**Document 1:**

**Specification for Specialist Occupational Therapy Input to Children’s Wheelchair Services**

**Version control**

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| **Version** | **Date** | **Author(s)** | **Comments** |
| 0.1 | 21/02/17 | G Hill | First draft  |
| 0.2 | 28/02/17 | G Hill | Updated following feedback from outgoing provider and Derbyshire wheelchair services |
| 0.3 | 01/03/2017 | G Hill | Updated following comments from outgoing provider |
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# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement

Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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| **Service Specification No.** |  |
| **Service** | Specialist Occupational Therapy Input to Children’s Wheelchair Services  |
| **Commissioner Lead** | NHS North Derbyshire CCG |
| **Provider Lead** |  |
| **Period** | 1st April 2017-31st March 2018 |
| **Date of Review** | 3 months |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**

Children and young people aged 0-19 represent 22% of the Derbyshire population (an estimated 171,500 children and young people in 2014). While the number of children in the 15-19 age range is declining, the population of 10-15 year-olds is increasing and set to reach more than 45,000 by 2020. The population of younger children is also increasing, although more slowly. 2010/11 data from the Department for Work and Pensions suggests 6% of children are disabled1. In North Derbyshire and Hardwick CCG populations, this could be 5,000 children and young people 0-19. A disability is described in law (the Equality Act 2010) as ‘a physical or mental impairment which has a long-term (a year or more) and substantial adverse effect on their ability to carry out normal day-to-day activities. A significant number of children and young people with physical disabilities may require a wheelchair or specialist seating to enable them to achieve optimal outcomes.The equipment supplied by the wheelchair service has the potential to impact upon several of the determinants of public health such as: improving individual lifestyle by increasing independence, improving access to transport and leisure by increasing social and community networks and reducing social isolation and consequent potentially depression (Source: Improving Services for Wheelchair Users and Carers – Good Practice Guide - December 2004). The timely provision and maintenance of an appropriate wheelchair is important to help improve mobility or perform tasks of daily living ensuring independence and maintaining wellbeing, while reducing dependence on other health and social care services (Transforming Community Services 2011). |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**

| **Domain 1** | **Preventing people from dying prematurely** |  |
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| **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **✓** |
| **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **✓** |
| **Domain 4** | **Ensuring people have a positive experience of care** | **✓** |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **✓** |

**2.2 Local defined outcomes**In order to measure compliance with the following outcomes, each service will complete a service template report which must be shared with both their senior management teams and with children’s commissioners. The service will deliver “Our expectations from health services”, as developed by children and young people: Individual level outcomes1. Children, young people and families feel they are listened to, involved in decisions about them and treated holistically.
2. Children and young people are actively engaged in managing their health, well-being and achievements, increasing confidence in management of their condition. Where possible and appropriate, the service will ensure this leads to independence and ability to self-care at a pace they can cope with.
3. Schools, settings and families (and young people when old enough themselves) are aware of when the service will attend to deliver therapeutic intervention, including both appointments and school visits. The service will work towards putting a reminder system in place suitable to the individual.
4. Families, schools and settings will understand the program of care which is recommended for their child.
5. Children, young people and families feel that assessment and planning was joined up around them with collaborative, integrated working that minimises repetition of their story.
6. Children, young people and families understand their care pathway. This means they will be communicated with effectively around progress, any changes to provision and when discharge is appropriate.

Service level outcomes1. All children and young people are seen within 7 week maximum wait time for first appointment.
2. The service will increase confidence and ability of appropriate school/settings staff and parents/carers to be able to become an integral part of the care of children with therapy needs.
3. Following involvement with the service, children and young people will be enabled to improve their access to the national curriculum.
4. The service will demonstrate the effectiveness of the work it carries out, including comprehensive and routine use of PROMs.
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| **3. Scope** |
| **3.1 Aims and objectives of service****Aims:*** Reducing the impact of communication/and or mobility difficulties on a child’s life.
* To support children and young people to achieve their optimal functional potential in order to participate in and enjoy every setting.
* To work in partnership with other professionals as part of an integrated, multi-agency approach to meet the needs of the child/young person and improve their quality of life.
* To support parents/carers and education settings so that the child is able to contribute as fully as possible into family and community life.

The service will adhere to this service specification and also align with the service specification for the Derbyshire wheelchair service and the eligibility criteria which apply to the Derbyshire wheelchair service. There must be an assessment against eligibility for all children's wheelchair provision from low, medium to high, including buggies, manual and powered wheelchairs.  This specification does not detail every individual care pathway or aspect of service, but provides an overarching specification for the outcomes of service delivery. The service will develop their own pathways and processes in conjunction with commissioners in order to meet the outcomes detailed and review and share these regularly. The pathways applicable to this service are detailed in a separate document. They will work with the existing wheelchair service and children’s occupational therapy services to ensure a seamless service for the child/young person.They service will:* Triage patients to see the most appropriate professional and identifying if referrals require a specialist assessment.
* Provide specialist assessment of children and young people, to determine the nature, severity and level of the wheelchair intervention required.
* Devise a care plan, intervention or treatment which may include specialist equipment to meet identified needs.
* Signpost and /or refer families and other professionals to appropriate health, education and social services.
* Review children to monitor changes and review management of the wheelchair provision.
* Delegate some aspects of delivery of the care plan to staff with a range of bandings and competencies and confidence depending on the nature of the work. This may be to deliver within education settings where appropriate.
* Provide advice which enables children, young people and families as far as possible to manage their own conditions.
* Use evidence based practice for any packages of care provided.
* Attend joint clinics with wheelchair services where needed.

**3.2 Service description/care pathway**Patient engagement and experience:Conduct* Parents to be listened to and clinicians to be open minded, respectful, polite and courteous towards families and children. Children and families must be treated as individuals and be given a right to choice.
* Ensure the child sees the same occupational therapist consistently, wherever possible.

Preparation* Provide pre appointment information to families when requested by them, such as photos of occupational therapists and/or locations.
* Gather pre appointment information from families and children, which they should be able to submit electronically where requested. Alerts should be used to identify any of these needs. Clinicians must be prepared for the appointments with this information.
* Give information to families and children which is accessible and appropriate to their level of understanding. This should include access to electronic information, such as websites and apps for young people. Information leaflets and on-line information must show due regard for Equality and Diversity.
* Provide information on support groups and group sessions where this is appropriate, including those in the local community.
* The services will deliver the outcomes as defined by children and young people in “Our expectations of health services”.

Feedback* Feedback must be sought regularly from families and children as to their experience of the service. Actions should be disseminated to parents in a culture of transparency to demonstrate “you said we did”.
* Feedback on service users experience is vitally important in shaping services and ensuring that outcomes are achieved. It is important to families that feedback is concise and accessible and does not take too long to complete.
* Feedback needs to be gathered about the whole of the patient experience, from how the families were greeted at reception to how they felt about the individual clinician. This must be fed back to the appropriate individual or responsible service to ensure a continuous improvement cycle. It is important that both positive and negative feedback are both fed back to the relevant people.
* There will be a variety of mechanisms available for parents/carers and children to be able to leave feedback, which will allow the feedback mechanism to be as accessible to all as possible. Feedback should be via a method which is accessible to the family.
* Any feedback from parents/families/children must be acknowledged and there must be a mechanism in place for reporting back to families what has been done with the feedback they have given.

Communication:* Consent to share information with other health professionals and other agencies, such as education and social care should be sought at the start so that families are not having to repeat information but that confidentiality is maintained.
* There must be effective integration and communication with the other health providers, with education and other agencies and with parents/carers, especially around changes in provision for the child dependent on their progress. Reports will be provided to parents/carers, GPs, health visitors or school nurses, referrers and any other relevant professionals and education settings, including SENCOs, where appropriate. This must include social workers for children in need or for children in care or subject to a safeguarding children’s plan.
* Occupational therapists must communicate effectively with schools and settings to ensure that the care is shared between all parties so that schools and parents are aware of their role and receive sufficient support to implement this so that this is jointly owned. It is appropriate to speak to the teachers and staff face to face or via a phone call where this is necessary to ensure that the child’s care plan is delivered safely and effectively.
* Occupational therapists must contact schools with adequate notice when there is any change to the care plan or a child or young person with newly identified needs, so that any training or adaptations can be put in place prior to the school term, wherever possible. Likewise, education settings need to share relevant information with occupational therapists.
* Inform families and children if there is going to be a wait for their appointment and what the time of the delay will be.
* Provide clear information about the services on the relevant local offer website to support parents and carers in accessing services, including eligibility criteria.
* Clinicians and/or appropriate management will prepare reports and attend tribunals as and when needed for active patients only and only as agreed with the commissioners on a case by case basis.

Integrated working and skills sharing:* To work with commissioners to ensure high quality, effective and best value service is delivered. This will include audit of case files and other aspects of service provision.
* A care plan / program which is person centred and shared across all agencies including parents so that this can be provided consistently throughout the year, with clarity about agreed provision and who will deliver this. Care plans must provide outcomes and goals and have a named occupational therapist. These must be reviewed at least annually.
* Train/coach the key agents of change in the child’s environment (e.g. parents, professionals from other areas) to enable them to successfully implement the care plan. This is especially important for children with complex needs. This training should include, but not be limited to; parents and carers, social care services, early help, GPs, practice nurses, community and hospital nurses, health visitors, school nursing, teachers, early learning providers, Youth offending services, social workers and other staff working with the child in an educational setting.
* Deliver effective transition planning, in collaboration with other agencies, the families and young people.
* Statutory targets must be met with regards to contributing to the assessment of SEND process.

Access, waiting times and locations of services* 7 week maximum wait time for first appointment.
* Appointments during the school day should be in or close to school settings or other places of learning to reduce children’s school or learning absence and improve access, where this is clinically the most the appropriate for the child. Appointments outside the school day should be made as close to the child’s home as possible.
* The service will be flexible towards families’ needs in terms of time of appointments, such as out of hours appointments and offering locations which are in a variety of settings and locations, suitable to the individual child and families’ needs. The appointments must be flexible to accommodate the needs of the families wherever possible. As part of the five year forward plan, children should be treated in their local community wherever possible and if specialist care is required out of their local community, a plan should be in place to return care to the local community wherever possible.
* Reducing inequalities and improving access, enabling those with physical, sensory or learning disabilities and those who do not speak or read English to have equal access to information through use of interpreters commissioned by the service and appropriate information media/leaflets.
* Patients will be discharged from the service if they do not currently require input, if the parents or carers self-discharge or refuse treatment, if the identified difficulties have resolved, if the child or young person has made optimum progress for that stage in their development.

Information and IT systems* All activity and patient contacts must be recorded on an electronic patient management system, to enable accurate planning and monitoring of all the above.
* Face to Face and none direct service contacts (training and telephone calls) with professionals/ parents/carers ensuring ‘every contact counts’.
* Service to have a system in place to be able prioritise those with urgent needs.
* Actively explore the use of text reminders for appointments.

Monitoring of outcomes* Training in the use of standardised outcome measures to assess the effectiveness of care programmes for individual children and their families and to evaluate the effectiveness and quality of the service overall will be seen as a valid part of continuing professional and service development. This should include outcome measures which look at the efficacy of the therapy as well as the whole child (PROMS).
* Joint goal setting along with children/young people and families and other relevant professionals. These should include SMART outcomes. Roles and responsibilities of each individual in the plan, including parents (e.g. such as ensuring child is brought to appointments), must be made clear and the methods which will be used to measure progress.

Qualifications and training* Qualified staff to be registered with the HCPC (Health and Care Professions Council).
* Staff to be trained to the appropriate level in terms of safeguarding children and young people and to access regular update safeguarding training in accordance with Derbyshire Safeguarding Children’s Board recommendations.
* All staff to be trained with the appropriate experience/competencies with any equipment they use.
* Staff to have undertaken appropriate prescriber training.

**3.3 Population covered**The service will be provided to children and young people aged 0-18 years (or 19 when attending a special school) who are registered with member GP Practices of NHS North Derbyshire and Hardwick CCGs.Out of area children or young people including Looked After Children placed in-areaFor children and young people in local North Derbyshire Special Schools referrals will be managed on a case by case basis. A cross border agreement will be agreed so that safe provision for children with therapy needs and clear roles and responsibilities are outlined. Looked After Children placed in area will be prioritised into service unless the level of intervention required is not possible within current capacity and would adversely impact the level of quality of service available to local children and young people. If a child is accepted into service the necessary arrangements with the responsible CCG will be made for recovering the cost of this activity. **3.4 Any acceptance and exclusion criteria and thresholds**Referrals into the service will be accepted from the Derbyshire wheelchair service and from other therapists currently working with the child, for children and young people up to the age of 18 (or 19 if in a special school).The Service should consider the use of the Common Assessment Framework as part of the individual child/young person’s assessment and implement wherever appropriate. There should be links with MAT’s established for all vulnerable children.Exclusion criteriaChildren for whom Occupational Therapy intervention would offer no identifiable benefit based on evidence of effective interventions or where it is contra-indicated.Children who do not meet the service referral criteria.Response time & detail and prioritisation* The first appointment should be within 7 weeks of referral.
* Critical referrals which are defined as the following will be prioritised:
	+ Safety/safeguarding concerns where relevant to a therapy intervention
	+ Prevention of breakdown of care
	+ Neo-natal/post surgical interventions
	+ Looked after children
* Children who require equipment must have their needs assessed for equipment promptly, within the 7 week timescales. Any exceptions will be referred to commissioners. Targets for subsequent provision of the equipment including wheelchairs is monitored as part of the overall wheelchair service specification.

**3.5 Interdependence with other services/providers*** Main Derbyshire wheelchair service
* Children, young people and their families and carers
* GPs
* Hospital/Community Paediatricians
* Orthopaedic teams
* Other Paediatric Therapists both inside and outside of Derbyshire
* School/Specialist School nurses/specialist nurses
* Health visitors
* Schools/settings staff
* CAMHS
* Continence services
* Children and Younger Adults department, particularly Disabled Children’s Teams and Multi-agency teams – Derbyshire County Council
* Specialist SEND teams
* Adult therapy services
* Equipment Services
* Voluntary sector
* Orthotic Services
* Housing providers
* 111 and out of hours services
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| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)*** Equality Act 2010
* Health and Social Care Act 2012
* Children and Families Act (2014)
* Department for Health & Department for Education: Statutory guidance on Promoting the health and wellbeing of looked-after children (2015)
* Department for Health and Department for Education: SEND code of practice 0-25 years (2015)
* National Framework for Children and Young People’s Continuing Care (January 2016)
* National Service Framework for Children, Young People and Maternity Services (October 2004) Standards 1, 2, 3, 4, 5, 6, 8 and 10
* NHS Employers’ employment checks standards
* NHS England: Who Pays? Determining responsibility for payments to providers (2013)
* CCG Outcomes Indicator set
* NICE CG89 Child maltreatment: When to suspect maltreatment in under 18s (2009)
* NICE QS31 Looked after children and young people (2013)
* NICE PH28 Looked after children and young people (2013)
* NICE PH40 Social and emotional wellbeing: early years (2012)
* NICE CG128 Autism in under 19s: Recognition, referral and diagnosis (2011)
* NICE CG170 Autism in under 19s: Support and Management (2013)
* NICE QS101 Learning disabilities: challenging behaviour (2015)
* NICE CG145 Spasticity in children and young people (2012)
* NICE NG43 Transition from children’s to adults’ services for young people using health or social care services (2016)
* NICE guidelines expected in 2017 relating to cerebral palsy and cystic fibrosis

SafeguardingThe Service must ensure that policies and procedures relating to safeguarding are adhered to and that it seeks the advice from the Derbyshire Safeguarding Children Team or Board as required. Staff must have undertaken training at the level appropriate to their professional role and all staff working with children must have enhanced DBS clearance.The Service will make itself aware of the recommendations resulting from Lord Laming’s report (March 2009) and implement any policy/procedure/practice as agreed nationally, regionally and/or locally and that is relevant to its safeguarding responsibilities. The service will also be aware of the following documents and adhere to any standards and guidance therein:* Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2014
* Working Together to Safeguard Children (2015)
* Department for Education: What to do if you’re worried a child is being abused: Advise for practitioners (2015)
* Derbyshire LSCB (Local Safeguarding Children’s Board) procedures

If children and young people do not attend appointments consistently this is likely to have a significant long term impact on their development and outcomes. It is therefore vital that where a child is not brought to an appointment (DNA’s) by parents/carers, there must be an escalation process to social care and the named Trust named nurse or doctor for safeguarding children where necessary. In all cases the referrer should be made aware of the failure of the parent/carer to bring the child for the appointment.**4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)** * COT Professional Standards for Occupational Therapy Practice (2011)

There is a lack of overall data on need for occupational therapy nationally in the paediatric population. Although there are guidelines for specific aspects of these services, there are no specific national standards which pertain to whole service provision. COT = College of Occupational Therapists**4.3 Applicable local standards*** Derbyshire’s Early Intervention and Prevention Strategy
* Derbyshire County Council: Transition Planning in Derbyshire: Pathways and Person-Centred Approaches (2015)
* Derbyshire Children and Young People’s Plan 2015-16 to 2017-18
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| **5. Applicable quality requirements and CQUIN goals**  |
| * 1. As detailed in specification.
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| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**The service will be delivered from locally and community focused locations and therefore are delivered from appropriate locations and within suitable child-friendly settings, including - child/young person’s home/place of residence- education setting- local health premises (as clinically appropriate) |
| **7. Individual Service User Placement** |
| Not applicable |

**References**

1. Annual Report of the Chief Medical Officer 2012 (Department of Health)
2. Interim Needs Assessment for Children and Young People with Special Educational Needs and Disabilities in Derbyshire (2016)
3. Special educational needs and disability code of practice: 0 to 25 years (Department for Education and Department for Health, 2014)
4. NICE clinical guideline 145 Spasticity in children and young people (NICE, 2012)