review to training and change management. One way of ensuring national rollout would be to make it compulsory for all organizations funded by the HSE to adopt and integrate the competencies into their service. Another would be to embed the competency framework into all relevant courses validated by Quality and Qualification’s Ireland.[[12]](#footnote-12) Training on the competencies for staff, managers and people using disability services will also be needed.

# Staff skill-mix for reconfigured disability services

The term ‘skill-mix’ has been described as the mix of posts, grades or occupations in an organization (Buchan and Dal Poz, 2002). It is about having the right people with the right skills doing the right jobs at the right time to provide effective care. The focus of a number of studies on skill-mix reviewed by Dubois and Singh were more on staff types than on staff members' skills or the effective use of those skills (2009). This study also found that international variations in the scope of practice of health care professionals are often due to an arbitrary grouping of skills that evolved from custom, traditions, incentives, and professional politics. Buchan and Dal Poz found that resource availability, regulatory environments, culture, custom and practices all played a role in determining the typical or normal mix of staff in a particular health system (2002). They suggest that grade mix might be a more appropriate term than skill-mix and that grade or job title are frequently used as a proxy for the level of skill or as a definition of a role.

One of the issues with the international literature is that the focus is primarily on nurses and doctors. Very few studies examined the roles of other health, social care staff, technical staff or ancillary staff, roles that are very important in the provision of disability services. Issues around the development of new roles are also relatively unexplored in the literature. New roles are increasingly important as disability services move more into the community, for example community connectors, liaison officers, local area coordinators, and key workers.

The main means of meeting the individual’s support and lifestyle requirements will be the person’s immediate network of supporters, which may include paid staff, as well as friends, community contacts and volunteers. A key role of staff working in the new model of disability services will be to develop and enhance natural community supports. These are defined as

…assistance, feedback, contact or companionship from people who are not service providers to enable people with disabilities to participate independently, or partially independently, in integrated employment settings or other community settings … with no compensation or nominal compensation (Weafer and Weafer, 2012).

The existence of natural supports is very important for the person with a disability. The natural supports can support salaried staff in their roles and can enhance the skill-mix of supporters available to the person with a disability. It is important that salaried staff have competencies in the area of working in partnership and engaging with family members and the wider community. Natural community supports include things like circles of support, microboards, peer-based strategies, individual capacity building, and befriending (Weafer and Weafer, 2012).

New staff roles and new skills for existing staff have been developed, or have been identified as being required for the new model of disability services. The role of a community connector has been described in England as ‘local people who know lots of people’ (Department of Health, 2001, p64) These people need to be good at connecting people in the course of everyday life and are considered essential to make the process of inclusion work. They need to be able to not only research and know the local community but remain alert for opportunity and nurture possible relationships and friendships. In addition to a standalone role, this skill needs to be adopted by all staff. For example, staff may support the service user to get to know his neighbours and staff in local shops and restaurants (Gomez, 2013). The gradual and thoughtful work of drawing community members into people’s lives will not just happen by chance. It is a skill that is vital but is not always fostered or recognized in support workers (Rouget, 2009).

With the likelihood of a personalised budgeting programme being available in Ireland in the coming years new positions such as liaison officers and brokers will develop to support people in the administrative side of their personal budget. Other roles currently exist that have developed along with service diversification. For example, a Personal Support Service Coordinator carries out a needs assessment in conjunction with the person with a disability and recommends the level of support they require. [[13]](#footnote-13) He then coordinates individualized support and supervises the personal/care assistants. Housing Managers is another role that varies from a purely caretaking role to a more comprehensive service that provides sheltered housing with various levels of support provided while promoting independent living.

The field of assistive technology concerns the practical tools that can support functional needs of people who experience difficulties linked to disability or ageing. It encompasses a broad spectrum of low tech and high tech technologies, for example, walking frames, wheelchairs, hearing aids, vision aids and computer-based communication aids. These technologies play a crucial role in enabling independent living and access to education and employment. Staff need to have skills in this area to support the person with a disability to adopt this new technology and use it to facilitate maximum independence. Research commissioned by the NDA looking at approaches to the use of assistive technology in Ireland and elsewhere found that there was a need for greater recognition of the importance of assistive technology and the value for money it represents (Cullen et al, 2012). The report found that assistive technology skills among frontline staff in education, employment, health and social care sectors was under-developed and problematic in Ireland. It also found a need to develop an effective approach that would provide access to expert knowledge and advice about assistive technology for non-specialists at all relevant levels (national to local) and at home, in education and in work. This would require the recruitment of skilled technical personnel. The report recommended that attention be given both to the inclusion of assistive technology in initial professional education and to assistive technology training as part of continuing professional development, with appropriate accreditation.

Existing staff have taken on a key worker role where they provide individualized care and support for a person with a disability in a group context. Having a skilled key worker is an important requirement in planning and achieving person-centered goals across systems (work, education, social welfare, financial resources, recreation, independent organisations, etc.).**[[14]](#footnote-14)** Key workers do not deliver all care and support but are responsible for making sure that people are keeping to what was agreed in their care plan and person-centred plan. The key worker can be any member of the multi-disciplinary team.

Dubois and Singh proposed multidisciplinary teams as the solution to the problem of fragmentation and discontinuity in services (2009). Working in multidisciplinary teams can deliver a coordinated and systematic approach and flexibility.[[15]](#footnote-15) It makes sense that care should be delivered in teams based around the service user rather than in professional silos (Addicott et al, 2015). However, the evidence on the effectiveness of multidisciplinary teams compared to care provided by a single group of professionals is inconsistent (Dubois and Singh, 2009). One reason may be that the educational preparation of health care workers for inter-professional teamwork is limited. A recent example in Ireland of successful multidisciplinary working was ‘Steps into Work’ a collaboration between the Department of Employment and Social Protection (EmployAbility) and the HSE mental health services whereby mental health professionals and job coaches jointly supported people with mental health difficulties returning to work (Mental Health Reform, 2017).

The potential issues and changes in the main existing staff roles relevant to the disability sector are summarised in Table 2. These are based on changes outlined in the literature and on knowledge of changes that are happening or that have been proposed within the service in Ireland. More research is required on the nature and extent of these changes in Ireland and how they are working in practice. It would also be useful to get the views of managers and users of disability services as to the future of different cadres of staff within the disability services and any challenges they are experiencing with this change (for example, industrial relations issues).

In the development of new skills the ‘Think Local Act Personal’ partnership in the UK[[16]](#footnote-16) advocates a person-centred training approach that is solution focused, recognising assets and strengths of the learners and local community. It is the responsibility of the practitioner to reflect on their style of consultation and conversation and assess how it is supporting the person. Embedding new habits and skills takes time and support for self-refection and reinforcement needs to be provided using a facilitation approach. In all cases, additional competencies and skills may be required specific to the circumstances and needs of the individual being supported and these should be determined and developed at the local level.

**Table 2: Likely changes to existing roles in transition to community-based services**

| **Job title** | **Issues** | **Probable role in new configuration of services** |
| --- | --- | --- |
| Registered Nurse for Intellectual Disability (RNID) | * Historically training used a medical model and activities largely centred around activities of daily living * Questions as to whether a specialist ID nursing discipline is required (Sheering and McConkey, 2008) * Unique benefits of the RNID role need to be articulated vis a vis other professions * Review of role of the RNID underway by Department of Health | * More limited need for this specialization in day to day support of clients with an intellectual disability living in the community * Opportunity for a liaison role with mainstream services including primary care and allied health professionals * Opportunities for a limited number of clinical nurse specialist and advanced nurse practitioner roles e.g. support the increased needs of residents who are aging, dementia care etc. * Will continue to have a key role in delivering person-centred care and planning * Need to develop and adopt more social care and community connector skills * Adoption of person in charge role and managerial / supervisory roles |
| Registered General Nurse (RGN) & Registered Psychiatric Nurse (RPN) | * Historically training used a medical model and activities largely centred around activities of daily living * Historical reasons for these staff working in disability services (e.g. people with ID wrongly placed in psychiatric services) * Unique benefits of these nursing roles need to be articulated vis a vis other professions | * RGNs & RPNs who have worked in residential services and have obtained experience working with clients with a disability can adopt roles as above for RNID * RPNs may be more suited to supporting clients with a mental health difficulties living in the community depending on experience |
| Social Care Worker (Degree level) | * Many overlaps between nursing role and social care worker role particularly at community level. | * The number of staff in this role is likely to increase with some replacement of nurses by this role * Key role in delivering person-centred care and planning * Adoption of person in charge role and managerial / supervisory roles |
| Social Care Worker/ Health care assistant/ personal assistant (Fetac level 5) | * Role is varied and includes transportation, domestic duties including shopping and preparing meals, personal care and hygiene, social activities and other health and wellness related activities. | * Will remain one of the key people providing day to day support to people with disabilities * Enabling and supporting clients * Flexible working to facilitate people with disabilities to live a life of their choosing * For some roles the duties may expand from health and physical care to include social care needs and domestic roles |
| Allied Health Professionals[[17]](#footnote-17) | * Often attached to the disability service | * Service providers may continue to employ these staff to make home visits or keep a central location where service users are brought * More use is likely to be made of mainstream community-based services for example, local primary care clinic * There may be a role for allied health professionals to help train their colleagues working in primary care in supporting people with a disability |

# Skills management

In 2017, the Minister of Health launched a National Framework to support the recruitment and retention of the right mix of staff across the health and social care system in Ireland and to build a sustainable, resilient workforce for the future (Department of Health, 2017). The framework may be useful in helping to guide service providers in the provision of an adequate skill-mix and to streamline various job grades and roles.

An alternative approach to achieving a specific mix of different types of personnel is to shift to adapting workers' attributes and roles to changing environmental conditions and demands. Skill management as this is called is described by Dubois and Singh (2009) as the mechanisms used by an organisation to optimise patient outcomes while ensuring the most effective, flexible and cost-effective use of human resources. The new Irish National Framework seems to be willing to explore some of these approaches. It lists some of the desired outcomes as:

* Increased career and role flexibility
* Changing skill-mixes
* The creation of new health worker roles
* New competencies and behaviours

Dubois and Singh describes two main dimensions of skills management: skill development and skill flexibility. These are further subdivided into the four personnel management tools of role enhancement, role enlargement, role substitution and role delegation (2009). These shift the focus away from the issue of numbers and occupational mix towards the range of roles, functions, responsibilities and activities each staff member is educated and able to perform.

However, what Dubois and Singh proposes is to blur the division of roles in the interest of responsiveness to patients’ needs while enabling providers to practice to the full scope of their abilities. This approach may be more appropriate for the disability sector where the focus is shifting from meeting care needs alone to also supporting people with disabilities to achieve their person-centred goals. Research also shows that an increasing number of roles can be undertaken by more than one provider, leading to role overlap. (Wanless 2002, Richardson et al, 1998). However, staff who have transitioned from institutions to community-based working have reported that the lack of role clarity was a challenge (McConkey et al, 2013).

It has been suggested that to achieve individualised outcomes at the community level a new set of staff that has not been working in institutions is required (Kendrick, 2014). This has happened to some extend in Ireland as funding was made available through a service reform fund that allowed service providers to recruit new staff who already have the existing skills and competencies or the ability to develop them without a history of having worked in the older service model (Genio, 2014, McConkey et al, 2013). Services that are increasing their community-based work have found that most projects began implementation with a core number of staff with the required skills and competencies and that other staff were supported to develop skills over time (Keogh, 2009). An ongoing NDA evaluation of transitions of people with disabilities to the community is showing that services are using a mix of old and new staff.

For skills management to work, human resource practices must create the opportunities for staff to develop the skills necessary to fill new roles imposed by changing services and allow flexibility in the use of skills and competencies (Dubois and Singh, 2009). This must be done within the social, legal, and political context of the rules and requirements to which organisations are obliged to adhere. This will be challenging as staff positions, job security, and traditional roles may override an open-mindedness that would lead to the flexibility and creativeness in roles required to enhance the lives of people with disabilities (Fitzsimons, 2012). Trade union issues may also present challenges. The OECD recommends that the ‘human aspects of restructuring’ be considered through strong leadership, good communication, training, and support to retain morale and trust (2007). However, changes to roles and skill sets can be a positive experience for staff. Research finds that staff perform better and are more motivated when they have more autonomy, are involved in decision making and work in a supportive environment (Aiken et al, 2008; WHO, 2006).

In a report on workforce planning in the UK’s National Health Service, Addicott et al, maintains that building a more flexible workforce with a breadth of skills and knowledge allows for greater adaptability and that workforce planning should pay more attention to the role of generalists in meeting the health and care needs of patients in the future. While this will help to address cost pressures, it will require a new approach to training, with support for adaptation from providers, commissioners, and professional bodies, and fundamental changes to professional regulation and incentives (Addicott et al, 2015). The need for a more skilled and more flexible workforce comes in a climate where there are difficulties in finding people with the right values and attitudes to work in the social care sector. The future demand for skilled care workers likely to increase, and supply likely to decrease (SCIE, 2016). Table 3 below provides some examples of how the various skill management interventions described above could be used in disability services along with potential advantages and disadvantages.

**Table 3: Definitions and possible examples of skill management intervention use in the disability sector**

| Skills management | Skill Management Processes | Advantages | Disadvantages | Possible examples in the disability sector |
| --- | --- | --- | --- | --- |
| Skills development | **Role Enhancement** Involves expanding a group of workers' skills so they can assume a wider and higher range (vertical enhancement) of responsibilities through innovative and non-traditional roles. Occurs within a given profession’s full scope of practice. | * Opportunities for individual staff achievement and recognitions * Greater work depth * Increased control and responsibility * Can enable one professional to cover a wider range of care needs or by enabling one patient to be cared for by fewer workers | * Evidence about the impact of role enhancement is limited and has focussed mostly on nursing * May cause a blurring of role boundaries leading to confusion, disagreements conflict and de-motivation * Could disguise a rationalisation programme leading to heavy workloads and unsupported staff | Social care staff taking on elements of a community connector role |
|  | **Role Enlargement** Involves the accrual and diversification of employees' skills by taking on roles and functions at parallel levels (horizontal enlargement) or lower levels (downward enlargement) | * Can shift service delivery from task-oriented approach to integrated care * Can increase cross-training in generic and nonclinical skills * Studies on the effects of the focus on role breadth tends to increase job variety, enhance task significance, increase autonomy, and improve motivation | * Extreme role enlargement can eventually threaten professional identity and increase workloads * Staff may perceive that their specialist knowledge and skills are being devalued as less qualified personnel are taking over their traditional areas of responsibility | Social care staff taking on responsibility for household tasks such as shopping, cooking and laundry which would have traditionally been performed by domestic staff in institutions |
| Skills Flexibility | **Role Substitution** Expanding practice scopes by encouraging the workforce to work across and beyond traditional professional divides to achieve more efficient workforce deployment. Includes competencies that would traditionally be considered outside practice scopes. | * A common management tool to address rising costs, personnel shortages, and access limitations * Allows a more cost-effective use of a diversely skilled and flexible workforce | * Evidence is variable as to whether role substitution lowers costs in the long term * This is impacted by higher absences and turnover rates of less qualified staff, greater levels of unproductive time due to lack of autonomy and capacity to act independently and higher rates of adverse events and risks for patients | Replace nurses with health care assistants or social care staff |
|  | **Role Delegation** Transferring certain responsibilities or tasks from one grade to another by breaking down traditional job demarcations | * Can use lower staff costs to perform the same activities * More time for higher qualified staff to devote more time to the interventions that only they can perform | * May affect the sense of connection between patients and their care provider * May deprive higher qualified staff of natural breaks in the intensity of their work leading to increased stress and job dissatisfaction * Without support can lead to excessive workload for the lower-skilled groups * Can lead to a perception that one group is off-loading tasks onto another | Shift roles traditional performed by nurses to social care workers e.g. medication management, and reporting |

Source: Adapted from Dubois and Singh, 2009

# Cost implications

As staff costs are frequently a key driver of service costs, workforce planning is an important tool in achieving a cost-efficient service. The creation of new staffing roles and changes to staff skills and competencies can have an influence on staff costs.

The 2012 Value for Money and Policy Review of Disability Services found it difficult to analyse the total number of staff working across the service as all of the voluntary sectors are not included in the HSE’s HR staff census.[[18]](#footnote-18) In addition, it is difficult to model the workforce needs and the structures and model underpinning service provision across the disability sector due to the existing historically derived skill-mix (FAS, 2009). The value for money report found variations in skill-mix across services with more nurses in the HSE (37.8%) compared to the voluntary sector (23.9%) and more health and social care professionals[[19]](#footnote-19) in the voluntary sector (21.3%) compared to the HSE (8.8%) (Department of Health, 2012). While the historical development of disability services resulted in a largely nurse led service there is evidence that this is changing (Department of Health, 2012, FAS, 2009).

The Value for Money Review estimated that substantial efficiencies could be accrued to the disability programme by altering the current staff mix, noting that a 10% change to non-professional personnel (i.e. from nursing staff to health care workers) would reduce the cost of providing care by €3.5 million annually (Department of Health, 2012). However, while this undoubtedly would lead to cost savings in the short-term it has been argued that this cheaper skill-mix may be not be cost-effective in the medium to long term because of the various hidden costs associated with skill dilution (Buchan and Dal Poz, 2002). The argument cites factors such as higher absence and turnover rates of less qualified staff, higher levels of unproductive time because care assistants have less autonomy and capacity to act independently and reported concerns about possible harm to patients if care assistants are required to work beyond their technical or legislated capacity. The evidence around the economic benefit of this approach is conflicting.

One of the main cost drivers identified by the Department of Health Review was rostering, which is key to an efficient service (2012). Rostering refers to the number, skill level and skill-mix of staff required to be on duty at any given time and which meet the assessed need of the people using the service. An important component of rostering affecting costs is that of rostering staff to work outside core working hours (overnight and at weekends), which attract additional payments. However, having staff available outside core working hours is essential if people with disabilities are to be supported to live a life of their choosing.

There are mixed views on setting minimum staffing and skill-mix levels within Irish disability services. According to the Department of Health’s Value for Money and Policy Review of Disability Services in Ireland, calculating the amount of resources used and their cost at individual level is the key building block to a more cost‐efficient service, regardless of the model of service (2012). Key contributors to unit costs were identified as:

* pay and conditions
* staff/client ratio
* rostering practices
* skill-mix

At the client level, contributors to unit costs were:

* level of functional ability
* challenging behaviour and co‐morbidity (particularly mental health conditions and autism)

The Irish Human Rights Commission, recommended that the Department of Health set out clear guidelines on staff to client ratios in disability services. The Department however, maintained that decisions on staff to client ratios should be made by local management (Irish Human Rights Commission, 2010). Minimum staffing levels are supported in the nursing home sector to avoid vagueness around terms such as ‘adequate staffing’ (McEney, 2007) and to meet basic safe care (Royal College of Nursing, 2010). Carver (2009) argues that the prescription of minimum staffing levels in disability services mitigates against person-centred planning. HIQA does not support minimum staff resident ratios in disability services but believes that it is the responsibility of each provider to determine the appropriate ratio according to the need to achieve optimal health and quality of life outcomes for residents taking into consideration the size and layout of the centre. In their systematic review on dispersed or clustered housing for disabled adults, Mansell and Beadle-Brown reported on studies that showed that staff ratio is a weak predictor of staff performance and that it is possible to have high staff ratios and yet poor performance (2008).

In the Irish disability sector, there is currently no standard approved needs assessment tool for people with disability. Some service providers use various needs assessment tools that are available on the market. These tools tend to assign a cost to a person from which a staffing numbers and skill-mix can be calculated. Needs assessment tools should not be used as a blunt resource allocation tool but should be used in conjunction with the person-centred plan and individual outcomes, which should be the key drivers of need and resource allocation **(Costello and Cox, 2013).** No evidence or examples were found of the optimal numbers of staff, rostering arrangements and skill-mix required to support people with varying levels of disability to live lives with meaning in the community. Developing such scenarios in an Irish context may be helpful.

# Conclusion and suggestions for next steps

This paper set out to explore if and how competencies and skill-mix of staff working in disability services will need to change and adapt to meet the needs of people with disabilities in a reconfigured community-based model of disability service delivery. The discussion around the context of the current disability services reform programme demonstrates how many policy strands are working together to allow people with disabilities to live more independently.

The review of competency frameworks shows how competencies can assist in recruiting, retaining and developing a workforce ready to work in this new environment. It showed that a number of disability focused competency frameworks exist, including in Ireland, and presents a rationale as to why a competency framework specific to staff working in community-based disability services would be useful. This is a key recommendation of this paper.

The section on skill-mix outlined some of the new skills that are required for the new model of disability services such as connecting with the community and natural supports, and support with personalized budgets and with assistive technology. It also examined potential changes to the roles of the main salaried staff such as role expansion and role substitution. The paper discusses these and other skills management strategies and outlines the opportunities, challenges and costs that may be associated with these changes.

A weakness of this report is that it was mainly done as a desk exercise with only minimal input from service providers and commissioners of services. It will be important then as a next step to consult with relevant stakeholders to gauge the appetite for more research in this area and for the development of a competency framework for disability services. Another weakness is that most of the research available was on medical and nursing staff with little research done on other cadres of staff or new roles.

Specific further research areas identified that can be advanced by the NDA are proposed as follows:

* Document and share best practice in overcoming challenges involving staff transitioning from institutions to working in the community or for staff in day services transiting their role.
* Document the actual role changes that are occurring and the challenges and opportunities that they provide, particularly from the perspective of management.
* Develop and share sample rosters and staff skill-mix for good quality community houses (e.g. those with a good HIQA report) for different profiles and configurations of people using services

Appendix

Table 2: Summary of sixteen disability related competency frameworks

| Target group | Name of Competency Frameworks Reviewed (reference) | Main disability type | Country | Appendix |
| --- | --- | --- | --- | --- |
| **Frontline staff** | Direct Service Workforce Core Competencies (National Direct Service Workforce, 2014) | All disabilities and ageing | US | A1 |
|  | Direct support Professionals Competency Areas (Direct Support Professionals Competency Areas, 2016) | Intellectual and developmental disability | US | A2 |
|  | Intellectual Disability Mental Health Core Competency Framework (Department of Developmental Disability Neuropsychiatry, 2016) | Intellectual disability and mental health | Australia | A3 |
|  | Recovery competencies for Mental Health Workers (O’Hagan M, 2001) | Mental health | New Zealand | A4 |
|  | Core capacities required for community agencies to generate and sustain substantively good individualised outcomes (Kendrick M, 2014) | Disability not specified | US | A5 |
|  | WALK[[20]](#footnote-20) | Disability not specified | Ireland | A6 |
|  | Core values of Cheshire Ireland[[21]](#footnote-21) | Physical disability | Ireland | A7 |
|  | The Daughters of Charity Disability support Services[[22]](#footnote-22) | Intellectual disability | Ireland | A8 |
|  | Generic service intervention pathway[[23]](#footnote-23) | Intellectual disability | UK | A9 |
|  | Positive Behavioural Support Competence Framework [[24]](#footnote-24) | People with challenging behaviour | UK | A10 |
| **Registration/ qualification** | Competencies of frontline staff who support people with a dual diagnosis[[25]](#footnote-25) | Intellectual or developmental disability and mental health | US | A11 |
|  | Standards of Proficiency for Social Care Workers (CORU, 2016) | Includes people with a disability | Ireland | A12 |
|  | QQI Level V course in Intellectual Disability Practice[[26]](#footnote-26) | Intellectual disability | Ireland | A13 |
| **Supervisors/ managers** | National Frontline Supervisor Competencies: (Sedlezky, 2013) | Intellectual and developmental disability | US | A14 |
|  | Management Competency Framework for Health and Social Care Professions[[27]](#footnote-27) | Includes people with a disability | Ireland | A15 |
|  | National Occupational Standards for Leadership and Management in Care Services[[28]](#footnote-28) | Includes people with a disability | UK | A16 |

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1. Frontline staff are taken to mean staff that directly provide regular care, and support for people with a disability. American literature uses the term ‘Direct Service Workers’ but this has been substituted to frontline staff where appropriate throughout this document to better suit the Irish context. In the US they are defined as paid workers (working full-time or part-time) who spend at least 50% of their work hours doing direct service tasks (The Lewin Group, 2014) [↑](#footnote-ref-1)
2. Including Registered Nurse for Intellectual Disability, Registered General Nurse, Registered Psychiatric Nurse [↑](#footnote-ref-2)
3. Transforming Lives is the programme to implement the recommendations of the Value for Money and Policy Review of Disability Services in Ireland (Department of Health, 2012) [↑](#footnote-ref-3)
4. <https://www.hse.ie/eng/services/list/4/disability/progressing-disability/pds-programme/> (Accessed May 2018) [↑](#footnote-ref-4)
5. <http://health.gov.ie/disabilities/task-force-on-personalised-budgets/> (Accessed May 2018) [↑](#footnote-ref-5)
6. <https://www.ihrec.ie/statement-un-convention-rights-persons-disabilities/> (Accessed May 2018) [↑](#footnote-ref-6)
7. <https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/workforce/> (Accessed May 2018) [↑](#footnote-ref-7)
8. <https://www.hse.ie/eng/about/who/qid/person-family-engagement/national-prog-person-centredness/> (Accessed May 2018) [↑](#footnote-ref-8)
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10. Only competency areas where at least three of the 16 competency frameworks had a competency in that area are included in Table 1. Five competency areas which were included in only one competency framework were excluded. These were human rights based approach; low arousal philosophy and practices; family and carer interventions; knowing and understanding relevant legislation; and context. [↑](#footnote-ref-10)
11. <https://www.ihrec.ie/statement-un-convention-rights-persons-disabilities/> (Accessed May 2018) [↑](#footnote-ref-11)
12. <http://www.qqi.ie/Pages/Home.aspx> (Accessed May 2018) [↑](#footnote-ref-12)
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14. <http://www.hse.ie/eng/services/list/4/Mental_Health_Services/dsc/communityservices/keyworker.html> (Accessed January 2018) [↑](#footnote-ref-14)
15. <https://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/workforce/> (Accessed January 2018, if requests username and password, click cancel) [↑](#footnote-ref-15)
16. ibid [↑](#footnote-ref-16)
17. physiotherapists, speech and language therapists, occupational therapists, and psychologists [↑](#footnote-ref-17)
18. Section 39 organisations are grant-aided by the HSE but do not considered HSE employees. Section 38 organisations are funded to provide a defined level of service by the HSE and, while not HSE employees, enjoy terms and conditions similar to HSE staff and are therefore included in HSE staff returns. [↑](#footnote-ref-18)
19. This category excludes nurses and includes disciplines such as speech and language therapists, physiotherapists, and social care workers. [↑](#footnote-ref-19)
20. <http://www.walk.ie/who-we-are/core-competencies/> (Accessed January 2018) [↑](#footnote-ref-20)
21. <http://www.cheshire.ie/about_corevalues> (Accessed January 2018) [↑](#footnote-ref-21)
22. <http://www.docservice.ie/about-us-core-values.aspx> (Accessed January 2018) [↑](#footnote-ref-22)
23. <https://hee.nhs.uk/sites/default/files/documents/Generic%20Service%20Interventions%20Pathway.pdf> (Accessed January 2018) [↑](#footnote-ref-23)
24. <http://www.skillsforcare.org.uk/Document-library/Skills/People-whose-behaviour-challenges/Positive-Behavioural-Support-Competence-Framework.pdf> (Accessed Jan 2018) [↑](#footnote-ref-24)
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