

Association of Paediatric Chartered Physiotherapists COVID-19 Survey Analysis: Caseload Management

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Introduction

Recent UK wide national health service (NHS) initiatives have prompted cost effectiveness strategies across allied healthcare services, resulting in reduced staffing and higher caseload pressures, particularly in the community. Literature has revealed these caseloads to be unmanageable at times, with one APCP survey reporting that fewer than half of paediatric physiotherapy respondents considered their workload manageable (Hodgson and Shannon, 2019). This has resulted in development of unpublished workload tools to support community caseload management, including the Nottingham demand tool and the Birmingham workload management tool.

In March 2020, Public Health England (PHE) introduced safety measures in response to COVID-19 that forced radical changes in face-to-face paediatric physiotherapy practice at a rapid pace. Those who were 'clinically extremely vulnerable' were advised to 'shield', educational institutions were partially or fully closed, and many children's healthcare services were put on hold. Furthermore, COVID-19 related clinical service need resulted in redeployment of clinicians, altering staffing capacity.

The APCP working group identified "caseload management" as an a priori theme to investigate the impact of these COVID-19 measures on existing overstretched paediatric physiotherapy caseloads and to consider the implications for practitioners.

Aim / Objectives

To explore respondent's experiences of managing paediatric physiotherapy caseloads, during the COVID-19 pandemic.

- To identify any changes in practice
- To identify the challenges imposed on practice
- To identify the opportunities within caseload management

Method Summary

An electronic survey was sent to all APCP members between June 4th and June 17th 2020. A qualitative approach utilising Framework Analysis (Ritchie 2014) has been applied. A detailed methodology of the

design, development delivery and analysis of this electronic survey is reported in the introduction and methodology section of this series. Further consideration of methodological limitations within this project have been detailed in the Introduction and methodology section. These are presented in Table 1.

Table 1: Survey Questions	Type of question
1. What has been your experience of managing your caseload during this period?	Open ended
2. Were you/are you able to continue seeing patients face to face?	Closed (Y/N)
3.What changes have you had to make in managing your caseload during this period?	Open ended

Results

All 472 respondents completed the 'caseload management' domain of the survey, although six respondents answered 'not applicable' to the series questions. Of these, two respondents reported being on maternity leave and one respondent stated they were redeployed. The remaining three failed to provide further detail, but represented different UK regions, banding and settings. Of the remaining 466 respondents, 92% reported a change in their caseload during this period, representing physiotherapists from all UK regions, bands and specialities. Respondents also included those re-deployed but continued to dedicate some time to contact their caseload.

The minority of respondents who did not experience a change in their caseload management represented those in non-clinical roles who did not hold an existing clinical caseload (3%) or reported no caseload contact due to being furloughed, redeployed or shielding at home (4%). Only 1% reported no change to their caseload, with the exception of using personal protective equipment (PPE). These respondents represented a range of specialities including inpatient neonates, research and education, specialist rehabilitation centre and an independent/private practitioner. Across survey responses, there was no direct link evident between children and young people (CYP) with COVID-19 symptoms and caseload management.

Respondents reported a wide range of emotions related to changes in caseload management during this COVID-19 period of interest. Some respondents described the process of trying to manage their caseload as 'challenging' or 'difficult'. One respondent stated: '*it was a very emotional time for everyone*' (R414), while another respondent reported managing their caseload during this time as '*nightmarish*' (R257). Others acknowledged new ways of caseload management to be '*interesting and varied*' (R17), '*positive*' (R265) and '*good*' (R390). These contradicting emotions were not defined by demographical variables; however, time restrictions and staffing uncertainty were linked to negative emotions.

Themes

Results from the survey analysis revealed 5 overarching themes, representing the changes in paediatric physiotherapy caseload management during the COVID-19 period of interest. These are presented in table 1 and will explore in further detail below.

Table 2: Presentations of themes and subthemes for Caseload Management

Overarching Theme	Subthemes
Caseload responsibilities	Role in caseload management
	Size of caseload
Methods of Assessment and Intervention	Face to face
	Telephone
	Virtual
	Written/emailed
Caseload Prioritisation	Methods
	Referrals
	Waiting lists
Supporting CYP and their families	Communication
	Guidance and support
	Parent led/parent autonomy
Risk Assessment and Safety	Infection Control
	Safeguarding

1: Caseload Responsibilities

This theme explores key changes in caseload responsibility during COVID-19, attributing to a change in physiotherapy role and/or size of caseload.

Roles

Analysis showed that some respondent's roles changed during this period. The most significant and common being re-deployment from community settings to acute adult services. For some respondents working in community settings, they had shared roles between redeployment and managing their caseload:

'Stressful when re-deployed as although most families self-managed, there were still some things to follow up - I was given time from ward duty for this however it felt disconnected' (R8).

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Role changes for inpatient teams included covering other specialities within physio.

Across all demographics apart from specialist inpatient services, participants were expected to work from home for some or all of the time. Respondents had different experiences of working from home with some finding it a positive experience and others finding it more of a challenge:

'We have been doing a mix of home and office working - harder working from home trying to do video consults with the distractions from home present' (R405).

For further results on role changes please use the link

Size of caseload

A change in caseload size was noted by the majority of respondents, although the setting in which the respondent worked determined how caseload size changed.

Most inpatient-based respondents reported a reduction in caseload size, attributing this to early discharges, reduced admissions and cancellation of non-essential surgeries. One respondent stated:

'Personally, this has led to reduced job satisfaction as normally so busy seeing patients and now mostly at a computer working on service development etc' (R348).

Another respondent from a tertiary centre felt that the move towards early discharge meant:

'I am unable to provide the level of rehabilitation to my patients that is required for them to meet their goals and optimise their potential recovery' (R10).

However, a reduction in caseload also led to opportunities, such as resource development and increased capacity to take on more families.

Conversely, primary/community-based respondents across all UK regions reported an increase in caseload size. This was predominantly attributed to re-deployment and subsequently, a reduced staffing capacity. As a result, some respondents reported caseloads to be managed centrally by team leaders, prioritised and delegated to remaining staff. One respondent reported:

'Losing autonomy in who we could decide to see as leads having to flag up through bronze/silver control' (R126).

2: Methods of Assessment and Intervention

This theme reflects the changes to methods of physiotherapy assessment and intervention during this period. The following subthemes reflect the 4 main methods of delivery, including face-to-face, telephone, virtual provision and written/mailed.

Face-to-face Provision

Within this survey domain, 31% of respondents answered 'No' to providing face-to-face services. For most, this was due to a transition to virtual therapy, although a few attributed this to personal shielding status or re-deployment. Those working in independent/private or neurodisability specialities, located in charity or hospice settings, or based in South East of England and London regions were least likely to provide face to face services.

Of the 69% of respondents providing face-to-face, 7% reported to be in the early process of restarting face to face services, and limited this provision to essential, urgent, emergency or highest priority contacts. More specific examples included those who would deteriorate if not seen, acute respiratory patients, early discharges from hospital, and those with equipment issues. These respondents were most likely to work in primary or secondary settings, in independent/private or neuromuscular specialities and located in regions of the Midlands and South West of England. The remaining 62% of respondents reported to continue face-to-face provision throughout this COVID-19 period, but all reported that this was only available for essential contacts as described above. These respondents were largely representing Scotland and Northern Ireland regions, worked in tertiary or secondary settings and specialised in respiratory and neonatal provision.

Telephone Provision

A minority of respondents from Northern Ireland, Wales, North East and Yorkshire and Scotland managed their outpatient/community caseloads primarily through telephone communication. One respondent described this method positively, stating:

'Better for those families who cannot/ do not attend to contact by phone - our DNA/WNB rates have decreased' (R70).

However, the majority of respondents used telephone communication in combination with other methods, noting its limitations when used in isolation:

'Very difficult as there is a lot less we can offer our patients over the phone' (R109).

Furthermore, the use of telephone methods was considered suitable for providing advice and signposting, but respondents raised concerns about using this method for:

'One case of serious pathology was not picked up by the telephone consultations, are they safe?' (R151)

Virtual Provision

Many respondents were restricted by lack of access to suitable technology resources in the early stages of the COVID-19 period. Furthermore, respondents noted a significant learning curve in virtual therapy provision:

'Difficult reinventing myself as a tech savvy therapist (which I'm not) (R340).

Virtual assessments were completed through use of pictures and videos sent by parents, as well as live video platforms. However, assessment limitations were reported in some specialities, such as establishing lung function measures in respiratory, or CYP with complex neurology:

'less likely to discharge as unable to complete a reliable physical assessment (tone, reflexes etc)' (R74).

Furthermore, virtual assessment was considered inadequate by some and raised concerns about the risk of missing 'red flags'.

Virtual interventions were delivered via video platforms and complemented by visual aids like dolls. Signposting to generic intervention resources online was also used e.g. You Tube. Respondents reported contradicting views regarding virtual interventions; whilst some reported this provision to be tiring or questioned intervention compliance from CYP and their families, others felt this was more time efficient for all involved:

'Difficult to ensure whether families are fully completing home therapy as provided' (R85).

'Parents have been very positive about the videocall, saving them 1 or 2 hours drive to our centre' (R51).

These contradicting views were largely determined by CYP and family engagement, which was challenged by language barriers, families with restricted access to technology or those who lacked confidence using this style of communication.

Virtual provision and its role in future practice was reflected in a number of responses; some raised concerns about the long-term effects of virtual intervention, particularly in complex patients with postural management needs; others reported a personal emotional loss moving away from face-to-face provision:

'I miss hands on physio, assessing and putting treatment into practice myself' (R38).

Conversely, one respondent working in neurodisability in a primary setting said:

'I feel that this will set us up for the future in being able to provide a more supportive, flexible and individual service to our families. (R38)

For further results on the use of virtual platforms please use the [link](#)

Written/Emailed

Many respondents reported that one of the first things they did during this period was to make sure that all CYP's on their caseload had an up to date treatment plan at home for families to complete with them. Other

materials that were sent included APCP information leaflets.

3: Caseload Prioritisation

This theme explores the use of rigorous prioritisation systems implemented to manage caseloads during the COVID-19 period of interest. Subthemes describe methods of prioritisation, referral systems and waiting list management, with a focus on those primarily affected by low or uncertain staffing capacity and increasing caseloads in the primary/community setting.

Methods of prioritisation

The most common methods of prioritisation were the use of traffic light' or 'red, amber, green' (RAG) systems. These were implemented by respondents in primary/community settings across all UK regions and were monitored by team leaders or peers. The highest priority patients included CYP at risk of being admitted to hospital, including respiratory exacerbations, or those facilitating early discharge from hospital, including post-operative needs. CYP with educational healthcare plans, equipment or orthotic issues were also considered high priority, as one respondent observed that:

'Priority caseload increasing as CYP grow out of equipment/orthotics' (R309).

Staffing capacity determined the priority level seen, with respondents reporting they were able to see medium priority patients when more team members returned from re-deployment or self-isolation.

Low priority CYP were commonly put 'on hold' with various follow up systems, whilst others described discharging low priority CYP and routine referrals, with the option to re-refer. However, long-term effects of these prioritisation methods raised concerns, as one respondent stated:

'Things which could be put on hold for a short time are now of concern and some measure of clinical risk' (R91).

Another stated:

'I am concerned that many will have long term postural changes that we cannot reverse'(R165).

Referral systems

Largely, a reduction in referrals was observed, particularly in inpatients and outpatient teams linked to surgery. One respondent also noted a: *'decline in unnecessary referrals'* (R62) but failed to define unnecessary referrals further. Several respondents from primary/community settings utilised a triage system, accepting only high priority referrals, whilst others accepted all referrals but discharged *'routine referrals with generic advice'* (R324).

Waiting Lists

Despite a reduction in referrals, the majority of respondents reported an increase in waiting lists, with one

respondent working in MSK stating *'waiting lists have doubled'* (R278). This was a source of anxiety for some respondents. One respondent from the primary/community setting detailed how they managed their waiting list:

'All on waiting list have been triaged and sent appropriate exercise and advice with a covering letter explaining they will be kept on the waiting list and will be contacted when able' (R413).

4: Supporting CYP and their families

The theme reflected reports of the changes in communication, guidance and support, and parental responsibilities affecting CYP and their families.

Communication

During the COVID-19 period of interest, the rapid transformation of paediatric physiotherapy services and reduced face-to-face contact prompted urgent communication with CYP and their families. This was largely achieved through initial written information:

'Letters sent to all on caseload informing them of level of physio service available and contact details' (R321).

Communication and information sharing with families continued throughout this period, implementing a wide variety of virtual platform initiatives not traditionally used:

'We are developing a series of communication changes to increase how families access our service: Facebook, what's app broadcasting list, generic email address'. (R301)

'We have put a lot of work into our facebook page with videos of positioning, exercises/ activities for all ranges of abilities and lots of links to useful resources. We are having lots of hits' (R360).

'We are developing webinars for routine advice/information' (R301).

However, certain technology would be needed to access this information, raising concerns about the impact on families without technology or confidence utilising such platforms.

Guidance and support

There were conflicting views on how respondents perceived families to be coping; some families reportedly coped well whilst others have needed holistic support extending beyond physiotherapy assessment and intervention, reporting concerns of social isolation, mental wellbeing and balancing responsibilities in the home. One neuromuscular respondent described the effects of lockdown on her caseload:

'Families are struggling to juggle home working, home schooling and managing therapy needs for a disabled child - difficult to support remotely and offer appropriate input for these children' (R85).

Another respondent from London reported:

'Lots of phone calls to check families were coping and managing to get food – many referrals for food parcels' (R295).

Respondents on the whole reported families were grateful for this support, although one respondent observed:

'Parents were initially very understanding but as time has gone on they are becoming quite impatient and frustrated at their child's lack of progress' (R25).

Parent responsibility and autonomy

There was an overall focus on empowering families to self-manage their physiotherapy plan at home and contact the team when problems arise during this period. Parent-led approaches were reported across all demographics. However, respondents shared different feelings towards this transfer of responsibility, largely determined by respondent perceptions of how families of CYP would engage and cope without regular face-to-face follow-up. One respondent reported:

'this has been a very positive experience for some families, enabling them to realise just how able they are supporting their child's physiotherapy needs.' (R190).

Others reported concerns that families had too many other pressures in their life during this time to engage and undertake intervention.

5: Risk assessment / safety of caseload

This theme explores how respondents managed the risks of providing a service to CYP's during COVID-19. The anticipated risks of reduced face-to-face physiotherapy provision is explored. Key subthemes include changes in infection control procedures and safeguarding.

Infection control

All respondents reporting face-to-face provision confirmed the implementation of national and local infection control measures. This included self-isolating when they had symptoms, reducing non-essential face to face contacts and social distancing in the workplace. As a result, many respondents working in primary/community settings reported working from home. Inpatient physiotherapists reported having 'clean' and 'dirty' teams rather than being speciality based. All respondents who had face to face contacts with CYP used PPE.

Results highlighted challenges including a national shortage of PPE and a lack of clarity implementing risk assessment and infection control measures, attributed to rapidly changing, vague and often contradictory, guidance:

'Hard seeing patients with PPE when PHE, the trust and the CSP give different guidance' (R234).

Another respondent reported:

'It has been a challenge in the private sector to get clear guidance and risk assessments' (R7).

One respondent felt:

'the generic information from the CSP is vague to interpret and it would have been nice to have a more collective approach from APCP members with maybe case examples' (R46).

The delivery of face-to-face contact raised several safety concerns. Respondents portrayed a lack of clarity and guidance towards risk assessing those who required face-to face contact and found themselves balancing the risk of CYP contact against the risk of no CYP contact:

'Without communication across the country from paediatric physios it has been concerning not knowing if what you are judging as "essential" (is correct) and when to complete face to face' (R46).

The 'shielding' of vulnerable CYP also created challenges to delivering essential face-to-face contact. Respondents found inventive ways to provide essential services including:

'I have set up ventilators in my car and on driveways so not to come into contact with families' (R4).

Others reduced number of visits by working closely with MDT e.g. working with nursing teams who are visiting to feedback observations.

Safeguarding

Many respondents used safeguarding concerns to inform their prioritisation system, with those CYP at highest risk receiving high priority physiotherapy provision. Respondents raised concerns about the:

'Complexity of safeguarding remotely' (R405). Closer MDT working was cited as a way of managing this risk, however one respondent highlighted limitations with this:

'At times I have had increased safeguarding concerns and found that other services are not functioning or collaborating and responding like they normally would, and this has been a struggle in ensuring children are safeguarded in some circumstances' (R38).

Most concerningly respondents from two separate tertiary centres reported a substantial rise in non-accidental injuries being admitted (R10, R65).

Discussion

This domain of the APCP COVID-19 survey demonstrated a significant shift in caseload interactions, management and delivery of care to CYP and their families. Respondent practice shifted from face-to-face contact and traditional 'hands on' care to remote virtual platforms. This was predominantly driven by restrictions in non-essential face-to-face contact, advised by key regulatory and governing bodies, and

enforced by closure of specialist centres, respite and hospices to all CYP except those with 'urgent' needs. However, as lockdown measures ease and non-essential services gradually restart, physiotherapists are faced with significant conflict between resuming traditional face-to-face caseload interactions whilst aligning with governing body guidance, such as social distancing. This conflict demands further attention to ensure a sustainable and safe transformation in the delivery of physiotherapy care.

Literature examining the working conditions and wellbeing of NHS healthcare professionals revealed physiotherapists experience high workloads and a lack of control of their role, leading to work-related stress (Ravalier et al, 2020). These factors have been significantly impacted upon by COVID-19, particularly for those working in community settings that are already prone to lack of support and isolation, further increasing risk of developing work-related stress (Preece, 2020). Strategies to improve cross-organisational working, particularly across acute and community services, could support better understanding of COVID-19 related caseload changes, informing appropriate re-deployment and staffing capacity to meet the needs of CYP and reduce inequalities evident in this survey. Furthermore, strategies to support staff well-being has been shown to enhance performance, improve patient care and retain staff, and should remain a priority for organisations and regulatory bodies following this period of caseload change. These findings corroborate with the Wellbeing domain of this survey.

In community/primary settings, 'prioritisation' was the most widely reported strategy to manage increasing caseloads. The strategy aimed to identify CYP with 'essential' needs. However, this strategy was considered short-term in its effectiveness, reflected in respondent concerns regarding the impact of physiotherapy withdrawal across lower priority caseloads. As non-essential services restart, efforts should be directed towards understanding the longer-term impact of COVID-19 prioritisation systems, particularly on medium and low priority caseloads, in an aim to develop safe and sustainable prioritisation across UK paediatric care.

Virtual therapy was the most common reported method to delivering physiotherapy care, balancing both safety of all involved whilst offering observational assessment. However, the comprehensiveness and accuracy of observational assessment raised concerns of safety and quality of therapy care. This calls for further research into the validity and reliability of observational assessment measures used in virtual physiotherapy care. Virtual assessment limitations were largely reported in neurology or respiratory specialities and those with safeguarding concerns. These limitations should be recognised and contribute to the prioritisation assessment when considering suitable method of contact. Furthermore, factors of technology infrastructure, individual's understanding of it, and engagement of CYP and families determined its success, highlighting the need for training to ensure virtual physiotherapy is more accessible and successful, including digital training for both professionals and families.

Respondents portrayed positive partnerships with families during COVID-19. This was depicted through increased efforts to communicate and share information through a variety of accessible platforms, as well as

offering holistic support, in which one respondent made referrals for food packages. Positive working partnerships were central to the success of virtual therapy, as therapy responsibility shifted to the CYP and their families in their homes. However, the impact of parent-led therapy programmes during this period has yet to be established. Furthermore, this survey is limited to professional viewpoints, lacking insight into CYP and family reported experiences, restricting further analysis of working partnerships during the COVID-19.

Finally, personal safety and caseload safety was widely reported as a concern throughout this survey domain. This was challenged by vague, changeable and at times, contradictory guidance. As a result, respondents withdrew contact with their caseload, concerned they were placing CYP or themselves at risk. Respondents reported using iCSP and social media to create networks for sharing advice, yet a lack of leadership to guide safe working conditions in paediatric care was evident. The results call for leadership and consistency to guide safe working conditions in UK paediatric physiotherapy care.

Findings support the need for the following recommended priorities:

Table 3.	Priorities for Supporting Future Paediatric Physiotherapy Practice
1.	Overcome inequalities around access to paediatric physiotherapy when face to face sessions are minimal.
2.	Develop clear MDT strategies for safeguarding during a pandemic.
3.	Develop strategies for cross organisational working during a pandemic, looking at caseload management as a whole and upskilling across acute and community teams.
4.	All practitioners to be supported by their employers to receive adequate resources and training to be able to undertake virtual sessions with their caseload.
5.	Development of clear and consistent national infection control guidance for client facing practitioners.
6.	Employee stress and wellbeing monitoring and support across all settings, with a priority for those working in community/primary care settings.
7.	Investigate the impact of COVID-19 prioritisation systems.
8.	Investigate CYP and family experiences of paediatric physiotherapy input during the COVID-19 lockdown period.
9.	Research into the validity and reliability of observational assessment measures used in virtual physiotherapy care.

Conclusion

Analysis of the responses to this domain of the APCP COVID 19 survey has provided insight into the initial effects on caseload management during the lockdown. Importantly it has highlighted clear priorities which will help focus future work to support paediatric physiotherapists in managing caseloads and will help to ensure equitable service for patients.

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