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Variable implementation of good practice recommendations for the assessment and management of UK children with neurodisability

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Abstract

Objectives

To determine whether UK child development teams (CDTs) have implemented good practice recommendations for the co-ordinated assessment and support of children with neurodisability. To explore some of the factors associated with variations in good practice implementation.

Design

Surveys were sent to every UK CDT in 2009/2010. Responses about CDT provision and ways of working were compared with good practice recommendations from national policy documents, and professional organisations. The extent to which CDTs in England and Wales met 11 selected good practice recommendations was scored; teams in Scotland and Northern Ireland were given a score out of 9 to reflect the optional use of the Common Assessment Framework and Early Support Materials in these countries.

Results

Responses were received from 225/240 (94%) UK CDTs. Thirty-seven percent of CDTs in England and Wales had implemented 9 or more of the 11 recommendations. Fifty-nine percent of teams in Scotland and 78% of teams in Northern Ireland met between 6-9 recommendations of good working practice. Higher levels of implementation of recommendations were found when the CDT had a Child Development Centre base, and for teams who had received increased funding in the 5 years preceding the survey.

Conclusions

There was considerable variability in the degree to which CDTs implemented good practice recommendations for the diagnosis and management of children with neurodisability. Evidence about child and parent satisfaction, and the effectiveness of CDT practices and provision is required, so policymakers, healthcare commissioners and clinicians can provide the most appropriate services to children with neurodisability and their families.

Key Messages:

There is significant variability in the services offered to children and families among Child Development Teams (CDTs) across the UK

Teams based in a Child Development Centre (CDC) are more likely than non CDC teams to have implemented good practice recommendations

Investigating whether a certain level of CDT service provision or a particular service model is associated with differences in child and parent satisfaction, and progress and outcome for children with neurodisability and their relatives, should be a focus for future research

Introduction

The main source of specialist health management for the increasing number of UK children with neurodisability is from multidisciplinary Child Development Teams (CDTs) (Blackburn *et al.* 2010, Kemp 2013, Parr *et al.* 2013). Historically it was recommended that specialist teams comprising of hospital, community health and education professionals should be established in every UK district to support children with disabilities and their families (Court 1976). Bax and Whitmore identified shortfalls in CDT services and recommended that CDTs should operate from a Child Development Centre (CDC) to facilitate multi-disciplinary and inter-agency co-ordination of services (Bax and Whitmore 1991). Subsequently, Hall concluded there had been significant CDT service development, but that too few CDTs provided a comprehensive service for children and young people (Hall 1997); he highlighted the need for research into variations in CDT provision. After reviewing the processes and practice of some CDTs, Yerbury concluded CDTs required a clear leader, regular planning meetings and joint in-service training (Yerbury 1997). In 1999, a comprehensive survey of UK CDT's found wide variability in services, organisation structures and working practices (McConachie *et al.* 1999); the following year the British Academy of Childhood Disability published the 'Standards for Child Development Services' (Lloyd Evans *et al.* 2000). In 2003 an Audit Commission report described the considerable variations in services received by young people and parents, and that support was provided later than expected, with families having to track down support and seek information (The Audit Commission 2003).

In the last decade, there has been considerable investment in the UK National Health Service (NHS), and major government and partnership initiatives have highlighted the need to improve services and support for children with neurodisability and their families, such as the National Service Framework, Every Child Matters, Aiming High for Disabled Children, the Bercow Report and Every Disabled Child Matters (HM Treasury and Department for Education and Skills 2007, Department for Education and Skills 2004, Department of Health and Department for Education and Skills 2004, Bercow 2008, Every Disabled Child Matters 2009). These documents have included many recommendations of good practice intended to improve the assessment of children and young people with neurodisability, and the support offered; these are summarised in Figure 1. However, the experiences of children, and families, would suggest that recommendations of good practice have not been fully implemented. In 2010 the Care Quality Commission organised workshops to elicit the views of children and young people with disabilities about the health services they received. The majority of children reported: insufficient support to match their needs, poor communication experiences, long waiting times, a lack of involvement in care planning, a failure to seek their views and a lack of choice about service provision (Triangle 2010). Young people identified that continuity of care, privacy, being listened to and being at the centre of communication would improve their experiences (Triangle 2010). More encouragingly, a survey of parents reported an overall increase in positive experiences for families of children with disabilities, although one in five parents had experienced difficulties in communication with professionals and had received inadequate information (Hamlyn *et al.* 2010).

In 2009-10, a further survey of UK CDTs was undertaken building on data gathered by McConachie *et al.* a decade earlier. Parr *et al.* found that, despite recent government initiatives aimed at improving services for children with a disability, there continued to be variability in the composition of teams

within CDT services; in general CDTs showed evidence of a recent reduction in team personnel, a decline in multi-agency working, and a reduction in funding and resources (Parr *et al.* 2013).

In the 2009/10 survey, information was gathered about whether CDTs had implemented the good practice recommendations shown in Figure 1. In this paper we report on whether CDTs had implemented the recommendations made, and explore some of the factors associated with variation in compliance.

[insert Figure 1 about here]

Methods

The survey methods have been described previously: CDT leads were sent a questionnaire and received reminders between June 2009 and November 2010. CDTs were grouped by Strategic Health Authority region (as this was the NHS planning and delivery structure at the time of the survey). Response rates were high with 82-100% of all teams responding to the survey from each region (Parr *et al.* 2013). Ethical approval was not required for this study.

Authors collated relevant documentation, supported by a literature search, in order to identify published good practice recommendations from the UK Department of Health, UK Government, and paediatric neurodisability organisations (Figure 1). Teams who reported that they implemented a recommendation were scored '1', and those that didn't were scored '0'. Teams in England and Wales had a 'good practice implementation score' out of 11, and Teams in Scotland and Northern Ireland a score out of 9 to reflect the optional use of the Common Assessment Framework and Early Support Materials in these countries. Variability in compliance with the good practice recommendations was examined with reference to geographical location, the presence/absence of a CDC team base, and reported funding changes for CDTs. Where appropriate, chi square was used to test the significance of differences, and a significance level of $p < 0.05$ accepted.

Results

Ninety-four percent (225/240) of UK CDTs responded to the survey. Thirty-seven percent of teams in England and Wales reported that they implemented ≥ 9 of the 11 identified good practice recommendations shown in Figure 1; a further 50% of teams met between 6-8 of the 11 recommendations. Fourteen percent of teams ($n=27$) met 5 or fewer recommendations of good practice. Teams from the West Midlands, London and South Central were most likely to have implemented the good practice recommendations, with 52%, 50% and 50% respectively of CDTs meeting ≥ 9 recommendations. However, in terms of consistency within a region, a majority of teams in England and Wales ($>50\%$) had implemented ≥ 9 or more of the recommendations in only 3 of 11 regions (Table 1). Fifty-nine percent of teams in Scotland and 78% of teams in Northern Ireland met between 6-9 recommendations of good working practice. Forty-one percent of teams in Scotland and 22% of teams in Northern Ireland met five or fewer recommendations.

[insert Table 1 about here]

Teams consist of health, education and social care staff – Recommendation 1

Table 2 shows the geographical variability for education and social care staff being core members of CDTs, and being available to the team. Fifty-nine percent of CDTs had at least one core team professional from education services (Educational Psychologist, Teacher, Early Years Practitioner, Portage Worker), and 36% included at least one core team professional from social care or voluntary sector. Regions with relatively high levels of core CDT education and social care representation included the West Midlands, South Central and Northern Ireland; by contrast, Scotland, the East Midlands and South West regions had fewer than 50% of teams with core education or social care representation (see Table 2). When core team members and professionals available to the CDT were combined, variability was still observed: for example, in the West Midlands 100% of teams had access to a member of Education staff; however, only 50% of East Midlands CDTs had access to an Education professional. Regarding social care, Northern Ireland and the North East were the only two regions where 100% of teams had access to a member of social care staff; in the East Midlands just 38% of CDTs had a member of social care staff available to the team. Overall, the availability of education staff was greater than the availability of social care staff.

[insert Table 2 about here]

The team makes use of the Common Assessment Framework & Early Support Materials, and has short waiting times - Recommendations 2 and 3

Initiatives designed to encourage early identification such as the Common Assessment Framework (CAF) and the use of Early Support Materials varied significantly across the UK (Table 3). South West and North East CDTs were most likely to use the CAF (88% and 86% respectively). The East Midlands and the West Midlands were most likely to use Early Support Materials (100% and 95% respectively). These initiatives were implemented in England and Wales and optional elsewhere in the UK. Consequently, Northern Ireland and Scotland were least likely to use the CAF (9% and 11% respectively), as well as being least likely to use Early Support Materials (22% and 14% respectively).

As part of the recommendation relating to short waiting times, the survey showed that the median waiting time for urgent referrals was 2 weeks (25% of teams); the median average waiting time for appointments was 8 weeks (16% of teams). Children waited more than 12 weeks in 15% of teams. 100% of North East CDTs and 94% of South West teams accepted referrals for children with any neurodisability diagnosis, in comparison to 69% of teams in Wales, suggesting some teams have some limitations in their assessment capacity or expertise.

Significant regional variability was found in the access to tertiary neurodisability services, with 87% of teams in London, 71% of teams in the North East and 64% of teams in Scotland considering they had access to tertiary teams, compared with 25% and 27% of teams in Northern Ireland and the South West respectively.

[insert Table 3 about here]

Multi-disciplinary assessments at one visit, or separate assessments, a meeting to discuss assessment results with parents, and whether reports were provided to parents (and other professionals) – Recommendations 4, 5 and 6

All teams used a combination of assessment methods, with all reporting some level of single MDT assessment, an individual professional assessment followed by an MDT meeting and/or an individual assessment without an MDT meeting. Northern Ireland and the South Coast were most likely to report MDT assessments (89% and 79% of teams respectively). The East Midlands (88%) and Northern Ireland (78%) had the greatest proportion of teams conducting an individual professional assessment followed by an MDT meeting. The North East and the South West had the greatest proportion of teams conducting an individual professional assessment without an MDT meeting (57% and 56% respectively).

Regional variation was also seen in whether MDTs held a meeting with families to feed back results; Northern Ireland and North East CDTs were the least likely to give information to parents in this way (44% and 29% respectively), whereas in Yorkshire and Humber (94%), and London (90%), this was much more likely.

All teams in Wales, the East of England, the South West, and South Central agreed with parents the circulation list for clinical reports; Northern Ireland CDTs were least likely to do this (67%). All teams in the South Central and South Coast regions routinely gave information about voluntary sector organisations, compared with 60% of teams in Scotland.

There was considerable variability in the format of assessment reports, with a minority of teams producing one MDT report; teams were more likely to issue an MDT report and individual reports from team members about their assessments (see Table 4).

[Insert Table 4 about here]

Specific telephone advice available for parents and professionals - Recommendation 7

No significant differences were found between teams regarding the types of telephone advice they had available. Overall, 48% of teams had telephone advice available for professionals, and 46% had telephone advice available for parents.

The team has a multi-agency strategic planning group, a defined team leader, and meets regularly for training or professional development - Recommendations 8, 9 and 10

Sixty-three percent of teams had a multi-agency planning group and 68% had a team leader. Regarding joint training or Continuing Professional Development, one third of teams did not meet together; 21% met at least monthly and 44% less often. There were no significant regional differences observed between teams regarding training or professional development meetings.

The team is based in a dedicated Child Development Centre (CDC) - Recommendation 11

65% of teams were CDC-based; there was no significant regional variation in the proportions of teams based in a CDC. In areas serving a larger than average population, with high numbers of new

patients seen per year, teams were less likely to be housed in a CDC: CDC teams served a mean population of 54,164 and non-CDC teams served a mean population of 58,635. CDC teams saw a mean of 468 new patients per year vs. 570 patients for non-CDC teams.

The presence of a dedicated CDC was associated with differences in working practices. CDC-based teams were more likely to: meet frequently to discuss patients than non-CDC teams (62% vs. 39% met weekly, $p=.006$); and meet more regularly to discuss management issues (43% vs. 36% met monthly, $p=.008$). CDC based teams in England and Wales were more likely to have implemented good practice recommendations than non-CDC teams (meeting ≥ 9 good practice recommendations - CDC teams 48% vs. non-CDC teams 13%; 6-8 of the recommendations - CDC teams 46% vs. non-CDC teams 57%; and 0-5 of the recommendations - 6% and 30% of teams respectively). In Scotland, 32% of CDC teams met between 6-9 recommendations vs. 27% of non-CDC teams; in Northern Ireland, 68% of CDC teams met between 6-9 recommendations vs. 11% of non-CDC teams. Overall, CDC-based teams were more likely to comply with each of the individual good practice recommendations, although this only reached statistical significance for holding meetings with families to feed back results of assessments ($p=.001$) and teams meeting to hold in-service training or Continuing Professional Development ($p=.001$) (Table 5).

[insert Table 5 about here]

Teams working in a dedicated CDC made more use of referral criteria than non-CDC teams (85% vs. 76%). Referral could be made to any CDT member in similar proportions of teams with and without a CDC; however, CDC teams were less likely to accept referrals from a non-doctor compared to non-CDC teams (84% vs. 96%, $p=.022$). 86% of CDC teams offered urgent referral and assessment, compared to 80% of non-CDC teams ($p=.049$). CDC teams were also more likely to carry out specific assessments/clinics for: epilepsy (54% vs. 46%), Cerebral Palsy (84% vs. 66%), Language Disorder (74% vs. 63%), Acquired Disorders (39% vs. 28%), Botulinum Toxin treatment (33% vs. 27%) and Sleep difficulties (35% vs. 26%). Assessments for the following conditions were undertaken by a similar proportion of CDC and non-CDC teams: Autism Spectrum Disorder (89% vs. 88%), Attention Deficit Hyperactivity Disorder (53% vs. 50%), behaviour management (46 vs. 46%), dysphagia (62% vs. 59%) and scoliosis (18 vs. 17%).

CDT funding, and rising workloads

London based teams were most likely to report increased funding in the 5 years preceding survey completion (40%), with the East Midlands and Northern Ireland having the most teams recording funding decreases (50% and 44% respectively). There were some associations between areas' funding changes and degrees of good practice implementation. For example, 50% of London teams implemented 9 or more recommendations whereas this was only achieved by 13% of the teams in the East Midlands. In their free text responses, some teams reported that funding had not matched rising workloads, particularly the increased referral rates of children with complex neurodisability.

Discussion

This large and comprehensive survey demonstrated significant variability among the services offered to children and families by CDTs across the UK. Our survey shows that most teams were not able to fully implement the recommendations of good practice: only one third of teams in England and Wales had implemented nine or more of the eleven recommendations, with 59% of teams in Scotland and 78% of teams in Northern Ireland meeting between 6-9 recommendations. Lack of good practice implementation suggests that teams may not be providing the most effective assessment and management for children and families – the core roles of the neurodisability multidisciplinary team. The fundamentals of how to provide a ‘good service’ for children, young people and families seem easier to describe than to implement in practice (Baird and Williams 2011, Edwards and Barber 2011, De Vries *et al.* 2007). It is uncertain whether commissioners and NHS managers appreciate the value of expert assessment and early intervention programmes for children with neurodisability, and the need to provide adequate resources. UK health service provision is increasingly based on evidence about what services are most effective (e.g. NICE guidelines): there is little evidence about whether the good practice recommendations described in the policy documents and guidelines lead to improvement in child and parent health outcomes, or cost savings. The need for CDTs to investigate how their services change outcomes should be a focus for future research (Parr *et al.* 2013).

Several factors were found associated with the variability in service provision and the ability of teams to implement published recommendations of good practice. These include geographical locality, the presence of a CDC base and changes in funding. A recent article by leading paediatricians highlights specific concerns for child health services in the context of Government reforms, many of which do not take into account sufficiently the needs of children and so threaten to exacerbate problems relating to access, inconsistent expertise available across the UK and limited diagnostic resources. To enhance the quality of services, the authors recommended increased integration, both within teams and wider services (Wolfe *et al.* 2011). Some respondents described an increase in the numbers of children presenting with complex neurodisability, alongside a reduction in their resources, suggesting that while austerity continues, and further reform of health services continues to be implemented, the demands placed upon CDTs are increasing.

Some regions in which a higher proportion of teams reported funding increases implemented more of the recommendations of good practice than regions where the greatest number of teams reporting funding reduction. As absolute levels of funding were not determined, it is difficult to comment further; however, any future investigation of the factors associated with services offered and recommendations implemented should compare in more detail the financial resources available to teams. In March 2012 RightCare published the “NHS Atlas of Variation in Healthcare for Children and Young People”. The atlas was based on 2008/09 data and showed clustering in terms of the highest rates of expenditure on community child health services per head in the North East, North West and pockets within London (RightCare 2012). These data correlate with some of the regional variations found in the survey. This could go some way to help explain why such large regional variations were found in the survey, and why many CDTs are stretched in terms of meeting the needs of large populations. Despite these observed variations, it is important to note that, in many aspects, teams across the country were working in remarkably similar ways – conducting joint MDT assessments and using initiatives such as the Common Assessment Framework and Early Support Materials. This implies that whilst some teams face particular financial and population-based difficulties, most provide similar services to other teams who may be relatively better resourced.

One of the good practice recommendations was for the team to be based in a CDC. When CDC and non-CDC teams were compared, CDC teams were more likely to achieve the recommended team working and family communication standards, and also more comprehensive specialist assessment and management services. A rather surprising finding was that CDTs covering larger populations, with the highest number of referrals, were less likely to have their own CDC base. It is possible that as larger teams may cover several health districts (or equivalent), and relate to a number of health and local authority commissioning bodies, it could be more difficult to identify a single location or source of funding for a CDC base; by contrast smaller teams may be in more discrete locations where health, education and social care services are likely to be co-located.

The strengths of this survey include the high response rate, and the relatively small amount of missing data; the survey was designed with an evaluation of the implementation of the good practice recommendations in mind. Regarding the limitations of self-report data, it is possible that some respondents may have under- or over-estimated the extent to which their service met recommendations of good practice. Borderline compliance may have been more like to be reported as 'meeting good practice' criteria; however, we have no reason to believe that systematic reporting bias occurred. Despite considerable consultation about the survey design and questions, and piloting, some survey responses were heavily annotated, indicating difficulties in selecting an appropriate reply; this may reflect the considerable differences between CDT practices.

In conclusion, despite the best efforts of professionals and teams across the UK, most teams were not able to comply with significant numbers of the good practice recommendations examined, drawn from a range of official and informed sources. Changes to the landscape of the UK NHS and the current economic climate are creating uncertainty and putting increasing strain upon resources and personnel, which could further affect the services that teams are able to offer to children with neurodisability and their families.

In the future, it is likely that health teams will systematically collect data about the services received by children with certain neurodisability diagnoses; these data will allow more comprehensive service planning, but will not tell us about the effectiveness of clinical practice. To fully understand what services should be provided, it is necessary to investigate whether more comprehensive delivery of some or all of the recommendations of good practice improves outcomes for children and families. Research challenges will include what outcomes to measure, and what tools should be used to measure progress; these clinical studies could be done with support from research funding to enhance provision in some services, compared with 'usual care' in others. In parallel, quantitative and qualitative research into parent and young person satisfaction with defined aspects of the CDT service would be desirable. As children and families frequently receive services from health, education and social care professionals, controlling for other services delivered would be crucial. It is now essential that clinicians, commissioners, policy makers and researchers work together to identify the evidence base for what services should be provided by the UK's CDTs, to support the best health and other outcomes for children with neurodisability and their families.

Figure 1: Good practice recommendation and their origins, and the related practice measured by survey questions

Good Practice Recommendations (numbers correspond to those used in the results text)	Practice Measured by Survey
1. Workforce including health care, welfare and education (Department for Education 2011, Court 1976)	Teams include health, social care/voluntary sector and education staff
2. Early identification and intervention (Department for Education 2011, Department of Health and Department for Education and Skills 2004, Bercow 2008)	The team makes use of the Common Assessment Framework ^a and has short waiting times ^b
3. Make use of Early Support Programme (Department for Education 2011, Triangle 2010)	The team makes use of Early Support Materials ^a
4. Well co-ordinated multi-disciplinary assessment (Department of Health and Department for Education and Skills 2004, Department for Education and Skills and Department of Health 2003, Kennedy 2010, Department for Education and Skills 2004, Lloyd Evans <i>et al.</i> 2000)	Multi-disciplinary assessments at one visit, or conducted by individuals followed by a multi-disciplinary meeting
5. Children and young people and their families routinely involved in decision-making, shared aims and objectives (Department of Health and Department for Education and Skills 2004, Lloyd Evans <i>et al.</i> 2000, Department for Education 2011, Department for Children Schools and Families 2007)	Meeting held with families regarding outcomes of assessments
6. Good quality information sharing and report writing (Bercow 2008, Department for Education and Skills 2004)	Parental involvement in the assessment reports (including agreement on circulation of reports)
7. Provision for out of hours contact arrangements (Lloyd Evans <i>et al.</i> 2000)	Specific telephone advice available for parents and professionals
8. Multi-agency group to co-ordinate the work of the team (Yerbury 1997, Department for Education and Skills and Department of Health 2003)	The team has a multi-agency strategic planning group
9. Clear leadership required for effective teamwork (Yerbury 1997)	The team has an identified leader
10. Teams should meet for in-service training in addition to providing assessment and support (Yerbury 1997)	The team meets for training or Continuing Professional Development
11. Teams operate most effectively when based in a dedicated centre (Bax and Whitmore 1991, Yerbury 1997, Department for Education and Skills and Department of Health 2003)	Teams based in a dedicated Child Development Centre

^aThese initiatives were implemented in England and Wales and optional elsewhere in the UK

^bShort waiting times were not given a score of "0" or "1" as guidelines have not given an 'appropriate' wait time

Table 1: The percentage of CDTs grouped by region that implemented different proportions of the good practice recommendations

	% CDTs implementing		
	0–5 recommendations	6–8 recommendations	≥9 recommendations
UK Region			
Scotland (n=22)*	41	54	5
Northern Ireland (n=9)*	22	78	0
Wales (n=14)	43	36	21
North East (n=14)	29	57	14
North West (n=29)	10	52	38
Yorkshire & Humber (n=18)	6	72	22
East Midlands (n=8)	50	38	13
West Midlands (n=21)	5	43	52
East of England (n=16)	6	50	44
South West (n=16)	19	44	38
London (n=30)	3	47	50
South Central (n=12)	17	33	50
South Coast (n=14)	7	64	29

* Teams in Scotland and Northern Ireland were given a score out of 9 to reflect the optional use of the Common Assessment Framework and Early Support Materials in these countries

Table 2 The percentage of CDTs, compared by region, with at least one professional from social care, and education services

UK Region	Education Staff Core Team Members (%)	Education Staff Core + Available Members (%)	Social Care / Voluntary Staff Core Team Members (%)	Social Care / Voluntary Staff Core + Available Team Members (%)
Scotland (n=22)	41	91	23	82
Northern Ireland (n=9)	44	78	78	100
Wales (n=14)	77	92	46	85
North East (n=14)	50	93	43	100
North West (n=29)	76	97	28	86
Yorkshire & Humber (n=18)	56	94	28	83
East Midlands (n=8)	38	50	13	38
West Midlands (n=21)	91	100	43	67
East of England (n=16)	50	88	31	81
South West (n=16)	38	88	38	88
London (n=30)	53	87	47	87
South Central (n=12)	67	83	50	75
South Coast (n=14)	64	93	21	86

Table 3 The percentage of CDTs, compared by region, reporting use of Early Support Materials and the Common Assessment Framework

UK Region	% using Early Support Materials	% using the CAF
Scotland*	(14)	(9)
Northern Ireland*	(22)	(11)
Wales	54	39
North East	93	86
North West	90	69
Yorkshire & Humber	72	61
East Midlands	100	38
West Midlands	95	71
East of England	88	75
South West	94	88
London	80	70
South Central	75	42
South Coast	86	43

* The use of the CAF and Early Support Materials were optional in these countries; data given in brackets are the proportion of teams using these initiatives

Table 4 The percentage of CDTs, compared by region, issuing different types of reports

UK Region	One MDT Report (%)	Individual Reports (%)	Both MDT and individual Reports (%)
Scotland	27	23	46
Northern Ireland	44	11	44
Wales	15	39	39
North East	21	57	21
North West	25	13	50
Yorkshire & Humber	50	6	33
East Midlands	25	25	38
West Midlands	38	24	33
East of England	6	19	75
South West	25	19	50
London	33	10	57
South Central	50	25	8
South Coast	64	7	14

Table 5 The percentage of CDC and non-CDC teams meeting individual recommendations of good practice

Practice Measured by Survey	CDC Teams (%)	Non-CDC Teams (%)
1. Teams consist of health, education and social care staff	80	75
2. The team makes use of the Common Assessment Framework and has short waiting times*	70	30
3. The team makes use of Early Support Materials*	65	35
4. Multi-disciplinary assessments in one visit, or conducted by individuals followed by a multi-disciplinary meeting	65	52
5. Meeting held with families to feedback the findings of assessments	81	65
6. Circulation of reports agreed with parents	93	89
7. Specific telephone advice available for parents and professionals	49	35
8. The team has a multi-agency strategic planning group	64	63
9. The team has an identified leader	72	60
10. The team meets for training or Continuing Professional Development	73	52

*CDTs in Scotland and Northern Ireland were excluded from these two analyses

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