The Highland Council

Education, Children and Adult Services Committee
8 October 2015

Agenda Item	10.
Report No	ECAS 85/15

Allied Health Professional Services

Report by Director of Care and Learning

Summary

This report updates on the progress being made to the reporting of waiting times data; and provides additional context around the work of allied health professions within Highland Council.

1. Background

1.1 Highland Council employs staff from four allied health professions: Occupational Therapy (OT); Physiotherapy; Speech and Language Therapy (SLT) and Dietetics.

1.2 This report provides some examples of AHP developments that have taken place since integration to improve the outcomes for children through universal, targeted and specialist intervention, introduces the data around service waits experienced by children; and outlines our approach to vacancy management, including proposals to decrease gaps in service provision.

2 Universal, Targeted and Specialist Intervention

2.1 The work of allied health professions to support children and young people include a range of options commonly referred to as **universal**, **targeted** and **specialist** support roles.

2.2 **Universal** work is more general and appropriate for all children irrespective of need/level with a positive impact on whole population/group. Work at this level has been limited in previous years, due to challenges releasing AHP capacity from direct therapy intervention. However, this work is critical to prevention of future difficulties for some children and in supporting all children to reach their potential. Some examples of universal work now implemented and under way in Highland, are set out below.

2.3 One of the Dietitians has continued to build on the help to Highland schools to improve their approach to food, with a view to its impact on mood, behaviour and learning. This approach to food includes both food provision and curriculum based learning.

2.4 Key themes of this work include:

- The development of critical consumer skills
- A progression and inclusive approach to “healthy weight” and “Size acceptance”
- A focus on knowledge, skills and attitudes
- Mapping and reforming the food environment
- Awareness of how food affects mood and learning

2.5 Policy guidance and around 40 lesson plans have been developed, piloted and evaluated. Some of these provided the core of the Primary “High 5” programme that around 100 schools have taken part in involving thousands of children in an 8 session programme. More recently, S1 to S3 resources for “BGE” have been developed and some of these are already being piloted. A board game on Food, Mood and Health has also been piloted with Highland pupils and is about to go to full production.

2.6 Food, mood and behaviour seminars, twilight “High 5” CPD sessions, in service training for specialist teachers, and a School meals stakeholder group, are all in place to help deliver this work.

2.7 AHPs (OT, SLT and physiotherapy) have been working as part of a team to develop simple guidance to be used alongside the developmental overviews in pre-school settings, enabling staff and parents to support children to achieve their expected developmental milestones (identified through the use of the overview). The vision is that this information will also be accessible as online resources for anyone to download to support a self-management approach, where appropriate, for children, young people, and their families. The resources will be increased over time to provide guidance around common concerns for older children which will also be accessible to education.

2.8 ‘Before Words’ supports the development of interactions between parents and their baby in order to build a positive relationship and promote learning. SLT works with midwifes, foetal scanning staff, early years practitioners, health visitors, nursery staff, child-minders and all those that work with babies and young children. SLT trains and supports them in giving verbal and cartoon based information to all parents during pregnancy and after the baby is born.

2.9 Evaluation from pregnant mums shows that if they had received the intervention, they were nearly **four** times more likely to talk to their babies, **five** times more likely to use a tuneful and interesting voice when talking to their babies, **five** times more likely to dedicate quiet time to talk with their baby, and **three** times more likely to sing or play music especially for their baby.

2.10 Evaluation from parents of babies aged 6-12 months is presently being carried out. ‘Words up’ follows on from this to support and train staff to use key messages to further encourage good communication when children are between the ages of 1-5 years.

2.11 SLT and OT have also been key members of the Highland Emerging Literacy Group. Literacy learning has 4 key primary drivers: concepts of print, oral language, phonological awareness and motor/perception skills. Their knowledge about child development around the last 3 of these was essential in creating a set of developmental continuums for education staff to use as a baseline for assessment and lesson planning. These are easily accessed via the Highland Literacy Website. The group now plan to build an online bank of examples of good practise.

2.12 The **Targeted** role enables an identified factor in health inequality to be tackled and does not necessarily require a referral to an AHP service. Examples of targeted work that has been developed/in development are set out below.

2.13 The delivery of Active Listening for Active Learning programme is being tested

using improvement methodology by SLT working with teachers. This improves children's ability to actively participate in the learning experience. Children are helped to recognise the importance of clear two way communication and to use compensatory strategies, such as peer support and active listening, when the communication breaks down and they don't understand or are misunderstood. Teachers are helped to identify children with communication difficulties and provide an environment where mistakes are part of the process of learning and where children can ask for support. Specific activities are done with targeted children, and teachers use strategies with the whole class.

2.14 Cerebral palsy hip screening (CPIPS) is an evidenced based surveillance programme for children with Cerebral Palsy (CP). The main goal of CPIPS is to prevent hip dislocation and severe contractures by early identification of these problems, enabling timely intervention. The programme also aims to encourage collaborative working between the child, their family and the clinical team. The service commenced on 06/01/14. All children with CP are offered an annual review carried out by a physiotherapist.

2.15 Outcomes include:

- Reduced pressure on Orthopaedic Consultant services as only those children identified by the CPIPS assessment as needing orthopaedic input need to be seen in the combined clinic, therefore children can be seen more quickly.
- Early identification of any problems through a robust assessment allows for early preventative intervention and minimises the risk for major surgery.
- There is equity of service for all children with CP in Highland with all children being seen as locally as possible.
- Consistent approach to assessments across Highland.
- Any change in management indicated by the assessment can be discussed at the CPIPS clinic with the parents.
- Sharing of learning takes place throughout the team and the co-ordinator is able to train and support the rest of the team/new staff.
- Prior to the implementation of CPIPs these children would only be seen by physiotherapy if there was a concern identified. This new service was delivered through redesign of the service.

2.16 Based on evidence there are a number of opportunities for increased targeted work, where AHP knowledge and skills could potentially improve outcomes for children. Some examples include:

- SLT assessment for every looked after child as evidence supports these children are in a high risk category for speech, language and communication problems
- AHPs working with communities in areas of deprivation to develop community resilience around supporting children to reach their normal developmental milestones, and to improve education attainment
- Targeted work with gypsy travellers

2.17 The **Specialist** role of an allied health professional is where a specific intervention is required and an individual young person is referred to a particular service for assessment and intervention as required.

2.18 All services are experiencing increasing demand and the majority of children still require specialist intervention due to the increasing complexity of need. For example, the dietetic service identified that referrals for feeding difficulties for formula fed infants were often delayed. Frequently these problems were caused by cow's milk protein intolerance. Dietetics worked collaboratively with an advanced paediatric nurse practitioner to set up an infant feeding clinic in March

2014, running every two weeks and enabling quick access to advice and support to parents, and reducing demand on GP services.

2.19 By July 2015, 145 infants with feeding difficulties had been seen in the clinic, an estimated 5% of births expected in that period of time. Since setting up the clinic the dietetic service has seen a 20% increase in referrals across the team adding pressure to the sustainability of new initiatives such as this in service delivery.

2.20 For some teams, achieving the 18 weeks RTT has meant high caseload numbers (in excess of 100 children on the caseload of 1wte practitioner are common in the South and Mid area mainstream SLT team). The impact of this is that the children are not seen as often as we would want for therapy intervention; others working with the child are not as well supported as we would wish; and ultimately, children stay on the caseload longer than they should because of the increased time taken to achieve their therapy goals.

2.21 In order to manage the demand for services, AHPs are identifying areas of work that will support others to identify when a service is required, thus reducing the number of inappropriate requests.

2.22 One example is that Physiotherapy wanted to ensure all children who in-toe were appropriately referred and ensure that those children who in-toed but had no other movement difficulties were not unnecessarily referred (this can be a normal part of development for some children). The team developed a pathway for managing referrals to physiotherapy for children who in-toe. GP's, Health Visitors and other Health Professionals have been asked to undertake a simple screening tool from which there is clear guidance on whether it is necessary to refer the child or not, and if so, whether the referral needs to go to physiotherapy or orthopaedics. They developed a standard leaflet to provide advice. Health Visitors received training at the Health Visitor forum in September 2014. Feedback from the Health Visitors Forum in April 2015 was that they felt more confident in their ability to advise and reassure parents.

2.23 In order to ensure that we understand the impact of any changes in service delivery around how the children/parents experience the service, all AHPs have implemented the paediatric care measure. Each AHP will be provided with an individual report of the feedback received about them and this will be discussed as part of the PDP process, with any actions identified being part of this process. Examples of the measure are attached as **Appendix 1**.

3. Waiting Times Data

3.1 All allied health profession (AHP) services use the NHS Highland AHP activity and waiting time's system to capture waiting times data. The NHS Highland service planning department have been working with the services to be able to pull data from the system and provide regular reports regarding each profession's performance.

3.2 AHPs are agents of change in health and social care. *The National Delivery Plan for the Allied Health Professions in Scotland, 2012-2015* sets out the recommendation for the delivery of AHP waiting times within 18 weeks from referral to treatment (RTT) with a target of 90% by December 2014. This is a key performance measure and is included in *For Highland's Children 4*. The methodology used by service planning to calculate this percentage is consistent

with that being used for NHS Highland AHP services.

3.3 The way that the data is inputted is being changed, to enable service planning to consistently provide quarterly reports around waiting times and percentage compliance against the target going forward.

3.4 The following tables introduce detailed waiting times data for each allied health profession. There is still some work to do around stratification, as currently the weeks 17-20 are included in one column, and in order to show data more accurately it would better to have a column that captures up to 18 weeks.

3.5 Data for the following reports was extracted on 20/08/15.

Table 1: number of children waiting for each profession stratified by 4 week periods

Service	0-4 weeks	5-8 weeks	9-12 weeks	13-16 weeks	17-20 weeks	21-24 weeks	25-28 weeks	29-52 weeks	Total
Dietetics	14	14	7		2				37
OT	7	10	6	9	2	5	7		46
Physiotherapy	12	8	3						23
SLT	14	38	41	29	12	14	9	14	171
Total	**47**	**70**	**57**	**38**	**16**	**19**	**16**	**14**	**277**

(NB: longest wait: 38 weeks for SLT)

Table 2: 18 week percentage compliance

Service	Number on List	No <18 wks	% <18 wks
Dietetics	37	37	100%
OT	46	33	72%
Physio	23	23	100%
SLT	171	130	76%
Total	**277**	**223**	**81%**

3.6 It should be noted that the data for OT is combined data and includes all children waiting for equipment, adaptations or therapy provision due to the integration of the health and social care OT team for children. Waiting times for equipment and adaptations (previously social care OT) are not currently included in the 18 weeks RTT target of the national delivery plan, and therefore will not be included in any other national data if this becomes available.

3.7 The data for SLT excludes those children awaiting SLT assessment as part of the Consultant paediatrician led locality assessment process for autism spectrum disorder. Indicative SLT reports for these children indicate that there are 41 children waiting with the longest wait at 38 weeks.

3.8 Further analysis of the SLT data included in the above table has shown that all of the children waiting longer than 18 weeks are waiting for additional support needs SLT service in South and Mid areas.

3.9 OT and SLT are the two professions that continue to have challenges in meeting the target. However it should be noted that OT has implemented a number of process changes that have shown steady improvement in their performance

towards meeting the 18 weeks target

3.10 These actions are based on demand, capacity, activity and queue theory and include:

- Implement single point of access (reducing the number of waiting lists);
- Implement triage consultation (telephone call) that promotes early discussion with those requesting help (parents, education staff, health professionals); identifies if occupational therapy or another service is required; and supports commencement of self-management activity whilst waiting face to face assessment through service developed advice leaflets. Often taking place within 2 weeks of the request being raised;
- Implement single caseload allocation process that increases allocations taken from the back of the queue (clear and equitable prioritisation of urgent cases based on impact on the child);
- Develop and implement a practitioner caseload management tool that identifies the fte workforce required per caseload, evidences clinical decision making around intensity of intervention, objectively supports discharge decision making.

3.11 At the end of June 2014 there were 149 children waiting for the integrated occupational therapy (OT) service (equipment, adaptations and therapy provision) with the longest wait at 52 weeks. By end of August 2015, there were 31 children waiting with the longest wait at 28 weeks (27 children within the 18 weeks target and 3 outwith).

3.12 The triage consultation will be formally evaluated for impact in the coming months but informal feedback received from parents and others asking for assistance has been very positive. Although face to face assessment is still taking longer than we would want, often families and those around the child are either being reassured they are doing the right things; and empowered to use the advice leaflets to commence activities that will support the child. Feedback from therapy staff is that this then improves the quality of information available at assessment and enables more specific intervention earlier in the assessment process than before.

3.13 The triage consultation does not constitute the commencement of treatment and therefore does not impact on the waiting times calculated for a child.

3.14 SLT is currently moving forward to implement all of the above processes to support improvement in the percentage compliance with the target. Early feedback is, once again, that parents are extremely positive about the telephone consultation so soon after the request for assistance has been raised.

3.15 Some NHS Board areas have been successful in achieving shorter waits for children. However, analysis of the service models demonstrate that there is: little focus on improvement activity at a universal level around prevention of future difficulty; services are streamlined to become entirely clinic based, regardless of whether clinic facilities are required, with families travelling to the nearest location; often there is little work taking place within the pre-school/school setting to support people working with the child.

3.16 In Highland, AHPs have tried to balance the demands of developing the services across universal and targeted intervention as these provide long term opportunities for prevention and early intervention. Service delivery often takes place where the child is e.g. at home, in pre-school setting or at school as this provides greater

opportunity to support those working with the child and to build on their skills in order to gain the greatest benefit for the child (this way of working has the strongest evidence base for delivering the best outcomes). In the short term these are less efficient ways of working with regards to waiting times; but over time should lead to more efficiency as skills and knowledge are shared across a range of professionals and are then transferrable when working with other children experiencing similar difficulties.

3.17 Use of technology may provide additional opportunities around service provision – there are a growing range of apps for therapy services that can support anything from speech, language and communication to gait analysis. The ability to securely "facetime" with a child provides the potential to deliver some speech and language therapy remotely; and could support clinical decision making through access to expert advice.

4. Vacancy Management

4.1 The underspend on AHP services in the 2014/15 year-end financial reports has come under scrutiny. The under spend is attributable to vacancies – retirements and resignations. People leaving employment have identified personal/family reasons for leaving, and all have reported high satisfaction with their posts in Highland.

4.2 Analysis of recruitment to posts over the past year has identified a number of contributory factors:

- Several posts have been redesigned within establishment to ensure maximum impact on service delivery, resulting in delay in commencing recruitment whilst scrutiny approval is sought.
- A number of posts have been successfully recruited to internally, providing promotional opportunities for staff; but this inevitably leads to teams carrying a vacancy over several months (9 months for one team following promotion of an internal candidate to band 7; recruitment internally to the vacancy created at band 6; and recruitment externally to the vacancy created at band 5).
- Part–time staff are always offered additional hours to provide additional capacity, but the hours they are available do not cover near the number of vacant hours.
- Agency staff have been sought but without success, with most agency workers expressing a preference to be within easy reach of major cities.
- AHPs in Highland are small in number, and there is a lack of a casual workforce (bank staff) available locally.
- There is a minimum of a 3 months gap in service for every vacancy based on the best case scenario for recruitment: like for like replacement; advertised on receipt of resignation; interviews carried out within two weeks of closing date; all paperwork for PVG filled in correctly; PVG checks and references returned quickly; formal offer sent on receipt of clearance; one month notice period before commencement of new post. One worst case scenario, including a three month notice period and some delays in these processes, caused one like-for-like replacement to take 8 months to commencement in post.

4.3 Over the last 6 months of 2014/15, a perpetual advert ran on MyjobScotland and the SHOW website, inviting people with AHP qualifications (along with health visitors and school nurses) who were interested in moving to Highland to get in touch to discuss upcoming job opportunities. This led to the successful recruitment to vacant posts in Skye and Lochaber. All vacant posts have been successfully

recruited to apart from an SLT post in Caithness. This post has been vacant since the end of May and has been advertised with no interest to date. Advertising has included: websites; UK professional journal; and the use of social media.

4.4 The underspend will be a continuing trend in 2015/16, although a number of part-time staff continue to do additional hours and the Council is funding NHS Highland to provide a member of staff to provide an regular visiting SLT clinic in Caithness.

4.5 In anticipation of difficulty in recruitment, some NHS Boards have previously implemented prospective recruitment for AHPs. This means advertising and recruiting to additional posts (above establishment) to enable a "buffer" for service delivery and the ability to flex the staff resource to cover any type of gap – vacancy/maternity leave/long term sick leave, thus reducing the impact on service users.

4.6 Whilst the above approach inevitably has risks, evidence over the last few years would indicate that this may provide a more sustainable solution, with regular review to identify the continued capacity required to maintain service delivery. In the event that the vacancies begin to stabilise future vacancies would be deleted to bring staffing within establishment.

4.7 This approach would help to maintain a more stable service delivery but would not address areas for further development or the growing demand on services.

4.8 Establishment (fte) for each service is attached as **Appendix 2** for information. This demonstrates that for relatively small services the impact of a vacancy can lead to a 50% loss of capacity in some areas.

5. Implications

5.1 **Resources and legal** There may be future resource implications, due to increasing demand on service delivery. It is possible that legal challenges may be made under the Children and Young People (Scotland) Act 2014 around impacts on a child's wellbeing due to delays in responding to a request and/or delays in capacity to deliver outcomes in reasonable timescales.

5.2 Delays in recruitment and long term vacancies are an **equality** and service delivery **risk** across Highland, creating a potential for greater impact on **rural** communities where staff numbers are small.

5.3 There are no **climate change/carbon clever** or **Gaelic** implications

6 Recommendation

6.1 Members are asked to note and comment on the information provided in relation to Allied Health Professions.

Designation: Director of Care and Learning

Date: 28 September 2015

Author: Claire Wood, Principal Allied Health Professions

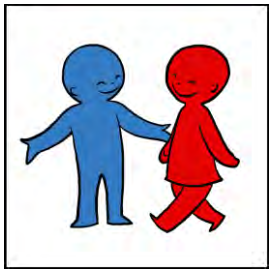
Name of therapist _____

PCM 10Q Parent

TalkingMats NHS SCOTLAND

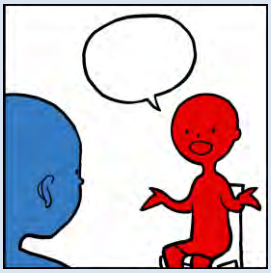
Please **tick, circle or mark** the scale.

How was the therapist at…



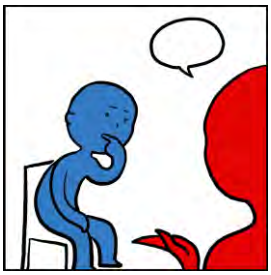
1… making you and your child feel at ease?

(being friendly and warm)



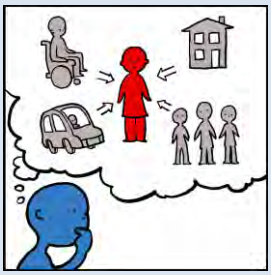
2… letting you tell your child's 'story'?

(giving you time to fully describe things in your own words)



3… really listening?

(playing close attention to what you and your child are saying)

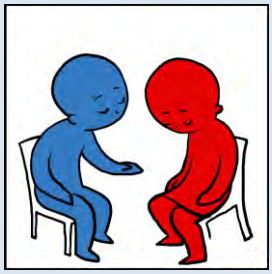


4… being interested in your child as a whole person?

(asking/knowing relevant details about their life, their situation)

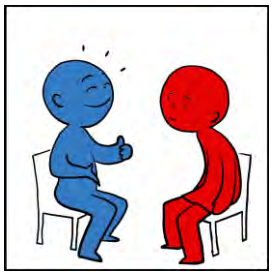
5... fully understanding your concerns?

(communicating that s/he had accurately understood your child's problems)



6… showing care and compassion?

(seeming genuinely concerned)



7… being positive?

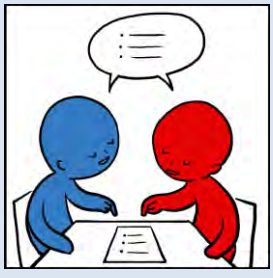
(having a positive approach and positive attitude)

8… explaining things clearly?

(fully answering your questions, giving you enough information)

9… helping you to take control?

(exploring with you what you can do to improve your child's health yourself)



10… making a plan of action?

(discussing the options, involving you as much as you want)

If you would like to explain any of your responses, please use this space or overleaf.

Appendix 2

Highland Council Allied Health Professions Workforce Information

Profession		fte
Speech and language therapy	South and Mid Mainstream	10.13
	South and Mid ASN	9.89
	North and West	15.67
Occupational Therapy	All Highland	12.29
Physiotherapy	All Highland	7.78
Dietetics	All Highland	4.95

NB FTE figures above are inclusive of qualified and clinical support worker staff

Additional Notes

Speech and language therapy

The South and Mid teams provide services for children only and are split into the specialisms of mainstream services (e.g. specific language impairment, dysfluency, language delay) and additional support needs (e.g. ASD, learning disability).

The North and West team have bases within Caithness, Sutherland, Skye and Lochalsh, and Lochaber and delivers the children's mainstream and ASD service along with the service provision to adults.

Occupational Therapy

Team members have bases within Caithness, Sutherland, Inverness and Lochaber delivering the service across equipment, adaptations and therapy throughout Highland.

Physiotherapy

Team members are based in Caithness, Lochaber and Inverness delivering the service throughout Highland.

Dietetics

- 3.95fte deliver a service to all Highland's children from Raigmore hospital. They provide acute and specialist care for inpatients and outpatients providing the direct children's service for South and Mid and supporting North and West NHS Highland colleagues to provide local services to children across this area.
- 1fte is based at the Pines with 50% of the post delivering clinical care to children with ASD/ADHD and 50% supporting the health improvement/prevention agenda.