WM QRS West Midlands Quality Review Service

NHS

Formative Review: Community Paediatric Occupational Therapy & Physiotherapy Services

Worcestershire Health and Social Care Economy

Visit Date: 6th June 2018

Report Date: September 2018

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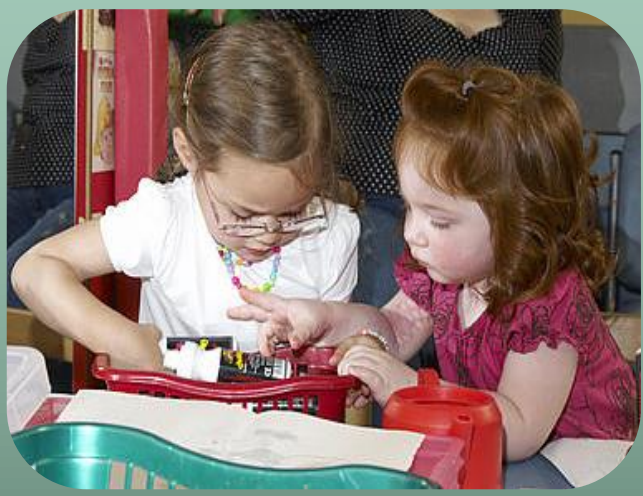

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INTRODUCTION

This report presents the findings of the formative review of Community Paediatric Occupational Therapy and Physiotherapy Services across Worcestershire that took place on the 6th June 2018.

Due to the changing demands for community physiotherapy and occupational therapy service across Worcestershire a service redesign had taken place in 2014 to ensure that an effective and efficient service could be provided. A service review was commissioned in April 2017as a result of ongoing capacity and demand challenges and concerns raised by individual staff, and an action plan to address the issues raised was drawn up. This review was commissioned to evaluate the progress being made in implementing the action plan.

WMQRS Formative Reviews work from a set of questions rather than a set of Quality Standards. They are not as robust as reviews that use a set of Quality Standards, but they are useful as a way of engaging with people to find the answers to questions and identify ideas for the way forward.

Reviewers looked at a range of documentary information and met with representatives from various stakeholders (see appendix 1). The visiting team that undertook the review are listed in appendix 2. Some issues emerged as common themes and, where possible, are described once only. Readers are therefore recommended to consider this report in its entirety.

The formative review questions to be answered were agreed in advance with the Trust and the teams involved and covered the following key headings: -

1. Is the team skilled and experienced in paediatric care?
2. Are the staffing levels and skill mix appropriate?
3. What arrangements are in place to ensure safe and effective care and treatment for children and young people referred to the service?
4. What arrangements are in place for the collection and monitoring of data and for audit?
5. Is there evidence of service user and carer feedback?

Appendix 3 has more detail for each of the question headings.

Responsibility for addressing the issues identified in this report lies with all the organisations working in partnership, bearing in mind that this is a formative review and may not have a full picture of local services. Worcestershire County Council Integrated Commissioning Unit (ICU) has particular responsibility for ensuring appropriate progress is made.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by: developing evidence-based Quality Standards; carrying out developmental and supportive quality reviews (often through peer review visits); producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are: better quality, safety and clinical outcomes; improved patient and carer experience; more robust information for organisations regarding the quality of their clinical services; and organisations with greater confidence and competence in reviewing the quality of clinical services.

More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff at Worcestershire Health and Care NHS Trust for all their hard work in preparing for and organising the review and for their kindness and helpfulness during the course of the visit.

WMQRS spoke to users of the service who were open and honest with us, and we would like to thank them for their time in speaking to us.

Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

Review Findings

General Comments and Achievements

Worcestershire Health and Care Trust was the main provider of community paediatric physiotherapy and occupational therapy services across Worcestershire. Services were delivered in a variety of settings including people's homes, schools, and community clinics.

Worcestershire County Council Integrated Commissioning Unit (ICU) was responsible for commissioning the paediatric occupational therapy service on behalf of three Clinical Commissioning Groups (CCGS), Redditch and Bromsgrove, Wyre Forest and South Worcestershire.

Community paediatric therapy services were delivered by teams in a north/south of county model of delivery. A Paediatric Physiotherapy and Occupational Therapy Clinical Service Lead had a county-wide remit.

Children and young people aged 0-18 years who were registered with a Worcestershire GP and who met the criteria of the services commissioned could access the services.

Worcestershire had seven specialist education schools within its locality. There were also requirements to support children and young people from outside the county who were being cared for within Worcestershire.

Reviewers were impressed by the enthusiasm and commitment shown by the staff who they met in relation to improving the quality of care for children, young people, families and carers. Most staff were highly experienced, and those who met with the reviewing team had a good understanding of the issues they faced and were motivated to improve the pathway for children and young people and their carers and families. Three members of the occupational therapy teams were also actively engaged with the West Midlands Children and Young People and Families specialist interest group.

Reviewers met with representatives from the occupational therapy service and occupational therapy team leaders. Of note is that reviewers only met one physiotherapist from the 'south' team (although the south team had submitted comments to the review team for consideration) along with the physiotherapy team leader for the 'south' team. Reviewers were told that the views of these representatives were representative of the teams' view but were unable to verify this.

The local authority representative who met the reviewers made them aware of the action plans being developed to address the issues raised by an Ofsted and Care Quality Commission (CQC) special educational needs and disabilities (SEND) review. The issues identified as part of the SEND review are not replicated in this report although some issues around community physiotherapy and occupational therapy support to special educational services are included.

QUESTION 1: IS THE TEAM SKILLED AND EXPERIENCED IN PAEDIATRIC CARE?

THIS SECTION DESCRIBES HOW THE CLINICAL TEAM WORKED TO PROVIDE PATHWAYS OF CARE.

SUMMARY:

Reviewers heard varying accounts from staff about the progress being made in implementing the actions from the service review. As part of the service review action plan it will be important to reflect where the changes are working well and where they may not be working as envisaged. Systems to provide clinical support and supervision worked well. There was an opportunity to improve the clinical consensus on the pathways of care.

REVIEW FINDINGS:

1. Following the 2017 service review an action plan had been developed. Staff who met with the reviewing team reported that communication between the teams and Trust management had improved in some areas. Many staff had attended 'Insights' training which included skills training on team working and leading transformation.
2. Reviewers were impressed with the process for the clinical and managerial supervision of staff. From discussions with representatives, the arrangements in place provided a good level of support in a structured way for all staff levels. Staff found that they were enabled by the system and could choose the most appropriate supervisor to discuss their clinical caseload. They had access to any of the specialist practitioners for complex cases. Group supervision was also in place with additional time allocated for education on specific topic areas. Staff could also access supervision relating to any issues around safeguarding.
3. Reviewers heard mixed messages about whether the services now being delivered were as envisaged in the 2014 redesigned service plan. From discussions with staff, it was clear to the reviewers that staff had insight and were motivated to improve the quality of care to children and young people, and their families and carers. Reviewers considered that the Trust management team should maximise the experience and enthusiasm within the teams and consider ways to provide a more supportive framework to allow the teams to take ownership of any service improvements.
4. Some staff felt that there were gaps in clinical leadership for some specialisms such as complex needs, spasticity management and chronic pain. Reviewers were told that this was due to secondments and other leave being granted which had resulted in other team members providing cover. Comments were also made that the 'north' teams were better resourced and that the 'south' teams felt neglected, whereas other staff who met with the reviewing team gave a different picture. Reviewers considered that was important for the managers and team leaders to ensure staff felt supported and that there was ongoing communication about the future direction of the services.

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QUESTION 2: ARE THE STAFFING LEVELS AND SKILL MIX APPROPRIATE?

THIS SECTION DESCRIBES HOW THE RESOURCES AVAILABLE WERE USED TO DELIVER THE PATHWAYS OF CARE.

SUMMARY:

Overall, the quality of the interventions being provided in each of the teams was considered to be very good; this was outlined in feedback from those using the service and other stakeholders. Reviewers saw that staff were trying to deliver a very high-level holistic service, but not resourced or commissioned to do so to this level. Staff set high expectations for themselves that have been higher than expected within the contract or service level agreement. The workload was demonstrably higher than calculated in the Trust's model, (see below) and these efforts by staff were not sustainable in the current configuration. This may be because staff were delivering a higher level of intervention than the model expected.

REVIEW FINDINGS:

1. **Restructuring of services**

During the autumn of 2014 the community paediatric physiotherapy and occupational therapy services had undergone a structural change to provide a wider skill mix and help with maximising the productivity of the service. Staff who met with the reviewing team were positive about these changes and the countywide roles had improved working across the county.

a. Band 7 Team Leaders for both physiotherapy and occupational therapy had been redefined to provide clinical leadership on a county-wide basis, to provide local expertise as part of the multidisciplinary team and to drive service development, audit and research for their specialism. Team leaders worked as advanced practitioners within a range of specialism cohorts which covered:

    i. Physiotherapy: emerging diagnosis pathway, complex care, cerebral palsy, spasticity management, pain and deteriorating conditions, neonatal care and musculoskeletal (MSK) and orthopaedic management of long -term conditions.

    ii. Occupational therapy: emerging diagnosis, neurodevelopment, learning disability child and adolescent mental health service and neonatal care.

    Staff who met with the reviewers considered the development of these clinical specialities had improved communication between the teams and improved the county- wide working, but some issues were raised by other staff, which are documented later in this report.

b. Band 4 physiotherapy and occupational therapy roles had been developed with a clear mentoring process and competency framework in place. However, reviewers were concerned that the development and oversight of these roles were dependent on an appropriate level of ongoing supervision and mentoring by other staff who already had a high clinical workload.

c. Neither the physiotherapy nor the occupational therapy services had dual competence technicians. In the future this may be an option as a more efficient way of managing workload and enhancing the service provision.

d. From January 2018 the paediatric MSK therapy service for children and young people over the age of eight had been transferred to Worcestershire Acute Hospitals NHS Trust. It was agreed that any referrals received up until the transfer date would remain under the care of the community services. Staff and reviewers considered that the move of the MSK service to the Acute Trust would greatly improve the workload of the teams once fully implemented. At the time of the visit the impact of reducing the MSK workload within the community teams had not been fully realised.

However, some issues were raised with the reviewing team as follows: -

e. Due to the increased workload across the service, the Band 7 team leaders/ advanced practitioners had limited time to progress the service development of their allocated specialism. Reviewers considered

that the lack of time to develop the specialist services fully was likely to have an impact on future service delivery and they were concerned that the opportunities defined in the service plan to develop the services would be lost.

f. The Band 6 staff who met with the review team also commented that the new structure meant that they were no longer involved with some of the more complex assessments and service development work for each specialism. Reviewers were also concerned that this might make it harder for the Band 6 staff to maintain their skills in assessing children and young people with complex needs. Staff were also concerned that the care of children and young people had the potential to be disjointed because of the multiple handovers of care between staff.

g. Some issues with time spent travelling across the county were also reported to the reviewers. Reviewers considered that this could be addressed by a better scheduling of appointments and / visits, and that some patients could easily be seen in a more convenient and time-saving environment. This may result in reduced choice for some service users by focusing on specific days or pathways at some locations, but overall would increase in the resource available, as less time would be spent travelling, and more in face-to- face interaction.

Reviewers considered that an evaluation of the skill mix may be helpful to ensure that the objectives of the restructuring were being met and the efficiency of the new ways of working optimised.

2. **Workload and capacity**

Reviewers were concerned about the continued high workload and the capacity of the teams to provide a safe and effective service.

a. Data seen by the reviewers showed that occupational therapy staff and physiotherapy staff had a very high level of intervention and complexity within their caseloads, with some staff showing double the workload (or more) on the Trust recommended workload toolkit. Reviewers were told that the team workload data were discussed and validated at team meetings and that concerns were raised with Trust management on a regular basis. Issues of capacity within both the physiotherapy and the occupational therapy teams had been continually documented on the Trust risk register since 2014 and it was not clear from those who met with the reviewing team that the teams were actively working with Trust management to manage the risks identified.

b. The high workload and capacity within the teams meant that staff were focussing on key priorities that had been agreed with senior managers and commissioners, such as the 18-week referral to treatment and urgent referrals, which was having an impact on the time to deliver education and, other therapeutic intervention and treatments and to measure quality outcomes. Staff also commented that they were extending the time between reassessment and reviews for some children and young people to meet other agreed targets.

c. Delays in distributing reports following initial assessment and reviews had also been identified however, at the time of the visit the improvement plan detailing the expected improvements in timescales for reporting had not been met.

d. The time available to work with and educate parents, carers and education staff was limited. Reviewers were concerned that this would have the effect either of staff providing low- level interventions or of an increase in contacts to the service for help and advice.

e. Reviewers were told that there was no inpatient children's therapy service at Worcestershire Acute Hospitals NHS Trust, and therefore hospital staff were referring more children and young people on discharge to the community therapists for assessment. As all discharges from the Acute Trust had to be seen by the paediatric community physiotherapy and occupational therapy services within two weeks of the child's discharge date, this was increasing the workload of the community teams. Reviewers considered that more clarity in the service specification and the hospital discharge pathway about which conditions should be referred to the team on discharge would help reduce the number children who

were referred for assessment but were then not appropriate for ongoing care by the community therapy teams.

f. Workload issues were exacerbated by the lack of a paediatric community respiratory physiotherapy service and by the reduction in other children's services such as, universal services (including 'early years' provision and children's centres), which was having an impact on the numbers being referred to the teams. The occupational therapy staff commented on the high number of inappropriate referrals being received from other agencies who could not refer elsewhere for support and advice.

g. Discussions with the lead commissioner for children and young people about the increasing workload for the services had been held, but the request from commissioners for data on the different pathway cohorts for the various clinical specialisms, to support the review of service specifications had not yet been answered by the Trust. Data were available on the levels of interventions and, an annual report was produced so the reasons for delaying further discussions were not clear to reviewers.

h. Reviewers were concerned that the data monitored by commissioners were limited to triage/assessments, reassessment/review, discharges and service user experience. Data showing the workload associated with delivering therapeutic interventions and treatment were not being utilised for commissioning the services. This view was supported by staff who met the reviewers, who were frustrated that the data showing the impact of weighting on caseload were available, but not used to inform commissioners.

3. **Support for schools.**

Reviewers had discussions with therapy staff and representatives from local schools.

a. Occupational therapy was provided on a case by case basis. Occupational therapy involvement was generally good with support and advice provided.

b. Concerns were raised about the level of provision of physiotherapy services to schools. Therapy staff reported that there were now 80 extra places in schools which had increased the number of children from 140 to 220. It did not appear that the contract to provide support to specialist schools had been amended to reflect the increase in referrals to the teams.

c. Educational service representatives commented that physiotherapy input to schools had also reduced over the last few years following the development of an in-reach service rather than a service with staff being based at specific schools.

d. The impact of both the numbers of children and young people requiring support: and the service delivery had resulted in some physical therapy and/physio therapy programmes not being updated since 2015. Although individual children had been reviewed, updated information/ targets had not always been received. This had also made updating Education, Health and Care Plans (EHCP) difficult.

e. Comments were also made that physiotherapy representatives did not always attend EHCP review meetings but sent reports instead. The criteria for determining which EHCP meetings were attended by physiotherapy staff were not clear or consistent and this appeared to be decided on an adhoc basis or by parental/carer demand.

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QUESTION 3: WHAT ARRANGEMENTS ARE IN PLACE TO ENSURE SAFE AND EFFECTIVE CARE AND TREATMENT FOR CHILDREN AND YOUNG PEOPLE REFERRED TO THE SERVICE?

THIS SECTION DESCRIBES THE CONFIGURATION AND OPERATING PROCESSES OF THE SERVICE TO DELIVER SAFE CARE.

SUMMARY:

The service specifications and service level agreements for both the community paediatric physiotherapy service and the occupational therapy service would benefit from being more specific about the expectations for the services. A good standard operating procedure was in place for children, young people, parents and carers once they were being cared for by the service; but, there were no clear access criteria. This appeared to result in inappropriate referrals, as referrers were also unclear about the role of the services. Reviewers were concerned that this may result in children and young people being referred because there was nowhere else to refer them, and that staff might accept inappropriate referrals as it could be easier than turning them away, adding to the workload impact.

REVIEW FINDINGS:

1. The teams had a good standard operating procedure covering the process from receipt of referrals to triage and then determining the most appropriate allocation to caseloads or response. The 'opt in' partial booking process was particularly good as once referred, families could choose an appointment time and venue that was best suited to their needs. This ensured that appointment schedules were better utilised and reduced the number of rescheduled and cancelled appointments. Staff saw this as also offering an additional safeguarding step.
2. Parents and carers told the reviewers that they could always contact the service and if necessary speak to a staff member.
3. **Service Specifications**

   Reviewers had several concerns about the service specifications in place for both the physiotherapy and occupational therapy services. In general, both service specifications were too broad and did not define detailed inclusion and exclusion criteria. This had resulted in the services accepting a very wide range of children and young people some of whom, did not require significant specialist interventions.

   Reviewers also heard from other organisations and professionals, including community paediatricians, who were not clear on the acceptance criteria for the physiotherapy and occupational therapy services, commenting that some referrals were not accepted and that there was then a lack of advice or signposting about other services that might offer support.

   The service specifications covered: referral to treatment, children in pain or post-surgery, any child with a reported change in condition, and annual reviews. In the service specification for paediatric physiotherapy respiratory conditions were excluded in the main text of the schedule but acute chest conditions were included in the appendix on referral priority criteria and in the action plan. It was also noted that discharges from the Acute Trust had to be seen within two weeks. Staff were working hard and achieving the targets set but this reduced the time available for staff to deliver therapeutic interventions and treatments (see earlier reference to this issue).

   Reviewers considered that defining the service specifications to give a clear role for the services and then defining the needs of the children and young people who should be referred was crucial to the sustainability of both the physiotherapy and the occupational therapy services.

4. **Service Redesign**

   As part of the redesign of the services and the definition of the service specifications, staff and reviewers had some suggestions for changes to the pathways of care. These changes may ensure that there is sufficient capacity for caring with children and young people with complex needs:

a. Care of children with Plagiocephaly and Talipes could be provided by other health care professionals. For example:

   i. Some community therapy teams do not see Structural Talipes. This group of children will be under the care of Birmingham Children's Hospital NHS Foundation Trust, because they will require surgery, and they therefore remain under the care of the hospital physiotherapy service.

   ii. In other areas, both Structural and Positional Talipes are seen by hospital-based outpatient physiotherapy services with community services only caring for children with neurological conditions.

   iii. Not all children who present with Plagiocephaly will require therapy, so if the criteria for referral were defined in the service specification not all children with Plagiocephaly would be routinely referred to the service.

b. Education for parents and carers could be increased so that they are enabled to provide low-level interventions to meet immediate needs. Ultimately this would enable the team to focus on specialist high-level skilled areas

c. Health and social care professionals could be educated on how referrals to the physiotherapy and occupational therapy services could become more appropriate to support children and young people could be better managed. This would also help to reduce late or inappropriate referrals.

d. Staff were also interested in developing universal services via social media such as 'You Tube' to provide information for parents and carers with the aim of reducing inappropriate referrals. Staff had already identified opportunities and realised that some support from the Trust in terms of governance and information technology would be required.

5. **Equipment**

   Reviewers heard of delays in accessing equipment in some cases. Access to equipment was via a central equipment store, but this was not directly accessible to schools. Reviewers heard that there was a lack of clarity about what should be 'health' funded and what should be 'education' funded. Representatives from the schools commented that on occasions they were having to purchase equipment. Access to equipment for children, was sometimes delayed, and additional time was spent by therapists resolving issues which added to the burden of their workload. The visiting team recognised that difficulties in funding, and access to equipment between various services, are recognised as national issues, but it is important to reduce, where possible, the impact on service users and staff. Health commissioners and the local authority may need to help clarify the situation for all parties. Service managers told reviewers they were making some progress on this issue.

6. Community paediatricians who met with the reviewing team were unclear about the process for notifying parents and carers if the referral to either the physiotherapy and occupational therapy services was not accepted. Reviewers commented that in their own organisations if a referral was not accepted then the duty of care to notify the parent or carer remained with the referring team. It may be helpful if the Trust clarified the organisational process with teams.

7. The CareNote system was in place across the Trust and was viewed positively by staff. Staff from different services commented about the use of the system for referring to the physiotherapy or the occupational therapy services. The therapy services felt that some of the free-text boxes were not sufficiently prescriptive to ensure that appropriate and consistent information was included in the referral. Other comments were supportive because the system could be used to access the child or young person's history to support the referral information received.

8. Integrated care pathways, including play work and early intervention, were in place, but reviewers considered that more staff capacity may be required to progress the pathways and develop new ones.

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QUESTION 4: WHAT ARRANGEMENTS ARE IN PLACE FOR THE COLLECTION AND MONITORING OF DATA AND FOR AUDIT?

THIS SECTION DESCRIBES HOW THE SERVICES COLLECT AND USE DATA TO INFORM AND IMPROVE DELIVERY.

SUMMARY:

Reviewers saw that the service was collecting data, but that the data were not being used to best effect. The data the service were reporting to the Trust and to commissioners were not always the data that should be known about the service. The service was collecting and reporting data on assessment, triage and review. The service was reporting internally on 18-week standard and also on mandatory training and PDR compliance. There appeared less focus on reporting beyond the service on the more important quality measures of interventions and outcomes. The visiting team believed that the Trust had access to the data required to allow consistent completion of the COPM (Canadian Occupational Performance Measure) which was required in the service specification. This would allow the service to have more meaningful discussions on the quality of delivery and service configuration models.

REVIEW FINDINGS:

1. The teams used the Birmingham workload management tool monthly, which weighted interventions into three categories (gain, maintain and review) demonstrating the complexity of interventions needed and the associated workload. The Nottingham workload analysis tool was also used to provide additional information to the Trust on an annual basis. The data clearly showed that workload was increasing.
2. The occupational therapy service used a modified version of the Royal College of Occupational Therapy caseload monitoring tool. Reviewers suggested that further consideration might be given to the use of this tool as it a) was reported to be time intensive and b) would require further staff development to ensure that all staff were interpreting information in the same way.
3. The data showed that the teams were meeting the targets for assessment, triage, reviews and discharge. Data for therapeutic interventions and treatment were not monitored by commissioners.
4. Data were collected for the Canadian Occupational Performance Measure (COPM) by the 'north' occupational therapy team, and there were plans to reintroduce the COPM for the 'south' team. Reviewers considered that use of the COPM could potentially demonstrate outcomes of any therapeutic interventions and provide data to permit the commissioning or development of services in a way that would improve health and reduce inequalities.
5. An audit programme was in place. The teams had completed audits for parent workshops and made changes as a result of feedback.

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QUESTION 5: IS THERE EVIDENCE OF SERVICE USER AND CARER FEEDBACK?

THIS SECTION DESCRIBES HOW SERVICE USERS VIEW THEIR CARE.

SUMMARY:

The quality of interventions being provided in all localities was very good. This was supported by the feedback received from users of the service and other stakeholders who met the review team on the day.

REVIEW FINDINGS

1. On the day of the visit the teams had randomly selected and contacted the parents/carers of service users to provide feedback on their experiences of using the physiotherapy and occupational therapy services. Some of those who were invited to give their views were not available when contacted. Five out of the six parents or carers contacted were extremely appreciative of the care they had received or were still receiving.
2. All parents were aware of who to contact for help and advice. Those who had requested support felt that the teams were responsive. They all spoke highly of reception staff who would in many cases, identify whether there was anyone in the office who could give immediate advice or help. Parents and carers also commented that if their child needed an appointment then this was arranged with minimal delay.
3. Both the physiotherapy and the occupational therapy services had undertaken audits covering parent and carer involvement, either from education sessions or from workshops delivered. Evaluation of these events was positive.

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OVERALL CONCLUSIONS

Community paediatric physiotherapy and occupational therapy services in the Worcestershire Health and Social Care Economy were provided by a committed team who wanted to provide the best quality of care for children and young people. The individual care being provided was appreciated by parents and the other stakeholders who met the review team.

Overall, the visiting team saw a service providing good care for those referred to the service, but reviewers saw that elements of the service were reactive, and the staff appeared busy firefighting. Reviewers saw that the impact of the workload of some clinical professionals was being manifested in different ways, with some staff coping with the pressure better than others.

Future service models will require greater agreement on what can and cannot be provided with the resources available. Greater clarity on the expectations of the level of service delivery would help align the model of care to the resources available.

Reviewers regularly heard staff say that they did not feel that the service pressures were understood by the Trust and senior managers. However, managers described work already in progress on a number of issues identified by this report. What was clear to reviewers was that there was a lack of connection between the efforts of senior management and those of the clinical teams. Reviewers recognised that a change in the way teams work and communicate around a common set of visions and values is important. A clear improvement in communication will be vital. Pivotal to this is the role of the front-line service managers and team leaders as a conduit to change.

Those in charge of teams and services, will have a vital role in harmonisation and leading change; these are both managers and clinicians and are a critical bridge to communication. The service investment in 'Insights' training and leading transformation will be a great advantage. There must be clear, accountable, and unambiguous objectives and core messages. Staff told us of the service they wanted to deliver; managers have a responsibility to the Board, commissioners and patients for delivery of the service specification. Where staff are leading change, they must be accountable and able to demonstrate that change is delivered within the organisational objectives.

The reviewers noted that the service had already participated in a number of reviews; and the visiting team believed that this review should now become the driver for change.

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APPENDIX 1 - INFORMATION CONSIDERED BY VISITING TEAM

Documentary Information

1. Reviewers looked at the following documentary information on the day of the visit

	Documentary Information
1	Organisational structure charts – Governance
2	Service specifications for community paediatric and occupational therapy service provision 2017-19.
3	Team Job Descriptions
4	Paediatric Physiotherapy Specialist Cohorts documentation
5	Standard Operating procedures on CareNote covering: • Referral to Children Young People and Families (CYPF) Paediatric Physiotherapy • CYPF Paediatric Physiotherapy triage • CYPF Paediatric Clinic opt-in journey • CYPF Paediatric Clinic admin journey • CYPF Paediatric Physiotherapy initial assessment clinic • CYPF Paediatric Physiotherapy new patient diary appointment • CYPF Paediatric Physiotherapy ongoing patients • CYPF Paediatric Physiotherapy tech block/group/hydro • CYPF Paediatric Physiotherapy equipment justification • CYPF Paediatric Physiotherapy
6	CareNote (2016) paediatric physiotherapy processes for clinical notes, diary appointments, caseload, correspondence, clinical letters, discharge, referral to treatment, making referrals and receiving correspondence
7	Care plan template
8	Patient information leaflets
9	Friends and Family feedback data February – April 2018
10	Parent workshop satisfaction audit
11	Written comments from deputy head teachers for consideration about the physiotherapy and occupational therapy services/ provision in school
12	Written comments for consideration from the South Worcestershire CYPF Physiotherapy Team
13	Pathways for: • Pre-school play • Talipes • Plagiocephaly • Normal development of walking
14	Paediatric occupational therapy information for 2017/18 Annual Service Report
15	Caseload and activity data including conversion rates
16	Codes for providing relevant time durations for triage, assessment and therapeutic interventions and reassessment provided by the service
17	Referral data
18	Risk Register
19	Community OT compliment data 2017

20	Equipment Management Justification form, hoist training record and bed assessment checklist. Pathways for equipment and provision of a restrictive cot.
21	Outreach and therapy support roles and responsibilities for seating at school
22	Worcestershire Health & Care NHS Trust Service Review – Paediatric Physiotherapy Service 2014
23	Service review action plan November 2017

Meetings

2. The table below lists the people who met the review team to discuss their views on the review questions.

Meetings
WHCT Paediatric Occupational Therapy Team
WHCT Paediatric Physiotherapy Team representative
WHCT Team leaders for Occupational Therapy x 2 and Physiotherapy x1
WHCT Clinical Lead for Physiotherapy and Occupational Therapy
Children's Clinical Service Manager
Community Paediatric Service: Consultant Paediatricians and Service Development Manager
Speech and Language Therapy representative
Child and Adolescent Mental Health Team representative
Community Equipment / Wheelchair Service representative
Worcestershire County Council Special Education Needs and Disability (SEND) Commissioner
Education representative from Fort Royal Community Primary School
Children's Community Nursing representative
Service lead for Health Visiting, Emotional Health and Well-being

3. The table below lists the people who were contacted by the review team to discuss their views on the review questions.

Telephone Calls
Worcestershire County Council Integrated Commissioning Unit Lead for Children and Young People
Chair of Special Education Needs and Disability Group, and Head of Chadsgrove School
Parents and Carers: 17 contact numbers were provided, and 11 parents or carers were contacted for their views (five contacts were not available when telephoned and one was not contacted due to time constraints of the reviewing team).

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Appendix 2 - Membership of Visiting Team

Visiting Team		
Sarah Acton	Head of Inclusion Services, Children and Families Division	Birmingham Community Healthcare NHS Foundation Trust
Yvonne Feasey	Team Leader, Children's Physiotherapist and Clinical Specialist	Staffordshire and Stoke on Trent Partnership NHS Trust
Petrina Marsh	Head of Department, Children's Therapies	Sandwell and West Birmingham Hospitals NHS Trust
Emma Wall	Children and Young People's Continuing Care Lead	NHS Sandwell and West Birmingham CCG

WMQRS Team		
Tim Cooper	Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 3 – FORMATIVE REVIEW QUESTIONS

Formative Review Questions
1 **Skills and experienced of the team in paediatric care** a. What enables you to deliver high quality care? b. Can you share situations where you are proud of the care you delivered? c. How would you describe the team you work with?
2 **Staffing levels and skill mix** a. Review of the skill mix has been ongoing. Has this helped you meet the needs of CYP & Families? i. In particular the development of the following: • Development of Band 4 assistant roles • Development of pathway leads (Band 7) ii. Are there any issues in service delivery, for example: • Meeting the service's role in the pathway of care and expected timescales • Undertaking assessments and therapeutic and/or rehabilitation interventions • Ability to undertake urgent review within agreed timescales b. In your opinion, what could be implemented to help meet the demands on the service in terms of different ways of working or efficiency? c. Do you use care pathways to deliver care? • If not, why not? d. How can care pathways be used further to improve care delivery? For example i. Early intervention work? ii. Other examples? e. Are standard operating procedures used for allocation and management of equipment? f. Are there any barriers to the service or team development that you would like to highlight (for example, Communication, MDT working, Time Management, Leadership)?
3 **Patient safety** a. What arrangements are in place to ensure safe and effective care and treatment for children and young people referred to the service? i. Process for clinical assessment ii. Treatment and clinical interventions iii. Documentation and report writing b. How do you involve families in the care you provide? Are families/carers supported, involved, able to give advice and given knowledge of the best way to care for their child or young person c. How do you involve the children and young people, including those with developmental needs in their care? d. Can you share the arrangements for liaison with other services and agencies and vice versa?

Formative Review Questions
4 **Data and monitoring** a. What arrangements are in place for the teams to collect and monitor data? b. What arrangements are in place for managing caseload review and monitoring? i. Individual responsibilities ii. Service leadership iii. Trust-wide iv. Commissioning
5 **Service user feedback** a. Is there evidence of service user and carer feedback from families of people being cared for by the service? b. Is there evidence of actions taken as a result of feedback?

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