2007 Information to guide good practice for physiotherapists working with children
Foreword

All babies, children and young people are important. They each have their own unique personality and potential. They deserve the best possible care and nurture to support their health and development.

Physiotherapists who work with children are specialist practitioners who have the right skills and specific knowledge to deliver appropriate care and educate and to encourage family involvement.

Paediatric physiotherapists should have an understanding of:
- child development
- childhood diseases and conditions that may impact on development and wellbeing
- therapeutic interventions that enable and optimise development and wellbeing
- the need to place the child at the centre of planning
- the impact that having a disabled child or a child who is sick has on family life
- how to keep children safe
- how to ensure that children and young people make choices
- how to develop their own skills and practice
- how to develop services in line with the Government guidance committed to improving quality and life chances for children.

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Introduction

What is the purpose of this booklet?

This booklet provides guidance on good practice for physiotherapists working with children. It is designed to help address the breadth of wellbeing of children, especially those who may be positively affected by paediatric physiotherapy.

It acts as a signpost to UK government policy and guidance, highlighting those which impact on paediatric physiotherapy practice and shares a list of contact details for a wide variety of information, services and activities that may be helpful for children and young people.

It is intended that this booklet and the forthcoming document on ‘Competences to deliver services for children and young people who require physiotherapy services’ (to be published in 2008) will help and support clinicians working within paediatric physiotherapy services as well as those commissioning, developing and delivering services for children to ensure that children and young people receive a high standard of care.

Who is this for?

• managers of children’s services
• managers and clinical leads for paediatric therapy services
• managers of paediatric physiotherapy services
• clinicians working in paediatric physiotherapy
• those commissioning services for children and young people
• parents and carers.

How to use this guide

The booklet is divided into five sections:

• Each section has a number of headings relating to its content and identified with the relevant page numbers. For the most part, the references are included at the end, however, for some areas, particularly around the legal and consent headings, additional references and reading are located in the section
• Section 4 relates to children’s services within England, Northern Ireland, Scotland and Wales. Each country has a dedicated chapter, which outlines its Children’s strategy, child legislation, key policy papers, CSP information papers and implementation tools
• The word ‘children’ relates to babies, children and young people
• The word ‘families’ relates to parents, carers and members of the extended families.

The content of this guide is current at the time of going to press, recognising that practice and legislation evolve. The resource may be accessed via The Chartered Society of Physiotherapy’s (CSP) website www.csp.org.uk linked to the Association of Paediatric Chartered Physiotherapist’s (APCP) website www.apcp.org.uk where it will be updated regularly.
Introduction

The information collated within the booklet is not exhaustive; it is intended to be used as a resource and a guide and not as a definitive document.

Links to relevant websites are included in order to access current information.

Supporting Information

The booklet is intended to be read and used in conjunction with additional published information from the CSP and the APCP, which is available from the CSP on 020 7306 6666 or www.csp.org/publications, or through membership to the profession’s clinical interest group, APCP, at http://www.apcp.org.uk/.

In particular, the guide supports and references the Health Professions Council (HPC) Standards of Proficiency(1), the CSP Rules of Professional Conduct(2), CSP Core Standards of Physiotherapy Practice(3) and the APCP Good Practice Guidance(4).

Building a business case

The CSP publication Making the Business Case for Physiotherapy(5) provides support in understanding the modernisation issues in healthcare, factors influencing what commissioners need to purchase and developing the business case in order to win contracts to provide a physiotherapy service.
1. Physiotherapy as a profession

What is physiotherapy?

Physiotherapy is an allied health care profession which promotes the health and wellbeing of all. Physiotherapy is a science based profession, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. Physiotherapists are autonomous practitioners, responsible for the assessment and interpretation of investigations to provide expert, holistic physical rehabilitation to those who require such intervention because of accident, injury, ageing, disease or disability. They also use their strong educational skills to teach, empower and promote physical wellbeing and independence by maximising individuals’ potential.

What is paediatric physiotherapy?

Physiotherapists working with children and young people bring their generic skills as physiotherapists. They may have to cover a wide range of conditions from respiratory, neurology and musculoskeletal in differing environments and must be able to demonstrate competence in all areas in which they practise. They recognise that children and young people are not adults and that as practitioners working in this specialist field they should have additional skills and knowledge around:

- holistic child development
- anatomy, physiology, neurological and psychological development from new born to adulthood
- the recognition of the ages and stages from infancy through transitions to adult life
- a range of child specific medical conditions and disability and the impact they have on participation and wellbeing
- the ability to recognise atypical development and assess, identify, clinically diagnose and offer a range of interventions and options using their clinical judgement and experience
- the understanding of the importance of working in partnership with the children and their families to help them gain an understanding of their situation, teaching and empowering them so that they are able to maximise their abilities and life opportunities
- the understanding of the possibility for involvement over a prolonged period if a child has a long term condition for which physiotherapy intervention could be beneficial
- the ability to provide an advocacy and educational role in partnership with the child or young person as they progress through key stages of development, engaging with others to ensure consistent optimum outcomes.

Paediatric physiotherapists have a duty to maintain their clinical reasoning skills and up to date knowledge within their specific area of practice to ensure that interventions are appropriate and effective. Continuing professional development (CPD) to increase specialist knowledge, skill and experience can be gained through clinical working with children, attending specialist courses, reviewing the evidence base, reflecting on practice and undertaking research and is a ‘life long’ experience for all physiotherapists.
2. Physiotherapy practice

Developing competence to practise safely helps to ensure consistent quality standards of care and delivery of services for babies, children and young people throughout the United Kingdom.

Relevant organisations
Chartered Society of Physiotherapy
Tel: 020 7306 6666
www.csp.org.uk

The Chartered Society of Physiotherapy is the professional, educational and trade union body for 49,000 chartered physiotherapists, physiotherapy students and assistants in the UK. It aims to support its members and help them provide the highest standards of patient care.

Rules of professional conduct and standards of Physiotherapy Practice (2, 3) set high standards for CSP members’ practice and conduct. Broader activity around the following supports members in meeting these:
• Qualifying and post-qualifying education
• Professionalism and competence
• CPD and career development
• Research, evidence-based practice and clinical effectiveness
• Professional networking and peer support (face-to-face and virtual).

The Society is a member-led organisation, governed by the CSP Council. This is made up of elected CSP members and is supported by a system of boards, branches, committees and groups. The CSP provides a wide range of member services and is also a campaigning organisation, raising the profile and lobbying on behalf of the membership and promoting the physiotherapy profession.

Health Professions Council – HPC
Tel: 020 7582 0866  www.hpc-uk.org

The HPC is the UK independent regulator for the allied health professions. It sets standards of professional training, conduct and performance for these professionals and keeps a register of those that meet the above standards. Action is taken if any registered professionals do not meet the standards of the HPC. Since 2006, all registrants must engage in CPD and re-registration with the HPC is linked to successful compliance with the CPD standards. The HPC was created by legislation called the Health Professions Order 2001 and replaced the Council for the Professions Supplementary to Medicine.

Association of Paediatric Chartered Physiotherapists APCP www.apcp.org.uk

APCP is the clinical interest group of the CSP for Chartered Physiotherapists working with children or an interest in children and their physiotherapy. APCP has a national committee which has representatives from the regional branches. The Association also has affiliated groups which have a specific interest in certain areas of Paediatrics.

Affiliated Groups of the APCP
Neonatal Care Group
Critical Care Group
Neuromuscular Group
Paediatric Physiotherapists in Management Services (PPIMS)
2. Physiotherapy practice

Legal and ethical framework

What is the legal framework that governs physiotherapy?

What does this section mean for children and young people?

Physiotherapists must understand and adhere to the law and rules that govern their profession thereby providing safe treatments in a safe environment for children and young people.

Chartered physiotherapists are regulated healthcare professionals, required to adhere to the rules and standards of the CSP, the regulations of the HPC and the legal and policy frameworks of the country in which they work. It is essential that physiotherapists working with children also have knowledge and understanding of relevant trust and local authority policies relating to the care of children. This is as relevant to private practitioners who treat children as those physiotherapists employed within the public sector.

Sadly, legal frameworks relating to children are often only reviewed following tragedy, as in the cases of Victoria Climbié, Caleb Ness and the Kennedy Report.

Recent reviews in the UK have driven the need for organisations to work more closely together, putting the child at the centre of care and using modern technology to improve communications. Increased movement in the population has highlighted the need for better access to information; for example, families relocating within the UK, children entering the country as asylum seekers, or during a transfer to specialist care away from their family and home locality.

It is essential for physiotherapists to understand the national and local policy and legislation which impacts on the way they work and deliver services. The documents listed below relate to UK-wide physiotherapy. The subsections relating to England, Northern Ireland, Scotland and Wales contain their relevant documents.


The UNCRC was ratified by the United Kingdom in 1991 and all four governments are committed to implementing the articles, reporting to the Committee on the Rights of the Child (one of the United Nations’ treaty monitoring bodies) every five years on progress. The Convention provides a set of minimum standards relating to children – defined as under 18 years. The standards mostly address under 16 year-olds and acknowledge the different needs of the 16-18 year group of young people.

The CRC is grounded in the Universal Declaration of Human Rights, which states that children are entitled to special care and assistance as they often lack the physical and political means to defend their own rights. Addressing the civil, political, economic, social and cultural rights of the child, the standards sit in three categories:

- Provision
- Protection
- Participation.

Children’s right to express their views and be heard in matters that affect them is now enshrined in law (Article 12 of the UN Convention on the Rights of a Child).

Paediatric physiotherapists should have the skills to work effectively in partnership with children and young people. These include having the abilities and qualities to listen, respect and respond to their views, priorities and wishes.

Disability Discrimination Act (DDA 1995 updated 2005)

The Disability Discrimination Act aims to end discrimination facing many people with disability.
2. Physiotherapy practice

It gives disabled people rights in the area of employment, access to goods, facilities and services.

**Human Rights Act (HRA 1998)**

The Human Rights Act includes the right to liberty and security, the right to a fair trial, the right to freedom of thought, conscience and religion and the right to freedom of expression. It also prohibits discrimination. See also CSP information paper relating to this.

**The Children Act 2004**

The Children Act (2004) provides the legislative spine for the wider strategy for improving children’s lives. This covers the universal services which every child accesses, and more targeted services for those with additional needs.

The overall aim is to:
- Encourage integrated planning, commissioning and delivery of services
- Improve multi-disciplinary working and remove duplication
- Increase accountability and improve the coordination of individual and joint inspections in local authorities.

The legislation is enabling rather than prescriptive and provides local authorities with a considerable amount of flexibility in the way they implement its provisions. The Act introduced the role of Children’s commissioner to actively seek children’s views and champion their causes.

**N.B. Section 12 of the Act** allows development of further secondary legislation and statutory guidance in setting up databases or indexes that contain basic information about children and young people to help professionals in working together to provide early support to children, young people and their families.

**Data Protection Act 1998**

The Data Protection Act gives individuals rights regarding the personal data organisations hold about them and gives organisations responsibilities regarding that data.

**Ethics and consent in paediatrics**

What are the consent issues for a paediatric physiotherapist involved with children and their families?

What does this mean for children and young people?

Physiotherapists must understand and adhere to the law and local policy in fully explaining and seeking understanding of the intervention, and ensure consent is obtained according to guidance.

The position on consent in relation to children is complex and at times confusing. Therefore, it is important to be familiar with the extensive body of literature including statute and case law, professional guidance, NHS guidance and scholarly writing on the ethical and legal approaches to children’s consent. In addition, since 2001 NHS Trusts and primary care organisations have developed local consent policies. Consequently, physiotherapists should be aware of their contractual obligation to follow local policy and procedure.

There are both ethical and legal justifications for obtaining consent. The philosophical basis of informed consent rests on the principle of respect for patient autonomy, which is associated with the notion of involving the patient in the decision making process. However, the law deals with the issue of consent in a manner distinct from the application of ethical concepts. The legal focus is upon the concept of valid consent which, by definition, has four elements: voluntariness, competence, disclosure, and comprehension. Therefore, for consent to be valid it must be
given voluntarily without undue influence, coercion, or force. In addition, the child giving the consent must have the necessary mental capacity or competence to do so at the time of treatment, which has particular relevance to children.

The law\(^1\) recognises broadly three stages of childhood with respect to consent. First, there are very young children who lack the capacity to consent to assessment and treatment. In such cases it is usual for the person(s) with parental responsibility\(^2\) to give consent. Second, there are ‘Gillick competent’ children. A child under 16 can consent to assessment and treatment provided he or she is competent to understand the nature, purpose and possible consequences of the proposed intervention\(^3\). Finally, there are children over the age of 16 who can give a valid consent to any surgical, medical or dental treatment without consent from the person(s) with parental responsibility\(^4\).

Up to age 18, where a child lacks capacity, the person(s) or local authority with parental responsibility can give consent on behalf of the patient.

The other two elements of valid consent, disclosure and comprehension relate to the idea that sufficient information must be provided to the child (and their parents, carers) so that he/she comprehends in a basic sense the proposed intervention. Communicating information in an age and cognitively appropriate manner is a key element to this process; e.g. use alternative or augmentative communication, use of pictures or photographs and the overall quality of the child’s health experience.

The following texts are recommended for their comprehensive discussion and exploration of not only valid consent but various other important issues relating to the care of children in health care.

\(^1\) Refers to England, Wales and Northern Ireland. There are some exceptions in Scotland; see further CSP (2005) Core Standards of Physiotherapy Practice 4th ed. London: CSP Standard 2

\(^2\) Parents, guardians or any other persons or authorities legally entitled to give consent on the child’s behalf see further the Children Act 1989 and the Adoption and Children Act 2002

**Bibliography**

**Statutes:**


**Cases:**


Sidaway v Bethlem Royal Hospital Governors and others [1985]1 ALL ER 643

Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1986] AC 112

Re R (A minor) (Wardship: Medical Treatment) [1991] 4 All ER 177

Re W (A minor) (Medical Treatment: Court’s jurisdiction) [1992] 4 All ER 627

Re E (A minor) (Wardship: Medical Treatment) [1993] 1 FLR 386

**Professional Guidance on Consent in Paediatrics:**

British Medical Association. *Consent, rights and ...
2. **Physiotherapy practice**


**Further reading:**


What is the role of the paediatric physiotherapist in safeguarding children?

What does this mean for children and young people?

Paediatric physiotherapists have a duty of care to work collaboratively with other services to safeguard children. This may involve sharing information and liaising with other agencies about concerns in accordance with local policies and procedures and national guidance as recommended in the Victoria Climbié Report(6).

The second joint Chief Inspector’s Report on arrangements to Safe Guarding Children(20) states:

- All agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children’s welfare are minimised
- Where there are concerns about children and young people’s welfare, all agencies take all appropriate actions to address these concerns, working to agreed local policies and procedures in full partnership with other local agencies.

Copies of the report are available from the website at www.safeguardingchildren.org.uk

Every Local Authority and NHS Trust has a Child Protection (Safe Guarding Children) Policy which must be adhered if there is any suspicion through direct contact or information that a child may be at risk of being harmed. All physiotherapists must adhere to their local policy.

There is also non-statutory guidance by HM Government which provides detailed information, a child’s version and a flow-chart to support practitioners through the process.
If a child informs a physiotherapist of a situation, she or he should explain to the child that in some cases the physiotherapist is obliged to take certain actions that may involve telling other people ‘and I may have to do this even if you ask me not to’.

A physiotherapist may wish to consider sharing the information with the Welfare Services of their organisation and ask the Welfare Services to take the necessary action. If a decision is reached to take action, then the professional who received the information from the child needs to be satisfied that such action has been taken (either by themselves or by a third party such as Welfare Services), and if the professional is not satisfied that the third party has taken the agreed action, then the professional themselves then needs to take action. This is, in essence, the practical application of the first four steps of the government guidance contained in ‘What to do if you think a child being abused’\(^{(21)}\). In the summary, the Flow Chart on page 12 and Appendix 1 on page 17 will be worth reviewing first. Appendix 3 is very comprehensive offering guidance on information sharing and confidentiality issues in these particular circumstances.

http://www.everychildmatters.gov.uk/resources-and-practice/IG00182/

### Checking staff against criminal registers

It is a criminal offence for people with certain convictions to apply for and work with children and vulnerable adults. It is also an offence to knowingly offer work to such an individual. In defining “Working with Children” the legislation makes no distinction between paid or unpaid work. The Protection of Children Act 1999\(^{(22)}\), make some checks compulsory and strongly recommends checks for other positions.

Commonly known as ‘CRB checks’, this can be done through the Criminal Records Bureau (CRB) Disclosure service in England and Wales and Disclosure Scotland for Scottish employers. The Protection of Children Northern Ireland (POC (NI)) and the Protection of Vulnerable Adults Northern Ireland (POVA (NI)) provide checks for Northern Ireland employers.

These are agencies set up to help organisations make safer recruitment decisions. They provide a service for organisations, checking police records and, in relevant cases, additional information held by Health and the Education Departments.

Two types of CRB checks are available in cases where an employer is entitled to ask exempted questions under the Exceptions Order to the Rehabilitation of Offenders Act (ROA) 1974\(^{(23)}\). This includes any organisation whose staff or volunteers work with children or vulnerable adults. An organisation may apply for a check to be undertaken. They are issued free to volunteers. The two levels of check currently available are called Standard and Enhanced Disclosures.

#### Standard Disclosure

This is primarily available to anyone involved in working with children or vulnerable adults, as well as certain other occupations. Standard Disclosures show current and spent convictions, cautions, reprimands and warnings held on the Police National Computer. If the post involves working with children or vulnerable adults, the following may also be searched:

- Protection of Children Act (POCA) List
- Protection of Vulnerable Adults (POVA) List
Enhanced Disclosure

This is the highest level of check available to anyone involved in regularly caring for, training, supervising or being in sole charge of children or vulnerable adults. Enhanced Disclosures contain the same information as the Standard Disclosure but with the addition of any relevant and proportionate information held by the local police forces.

If requested on the disclosure application form, the check will also show if someone applying for a childcare position is on either of the two government-held lists of people considered unfit for such work. In this case, where a person who appears on the list is applying for a childcare position, it is the responsibility of the manager to ensure the police are informed.

This check can be made only for those who do work that involves regularly caring for, training, supervising or being in sole charge of children (under-18s) or vulnerable adults.

The CRB recognises that the Standard and Enhanced Disclosure information can be extremely sensitive and personal. Therefore it has published a Code of Practice to ensure responsible provision of information. An employer cannot demand disclosure for existing employees. Retrospective checks may only be carried out on existing members of staff if the employee's contract or conditions of employment state that a police check can or may be carried out, or the employee has given written consent. An employer recruiting staff to work with children must include a statement to that effect within the application form, which the prospective employee must sign, indicating their willingness to provide a Disclosure. If the prospective employee then refuses to provide one, the employer should be within their rights not to proceed with an application. Furthermore, when the law requires a Disclosure and a prospective employee refuses to apply for one, then the employer would be within their rights not to take the job application any further.

An individual applying for a Standard or Enhanced Disclosure has to go through a Registered Body or Registered Umbrella Body.

A copy of the Standard or Enhanced Disclosure is sent out to the applicant as well as the Registered Body.

Criminal Records Bureau Information Line: 0870 9090811

A joint publication from government bodies has been published to assist in safeguarding children.

Factors influencing physiotherapy practice

What are the factors that support physiotherapy practice?

What does this mean for children and young people?
Physiotherapists have a duty to continue learning throughout their professional life and demonstrate they are utilising the best intervention for the child or young person.

Paediatric Competences and Standards

The use of Competences by healthcare workers has been identified as being important to the commissioners of health services. APCP is developing a professional competence framework to ensure providers meet the standards required, not only under the statutory frameworks as described below, but also the standards set by the CSP and APCP. This supports the delivery of consistent high quality standards of care for children and their families.

Competence is not just about knowledge, skills and abilities or just about being able to...
2. Physiotherapy practice

- demonstrate technical skill. It is also about thinking, critical analysis and learning, the assimilation of new learning with previous learning, integration of new knowledge, skills and abilities with prior knowledge and application of new learning in practice.

Skills for Health (SfH) is the sector skills council for the healthcare sector licensed by the Department for Education and Skills (DfES); (DfES has now been superseded by The Department for Children, Schools and Families) to develop the health workforce across the UK (NHS, independent and voluntary). It works with employers to identify the skills needed to deliver high quality competent healthcare. The SfH competence framework, in turn, is linked to the NHS Knowledge and Skills Framework (KSF). The SfH competences are already mapped against this framework with each competence being linked to a relevant KSF dimension and level.

SfH has developed a suite of National Occupational Standards (NOS) for Children’s Services These aim to describe the competences required by healthcare staff working with children. http://www.skillsforhealth.org.uk/tools/view_framework.php?id=115.

APCP, supported by the CSP, are producing guidance on workforce competence linking to HPC and CSP standards, the KSF and the National Occupational Standards. This guidance will be specifically linked to SfH Competences.

The working party looking at this aspect of paediatric physiotherapy practice will be producing the guidance which will supplement this Guide to Good Practice in 2008.

Workforce development – Continuing Professional Development (CPD)

CPD is a systematic, ongoing structured process of maintaining, developing and enhancing skills, knowledge and competence both professionally and personally in order to improve performance at work.

The CSP expects its qualified, associate and student members to maintain and develop their skills, knowledge and competence through CPD in order to provide safe and effective practice. (25, 26).

There is a strong link between evaluation, learning and the enhancement of patient care and quality of service.

Assistants and graduates learn good practice in a variety of settings; e.g. hospitals, schools, child development centres through CPD e.g. formal learning, reflective practice, in-service training and shadowing with a senior member of staff (27, 28). All assistants and new graduates should have a senior member of staff who is responsible for their appraisal and who will help identify specific areas of learning required by that individual. There are courses run specifically for assistants, for new graduates and advanced practitioners working in paediatrics (29).

Supervision and appraisal should also be available to more senior staff to develop their clinical reasoning skills and broaden practice (30).

See also relevant CSP information papers (31-35).

Evidence-based practice

The evidence base for paediatric physiotherapy is growing and practitioners can draw on a range of resources to support decision-making about which interventions may be most appropriate for children and young people. The most well used definition of evidence-based practice is that it is the ‘conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.’ (36)
2. Physiotherapy practice

A more recent definition is: Evidence-Based Practice (EBP) requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.(37)

Paediatric physiotherapists have a duty to have an up to date knowledge of their specific area of practice to ensure that interventions are appropriate and effective. They also need clinical reasoning skills to fit the best intervention for the child, family and social situation. At times compromises may need to be made but this needs careful documentation.

Sources of evidence for interventions

- Research
- Clinical guidelines, effectiveness bulletins and other summaries of evidence of effectiveness
- Clinical interest and occupational groups
- National guidance e.g. National Service Frameworks, National Institute of Health and Clinical Excellence guidelines
- Local standards and protocols
- Information derived from the use of outcome measures
- Audit
- Expert opinion.

The use of physiotherapy time, the nature of intervention and the longer term effects of practice have become increasingly important in the cost-benefit analysis within the NHS. These and other external pressures have added impetus to the use of outcome measurement within routine physiotherapy clinical practice and in physiotherapy research. The value placed upon accurate, appropriate and timely outcome measurement is demonstrated in the professional body standards and is expected to be a key attribute of professional practice.

The CSP’s Core Standards(3) state physiotherapists should select and use quality outcome measures appropriate to the child. The physiotherapist is advised to ensure that the measure used can evaluate change in the child’s health status and that they should apply them in a timely manner. Audit guidance and tools are provided in the CSP Core Standards(3).

Finding and using an appropriate measurement tool is often a challenge to physiotherapists, particularly when ensuring the process remains child and family centred. The whole process of assessment, goal setting, management and evaluation must be focused on ongoing collaboration with children and their families, other professional groups and service providers. Therefore, decisions regarding use of measurement tools cannot be taken in isolation but must form part of this continuous process toward meeting the requirements of these key participants(39, 40).

Moving and handling

What does this section mean for children and young people?
Physiotherapists are obliged to undertake full risk assessments and to ensure that everyone is trained in moving and handling techniques necessary in the care of a child or young person.

Moving and handling is an integral part of paediatric physiotherapy practice and paediatric physiotherapists must operate within the legal framework of health and safety law. These laws apply to the therapy carried out by those working with children as equally as the therapy that is carried out by those working with adults.

In paediatric practice it is often more about the posture that the therapist or carer has to assume, or the equipment they have to work
with, when carrying out therapy than the ‘load’ they are handling.

All proposed intervention should be assessed for any potential risks to either the child or therapist and if a risk is identified and cannot be avoided during the therapy activity this risk must be assessed – physiotherapists are legally bound to formally carry out this risk assessment and document findings. However, this is just the beginning – a risk assessment in itself is not helpful unless action is taken and control measures implemented to reduce the identified risk.

The risk assessment is part of a process which identifies potentially hazardous moving and handling that may be involved in the proposed therapeutic intervention. There are four areas to include in a risk assessment:

1. Task
2. Individual (the handler)
3. Load (the child)
4. Environment.

The identified risk is given a grading of high, medium or low dependent on the likelihood of injury occurring and the consequences or outcomes for both the therapist and the child. The risk is managed by the introduction of control measures and these may include for example: training, use of equipment or adaptation of the proposed invention. The outcome of the risk assessment may mean that the therapist has to adjust the goals of treatment to minimise the risks involved in the therapeutic action.

Risk assessment is an ongoing (iterative) process and should be reviewed at regular intervals or when there is any significant change in the child, therapist, task or environment.

Caring for dependent children may involve constant repetitive manual handling. The child as a ‘load’ may be mobile, flexible, precious, possibly unwell or in pain, sometimes resisting and always unpredictable. Sensory deficit has an impact on the child’s ability to function. Movement, sensory processing, perception, communication and the environment in which handling and therapeutic activities are taking place are all affected by the sensory deficit a child may have; and these should be taken into consideration in the risk assessment process. Challenging behaviour can also affect the child’s ability or willingness to move and thus increase the risks when handling.

Delegation is commonplace within paediatric physiotherapy practice and paediatric physiotherapists have a duty of care to themselves and people they work with be they colleagues, the child or the carer.

They must assess the risk of injury and cumulative stress associated with the moving and handling of the children they are working with and take all possible steps to reduce the risk. The paediatric physiotherapist has ultimate responsibility for any therapeutic activity they delegate to carers.

Documentation is of the utmost importance as this provides a critical link between assessment, clinical reasoning and the child’s functional outcomes or goals.

The fundamental aim must always be to reduce the risk of injury occurring to the handler as far as is practicable whilst at the same time ensuring the best possible outcome for the child.
2. Physiotherapy practice

Legislation

• Health and Safety at Work Act 1974\(^{(41)}\). This act forms the basis of all health and safety law. It sets out duties for employers and employees and covers all aspects of health and safety in the workplace.

• Control of Substances Hazardous to Health 1999 updated 2002\(^{(42, 43)}\). Employers must not expose employees to substances hazardous to health and a suitable and sufficient risk assessment must be carried out.

• Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995\(^{(44)}\). Employers must notify the Health and Safety Executive about accidents which happen at work resulting in death, personal injury or sickness where an employee is off work for more than three days.

• Management of Health and Safety at Work Regulations 1999\(^{(45)}\). Where an employer employs five or more employees the regulations place an obligation on the employer to actively carry out a risk assessment of the workplace and act accordingly. The risk assessment is intended to identify potential health and safety and fire risks and provide the employees with a ‘safe system of work’.

• Manual Handling Operations Regulations 1992 updated 2002\(^{(46, 47)}\). The regulations came into force in January 1993 and are aimed at preventing injury from manual handling activities in the workplace. It sets out a hierarchy of measures to risk assess potentially hazardous manual handling procedures. The regulations apply when loads are moved by hand or bodily force.

• Lifting Operations and Lifting Equipment Regulations 1998\(^{(48)}\). All lifting equipment must be sufficiently strong, stable and suitable for the proposed use. Lifting equipment must be visibly marked with appropriate information (i.e. weight limits, size etc) Lifting equipment for lifting people must be checked at least once every six months and all lifting operations must be carried out by competent personnel.

Useful resources


• http://ergo.human.cornell.edu/ahRULA.html Rapid Upper Limb Assessment Guide

• http://ergo.human.cornell.edu/ahREBA.html Rapid Entire body Assessment Guide

• www.hse.gov.uk Publications
2. Physiotherapy practice

Transition issues from paediatric to adult services

‘Transition should never be considered a sprint, a baton pass or simply the event of transfer between paediatrics and adult care. Transition is in reality a marathon, starting on the day of diagnosis. Transition is an age and developmentally appropriate process, addressing the psychosocial and educational/vocational aspects of care in addition to the traditional medical areas. Transition starts within paediatrics but continues on into adult services and is therefore, by definition, a paediatric and adult concern.’

Any physiotherapist who encounters young people in their working practice needs to ensure they address the important issues raised during adolescence. One of the most important issues raised during this stage of development is that of transition. Transition can be defined as ‘the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult oriented health care systems.’ Transition has been recognised as an important standard of care in several major policy documents. Careful planning and delivery of treatment is essential to facilitate a young person’s independence and successful transition to the adult world. This is best addressed as part of a multi-disciplinary team, where the physical, physiological, psychological, social, educational and vocational needs of a young person can be met. Careful planning and delivery of treatment is essential to facilitate independence and transition to the adult world. The key to successful treatment is empowerment of the young person thus instilling a sense of responsibility and ownership of their illness, as well as providing opportunities for the development of a young person’s confidence and capacity in dealing with everyday life. One way this can be achieved is through co-ordinated transitional care planning.

Physiotherapists need to recognise the role they can play in assisting with the development of age and developmentally appropriate transitional care plans for young people. The patient/therapist relationship allows for ongoing continuity and support which young people identify as an important aspect of care. Physiotherapists can facilitate a young person in identifying needs and potential barriers to ‘growing up and moving on’ and assist with the development, planning and co-ordination of transitional care packages.

A qualitative study identified transitional care packages as needing to be:

1) Multidimensional – addressing all areas of a young person’s life
2) Coordinated (multi-disciplinary) and individualised
3) Supportive – seeing the same healthcare professional at each appointment
4) Developmentally appropriate
5) Age appropriate – facilities/information.

Early preparation of young people (especially those young people with disability and/or complex or long term conditions) and their families for transition to adult services is advantageous, ideally in early adolescence. A coordinated, planned and individualised approach to transition will assist with identifying those skills that are needed for independent adult living, as well as aiming to assist with maximising health outcomes.

A key area of transition for physiotherapists to take a lead in is addressing the exercise related risk factors of common morbidities of childhood onset disease; e.g. osteoporosis, cardiovascular disease and obesity. The latter are important since adolescence is the time when adult health promoting and self-management behaviours become established. Transition planning should also
provide support for parents/carers through the process.

In a Delphi study of transition involving young people, their parents and rheumatology professionals, staff knowledgeable in transitional care were considered best practice but only currently feasible in a few UK hospitals, and there is a current lack of formal training opportunities in adolescent health in the UK. This deficit is currently being addressed by a Department Health funded intercollegiate e-learning project in conjunction with the Royal College of Paediatrics and Child Health. Furthermore, a new national multidisciplinary Association for Young People’s Health is to be launched in early 2008 which also aims to promote multidisciplinary training and education in young people’s health including transition.

**Useful websites:**

**UK**

Transition Information Network.
Website: http://www.transitioninfonetwork.org.uk

DreamTeam website of the Adolescent Rheumatology Team at Birmingham Children’s Hospital.
Website: http://www.dreamteam-uk.org

Transition Pathway
Website: http://www.transitionpathway.co.uk/

No Limits.
Website: http://www.nolimits.org.uk

Moving on up.
Website: http://www.movingonup.info/


**Youth Health Talk**
Website: http://www.youthhealthtalk.org/

**Australia**

Royal Children’s Hospital, Melbourne – Transition to adult services.
Website: http://www.rch.org.au/transition

**Canada**

Disability Ontario Online Resource for Transition to Adulthood – D.O.O.R. 2 Adulthood
Website: http://www.door2adulthood.com

SickKids – Good 2 Go Transition Program.
Website: http://www.sickkids.ca/good2go

**USA**

Health Care Transitions.
Website: http://hctransitions.ichp.edu/

Adolescent Health Transition Project.
Website: http://depts.washington.edu/healthtr/index.html

Kentucky Cabinet for Health and Family Services – Transition Resources.
Website: http://chfs.ky.gov/ccshcn/ccshcntransition.htm

**Health and wellbeing**

**Public Health**

The health and wellbeing of the people living in the UK is becoming increasing high in the profiles for governments. Public Health addresses the health needs of the population from the cradle to grave and encompasses education, prevention of illness, empowering the individual to make healthy choices and redesigning services to support this philosophy. The CSP documents provide the policy background and advice to support physiotherapists in promoting health and wellbeing.

For children there is a huge opportunity for physiotherapists to undertake work to
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- invest in the ongoing health and wellbeing of the younger population. Major areas where physiotherapy can become engaged is in a proactive approach in preventative and self management of health conditions and encouraging the family focus to take full responsibility for the health of all members of their family. Forecasts of the health of our future generations is grim. Strategies are needed to develop and to address obesity, mental health problems, smoking and substance misuse in children and younger people, to address relationships and prevention of teenage pregnancies and to promote active life styles amongst the youth.

The CSP has provided information papers on public health relating to each of the four UK countries\textsuperscript{69-62}. This document also references the policy documents and guidance produced by the individual countries in relation to public health. Individual physiotherapists need to identify local population needs and look at how to address them, how to link activity with local government targets, and how to influence commissioners in demonstrating that physiotherapy has a prime role to play in the public health of the local community.

When addressing public health issues it is essential to consider not only health but also social care in the community including public transport, access to leisure facilities and schools in assessing how best to input and influence the wellbeing and the health of the population.

Locations and settings

**Children and their families accessing paediatric physiotherapy**

**What does this section mean for children and young people?**

Paediatric physiotherapists work in a variety of locations and settings. These include hospitals, clinics, child development centres, Children Centres, Extended School provision, Childcare provision and Early Years settings, children’s own homes, hospices, social care respite provision, mainstream schools and special schools.

Where possible, children should have access to their physiotherapy in the setting most appropriate for their assessment, treatment and on going support and enables them to achieve their outcomes. Working in a variety of settings should help improve communication and collaborative working with others who are supporting the child. Children may also respond in different ways in different places and paediatric physiotherapists should be mindful of this when they are discussing and deciding on the best location with the child and family.

The paediatric physiotherapist should ensure that the locations they work in or the settings they visit are fit for purpose, providing a safe environment for children to have their assessments, interventions and on going support, and meet the child’s needs and developmental potential.

In order to support children in various settings, the paediatric physiotherapist should have the skills to tailor their intervention, communicate well with staff and family and share skills and knowledge so that all involved are holistically and collaboratively working with each other to help meet the child’s needs.
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The paediatric physiotherapist should also take account of their personal safety and adhere to their local lone working policies when planning assessments or treatment sessions.

**Early Years settings, schools and colleges**

Physiotherapists working in Early Years settings, schools and other educational establishments should work in partnership with the other early years practitioners, school and college staff so that the children and young people benefit from co-ordinated, integrated support to facilitate them achieving the best possible outcomes [63].

Paediatric Physiotherapists should adhere to the SEN Code of Practice and demonstrate good practice in treatment of children [64, 65].

It may benefit children to have the involvement of paediatric physiotherapy to support them achieve their outcomes within their educational settings. Paediatric physiotherapy services may tailor the way they deliver to meet children’s needs.

**Children in hospital**

Work was undertaken ahead of the full Children’s NSF in response to the Kennedy Report. It addressed the environment of the child in hospital and the fact that child-friendly, safe and effective treatment helps reduce the time spent in hospital and disruption to the family’s life.

The NSF [52] is divided into three parts and considers children’s rights and vulnerabilities in addition to care provision for children and involvement of parents.

**Part one: Child-centred Hospital Services**

Secondary care teams should work closely with community based services for prevention and treatment, integrating care around each child’s specific needs and delivering a planned and co-ordinated care pathway. This section also encourages asking about a child’s safety, looking for signs of neglect or abuse, and taking a multi-agency approach to child protection if necessary.

Staff should treat children as children and not mini-adults, pitching services for children and young people at an appropriate level and ensuring that play, recreation and education are built into service provision.

Sharing information with parents, children and young people in an appropriate manner is essential, including outcomes and bad news, and addressing and obtaining consent. Health care workers should work in partnership with children, young people and their parents in both the treatments and in shaping services, taking into account the wider lifestyle of each child in treatment, convalescence and prevention of future deterioration. This encompasses ethnicity, education and development of the child towards adulthood and the provision of transition between services.

**Part two: Quality and safety of care provided**

Clinical governance provides annual evidence of child-focused multi-agency service planning and delivery and ensures safe, evidence-based and audited services by trained workforce for all children within hospital settings.

**Part three: Quality of setting and environment**

The treatment of babies, children and young people should be child-friendly in healthy and safe settings.

Health promotion should be highlighted in addition to care provision.

**Tertiary Care**

Tertiary hospitals predominantly deal with children with conditions that are rare, intractable, complex, unusually severe, or complicated by other disorders, who are therefore thought to do better if they are referred to tertiary services for diagnosis or treatment.
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National Institute for Health and Clinical Effectiveness (NICE) guidelines set the age limit for access to tertiary paediatric services at nearer 21/22 years.

**Hospices for children**

There are over 20,000 children living with life limiting diseases. Association of Children’s Hospices (ACH): ‘works together with other organisations to support the development of best practice and provision of children’s hospice services across the UK’. The hospices provide physical and emotional support in a home from home atmosphere. The hospices provide specialist staff and equipment to support specialised play and laughter as well as medical care. The role of the hospice includes care for the child and for the family, including bereavement counselling.

Information on UK based children’s hospices can be obtained from:
www.childhospice.org.uk

**Supporting practice**

**Interactive CSP – iCSP**

The interactive CSP (iCSP) networks provide opportunities for physiotherapists to communicate and share knowledge with one another. There is a paediatrics network which covers all aspects of practice and service delivery and a network dedicated to healthcare policy on which many of the policies and Acts are featured to assist physiotherapists to understand their impact on practice.

iCSP – is a free, easy-to-use website accessed via www.interactivecsp.org.uk, enabling CSP members and APCP members to share knowledge based on each user’s specific clinical, professional and workplace interests. It provides quick access to resources, including documents, news, events and useful websites, and also to peers through email and online discussions.

APCP moderates the paediatric network on this website and manages the content of the network, under the leadership of APCP public relations officer.
What are the key factors that support the delivery of paediatric physiotherapy services?

Delivery of high quality services is high on the government agendas and much of the policy work focuses on how to improve and maintain services designed around the needs of the users. Many of the key factors that influence the delivery of high quality services for children and their families can be divided into four categories: Clinical Services, Governance, Quality, including appropriate use of workforce skills, and the Knowledge and Skills required to deliver the services. The four sections have been divided into core, desirable and extended factors and linked to the relevant drivers.

Clinical Services:

Core
- Skilled assessment by appropriately trained staff in a location suitable for individual children’s and family’s needs. This would be available for children, having a wide variety of diagnoses
- Mutually agreed goals that are reflective of the child’s needs (National Workforce Competency Framework Section 2 (Assessment of Health and Wellbeing))
- Formation of a package of care/care pathway that meets the child's assessed clinical need. This will include a 24 hr postural management programme when appropriate
- Regular communication between therapists and families, including the copying to parents of all letters to other professionals
- Liaison with the training of other agencies involved with the child and their family, e.g. MDT
- Regular use of outcome measures to assess the effectiveness and cost efficiency of service delivery
- Clear and transparent discharge from services at the appropriate time.

Desirable
- Hydrotherapy availability, ideally in a child friendly environment
- Provision of an orthotics service
- Access to rebound therapy
- Gait analysis by a trained practitioner
- 24/7 services delivery (in hospital settings)
- Involvement in the development of care pathways for a variety of conditions
- Prescribing, including the use of Botulinum Toxin
- Direct access to assistive technology
- Access to therapeutic horse riding.

Extended
- Health promotion activities
- Developmental massage
- Complementary therapies
- Palliative care.

Governance:

In this section all entries are considered core, as issues of clinical governance are not optional.
- All staff are professionally registered, where appropriate, and will work to the standards of their professional body
- All staff make user involvement central to service delivery
- All staff are part of an ongoing process of Professional Review and Development (PRD) involving the production of professional portfolios and participation in ongoing training, both internal and external
- All NHS staff are subject to a KSF, which will support their professional development
- All staff are CRB checked to an enhanced level
- All staff are expected to use measurable outcome tools to assess the effectiveness
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- Effectiveness of their practice. These will include those recommended by APCP\(^{(71)}\)
  - All staff participate in the appropriate mandatory training, e.g. Safeguarding children
  - All staff partake in some form of supervision, either formal clinical supervision or some form of mentorship or peer review. A regular log of attendance will be kept according to local trust policy
  - All staff are involved in audit of their practice
  - All staff are aware of and take part in risk assessment, in moving and handling and in other areas of their practice, according to local trust policy\(^{(75)}\)
  - All staff are aware that it is their responsibility to deliver services in a cost effective way, which falls within budget.

Quality:

Core
- All services are delivered in a timely fashion. Waiting times will be regularly audited\(^{(76)}\)
- All interventions are delivered in a child centred way at a location appropriate to that child’s needs\(^{(73)}\)
- All interventions are based on the best available evidence\(^{(53)}\)
- All staff work to APCP, CSP and HPC standards as well as to local service standards
- The service is constantly reviewed to ensure it continues to utilise the most appropriate workforce, both in terms of grade and skill required, in order to deliver a cost-effective, sustainable service\(^{(67)}\)
- The service provides regular training to both families and other agencies to ensure the delivery of best practice\(^{(68)}\)
- The service contributes to the production of educational statements and other statutory documentation\(^{(64, 77)}\)
- Individual members of the service are responsible, as autonomous practitioners, in ensuring the quality of the service they deliver
- The service is proactively risk managed to ensure that it is always fit for purpose
- The service liaises with other providers, both other agencies and the voluntary sector, to ensure that the needs of the child remain central to all
- The service uses the facilities available to it e.g. IT, accommodation, in the most cost effective and efficient way, to ensure the sustainability of service delivery.

Desirable:
- Members of staff support the team around the child approach (TAC) by acting as Key workers.
- The service supports the co-location of appropriate staff\(^{(68)}\)
- There is a specialist post, with research and development at the core of its purpose
- A specialist transition service is in place
- The development of income generating activities is considered, in order to further boost activity
- The development of a Patient and Public Involvement Forum (PPI) within the service supports user involvement\(^{(72)}\).

Extended
- A consultant physiotherapist post which spans trusts, promotes and supports research and development within the specialty.

Knowledge and Skills:

Core
- All paediatric physiotherapists are registered with the HPC (basic legal requirement)
- All staff participate in an induction process appropriate to their workplace\(^{(78)}\)
- All staff are experienced in working with
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children and have achieved the common core of children’s competencies
• All staff have achieved the competencies necessary for their professional body
• Individual staff members’ KSF outlines in the NHS reflects those knowledge and skills that they need to be part of the children’s workforce
• All staff members participate in postgraduate training appropriate to the demands of their job.

Desirable
• Further specialisation within the service to meet specific need, supported by postgraduate training
• Links to academic institutions, particularly those involved in paediatric physiotherapy research.

Extended
• Specialists in the following areas:
  Gait analysis; diagnostics; injection therapy; neonatology; mental health.

Working in partnership with children, families and other service providers

Working in partnership is one of the fundamental skills of paediatric physiotherapists and is a crucial element of their involvement with children and their families. For some children and young people there is an even greater need to work in partnership with children, young people and their families and other service providers.

‘Children and young people who are disabled or have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, enable them and their families to live ordinary lives.”

Another example: states: ‘Delivering services to disabled children is a corporate responsibility and improvements in outcomes for children and their families can only be achieved by close collaboration between parents, professionals and agencies working with children and their families’. 

To support the delivery of these standards, paediatric physiotherapists should have the skills and qualities to work in partnership with children, young people parents and carers, other professionals and service providers.

The concepts and ethos of multi-disciplinary working has expanded over the last few years and working in partnership with children, families and other service providers is one of the key features for the children’s agenda across the whole of the UK.

Effective inter-agency working is underpinned by two aspects of the Every Child Matters integrated working focus and includes the workforce reform and multi agency working. The workforce reform includes the introduction of the Common Core Skills and Knowledge for the Children’s workforce to ensure all professionals have the knowledge and skills to work effectively with children and families and access to training when relevant. Multi agency working brings professionals from different agencies together to meet the needs of children and families and jointly agree the delivery of the actions arising from a common or specialist assessment.

In England, the Common Assessment Framework and the role of the Lead Professional are mechanisms to support the process of multi agency working.

‘The Common Assessment Framework for the children and young people (CAF) is a shared assessment tool used across agencies in England. It can help practitioners develop
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- a shared understanding of a child’s needs, so they can be met more effectively. It will avoid children and families having to tell and re-tell their story. The CAF is an important tool for early intervention. It has been designed specifically to help practitioners assess needs at an earlier stage and then work with families, alongside other practitioners, to meet them. (80, 82)

Paediatric physiotherapists in England will need to have a working knowledge of the Common Assessment Framework and its purpose and function. They will need to know how to complete a CAF pre-assessment checklist (83) and a CAF and the arrangements and practice for processing CAF within their local areas. They will also need to have an understanding of how their specialist assessments can be supported by the CAF.

Sharing information is an integral part of agencies working together to support children and their families. With children, adherence to the CSP’s Rule 3 (84) is essential and the DH has published guidance to support workers in understanding their responsibilities (82).

For some children and especially those who may require long term intervention, a coordinated approach through interagency working may be established practice. The team around the child concept, key worker or lead professional involvement and child focused, family centred planning facilitate integrated working practice as well as enabling children and young people and their parents to be key decision makers and central to all planning (85-88).

Report writing to support assessment and planning based around the needs of children and their families

Paediatric physiotherapists are required to prepare reports for children for a number of reasons. These include:
- Following initial assessment of a child to inform the referrer
- Following re-assessment at regular intervals during the child’s involvement with physiotherapy
- To refer to another professional or service
- To support a referral to a tertiary centre
- To support a child into an educational setting
- Following a request for an assessment for Statement of Special Educational Need (SEN)
- To support an SEN Tribunal dispute
- To support a legal case.

All physiotherapy reports should comply with the CSP Core Standards, the APCP Guide to Good Practice and the APCP Guidance on SEN (3, 4, 65).

It may be necessary for some reports to be accompanied by additional information as listed below. This is especially the situation if the report has been requested as part of a legal case or if the child and family are involved in an SEN Tribunal case.

The following gives some advice as to what is recommended to be included both in the report and with the report.
- The reason why the physiotherapist is writing the report including who made the request
- How long the physiotherapist has known the child and family
- Whether the report has been undertaken in collaboration with the child and family
- The liaison and communication between different physiotherapists and reasons for not communicating if this is the situation
- The physiotherapist’s involvement with the child and family, including interventions and within different settings
- How much they know about the other services involved with the child and family
- A developmental history of the child (from...
their own observations if known previously or from the parents)
- The concerns of the child and family
- What is reported by families and what is actually observed or demonstrated during assessment
- Detailed clinical observations
- Results from standardised validated paediatric assessment tools where this is clinically appropriate
- Summary of child's strengths and difficulties
- Physiotherapy intervention necessary
- Consideration should be taken when writing reports to ensure the language is understandable and accessible to all those who may wish to read it
- All reports prepared for education purposes should be written with the aim of providing information to staff in order to support the child’s inclusion and promote their physical wellbeing and function within the educational setting
- Consent
- Parental copies.

Legal and tribunal report writing
All reports written for solicitors and SEN tribunals should be accompanied by a curriculum vitae. The CV should include:
- Why the physiotherapist feels they are competent to write the report, to include their HPC registration, CSP membership and specialist group membership
- The physiotherapist’s paediatric experience and whether this has been within acute, specialist, tertiary or community settings
- Their communication with other professionals involved
- If for a tribunal, whether they have worked with children in mainstream and special schools settings
- Confirmation of whether they have attended the CSP Expert Witness course
- A summary of their CPD Portfolio
- A summary of their portfolio of involvement with legal cases or SEN Tribunals.

Assistive Technology
Assistive technology (AT) is an umbrella term for a wide range of products. A commonly accepted definition is “..any item, piece of equipment or product system whether acquired commercially off the shelf, modified or customized that is used to increase, maintain or improve functional capabilities of individuals with disabilities.” (89).
Therefore in terms of devices or equipment it includes walking sticks to environmental control systems, or simple dressing aids to communication aids.

The benefits and purpose of AT are in many respects self evident. When appropriate equipment is provided in a timely manner it allows children to move around their environment, communicate with others and take part in developmentally appropriate activities that they would be unable to do without this technology. It also enables the family and carers to look after a child in activities which the child cannot undertake independently such as personal care, e.g. hoisting, bathing and toileting.

Physiotherapists are routinely involved in the assessment and prescription of some AT devices such as standing supports or orthoses. However it is important to have an understanding of a wider range of AT so that one can understand the role that AT plays in family life and when it might be a solution to a problem.

Community equipment services play an important part in helping people to develop their full potential and to maintain their health and independence. A wide range of equipment and adaptations can now be provided from 138 services in England with the majority of items being provided within seven
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- days of a professional decision being made. Additional resources may be found through the Foundation for assistive technology – www.fastuk.org

ICES (Integrating Community Equipment Services) is a Department of Health funded initiative across health and social care to develop community equipment services in England, remove unnecessary barriers for users and modernise services\(^{(9)}\).

The mission of the ICES Team is ‘To support and encourage the development and integration of people centred equipment services for the enhancement of health, wellbeing and independence’. Further information can be accessed via http://www.icesdoh.org/
4. UK country-specific child-related policy

All member countries of the UK have been developing frameworks of care for children to ensure that they have good quality services available to them. The section on England addresses many of the common issues across the UK. The following sections relate country-specific work to local policy drivers. Each country’s framework is summarised in this section and link to the standards set by the United Nations Convention on the Rights of the Child 1989. Each country’s section outlines their Children’s strategy, the national Child legislation, key policy papers, and implementation tools. The sections also refer to relevant CSP information papers.

**What does this mean for children and young people?**
Physiotherapists must be aware of the policy drivers and guidance in order to deliver the high quality services for children and young people set by the Government.

**England**
*Change for Children* is the programme of local and national action through which the whole system of children’s services is being implemented. The changes are described in *Every Child Matters* and include revision of The Children Act, the standards of service design and the way that services are delivered. Considerable emphasis is placed on cross-professional working, involving and centring services on the child and their family and raising the quality of services for all children and young people from birth to age 19.

A range of guidance documents has been produced, including statutory guidance under the Children Act 2004.

The children’s strategy in England is called *Every Child Matters* and sits under the Department for Children, Schools and Families, where the most recent developments are sited and should be viewed in addition to the Department for Health’s website.

**Every Child Matters (September 2003)**

*Every Child Matters* sets out the Government’s aim to ensure that every child has the chance to fulfil their potential by reducing levels of educational failure, ill health, substance misuse, teenage pregnancy, abuse and neglect, crime and anti social behavior among children and young adults.

*Every Child Matters* focuses action on four main areas:
- Supporting parents and carers
- Early Intervention and effective protection
- Accountability and integration, locally, regionally and nationally
- Workforce reform.

The key messages from *Every Child Matters* are the cornerstone of the Government strategy and the NSF supports that vision; that every child should be supported to:
- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing.

*The Common Assessment Framework* (CAF) looks at the best way of sharing an initial assessment amongst professionals that may be requested by anyone identifying a child with unmet needs. The common front sheet of the assessment will be held by a named service, for access as needed and updated appropriately by other professionals engaged in the welfare of that child. Sharing information and the development of trust between organisations is crucial in providing quality and seamless services and to prevent duplication.
The Framework for the Assessment of Children in Need and Their Families addresses the wider needs of the child and their family (94).

Choosing Health focuses on nine key areas where people can make healthier life choices. The policy targets children, especially where they are unable to make a choice (too young or passive e.g. passive smoking) (95).

Public Health in England supports physiotherapy involvement with children in addressing the issues laid out in the policy (59).

Children’s Trusts – set up in response to Lord Laming’s report, the government expects children’s trusts to be introduced to all areas by 2008 and led by local authorities and supported by health and voluntary and community sectors (6).

The trusts work on pooled budgets, joint needs assessments and use of the CAF, joint training in common issues and working in teams to one manager. 35 pathfinder Children’s Trusts were announced in 2003 to test out the theory of the Trusts and to help design policy. The Trusts all set up independently of one another in response to local circumstances and are therefore running in widely different manners, but all to the Every Child Matters’ key outcomes.


The National Service Framework for Children, Young People and Maternity Services (NSF Children) was published in England in October 2004 as part of The Change for Children programme. It covers health service provision for children from gestation to adulthood, extending to 25 years for those living with a Learning Disability. The CSP has published an information paper to support implementation by physiotherapists (96).

The Framework puts into the context of children the commitments of the Government reflected in the NHS Plan and the NHS Improvement Plan, to put the patient at the centre of service provision, to encourage partnership working and improve communication in order to focus the services around the child and its family. It also emphasises the driving force behind the NSFs; to raise standards of care and reduce inequalities of provision across the country (97, 98).

Implementation of this NSF will challenge the profession but offers a wide platform of opportunity to place physiotherapists as key players in the development and provision of children’s services.

The Children’s NSF is aimed at everyone who comes into contact with, or delivers services to children, young people or pregnant women.

The NSF is divided into three parts: Standards 1 – 5, described as the Core Standards, the first five standards address service provision for all children, young people and their families and carers to achieve high quality service provision for all children and young people;

Standards 6 – 10, for children covered by the first five standards, but who have particular needs; Children and young people who are ill; Children in hospital; Disabled Children and Young People and those with Complex Health Needs; Medicines for Children and Young People;

Standard 11, for mothers and babies, from pre-pregnancy to three months post-birth, again in conjunction with the previous standards as applicable.

There are also seven exemplars, demonstrating practice using the NSF:

- Complex disability
- Maternity services
4. UK country-specific child-related policy

- Asthma
- Autistic spectrum disorders
- Chronic Fatigue Syndrome / Myalgic Encephalopathy (CFS / ME)
- Acquired brain injury
- Discharge and support of children requiring long term ventilation in the community.

Supporting documents include:

*The Information Strategy*: which addresses the key information technology challenges that need to be met in providing services for children and their families; challenges that face national agencies and local organizations across all care settings(99).

*Supporting Local Delivery*: produced jointly (DH & DfES): sets out the national support that will be provided to local agencies to support them in implementing the National Service Framework for children, young people and maternity services. It also identifies how the NSF, and the wider health agenda, fits into the Every Child Matters - Change for Children programme, and what this means for health organisations(100).

The website is regularly updated and the source of current information: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en

*Removing Barriers to Achievement* sets out the government’s vision for giving children with special educational needs (SEN) and disabilities the opportunity to succeed; it also sets out a programme of sustained action and review over a number of years to support early years settings, schools and local authorities in improving provision for children with SEN(63).

It gives government commitment to partnership working between local authorities, early years settings, schools, the health service and the voluntary sector.

It incorporates government strategy for improving childcare for children with SEN and disabilities.

Its main focus is on working together to unlock the potential of the many children who may have difficulty learning, but for whose life chances depend on a good education.

There are four key areas:

1. Early Intervention
2. Removing barriers to learning
3. Raising expectations and achievement
4. Delivering improvements in partnership.

**Early Support: Helping every child succeed**

Early Support, accessed via: www.earlysupport.org.uk is the central government recommended mechanism for achieving better co-ordinated, family-focused services for young disabled children and their families across England(101). It stems from government priorities for restructuring children’s service in response to Every Child Matters and the National Service Framework for children. It builds on existing good practice to integrate services in partnership with families who use services and is designed to ensure that the services provided are well co-ordinated and responsive.

Early Support puts the needs of families with young disabled children first. It is designed to ensure that professionals deliver services which are well co-ordinated, family centred, timely and responsive.

The principles and approach of Early Support are reflected in a set of materials and resources including:

- information booklets for families on conditions or disabilities
- a family pack containing a family held file, the family service plan and standardised information about services which may help the family
4. UK country-specific child-related policy

- a monitoring protocol for deaf babies and children
- developmental journals for babies and children with visual impairment and for babies and children with Down Syndrome
- a service audit tool to help both practitioners and strategic planners
- a professional guidance for those working with families using the Early Support approach.

Aiming high for disabled children: supporting families HM Treasury and Department for Education and Skills 2007 is a report on the Government’s Disabled Children Review and highlights the need to ensure that every disabled child can have the best possible start in life, and the support they and their families need to make equality of opportunity a reality, allowing each and every child to fulfil their potential. It addresses:
- Access and empowerment
- Responsive services and timely support
- Improving service quality and capacity
- Next steps.

Sure Start Children’s Centres

The Sure Start Children’s Centre programme builds on existing good practice and is based on the concept that providing integrated education, care, family support, health services and support with employment are key factors in determining good outcomes for children and their parents.

The Centres are places where children under five years old and their families can receive seamless holistic integrated services and information, and help from multi-disciplinary teams of professionals. All Sure Start Children’s Centres will have to provide a minimum range of services including:
- appropriate support and outreach services to parents/carers and children who have been identified as in need of them
- information and advice to parents/carers on a range of subjects, including: local childcare, looking after babies and young children, local early years provision (childcare and early learning) education services for three and four year olds
- support to childminders
- drop-in sessions and other activities for children and carers at the centre
- links to Jobcentre Plus services.

Sure Start Children’s Centres in the most disadvantaged areas will offer the following services:
- good quality early learning combined with full day care provision for children (minimum ten hours a day, five days a week, 48 weeks a year)
- good quality teacher input to lead the development of learning within the centre
- child and family health services, including ante-natal services
- parental outreach
- family support services
- a base for a childminder network
- support for children and parents with special needs, and
- effective links with Jobcentre Plus to support parents/carers who wish to consider training or employment.

The Government is committed to delivering a Sure Start Children’s Centre for every community by 2010 and are expected to use the Early Support approach and materials to deliver high quality services for families of young disabled children. The Children’s Centre Practice Guidance provides support in the development of Children Centres and Section 17 is dedicated to ‘Working with disabled children’.

Website: http://www.surestart.gov.uk/

Extended Schools

Children succeed best when they are healthy, self confident and well motivated. Extending
the range of services that schools can offer is crucial to making sure children and families are given support they need to thrive.

Extended Schools core offer of services includes:
- A varied menu of study support activities such as homework, sports and music clubs
- High quality childcare provided on primary school sites or through local providers
- Parenting support
- Identifying children and young people with particular needs to ensure swift and easy referral to a wide range of specialist support services such as speech and language therapy, child and adolescent mental health services, family support services, intensive behaviour support and sexual health services
- ICT, sports and arts facilities, and adult learning for the wider community.

Additional support information may be obtained from: www.everychildmatters.gov.uk/ete/extendschools

Additional useful websites to support child wellbeing:
Choice for Parents, the best start for children: Ten year strategy for childcare 2004 DfES www.everychildmatters.gov.uk
Improving the Life Chances of Disabled People: 2005 PM’s Strategy Unit www.everychildmatters.gov.uk
Right from the Start 1994 SCOPE: www.rightfromthestart.org.uk
The Lead Professional: Practitioners’ and Managers’ Guides 2006 DfES www.everychildmatters.gov.uk
Implementation of the Lead Professional Role 2006 DfES www.everychildmatters.gov.uk
Toolkit for Managers of Multi-agency Teams 2006 DfES www.everychildmatters.gov.uk
Making It Happen: Working together for children, young people and families: www.ecm.gov.uk

Services for Disabled Children- a review of services for disabled children and their families: 2003 Audit Commission www.audit-commission.gov.uk

Integrated Approach: Best Practice in Multi Agency Working: Find out more about information on structuring teams; advice on common problems; checklists and toolkits; glossary; success factors – the strategy and practices that have worked for other teams; fact sheet. Available online www.ecm.gov.uk/multigencyworking

Care Co-ordination Network UK 2004 New Standards for Key Working: Available www.york.ac.uk/inst/spm/ccnukstandards.htm


Northern Ireland
Our Children and Young People – Our Pledge is a ten year strategy (2006 – 2016) to produce improved outcomes for all children and target services towards those who need help, to narrow the gap in outcomes between those who do best and those who do worst. The Government’s vision is for all children and young people living in Northern Ireland to thrive and look forward with confidence to the future.
By 2016, the strategy’s target is for all children and young people to be:
• Healthy
• Enjoying, learning and achieving
• Living in safety.

The main emphasis within Northern Ireland (NI) at present is to develop working together in multi agency teams, inclusion and improved collaborative working with Education.

The “Standards and Guidance for Promoting Collaborative Working to Support Children with Special Needs”, is a pilot project currently running in special schools within NI. It gives guidance on the promotion of collaborative working between Health and Education Professions supporting children with special needs in special schools, working together to best meet the needs of children. It endorses joint responsibilities for policy development, implementation, service delivery, commissioning and accounting. It outlines standards to promote collaborative working at all levels and identifies needs for partnership agreements.

The Children’s and Young Peoples funding package (Peter Hain MP) was the allocation of funding to directly address the most pressing needs of children and young people. There has been funding for extended schools, additional early years provision, more counselling and therapy support, increased youth provision, better provision for looked after children and improving child protection arrangements.

The aim is to reduce under achievement and improve the life chances of children and young people.

‘Fit Futures’ is looking at joining health, education and sport in seeking to reduce obesity in children. The aim is to stop the rise in childhood obesity by 2010.

Families Matter: Supporting Families in Northern Ireland 2007, emphasises the Government’s determination to improve life chances for children and young people. Its vision “Our Children and Young People, Our Pledge” looks at moving parents into a central position in policy terms and strategic direction. It aims to empower and assist parents to be responsible in helping their children reach their full potential. The drivers for the document are Every Child Matters: Change for Children programme, ten-year children’s strategy and The Child Poverty Review.

The Children’s Strategy is to assist organisations to work together at all levels; facilitating better information sharing, putting together common standards and ensuring the focus remains on the child or young person.

Health for all Children, This recommends a move away from a medical model of screening for disorders, with greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk. www.dhsspsni.gov.uk/hssmd 15-04.pdf

A Healthier Future is organised around five themes, investing in health and wellbeing, involving people – caring communities, responsive combined services, teams which deliver and improving quality. Targeted groups are children who need care or extra support and people with learning disabilities.

The following additional articles address wellbeing of children in Northern Ireland and may all be located on; www.dhsspsni.gov.uk

The Children (Northern Ireland) Order 1995
4. UK country-specific child-related policy

The Education (Northern Ireland) Order 1996
The Special Needs and Disability (Northern Ireland) Order 2005
The Disability Discrimination Act 1995
Code of Practice on the Identification and Assessment of Special Educational Needs 1998
Supplement to the Code of Practice on the Identification and Assessment of Special Educational Needs 2005
SCIE Report to Managing Risk and Minimising Mistakes in services to Children and Families
Best Practice – Best Care 2001 A Framework for Setting Standards, Delivering Services and Improving Monitoring and Regulation in the HPSS
A Healthier Future – A Twenty-Year Vision for Health and Wellbeing in Northern Ireland 2004
Children’s and Young Peoples Funding Package Peter Hain 2006
Fit Futures Implementation Plan 2007
Co-operating to Safe Guard Children (Northern Ireland) 2003
Understanding the needs of Children in Northern Ireland 2006
The Disability Discrimination (Code of Practice) (Schools) (Appointed Day) Order (Northern Ireland) 2006
A Northern Ireland Review of Advocacy Arrangements for Disabled Children and Young People with Complex Needs 2006
Clinical Governance and Risk Management: Achieving safe, effective, patient focused care and services National Standards 2005.

Scotland

Health and Education are devolved to the Scottish Parliament.

- This recognizes the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. No child should be deprived of the right of access to health care services.
- Scotland’s children need to be safe, nurtured, active, healthy, achieving, included, respected and responsible in order to become successful learners, confident individuals, effective contributors, and responsible citizens.
- There is an emphasis on providing care locally with effective interagency working. Where possible, with regard to safety and quality, hospital care is delivered as locally as possible.

NHS Reform (Scotland) Act 2004\(^{(108)}\)

This Act provides the legislative basis for the establishment of Community Health Partnerships (CHPs) which are considered vital for the modernisation and redesign of NHS Scotland and of joint services with Local Authorities. The priority is working towards a decentralised but integrated health and
social care systems. In particular, CHPs will seek to close the health gap, reducing health inequalities.

In relation to child health:
Children and young people, their parents and carers are involved in the design of services. Areas highlighted include:
• More care for children is provided closer to home
• Guidelines for the management of common childhood conditions by primary and secondary care are agreed and implemented
• Services and initiatives to improve the health of children are developed further, for example around the growing prevalence of obesity in children and young people
• Children with additional needs have shared assessment by relevant agencies, agreed coordinated care plans and monitoring of outcomes
• Clear processes are in place to agree funding arrangements for children with complex needs
• Services for vulnerable families are integrated with local authority services in a way that ensures referral access by all relevant agencies and joint working amongst health, education and social work staff.

Education (Additional Support for Learning) (Scotland) Act 2004

The Act replaces the system for assessment and recording of children and young people with special educational needs, including the Records of Needs process, established by the Education (Scotland) Act 1980.

Additional Support for Learning legislation requires agencies such as NHS Boards to respond to requests for help from education authorities within a period of ten weeks, including services based in the community and managed by CHPs.

The process for assessment and recording educational support needs is detailed in the publication, Statutory Guidance relating to the Education (Additional Support for Learning) (Scotland) Act 2004. Agencies must adopt an integrated approach to assessment, intervention, planning, provision and review.

There is a duty to help an education authority unless the help asked for:
• is incompatible with the agency’s statutory or other duties; or
• unduly prejudices the agency in its discharge of its own functions.

A response to a request for assessment should be made within ten weeks.

Health for All Children

To be implemented throughout the UK this recommends a move away from a medical model of screening for disorders, with greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk.

Building on Success: Future Directions for Allied Health professionals 2002

Shaping the future of Allied Health Professional; key areas includes service design, clinical governance, research and development, career pathways, recruitment and retention.

Delivering care, enabling health, Scottish Executive November 2006

This builds on the national strategy for nursing and midwifery and the AHP strategy; Building on Success. It considers the contribution of Nursing, Midwifery and AHP services (NMAHP) to health care policy in the key areas of culture, capability and capacity. Delivering for Health is the policy context for health care in Scotland. The document
considers the NMAHP contribution to meeting the identified need of Scotland’s population. Enabling is described as being fundamental to Allied Health professional practice and services.

Supplementary information relating to Children’s Services in Scotland can be found at www.scotland.gov.uk/Publications

**The Information Management and Technology (IM&T) Strategy (2002)**\(^{(114)}\)

Published by the Scottish Executive Health Department recommended that all Scottish NHS Boards implement The Support Needs System (SNS) by 2004. SNS was established in 1993, with the aim of enabling early identification, assessment and monitoring of children with additional support needs in a consistent manner across Scotland. Additional information may be obtained via: http://www.isdscotland.org/isd/3397.html.

Additional articles address wellbeing of children in Scotland.

**Education (Additional Support for Learning) (Scotland) Act 2004**


**Joint Inspection of Children’s Services and Inspection of Social Work Services (Scotland) Act 2006.**


**Building a Health Service: Fit for the Future: Scottish Executive 2005** www.scotland.gov.uk

**Delivering a Healthy Future: An Action Framework for Children and Young People’s Health in Scotland: A draft Consultation 2006**


**Getting It Right for Every Child: Implementation Plan: Scottish Executive 2006** www.scotland.gov.uk

**The Same As You: A review of Services for people with Learning Difficulties: Scottish Executive 2004.** www.scotland.gov.uk

**Publication-SCLD Bulletin: Scottish Consortium for Learning Disability: Contact 0141 4185420** www.scld.org.uk

**Wales**

**Designed for Life**

‘Building upon the work already begun in Building for the Future, Improving Health in Wales and Health Challenge Wales, this strategy will outline how we will get there. It is called Designed for Life; this encapsulates our whole approach. Design needs to be inspired, yet practical, actively planned, modelled and built by experts. High quality design is durable, safe and effective – it delivers to people what they want. In short, it is fit for purpose, and our purpose here is an improved quality of life for the people of Wales - adding not just years to life, but life to years. Much of the achievement will rely on good partnerships, especially across the NHS, public health, local government and voluntary organisations.’\(^{(115)}\)
4. UK country-specific child-related policy

Over the past few years’ paediatric physiotherapy services in Wales have engaged with the health Modernisation agenda set out by the Welsh Assembly Government. National strategies such as *Designed for Life* have been supported by the development and publication of Children’s NSF for Wales and by the Children and Young Peoples Specialist Service Standards[115-117].

**Children’s National Service framework (Wales)**[116]

The overall aim of the Children’s NSF is that “all children and young people achieve optimum health and wellbeing and are supported in achieving their potential”. The scope of the Children’s NSF includes all children and young people from pre-conception to 18th birthday, for whom NHS Wales and local social services authorities have a responsibility. Special consideration will be given for transition management into adult services beyond the 18th birthday for those requiring support services.

The framework contains 21 standards and 203 key actions, which are based on the 42 Articles of the UN Convention on the Rights of the Child and the Assembly’s seven core aims for children and young people. A Self-Assessment Audit Tool has been designed as part of a performance measurement system for the Children’s NSF for use by all statutory organisations that deliver services for children and young people, including the delivery of maternity services.

Children and Young People Specialist Service Standards (CYPSS)[117]:

‘Children are special and some children need very specialised health services to diagnose and treat their diseases. There has been considerable change in the configuration and range of specialist services available to the children of Wales in recent years. Many services have been developed but some have not proved sustainable because of concerns about continuity of care, or workload or staffing levels’.

In 2002 it was agreed that any review of tertiary services for children in Wales should:
- define in detail what are specialised services for children
- review the incidence and prevalence of diseases which require specialised care
- assess the quantity, quality and costs of the existing provision
- assess how any undesirable variations in cost, volume and quality of existing provision can be reduced
- propose options for improvement.

Specialist Services under review include:
- Neonatal
- Paediatric intensive care
- Paediatric specialist medicine
- Paediatric neurosciences
- Paediatric oncology and palliative care
- Paediatric specialist anaesthetics and surgery.

For easy to read aide memoirs and synopses of all the above documents go to the following site: www.healthcarealliances.com

**Therapies for Modernisation**

In addition, the publication in 2006 of a specific Therapies Strategy for Wales has contributed to the transformation of the delivery of Health and Social Care in Wales[118].

‘This document sets out important objectives and key actions applicable across the entire physical, social and psychological spectrum of wellbeing, health improvement, accident and ill health prevention and the management of illness, injury and disability. It provides a platform from which therapists and their support staff should be engaged and employed to support and deliver service provision, developments and modernisation across Wales. Some of this agenda is challenging, but the potential benefits are considerable. This strategy provides a framework from which action and more detailed work will be required at a local level to fully explore how these benefits will be achieved.’
be realised. The Government, commissioners, providers, professionals and the public must seize the opportunities and work together to ensure that Wales secures the powerful contribution of the Therapy Services to its health and social care agenda.’

Sport and leisure

For many of the children and young people that physiotherapists work with opportunities to participate fully in sporting and leisure activities can seem very limited and they may be asked for advice.

The English Federation for Disability Sports (EFDS) provides details of local Disability Sports Development Officers and of their own Regional representatives. These individuals should be able to advise on all local sporting activities, and will possibly be able to work with physiotherapists to develop new opportunities.

EFDS website provides a vast array on information ranging from funding opportunities to information on specific sports. Information relating to disability sporting events around the country can be found on EFDS’ website: www.disabilitysport.org.uk

The EFDS also produces a quarterly magazine ‘Inclusive Sport’.

Disability Sports Northern Ireland.
Website: http://www.dsni.co.uk/

NI Gillian McKenna (gillian.mckenna@SPECIALOLYMPICS.ie)

Federation of Disability Sport Wales (FDSW).
Website: http://www.disabilitysportwales.org/

Sport Scotland.
Website: http://www.sportscotland.org.uk/

**Other useful websites relating to disability sports include:**

British Gymnastics
Website: http://www.british-gymnastics.org/

British Blind Sport.
Website: http://www.britishblindsport.org.uk/

UK Deaf Sport
Website: http://www.ukdeafsport.org.uk/

Mencap Sport.
Website: http://www.mencap.org.uk/html/mencap_sport/
5. Useful general information

WheelPower – British Wheelchair Sport.
Website: http://www.wheelpower.org.uk/

CP Sport England & Wales.
Website: http://www cpsport.org/

For more specific information on competing in disability sports at National and International levels:

British Paralympic Association.
Website: http://www.paralympics.org.uk/

Cerebral Palsy International Sports and Recreation Association (BALASA).
Website: http://www.cpisra.org/

British Amputee and les Autres Sports Association (BALASA).
Website: http://www.fastuk.org/atcommunity/orgview.php?id=2633. Tel: 01204 494308

Sport specific sites of interest include:

The Wheelchair Football Association
Website: http://www.thewfa.org.uk/

National Wheelchair Tennis Association of Great Britain.
Website: http://www.btf.org.uk/
WheelchairTennis/

Great British Wheelchair Rugby
Website: http://www.gbwrr.co.uk/

Great Britain Wheelchair Basketball Association
Website: http://www.gbwba.org.uk/

British Amateur Swimming Association – Disability Swimming.
Website: http://www.britishswimming.org/vsite/vnavsite/page/directory/0,10853,5026-142732-159948-nav-list,00.html

Halliwick Association of Swimming Therapy in the UK.
Website: http://www.halliwick.org.uk/

The Art of Swimming - Shaw Method.
Website: http://www.artofswimming.com/

Swimming and CP.
Website: http://www.cerebralpalsysource.com/Treatment_and_Therapy/swimming/index.html

New Age Kurling.
Website: http://www.kurling.co.uk/

International Blind Sports Association – Goal Ball and other sports
Website: http://www.ibsa.es/eng/

The British Ski Club for the Disabled
Website: http://www.bscd.org.uk/

The British Disabled Angling Association
Website: http://bdaa.co.uk/

British Blind Sports.
Website: http://www.britishblindsport.org.uk/

International Federation of Blind Sports.
Website: http://www.ibsa.es/eng/

The Clavert Trust offers adventurous outdoor activities for people with disabilities at their three Centres England – Scottish Posture and Mobility Network
Website: http://www.calvert-trust.org.uk/

Riding for the Disabled. Provides comprehensive information relating to localities and the Association’s activities.
Website: http://www.riding-for-disabled.org.uk/

The Fortune Centre of Riding Therapy
Website: http://www.fortunecentre.org

The Federation Riding for the Disabled International
Website: http://www.frdi.net/

MS Trust. Hippotherapy – a new movement experience: what fun!.
URL: http://www.mstrust.org.uk/publications/opendoor/0605_10_11.jsp

Revive MS Support. Hippotherapy.

Calvert Trust Riding for the Disabled – Exmoor Equestrian.
Website: http://www.equinetourism.co.uk/equineestablishments/calverttrust.asp

Royal Association for Disability and Rehabilitation (RADAR). has a range of
useful publications including ones relating to accessible holidays and leisure pursuits
Website: http://www.radar.org.uk/radarwebsite/

The following charities provide wheelchair training courses for children and young people:
Whizz Kidz.
Website: http://www.whizz-kidz.org.uk
The Association of Wheelchair Children.
Website: http://www.wheelchairchildren.org.uk/
The Scottish Posture and Mobility Network
Website: http://www.spmn.org.uk/

Specialist holidays
These are some of the national organisations that provide and support specialist holidays for the disabled client often incorporating activities for the family/carers. There may be local organisations that provide/fund such holidays. If so, information may be obtained at your Tourist Information Centre/Local Council.

Calvert Trust Activity Holidays for the Disabled.
Website: http://www.calvert-trust.org.uk/

Royal Blind Society – holidays.
Website: http://www.royalblindorganisation.org/holidays.htm

Enable Holidays
Website: http://www.enableholidays.com
Disability Now – accessible holiday accommodation.
Website: http://www.disabilitynow.org.uk/directory/adv_accomm.htm

John Grooms Holidays – Provides the highest quality holidays for the disabled
Website: http://www.johngrooms.org.uk/landing.asp?id=9

Tall Ships Youth Trust – Supports the personal development of young people through crewing tall ships. Website: http://www.tallships.org/

Voluntary agencies and support groups
There are many easily accessible voluntary agencies and support groups both nationally and locally for children, young people and their families/carers. Below are just a few of the well known national agencies but it is worth investigating local voluntary agencies/support groups.

Contact a Family
Website: http://www.cafamily.org.uk/

Scope UK.
Website: http://www.scope.org.uk/

High/Scope UK.
Website: http://www.high-scope.org.uk/

HemiHelp.
Website: http://www.hemihelp.org.uk/

Erb’s Palsy Group.
Website: http://www.erbspalsygroup.co.uk/

BLISS – the premature baby charity
Website: http://www.bliss.org.uk/

National Association of Toy & Leisure Libraries.
Website: http://www.natll.org.uk/

The Variety Club Children’s Charity.
Website: http://www.varietyclub.org.uk/

Cerebra: for Brain Injured Children and Young People.
Website: http://www.cerebra.org.uk
Whizz Kidz.
Website: http://www.whizz-kidz.co.uk

YoungMinds. Young people and mental health issues including advice and information sheets on eating disorders and self harm
Website: http://www.youngminds.org.uk/
Other relevant Clinical Interest Groups and Occupational Groups (CI/OGs)

There are nearly 40 CI/OGs recognised by the CSP and new ones continue to develop. Interest groups represent a distinct field of physiotherapy clinical practice that may be specific to a client group, a clinical area or a specific treatment approach or modality. The occupational groups all represent physiotherapists working in a specific occupational area.

The following recognised CI/OGs link to paediatrics:

Acupuncture Association of Chartered Physiotherapists: AACP www.aacp.uk.com

Association of Chartered Physiotherapists in Cystic Fibrosis: ACPCF


Association of Chartered Physiotherapists in Electrotherapy: ACPIE

Association of Chartered Physiotherapists in Independent Hospitals and Charities: ACPIHC

Association of Chartered Physiotherapist Interested in Neurology: ACPIN www.acpin.net

Association of Chartered Physiotherapists in Reflex Therapy: ACPIRT

Association of Chartered Physiotherapists in Management: ACPM www.physiomanagers.org.uk

Association of Chartered Physiotherapists in Occupational Health and Ergonomics: ACPOHE www.acpohe.co.uk

Association of Chartered Physiotherapists in Orthopaedic Medicine and Injection Therapy: ACPOM www.acpom.org.uk

Association of Chartered Physiotherapists in Oncology and Palliative Care: ACPOPC www.acpopc.org.uk

Association of Chartered Physiotherapists for People with Learning Difficulties: ACPPLD www.acppld.org.uk

Association of Chartered Physiotherapists in Respiratory Care: ACPRC www.acprc.org.uk


Association of Chartered Physiotherapists in Therapeutic Riding: ACPTR

British Association of Bobath Trained Physiotherapists: BABBT www.bobath.org.uk

British Association of Chartered Physiotherapists in Amputee Rehabilitation: BACPAR www.bacpar.org.uk

British Association of Hand Therapists: BAHT www.hand-therapy.co.uk

Chartered Physiotherapists Interested in Massage and Soft Tissue Therapies: CPMaSTT

Chartered Physiotherapists in Mental Health: CPMH www.cpmh.org.uk

Chartered Physiotherapists Promoting Continence: CPPC

Craniosacral Therapy Association of Chartered Physiotherapists: CTACP

Chartered Physiotherapists Working as Extended Scope Practitioners: ESP

Hydrotherapy Association of Chartered Physiotherapists: HACP

Haemophilia Chartered Physiotherapists’ Association: HCPA

International Support Group for Chartered Physiotherapists: ISC4CP

Medico-legal Association of Chartered Physiotherapists: MLACP

Organisation of Chartered Physiotherapists in Private Practice: OCPPP www.physiofirst.org.uk
Appendix – Resources and references

Physiotherapy Pain Association: PPA.
Physiotherapy Research Society:
PRS www.prs-uk.org

The following CI/OGs are not formally recognised by the CSP but also address children within the specialty:
Association of Chartered Physiotherapists working with Acquired Brain Injury
Renal
Burns
Paediatric Physiotherapists in Management Service
NB Those CI/OGs without a website may be contacted by logging onto the CSP website; www.csp.org.uk/specialist group section.

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References:


Appendix – Resources and references


Appendix – Resources and references


32. The Chartered Society of Physiotherapy. The personal development plan (PDP) as part of the development review process (CPD 28).


Appendix – Resources and references

- London: Association of Paediatric Chartered Physiotherapists (ACPC); 2005.


Appendix – Resources and references

58. The Royal College of Paediatrics and Child Health. Adolescent Health Project
Website: http://www.rcpch.ac.uk/Education/Adolescent-Health-Project


Appendix – Resources and references


Appendix – Resources and references


Appendix – Resources and references


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