

How are Specialist Community Paediatric Team (SCPT) OT meeting the National Drivers set out for Occupational Therapy?

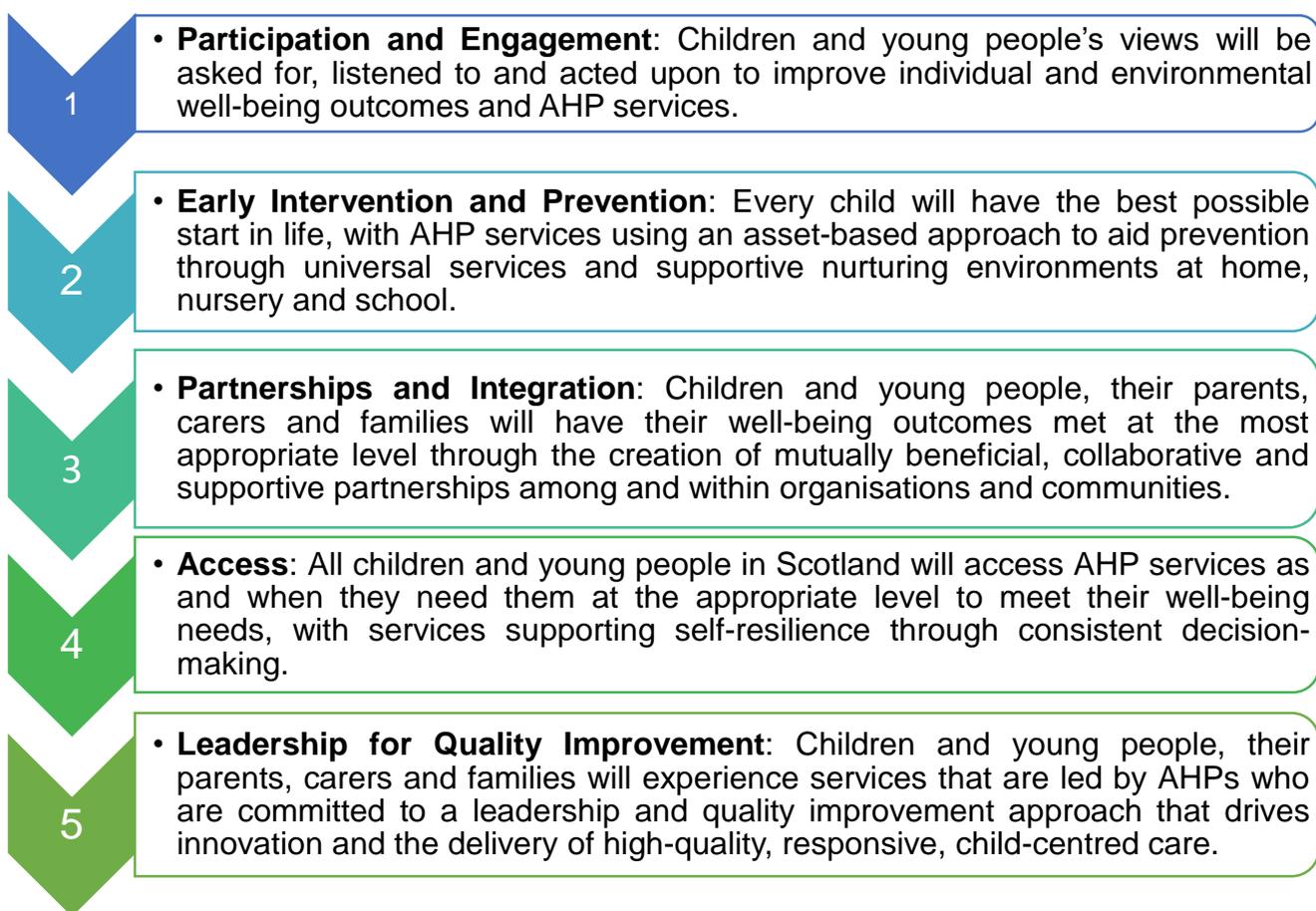


[Ready to Act](#) is the first Children and Young People's Services transformational plan in Scotland to focus on the support provided by Allied Health Professionals (AHP's). The plan describes the design and delivery of AHP services to meet well-being needs of children and Young people.

Ready to Act is underpinned by the

1. [Children and Young People \(Scotland\) Act 2014](#)
2. [Principles of Getting it Right for Every Child \(GIRFEC\)](#)
3. [United Nations Convention on the Rights of the Child.](#)

The Plan sets out **5 key ambitions** that focus on the importance of prevention and enablement and promotes 'least intrusive' interventions through a tiered model of service design and delivery directly linked to well-being outcomes.



Why use a Population-Based Approach?

The way to make the whole population as safe as possible is to ensure they are well informed and empowered to make good decisions about their health and well-being to prevent harm from happening (prevention). It is also important that everyone takes personal responsibility for their own health and well-being if they can. Public Health Scotland will provide education to the population on key messages that support health and wellness for example:

- 5 a day - eating 5 pieces of fruit and vegetables a day helps support a healthy diet.
- Exercise is good for you.
- How to detect early signs of stroke.
- Cardiopulmonary Resuscitation (CPR).
- Talk to your baby to help develop language and communication skills.
- Read to your child.
- Vaccinations.

Are some people more at risk than others in the population?

At a population level we can predict that some people are more at risk of developing illness and disease than others and therefore need more specific information than the general population. When we know this we can target specific information to these groups of people with the initial aim of supporting them to make different and better choices to stay healthy to be able to take responsibility to self-manage whilst having the knowledge and confidence of when to seek more specialist help. Examples of targeting specific groups within the population at a public health level:

- Stop smoking campaigns.
- Cot death.
- Be alert to the early signs of breast cancer.
- Flu vaccine for under 5's and elderly.
- Early signs of dementia.
- Parenting hints and tips.
- Pregnant mothers - folic acid, alcohol consumption, smoking cessation.

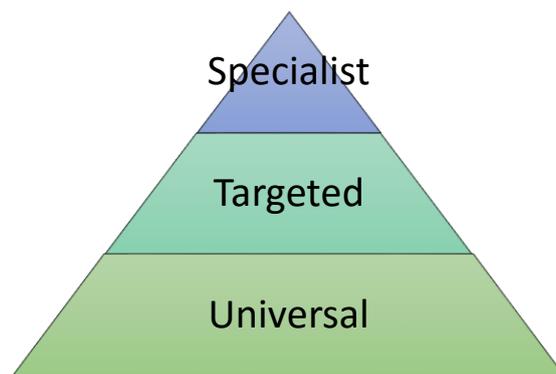
Can't everyone just get the same amount of help?



The NHS is free and equitable at the point of access - everyone is entitled to access the service, however not everyone has the same right to the level of input – the input you receive is based on your individual needs. Within the NHS we have a staged model of care that allows everyone to receive the right amount of care they need, at the right level, when they need it. For example everyone is able to go to A & E but you are triaged when on arrival and depending on the level of help you require you may be admitted to hospital, you may go to surgery, you may get stiches and go home – it is all based on your level of need.

What is a Tiered Model of Service Delivery?

The tiered model of service delivery directs our involvement with a family into three separate layers of service delivery. When we are considering how we are involved with families we have traditionally delivered in the third level - **Specialist**. This has meant waiting until the child and family's need have risen to such an extent that they must come to see an Occupational Therapist to receive the help they need. If we stick with this model we are always waiting for a child's needs to escalate to a certain threshold before we would help. It also means that regardless of need, all families must go through this same system to see an Occupational Therapist i.e. be referred. We are all aware, having met with parents and families, who have sat on a long waiting list, that the help they actually needed was a piece of advice or a strategy to try with their child and this could have been delivered more quickly and efficiently if there had been another route rather than referral (**specialist**) to see an Occupational Therapist. With a targeted model there is; you direct some of your Occupational Therapists to provide information and education at a **universal** and **targeted** level with the view that you are trying to prevent the child's needs escalating in the first place (prevention and early intervention) by skilling up education staff, health staff and parents/carers to be able to help and support the child.



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Further information on a tiered model of service delivery can be found within the [RCOT Fact Sheet - 'Occupational Therapy with Children and Young People'](#).

Universal

Universal services are for all children and young people. For Health this would be our G.P. surgeries, Health visiting services and district nurses. Within Education services this would be nursery placement from the age of 3 years and Primary and Secondary schooling. Offering a preventative approach and promoting well-being for children and young people and their families is an essential role for AHP's. The universal workforce are trained to a high level to support all of the population. We can support Universal services by providing information and literature that supports the population and keeps them safe and well-informed to make the best decision for themselves and their children. Education leaflets that up-skill the population is one way to achieve this. We can also input into activities and programmes organised by others to improve skills and confidence of the population and the universal workforce.

Targeted

The targeted input is focused towards a group of people or workforce that work directly with a specific group who have been identified as having greater well-being needs e.g. giving information to health visitors completing the 30 month check, Class Teacher wanting support with a group of children with reduced fine motor dexterity. The purpose of providing targeted intervention can be to change attitudes, environments and opportunities by providing programmes, training, education, advice and consultation to those working directly with the child to improve their overall outcomes and opportunities and prevent harm.

Specialist

The specialist level is for direct intervention, for those children whose needs cannot be met by universal or targeted help. The Occupational Therapist will work directly with the child and family setting specific goals that will be accomplished through an episode of care.

The Skill Mix used within a Tiered Model of Service Delivery

Like any team your aims and goals are the same and your interdependency on each other is essential to achieve them, with everyone performing different tasks and roles in order to achieve the aims and goals for the entire team.

When considering who should do what within a tiered model of service delivery the description below indicates the mix of staffing required at each stage.

Universal

- Universal delivery requires a skill mix of mostly Band 7's and 6's supported by Bands 5, 4 and 3 to gain experience.

Targeted

- Targeted delivery requires Band 8's and 7's in training the specialist workforce and offering complex consultation, complex clinical decision making and negotiation. Other training can be designed by the Band 7 staff and delivered with the Band 6 and 5 staff to gain experience. Band 3 and 4 can also support delivery.

Specialist

- Specialist delivery requires Band 3 - 6 delivering specialist interventions. Band 7 and Band 8 offering clinical support and second opinion.

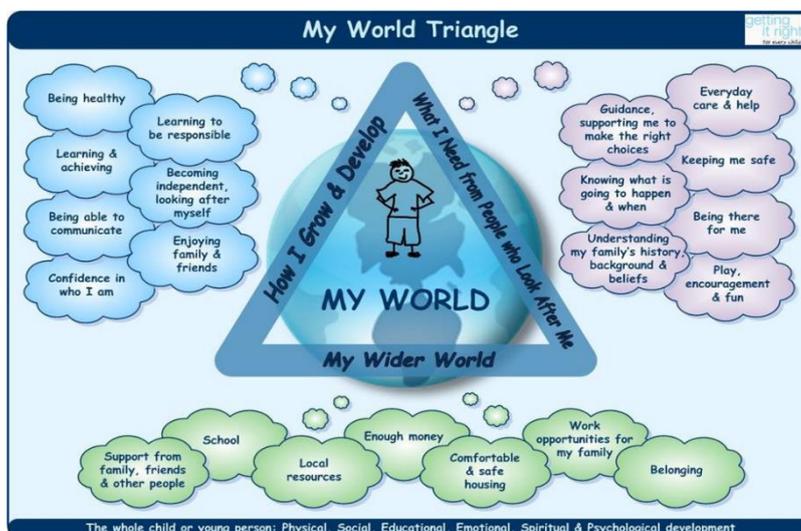
Why don't we target our resources to the people with the most severe conditions?

The severity or complexity of a condition does not correlate with the level of risk. Using severity of condition does not help us to do the most good and least harm. For example Professor Stephen Hawkins has a very severe medical condition that impacts on his movement and communication with an impact in all self-care, productivity and leisure occupations on a daily basis. However with the correct environmental adjustments (which an Occupational Therapist could recommend but that must be complied with by Stephen's family and carers), with the correct wheelchair for mobility and communication aid Professor Hawkins is achieving and resilient and does not require constant involvement from an Occupational Therapist – he does need to know when to seek help but the responsibility and empowerment for this action sits with him and not the Occupational Therapy service. We must consider that intervening when someone is not at risk can also cause harm by creating dependency and not promoting independence and resilience.

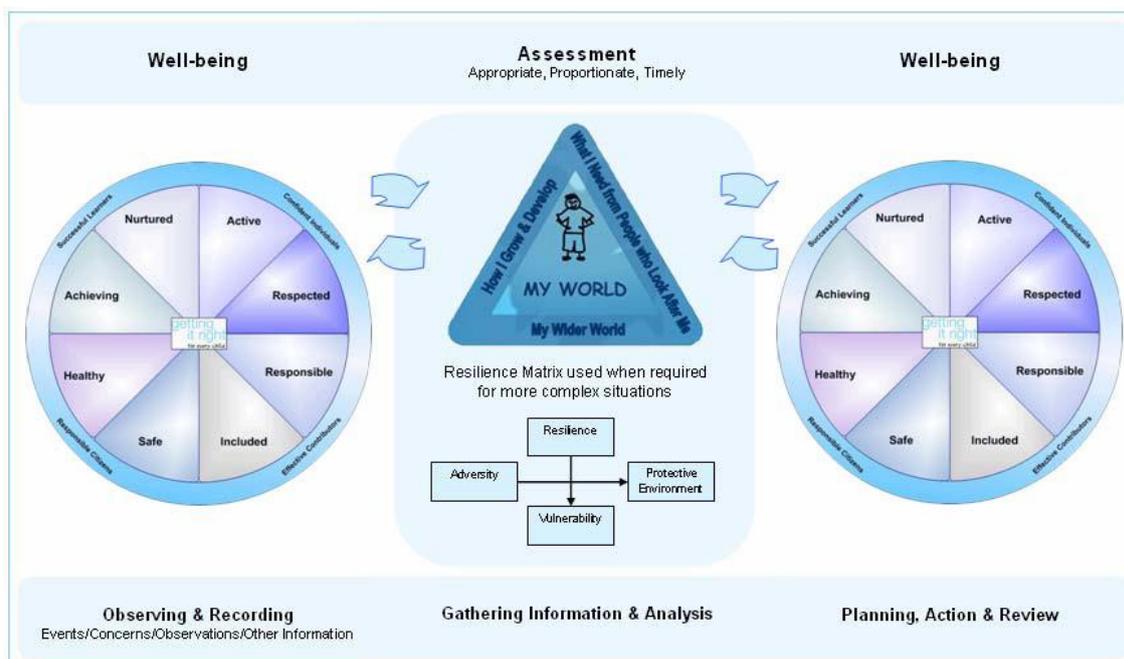
How do we deliver our services to ensure well-being and resilience are taken into account?

Within the legislation of the Children in Scotland Act children's needs are to be considered in terms of well-being, **there is no objective measure of well-being it is subjective and based on the individual's perspective.** The best people to tell you if they need help and have a well-being need is either the individual or the people closest to the individual.

My World Triangle allows you to consider the child's individual needs under three headings – how I grow and develop, what I need from the people who look after me and my wider world.



The GIRFEC **Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI)** indicators allow you to consider the 8 well-being components and to explore whether one area or more are being affected for the child at this moment in time.



The national practice model asks you to consider the SHANARRI indicators for that individual child with consideration of the child's wider world. Using the resilience matrix is helpful for analysing whether the child has sufficient resilience and a protective environment to ensure well-being can be restored or whether there is a vulnerability or something affecting the environment or another adversity which would be impacting on this child's well-being which requires action from the Occupational Therapy service.

It asks that each practitioner in contact with the child/young person and their family asks the 5 GIRFEC questions:

1. What is getting in the way of child/young person's wellbeing?
2. Do I have all the information I need to help this child/young person?
3. What can I do now to help this child/young person?
4. What can my agency do to help with child/young person?
5. What additional help, if any, may be needed from others?

What is Foreseeability of Harm?



Within the [Care Aims Model](#) the concept of 'harm' and 'foreseeability of harm' are key concepts that lie at the heart of the model but can be difficult concepts to gain an understanding of.

One concept is that 'foreseeability of harm is enabled by proximity of the relationship with the child/family'. So if we relate this back to our own experience – if we call NHS 24 for advice for our ill child, the operator will ask you a range of questions to help them determine the next course of action, as you are with your child and know them best your answers to 'is she eating normally?', 'is she sleepier than usual?' 'Has she had this rash before?' 'When did you notice her beginning to be un-well?' are taken much more seriously than if a stranger were answering these questions.

Another example would be if you were downstairs and someone was up-stairs and shouted 'the child is about to fall down the stairs' the adult at the top is in a much better position to predict foreseeability of harm - and do something about it- than you are.

A common example of a referral route is one from a G.P. that reads *"Please see this 10 year old boy, he presented at the surgery today with his mother, who had been advised by the school that they are concerned about his motor skills. His mother is not concerned as he plays football and rides his bike, on examination there was nothing exceptional to note."*

The person who was proximal enough to the child to see potential harm was the class teacher but instead of asking for help directly (through targeted consultation) has advised the mum to request a referral be made via the G.P.

The person requesting help must be able to deliver on the advice, strategy, change to environment etc... if this is the help that is needed.

Problem Centred Thinking v's Outcome Centred Thinking

Problems or functional difficulties are often the triggers for a referral request. You are usually being asked for help because the problem is associated with your profession, so for example for Occupational Therapy - a child has a hemiplegia and is not able to use both hands functionally. The referrer knows that this could cause harm now and in the future so send a referral to O.T. for assessment and advice for the child with hemiplegia who is not using their affected upper limb for functional tasks. This action can also raise anxiety in others - for example the child is aware he is being seen by medical professionals who are looking at the way he does things and suggesting he needs to see someone else who will help him move his hand better. The parents are worried something is wrong or has got worse or they have missed something of their child needs specialist help and they won't know how to help him until they have seen an OT.

If the OT stays in medical model/expert mode when they see the patient they will use their knowledge of upper limb neurology, tone management, knowledge on the use of botox, splinting and therapeutic interventions to focus on the problem - the affected upper limb is not being used functionally. This course of action will promote alignment, prevent deformity and keep range of movement. Therefore we do not ignore these problems - they still need to be addressed, however addressing only these problems will not necessarily result in an improvement in participation.

Will this Approach improve the Outcomes for this Child? Is there a different Approach?

As the professional you have access to in-depth knowledge of evidence based practice, local services and resources to help direct people to the most likely sources of help in as timely a way as possible **BUT** without the patient's story this judgement will always be limited to problem/condition-driven thinking and generalised. If you want to use a person-centred approach you must ask for the patient story first and then apply your expertise to their story. The professional has therefore to ask the right questions to get the story, listen to the answers they are being given, allowing the patient to lead, don't judge, don't assume, don't assess just listen.

The So What Questions

The so what questions help you get to the nub of the concern. We will expand on the example above about the boy with a hemiplegia. The following illustration is not an extract from a triage discussion but is used to illustrate the use of the so what line of questioning to get an outcome versus the problem-based approach.



Therapist - why have you come to see me today?

Parent - My child has a hemiplegia

Therapist - so what?

Parent - Well he can't use his left hand and arm

Therapist - so what?

Parent - Well he can't tie his laces or put on his clothes

Therapist - so what?

Parent - Well he can't play in the football team after school as he doesn't want any of the other boys to know he can't tie his laces and he can't go on a sleepover with his friends as he doesn't want to ask his friends mum to dress him in the morning so he is really left out at school and he is becoming quite withdrawn from his friends and I am worried, it's not like him.

Therapist - ah I see now how this is affecting you and your son and I know we can work together to make this better for you.

As you can see from this line of thinking we are now so much clearer about the child's and parental goals and motivation for therapy. We are therefore clearer of the impact this is having on the child's well-being. We can see that something is different for the child in terms of resilience and environment - as he is wanting to become more independent the environments he is to perform in are growing and changing and he is not as confident these environments and people will be as protective and nurturing to him, he is losing confidence in his skills and hope that his skills could develop in the future, he is withdrawing from challenging situations. The parent is proximal enough to her son to see the harm and the foreseeable harm in the future, if this is not addressed, and is also the right person to assist in changing the environment and helping to build up skills.

What is your Duty of Care at each step of the Patient's Journey?

As a qualified health practitioner working in a public service, the broad ethical, legal, professional and employment requirements governing your practice mean that your duty is:

Pre-Referral (Universal and Targeted)

To work to prevent harm occurring as a result of impairment, disease, delay or deprivation in the population by working collaboratively at Universal and targeted levels to:

- a. Promote health and educate/support the public to self-help;
- b. Target vulnerable populations and educate them to manage their own risk;
- c. Support other professionals to manage risk by giving them skills in identification of risk and information about desirable action;
- d. Support commissioners to make sound decisions about use of public funds;
- e. Ensure that your services are as accessible as they can be to the whole population.

Referral (Request for Support to Specialist Services)

Once potential harm to an individual has been identified and not managed effectively at universal and targeted, to respond as quickly as possible, by looking for evidence of any harm or future harm that is unlikely to be managed at universal and targeted levels. During the triage process, you will make a judgement about whether it would be appropriate for you to investigate further by accepting the referral, or to signpost the referrer to other possible sources of help available and support them in carrying out their duty of care where possible through consultation, education and information.

Triage is based on the following guidelines:



- Functional ability (level of disability resulting from the problem).
- Impact of the disability on daily life and the burden of care on the carers/educators.
- Impact of the environment (s) on the client's ability to live their chosen life.
- Level of **anxiety and insight** shown by client/carers/educators/others.
- Timing - evidence available that suggests delaying care has an impact on the outcome.

Assessment (Specialist Services - Duty to Assess)

During the assessment you will be identifying what the current concerns are and the impact they are having for the child and family at this time, you will also be considering their goals, risk and perception of risk, context and support and relating these to the service you could deliver for them, you may identify a risk that cannot be met by your service and in this instance you would convey this to the child, family and referrer. Good practice would encourage engagement and collaboration with anyone else who has a duty to this client and try to develop a joint formulation (with the client, if possible) of what combination of interventions will most successfully result in change and reduction of the client's risk.

Once you have enough information from the assessment you would be able to decide whether the child requires direct intervention at a specialist level from OT or whether Occupational therapy cannot help at this time and provide targeted interventions such as signposting, education, literature, and programme/strategy.

Admission to Level 3 of the service is based on the following guidelines:

- Motivation - the clients (or carer's) likely engagement in and responsibility for treatment.
- Likely outcome - the evidence for, or previous response to treatment indicating, a good prognosis.
- Stability of the condition/situation (in relation to the likely effectiveness of care).
- Level of help the client is already receiving from other services, and the client's response to this (in relation to prognosis).

Intervention (Specialist Service)

Each Care Aim explains clarifies why the clinician is intervening at this stage, and requires the clinician to (helps to) identify the predicted outcome and to set short term goals with the child/young person/family i.e. what will life look like when goal is achieved?

At the end of each episode, the effectiveness of therapy can be measured, according to the Care Aim used, the predicted outcome of goal set against the baseline taken at the start.

Involvement with many clients requires more than one episode and thus a Care Pathway is described in terms of episodes, care aims and clinical outcomes.

Discharge (Specialist Transition)

To safely discharge the client from your care by:

- Preparing them/their carers for discharge.
- Clearly communicating your reasons for discharge to everyone involved.
- Handing any residual risks over safely to the client, carer, referrer or another responsible person e.g. the GP and signposting them to relevant self-help resources.
- Clarifying routes back to you and circumstances when this might be appropriate.
- Offering consultancy support to Universal and Targeted services, if needed, during the handover period.

Post-Discharge (Universal and targeted)

To reflect on the outcome of the care offered and, if appropriate, make/suggest any adjustments to practice/policy/procedure that are implied by the outcome.

Effective Referral Conversations

In line with this reasoning, we are developing a more effective way of ensuring that the correct children get the correct help from our service at the correct time. This is via First Contact appointments. A First Contact appointment will take place within 6 weeks of referral being received. The function of this one off triage type appointment allows us to have a face to face discussion with the person who is most concerned and most able to put support actions/changes in place for the child – what in care aims we would call ‘the agent of change’ or ‘primary requestee’. This primarily would be a parent/guardian however where the concern is raised by school, it would be a positive experience to ensure they are allowed to share their reasoning for requiring our help.



Why have a conversation when we have a referral form completed?

Often referrals received are problem driven and from paper referral we can try to assume the impact for the child/young person on their everyday functioning. This then allows us to make decisions for the family. However, we know from evidence that resilience and well-being have a greater impact on how a child/young person/family deals with a problem. Our expert knowledge is important to predict foreseeability of harm and much more powerful when married together with the patient’s story to hear exactly how the problem/condition is impacting on this child/young person in their life right now and for their future. This then allows the child/young person/family to make decisions about how we can help to support greater well-being.

First Contact also allows us to quickly give support to the child/young person by identifying if they have a need that Occupational Therapy can support, what they can do while they wait for the specialist support or who else can help them if it is not us.

Appendix

Specialist Children's Services (SCS) Occupational Therapy Services Referral Criteria



We operate an open referral system which allows parents/carers and all professionals to access our service to ask for help.

Occupational therapy is needed when established support is in place and the child/young person (aged 0-18 or 19yrs if still attending secondary school or special education) continues to experience issues with their occupations.

Occupations for children/young people are:

Self-care: developing the ability to look after yourself in areas such as dressing, personal care, and mealtimes and accessing your community.



Education: learning and being productive is vital to give yourself a sense of purpose, such as school work, life skills, break time and play, moving between activities.



Play and Leisure: having fun is extremely important, it is through play that learning happens and friendships are formed.



In partnership with the child/young person and the team around them strategies for participation will be explored, for example: changing the way a task is done, modifications to the environment, recommending or providing equipment, teaching the child/young person, parents or staff new techniques and/or developing the child/young person's skills and/or abilities.

How Occupational Therapy is provided

Occupational Therapists working at a universal level understand the importance of early intervention and prevention to promote the well-being of all children and young people. Working at a universal level we will provide information and literature, be involved in activities and programmes organised by others to improve skills and confidence, working with partners to increase participation and support the nurturing environment.

Targeting our support to groups of parents and professionals who work directly with children/young people with potentially greater well-being needs is the effective way to deliver training, programmes, strategies, environmental changes that support these children/young people all day every day.

Some children require individualised occupational therapy at certain times in their lives. This is provided in episodes of goal focused care with the ultimate outcome of promoting self-reliance and resilience.