

2016

Working with Children - Guidance on Good Practice



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Introduction

What is physiotherapy?

Physiotherapy is an allied health care profession which promotes the health and wellbeing of all. Physiotherapists are autonomous practitioners who provide expert, holistic physical rehabilitation. At the core is the patient's involvement in their own care through education, awareness, empowerment and participation in their treatment. Physiotherapists enable and encourage development and facilitate recovery. They also use their strong communication skills to teach, empower and promote physical wellbeing and independence by maximising individuals' potential and participation

What is paediatric physiotherapy?

Paediatric physiotherapists recognise that **children and young people are not just small adults**. They have generic skills as physiotherapists but require additional specialist knowledge and clinical skills to enable safe and effective assessment and treatment of babies, children and young people. They treat a wide range of conditions including developmental delay, respiratory, neurological, neuromuscular and musculoskeletal in differing environments, working within their scope of practise.

Paediatric physiotherapists acknowledge the importance of working in partnership with the child, parents, carers and a wide range of other professionals to maximise a child's physical abilities and independence.

Additionally they empower parents and carers to feel confident and competent to incorporate physical management strategies into daily life.

Paediatric physiotherapists have a duty to maintain their clinical reasoning skills and update 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 lifelong commitment for all physiotherapists.

What is the purpose of this publication?

This document provides guidance on good practice for physiotherapists working with children, especially those who may be positively affected by paediatric physiotherapy.

This document is designed to assist paediatric physiotherapists in their continuing professional development and to guide physiotherapists to a wide range of information.

It acts as a signpost and includes links to UK government policy, guidance, various publications and websites, highlighting those which impact on paediatric physiotherapy practice.

Who is this publication for?

This publication is designed for:

- Clinicians working in paediatric physiotherapy or interested in it
- Managers and clinical leads for paediatric physiotherapy services
- Commissioners for children's services

- As legislation, policies & procedures vary across the four countries within the UK, it has been necessary in some sections of the document to outline relevant information specific to each country. When doing this the countries have been listed in alphabetical order.
- The word “child” has been used throughout the remainder of this document; it implies baby, child or young person.

Physiotherapy Practice

It is important for physiotherapists to develop competence to practise safely, this helps to ensure consistent quality standards of care and delivery of services for children throughout the United Kingdom.

Legal and ethical framework

What is the legal framework that governs physiotherapy?

The information contained within this document gives an overview which is accurate at time of writing. However the fine detail and application of legal guidelines is continually evolving. For this reason it is recommended that for updated information readers use the links to relevant websites included within this document.

Chartered Physiotherapists are regulated professionals. They are bound by the Health and Care Professions Council (HCPC), and anyone who uses the title ‘Physiotherapist’ is required to be registered with the HCPC and adhere to their standards of conduct, performance and ethics. These standards were revised in 2015, and published in 2016.

The [HCPC](#) is a regulator, which is set up to protect the public. To do this, it keeps a register of health and care professionals who meet the [standards](#) for their training, professional skills, behaviour and health. Importantly for service users they outline what the public should expect from their health and care professional.

The professional organisation for Chartered Physiotherapists is the [Chartered Society of Physiotherapy](#). The CSP is a member-led organisation governed by an elected Council. This is made up of elected CSP members and is supported by a system of boards, branches, committees and professional networks. It provides a wide range of member services, supports members in providing the highest standards of patient care, campaigns on behalf of all physiotherapy staff and promotes the physiotherapy profession. It also trains and supports stewards in the workplace and provides legal support.

[Professional Values and Behaviour \(2011\)](#) and [Quality Assurance Standards \(2012\)](#) 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;
- continuing professional development (CPD) and career development;
- research, evidence-based practice and clinical effectiveness;
- professional networking and peer support (face-to-face and virtual).

The Association of Paediatric Chartered Physiotherapists (APCP) is the professional network of the CSP for Chartered Physiotherapists working with children and young people or with an interest in physiotherapy for children. APCP has a national committee which has representatives from all regions of the UK. The Association also has representation from its range of specialist groups, which can be found on the [APCP website](#).

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.

All professionals who work with children in England and Wales are required to have current DBS ([Disclosure & Barring Service](#)) enhanced checks. These are requested by the employer. There are similar regulations for working in Northern Ireland ([Access NI](#)) and Scotland ([Disclosure Scotland](#)). These services help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups including children.

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

Paediatric physiotherapists require enhanced disclosures which are 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 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. If the case arose where a person who appears on the list is applying for a childcare position, it is the responsibility of the employer to ensure the police are informed. If a situation arose where it was deemed appropriate to refer an individual to the POCA List then the responsibility for this would rest with the employer. Additionally, for professional staff the employer will also want to inform the relevant regulatory body of the situation causing concern and the regulatory body will take a decision regarding actions required.

It is essential that physiotherapists who work with children and young people have an understanding of the relevant legal frameworks, as well as local policies to ensure they work effectively, and deliver services appropriately.

England- In an effort to replace different laws and guidance about Social Care in 2015 the [Care Act 2014](#) was introduced. It outlines the way in which local authorities should carry out carer's assessments and needs assessments; how local authorities should determine who is eligible for support; how local authorities should charge for both residential care and community care; and places new obligations on local authorities.

In September 2014 the [Children and Families Act](#) was introduced in England and Part 3 included clauses on:

- The local offer
- Personal budgets
- Education Health and Care Plans (EHCP)

The [SEND Code of Practice \(2015\)](#) (Special Educational Needs and Disability) is a statutory guidance document for organisations which work with and support children and young people who have special educational needs or disabilities in England.

All children have a right to an education that enables them to make progress so that they:

- achieve their best
- become confident individuals and live fulfilling lives
- make a successful transition into adulthood- whether that's into further and higher education, training or work

Information and Advice Services have been appointed in all areas of England. The following links are examples of information published in one area, where independent support is offered to families, [Wolverhampton Information, Advice and Support Service](#) and their [Education, Health and Care Plans](#). Please check your local area's service.

Statutory guidance for governing bodies of maintained schools and proprietors of academies in England was published in January 2016 '[Supporting pupils at school with Medical Conditions](#)'

Legal frameworks are continually evolving, and it is recommended that professionals involved in this area of work update their knowledge regularly. One detailed source of information is the [Council for Disabled Children](#). This organisation is the official Government partner for the SEND reforms. They publish a monthly newsletter which outlines developing guidelines and further details of the application of the law, and includes practical examples and resources. They have recently published '[Disabled Children: A Legal Handbook 2nd edition](#)'. This 576 page document is a definitive guide to the legal rights of disabled children and their families in England and Wales. It is available to download free as pdf document.

Northern Ireland-The Commissioner for Children and Young People (NICCY) was created in accordance with 'The Commissioner for Children and Young People (Northern Ireland) Order' (2003), to safeguard and promote the rights and best interests of children and young people in Northern Ireland (NI). Under Articles 7(2)(3) of this legislation, [NICCY](#) has a mandate to keep under review the adequacy and effectiveness of law, practice and services relating to the rights and best interests of children and young people by relevant authorities. The remit of the Office is for children and young people from birth up to 18 years, or 21 years if the young person is disabled or in the care of social services.

In carrying out his/her functions, the Commissioner's paramount consideration is the rights of the child and NICCY is required to base all its work on the United Nations Convention on the Rights of the Child ([UNCRC](#)). A number of articles in the UNCRC are particularly

relevant to the provisions contained in the draft Special Educational Needs and Disability Bill.

Within Northern Ireland the legislation for children with special educational needs (SEN) is contained within the [Education \(Northern Ireland\) Order 1996](#) (the 1996 Order) and the [Special Educational Needs and Disability \(Northern Ireland\) Order 2005](#) (the 2005 Order), supported by Codes of Practice and a number of Statutory Rules. The 1996 Order provides a legal framework for the assessment of, and provision for SEN. It requires the Education Authority (EA), formerly the Education and Library Boards (ELBs), to identify, assess and make provision for children with SEN within their area. In 2012 the Executive agreed a series of actions for SEN following a consultation process, these proposals suggested that a broad range of amendments to existing regulations would be required. These include regulations in relation to pre-school; changing statements to Coordinated Support Plans; reducing timescales for statements and altering requirements for the review of statements.

The Special Educational Needs and Disability Bill passed through the Assembly at the end of January 2016. This Bill has asked for greater co-operation between Health and Education services with more statutory responsibilities for interventions identified as 'likely to be of benefit' to a child in their educational attainment. The SEN Regulations and the Code of Practice are not yet finalised, both are anticipated to be published in Spring 2017.

Within Northern Ireland the Health and Social Care Trusts address health & social care needs of individuals and their families/carers. The Carers and Direct Payments Act (Northern Ireland) 2002 was implemented in two stages. The first stage which came into force in March 2003 made three main provisions. The Act allows Health and Social Services Trusts to provide personal social services to support carers directly. It gives them the right to an assessment of their own needs. Trusts are required to inform people of their legal right to a care assessment. The second stage of the Act, implemented in April 2004, widened the availability of Direct Payments.

The main changes that the new legislation brings are that Trusts have the power to make Direct Payments in certain circumstances including to disabled people (including 16-17 year olds) for services to meet their own assessed needs and to people with parental responsibility for disabled children. Legislation concerning Northern Ireland can be found on the government [website](#).

Scotland- The [Public Bodies \(Joint Working\)\(Scotland\) Act 2014](#) mainly relates to adults; however the law outlines the duty that public organisations should work together and co-operate where needed, to ensure a focus on the care and support (including carers' support) and health and health related needs of their local population. It also aims to support smoothing the transition from children's to adults' services.

The legal framework for Scotland is outlined in the [Children and Young People \(Scotland\) Act 2014](#) (CYPA). This is an act of the Scottish Parliament to make provision about the rights of children and young people and to make provision about investigations by the Commissioner for Children and Young People in Scotland. The Act is a wide-ranging piece of legislation containing eighteen parts in total and spanning policies that have developed over a number of years including children's rights, children's services planning, kinship care, aftercare, continuing care, corporate parenting, early learning and childcare.

This Act outlines changes which will be implemented from August 2016 and is based on the wellbeing of the child. The CYPA was developed from local experience of 'Getting It Right for Every Child (GIRFEC)'. GIRFEC is a key policy driver to improve outcomes for all children. Across Scotland all Community Planning Partnerships (CPPs) have been working to implement and embed it in everyday working practice, actively working to make changes to culture, systems and practice to meet the existing policy requirements. GIRFEC is the national approach to reforming children's services to improve outcomes for all children and young people and it overarches all other policies for children, young people, families and those who

work with adults looking after children. It provides the strategic policy framework supporting other key policies and initiatives.

[Ready to Act 2016](#) is the first children and young people's service plan in Scotland to focus on the support provided by allied health professionals (AHP's) It is underpinned by the CYPA, the principles of GIRFEC and the United Nations Convention on the Rights of the Child. The plan links with the "Triple Aim" for public services in Scotland – improving quality, safety and experiences of care, increasing population health, wellbeing and equity and ensuring best value for resources. The plan sets out five key ambitions for AHP services for children and young people based on the outcomes they, their parents, carers, families and shareholders felt mattered to their lives.

Wales- The [Social Services and Wellbeing \(Wales\) Act 2016](#) has the fundamental principles of:

- People - Putting an individual and their needs at the centre of their care and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.
- Well-being -Supporting people to achieve their own well-being and measuring the success of this care and support.
- Earlier intervention - Increasing preventative services within the community to minimise the escalation of critical need.
- Collaboration - Strong partnership working between all agencies and organisations.

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 of the population has highlighted the need for better access to and sharing of 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. Wales also has a [Children's Commissioner](#) who champions the rights of children in Wales. Gwent (Aneurin Bevan University Health Board) is currently moving towards an Integrated Service for Children with Additional Needs (ISCAN). This has been developed in partnership with parents. Specific care-coordinators without a clinical caseload support the Child Development team (CDT) and link with families throughout the process. There is a single entry referral for all children who need to see more than one service with child health and mental health teams collaborating from the point of referral. It is hoped that education and social services will be able to join this new development in the future.

The process of educational needs in Wales is currently under consultation. In July 2015 the Welsh Government launched a consultation on the [Draft Additional Learning Needs and Education Tribunal \(Wales\) Bill](#). The proposals in the draft Bill largely follow the proposals set out in the 2014 White Paper, notably a single category of 'Additional Learning Needs' to replace Statements, School Action and School Action Plus.

There has been much discussion around the proposed Individual Development Plan or IDP which would ideally be an online document designed to be current and ensure accountability and improve communication between parents and professionals. So far the drive for this has been from Education but the process is holistic and can include issues outside of school.

The draft Bill sets out proposals for a new legislative system for supporting children and young people up to the age of 25 who have additional learning needs. The Welsh Assembly Government has adopted the United Nations Convention on the Rights of the Child ([UNCRC](#)) for children under 25 years of age.

Legal Framework relating to NHS Organisations

The [Francis Report](#) was published in 2013, as a result of the enquiry into Mid Staffs Foundation Trust. The report outlined 290 recommendations

The 290 recommendations are divided into five main areas, some of which would require new laws.

New 'fundamental standards' of compliance, with clear means of enforcement

- Hospitals should agree lists of 'fundamental standards' about patient safety, effectiveness and basic care
- To cause death or serious harm to a patient by non-compliance should be a criminal offence
- Individuals should be supported to report non-compliance, and should be protected when they do so
- Standards should be created by the National Institute for Health and Clinical Excellence ([NICE](#)) policed by the Care Quality Commission ([CQC](#)).

Greater openness, transparency and candour

- A 'duty of candour' should be imposed, by law, and deliberate obstruction of this duty should be made a criminal offence
- Complaints should be treated seriously when they occur, and questions answered truthfully
- Any patient who has been harmed by a healthcare worker should be informed, as should their family, regardless of whether the information will lead to a complaint
- Every provider trust must be obliged to tell the truth, as a contractual duty.

Improved support for compassionate, caring and committed nursing

- Student nurses should have direct care experience under the supervision of a registered nurse

- Healthcare support workers should undergo consistent training, and should be regulated by a registration scheme
- A code of conduct should be established for those working with elderly, and vulnerable patients
- Nurses should be given more representation at leadership levels within hospitals.

Better healthcare leadership

- A common code of ethics and conduct, based on patient needs and public expectations, should be adopted by all senior managers in the NHS
- Boards must be accountable for the presentation of information, and standards
- It should be a criminal offence to make a willful false statement on issues of compliance or fundamental standards.

Accurate, useful and relevant information

'Accurate, useful and relevant information is the lifeblood of an open, transparent and candid culture' according to Robert Francis QC.

- Electronic patient information systems should allow patients user-friendly, real-time and retrospective access to their records, and a facility to enter comments. Systems must be designed by healthcare professionals, in partnership with patient groups, to ensure both are engaged in the process and to ensure the accuracy, utility and relevance of the system.
- It should be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics.

There are various other reports published in recent years including, [Berwick](#) (2013), [Keogh](#) (2013), [Andrews](#) (2014) all of which aid reflection and learning and can help direct service review and development.

What does this mean for children and young people?

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

Ethics and consent in paediatrics

What are the consent issues?

The position on consent in relation to children is complex. Therefore, it is important to be familiar with the extensive body of literature including statute and case law, professional guidance, department of health guidance and scholarly writing on the ethical and legal approaches to children's consent. In addition the [CSP Consent and Physiotherapy Practise](#) 2016 paper has been developed to provide professional support with regards to consent policies. Physiotherapists should also 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](#).

The legal focus is upon the concept of valid consent which, by definition, has three elements: capacity to give consent, consent must be given voluntarily and the person must have all the information they ask for in order to make their decision. The issue regarding capacity is of particular importance when dealing with children.

The law recognises broadly three stages of childhood with respect to consent:

- Children who lack capacity- If the child does not have the capacity to give their own consent e.g. they are too young or do not understand fully what is involved, then a parent/ person with parental responsibility, or the Court, may give consent on the child's behalf. If you have concerns that the person with parental responsibility is not acting in the best interests of the child, you have a duty to consider what action you must take to protect that child. (See Safeguarding)
- Children with capacity- A child under 16 who has the capacity to make their own decisions may be referred to as 'Gillick competent' after the [legal case](#) that established children can make their own decisions in certain circumstances. The [Fraser guidelines](#) refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case.
- Children over the age of 16- All 16-17 year olds with capacity are permitted by law to give their own consent to medical, dental and surgical treatment. Those children who are 16 or over on the date they attend for treatment do not need parental consent for physiotherapy. You should not share confidential information about 16-17 year olds with their parents, or others, unless you have specific permission to do so and/or you are legally obliged to.

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 or 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 of alternative or augmentative communication, use of pictures or photographs.

The case of [Montgomery v Lanarkshire Health Board \[2015\]](#) is the relevant case law on informed consent in the UK. A simple summary can be found on [NHS choices](#)

The respective Health Departments in each of the UK Nations provide detailed and comprehensive guidance on all matters of consent for specific patient groups and you should refer to this guidance for your particular country.

England- [Reference Guide to Consent for Examination or Treatment](#). Department of Health. London. (2009).

Northern Ireland- [Department of Health, Social Services and Public Safety Northern Ireland](#) published a range of documents to assist with seeking consent, some of these are listed below:

- [Reference Guide to Consent for Examination, Treatment or Care](#).
- [Good practice in consent: implementation guide for healthcare professionals](#)
- [Good practice in consent: desk aid 12 key points in consent](#)
- [Seeking consent](#)
- [Working with children](#)

Scotland-

[A Good Practice Guide on Consent for Health Professionals in NHS Scotland](#). Scottish Executive Health Department. (2006)

- [National Guidance for Child Protection in Scotland 2014](#)
- [Consent- children and young people](#)
- [Consent and Participant Information Sheet](#)

Wales-

- [Reference Guide for Consent to Examination or Treatment](#). Welsh Assembly Government. (2008).
- [Consent in Healthcare- Information for Children and Young People in Wales](#) (2013)

Duty of care

The existence of a duty of care between a patient and their health-care professional is taken in law to exist – it does not need to be proved, and the healthcare professional cannot absolve themselves of this duty under any circumstances. Good decision-making on your behalf will require you to ensure that you have shared and exchanged information with your patient and

you have not made assumptions regarding the type of information a patient may want, the level of understanding they may have and the choices they may make.

It is important to give information and options in a balanced way so as not to overtly influence their decision. You should inform of all options and may offer your opinion as to a preferred option but make clear that they have a choice. A therapist should also answer any questions fully, honestly and in a balanced way.

Documenting consent

Consent can be verbal or written. Implied consent is where the behaviour of the patient implies they have consented for an intervention e.g. rolling up a sleeve for a blood test. It is good practice not to rely on implied consent as the understanding of events may be questioned at a later time.

In most cases verbal consent is acceptable provided it is documented. Written consent would be required for any treatment which may involve risk to the patient such as injection therapy or acupuncture. Most healthcare providers will have their own consent forms for written consent. There is, in law, no given time period until consent 'expires'. It is good practice however to confirm consent, and document that you have done so, if new information becomes available about the proposed intervention, the patients circumstances change or there has been a significant period since consent was first obtained.

Special issues for consent

Videos/ Images- This can be broadly divided into two categories, images for patient care and images for education or research purposes. Written consent is required and if you intend to use the images for anything other than documentation within the clinical record you must inform the patient of when, where, how and why the images will be used. The patient can withdraw consent at any time but they should be made aware that if the images are intended

for web-based features, the images may not be able to be removed entirely. Any images are subject to the [Data Protection Act 1998](#). Images taken of a child, with parental consent, may be subject to the child withdrawing consent when they develop the maturity to make that decision. This would be considered if the child or young person is identifiable from the recording and it is reasonably practicable to act in accordance with their wishes. More details can be found in [Good Medical Practice 2013](#). Please check local policies as each trust may have their own additional consent guidance for videos/photographs.

Social media- The advent of social media means that practitioners must be very careful about sharing images without consent or discussing cases on open media sites that may cause the patient to be identified. [Social Media Guidance for CSP Members 2014](#) states that social media offers great opportunities to share, influence and learn, but as with any other form of communication you need to remain professional and legal at all times. According to the [HCPC guide to social networking](#), action can be taken under fitness to practice if a registrant has posted confidential information about a service user without their consent. Please check local policies as each trust may have their own additional consent guidance for videos/photographs.

Using patients for educational events- If you are using a patient for educational or training purposes, written consent is required as this is not considered part of patient care. The child and/or the person with parental responsibility must understand the nature of their participation and make a free choice as to whether to participate.

Interpreters- If an interpreter is required for patient care, it is good practice not to use family members as there may be cultural or privacy issues that could alter the message you are trying to convey. The CSP recommends that child interpreters are not used due to the welfare, protection and capacity issues of the child themselves. Any interpreter must have the patient's consent to participate in the therapy session and cultural sensitivities may preclude that consent e.g. availability of an interpreter of a particular gender. It is important to work in accordance with all local guidance regarding involvement of interpreters.

What does this mean for children and young people?

Physiotherapists must understand and adhere to the law and local policy in fully explaining any intervention and ensure that informed consent is obtained according to guidance.

Safeguarding

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

Safeguarding is a term which is broader than 'child protection' and relates to the action taken to promote the welfare of children and protect them from harm. Safeguarding is everyone's responsibility. Safeguarding is defined in [Working together to Safeguard Children 2015](#) as:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes

Every Local Authority and NHS Trust has a Child Protection (Safeguarding Children) Policy, which must be adhered to 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.

Government guidance for each UK nation sets out the responsibilities of different organisations to work together to safeguard and protect children. The guidance also sets out what they should do if they have any concerns that a child is at risk of abuse.

England- The Department for Education is responsible for child protection in England. It sets out policy, legislation and statutory guidance on how the child protection system should work. At the local level Local safeguarding children boards (LSCBs) co-ordinate, and ensure the effectiveness of, work to protect and promote the welfare of children. Each local board includes: local authorities, health bodies, the police and others, including the voluntary and independent sectors. The LSCBs are responsible for local child protection policy, procedure and guidance. See more in [Working Together to Safeguard Children](#)

Northern Ireland-The Northern Ireland Executive government is responsible for child protection in Northern Ireland. They set out policy, legislation and statutory guidance on how the child protection system should work.

The Safeguarding Board for Northern Ireland (SBNI) co-ordinates, and ensures the effectiveness of, work to protect and promote the welfare of children. The board includes representatives from health, social care, the police, the probation board, youth justice, education, district councils and the NSPCC. The SBNI is responsible for developing policies and procedures to improve how different agencies work together. The policy [Co-operating to Safeguard Children and Young People in Northern Ireland 2016](#) explains more.

Scotland- The Scottish government is responsible for child protection in Scotland. It sets out policy, legislation and statutory guidance on how the child protection system should work.

Child Protection Committees (CPCs) are responsible for child protection policy, procedure, guidance and practice at the local authority level. CPCs make sure that all the different local agencies, such as children's social work, health services and the police, work together to protect children.

The key guidance for professionals in Scotland are [Scottish Government \(2014\) National Guidance for child protection in Scotland](#) and the [Brock Report](#). Getting it right for every child ([GIRFEC](#)) is the Scottish government's approach to making a positive difference for all children and young people in Scotland. Its principles help shape all policy, practice and legislation that affects children and their families.

Wales-The Welsh Government is responsible for child protection in Wales. The Welsh child protection system is similar to England's system. However, when the [Social Services and Well-being \(Wales\) Act 2014](#) came into force in April 2016 Wales now has its own framework for social services. Child protection concerns that end up in the courts will continue to be treated in the same way as England.

At the local level regional safeguarding children boards co-ordinate, and ensure the effectiveness of, work to protect and promote the welfare of children. Each regional board includes any: local authority, chief officer of police, Local Health Board, NHS trust and provider of probation services that falls within the safeguarding board area. The regional boards are responsible for local child protection policy, procedure and guidance.

The NSPCC have several useful documents regarding safeguarding children including [Safeguarding Looked After Children](#), [Photography and Sharing Images](#), and [Safeguarding Deaf and Disabled Children in Sport](#). Also on the NSPCC site is a series of short films on [Safeguarding Children and Young People within Faith Settings](#).

You should know who your employer's Child Protection and/or Safeguarding Children officer is, what your employer's policy is and ensure that you have attended appropriate safeguarding training.

There are further specific concerns regarding some children who may be vulnerable to grooming or sexual exploitation, fabricated or induced illness, female genital mutilation (FGM) and radicalisation. You can find additional resources here:

[What to do if you're worried a child is being abused: advice for practitioners](#)

[Multi-agency statutory guidance on female genital mutilation 2016.](#)

[Safeguarding children and young people from sexual exploitation](#)

[Safeguarding children in whom illness is fabricated or induced](#)

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 [Laming Report](#).

Factors influencing physiotherapy practice

Paediatric Competencies and Standards

Competence is not just about knowledge, skills and abilities or about being able to demonstrate technical skill. It is also about thinking, reflection, critical analysis and learning. A demonstration of assimilation of new learning with previous learning, integration of new knowledge, skills and abilities with previous knowledge, and application of new learning in practice as defined by Dreyfus in 1980 [The Five-Stage Model of Adult Skill Acquisition](#)

Competencies are reflected in individual job descriptions at a local level. The use of competences by healthcare workers has been identified as being important to providers and commissioners of health services. APCP has developed several competency documents such as the [Neonatal Competence Framework](#) to ensure providers meet the standards required, [A Competence Framework and Evidence Based Practice Guideline for Physiotherapists Providing Respiratory Interventions for Preterm Infants in the United Kingdom](#) and [Guidelines for Nasopharyngeal Suction of a Child or Young Adult](#). Competency sits not only under the statutory frameworks 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.

Wales- [Modernising AHP Careers in Wales, a Post-Registration Framework](#), was launched in October 2016. It aims to link AHPs' individual aspirations and development with organisational workforce plans. The framework sets out how organisations can be encouraged to introduce career advancement pathways that offer genuine development opportunities for the workforce, while ensuring this development meets future service demands

Workforce development – Continuing Professional Development (CPD)

CPD is a systematic, ongoing structured process of developing, maintaining and enhancing skills, knowledge and competence both professionally and personally in order to improve performance at work. There is a strong link between evaluation, learning and the enhancement of patient care and quality of service. (See Francis report p?)

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, as identified in the [joint statement on continuing professional development for health and](#)

[social care practitioners](#) 2007 and the [Code of Member's Professional Values and Behaviour](#).

The CSP has its own [resources](#) for CPD accessible for members.

Graduates and assistants develop good practice through ongoing CPD in a variety of ways, e.g. formal learning, reflective practice, peer review, in-service training and shadowing a senior member of staff. There is further information in the CSP's [Supervision, accountability and delegation of activities to support workers](#). Every locality will offer various opportunities depending on service and staff needs.

Clinical supervision and appraisal must also be available to all staff working with children to develop their clinical reasoning skills and broaden practice. All paediatric therapy staff 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. The [APCP](#) facilitates learning for all levels with study events nationally and locally e.g. Introduction to Paediatric Physiotherapy.

[iCSP](#) – is a free, easy-to-use website 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 peer-to-peer through email and online discussions. APCP moderates the paediatric network on the CSP website and manages the content of the network, covering all aspects of paediatric practice and service delivery under the leadership of APCP national committee.

Skill mix

To support paediatric physiotherapists there is a requirement for the physiotherapy administration and clerical support teams to be developed and enhanced to support clinicians and enable delivery of a timely, efficient, effective, equitable and standardised service across the UK.

In order to support the delivery of safe and effective interventions it is important to have skill mix in relation to band 2-4 support workers and planning for a structure in relation to band 5-8 physiotherapy staff with appropriate skill mix to facilitate succession planning and service change with new models of delivery.

Record keeping

Physiotherapy staff who work across a variety of settings, have a professional and legal obligation to keep an accurate record of their interaction with patients. Records can be electronic or paper or a combination of these, and in whatever format their employer specifies.

There are [standards for the clinical structure and content of patient records](#), which have been compiled by the health and social care information centre (HSCIC) in 2013, and are supported by the CSP.

Staff should review the standards to ensure that assessment, treatment, discharge and referral records include the information required to ensure consistent recording of patient data across all contexts.

There are two HCPC documents which set out the responsibilities that all physiotherapists have in relation to meeting regulatory obligations in their record keeping practice:

1. [Standards of conduct, performance and ethics](#)
2. [Standards of proficiency- Physiotherapists](#)

Physiotherapy records are legal documents that may be called upon for a range of legal purposes. The purpose of the physiotherapy record is to allow a third party reader to make a judgment based on the content of the record and therefore, the physiotherapy record may be the only robust defence against any claim or error, omission, act or negligence in the course of clinical practice.

The physiotherapy notes must be an accurate account of events at the time they are recorded. The assessment/intervention recorded must be factually correct at the time.

If there is no record made then the law may consider the events 'not to have happened' and look to other sources to make a judgment.

More information regarding patient's access and handling and use of information can be found on the [CSP website](#) and under the [Quality Assurance Standards for Physiotherapy Service Delivery](#)

Registered health professionals are accountable for the care of their patients; they remain professionally accountable for the appropriateness of any delegated duties and acts or omissions of care undertaken by students or support workers who they are supervising. Additionally they remain professionally accountable for the quality of record keeping entries

undertaken by students and support workers, in respect of delegated duties relating to their patients.

Report writing

Paediatric physiotherapists may be required to prepare reports for children for a number of reasons. These may include the following, with countrywide variations:

- Following initial assessment of a child to inform the referrer of their findings
- Following re-assessment at regular intervals during the child's episode of care
- To refer to another profession or agency or request further action
- To support a referral to a tertiary centre
- To support a child into an educational setting
- Following a request for an assessment for EHCP/ Statutory assessments
- For annual review reports
- For an SEN tribunal
- For a legal case
- Writing reports for DLA (Disability Living Allowance) applications and appeals
- Safeguarding/Child in need meetings
- Discharge/Transition/Transfer to other services

Any report written is a legal document and can be used for legal purposes. Physiotherapists should be providing clear advice for all children who they have responsibility for.

Advice should be:

- Clear and concise avoiding ambiguity.
- Advice and facts should be substantiated by the child's case notes, and where possible evidence based.
- Advice should only be given in respect of those areas where the physiotherapist has the necessary skills, knowledge and expertise.

When writing a report, physiotherapists should be mindful of the purpose of the report, and the readership of the report, adjusting the amount of detail given and the language/terminology used accordingly. All reports should have your signature, name printed, job title and date and form part of the child's records. It is good practice to include a statement at the end of any report stating '*This report is written for the purpose described in the title and should not be edited, summarised or circulated for any other reason without prior consent of the author*'.

All reports should comply with CSP quality assurance standards, the [APCP guidance on SEN](#) and [EHCP's](#) and the employer's guidance of report writing.

Reports written for solicitors and SEN tribunals may be accompanied by curriculum vitae if requested (CV). The CV should include:

- Why the physiotherapist feels they are competent to write the report, to include their HCPC registration, CSP membership and specialist group memberships
- The physiotherapist's paediatric experience and what settings this has been within
- Any communication with other professionals involved
- If for a tribunal, whether they have worked with children in mainstream and/or special schools
- A summary of relevant CPD
- A summary of their portfolio of involvement with legal cases or SEN tribunals

Should staff receive any direct requests from solicitors for reports or copies of clinical records, it is vitally important that they follow local guidance regarding release of such information.

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.

Evidence-based practice

A definition for evidence based practice 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'

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 definition suggests that EBP requires the integration of best research evidence, individual clinical expertise and patient choice.

The diagram demonstrates the importance of different sources of evidence, from research, clinical practice and patients. For each individual patient and every clinical decision, the relative contribution of each evidence source (size of circle) may vary considerably.



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 find the best intervention for the child, family and social situation and this needs careful documentation. Where there is a lack of evidence, a consensus of expert opinion can be sought.

Sources of evidence for interventions may include:

- research;
- clinical guidelines;
- professional networks and occupational groups;
- national guidance e.g. National Service Frameworks, National Institute of Health and Clinical Excellence (NICE) guidelines; Scottish Intercollegiate Guidelines Network (SIGN guidelines)
- local standards and protocols;
- information derived from the use of outcome measures;

- audit and evaluation;
- expert opinion;
- public and personal involvement;
- national and international scientific meetings and professional conferences;

The use of physiotherapy time, optimal skill mix, the nature of intervention and the longer term effects of practice have become increasingly important within the commissioning process. Practitioners (providers) need to be aware of the need to collect good quality data on their service to supply to senior management in order to inform commissioning.

The development of a UK-wide [Cerebral Palsy Integrated Pathway](#) (CPIP) is an excellent example of evidence based practice. CPIP is based on CPUP, a Swedish multidisciplinary follow-up programme for children, who are now adults with CP, since the 1980s. CPIP was developed by a group of physiotherapists and children's orthopaedic surgeons and from all regions of Scotland. The aim was to provide a high quality, standardised follow-up programme, including hip surveillance, for children with cerebral palsy (CP) that will identify musculoskeletal problems by regular physical and radiological examinations to enable timely and effective management for these problems during childhood.

Responding to the positive feedback from APCP members and other professionals in Scotland, the APCP has committed to introducing the Cerebral Palsy Integrated Pathway across all regions of the UK.

The pathway involves a nationally agreed protocol of standardised musculoskeletal examination for children with CP to ensure equity. It is based on best practice guidelines from Sweden and Australia and meets the principles of care recommended in the 2012 NICE Clinical Guideline 'Spasticity in children and young people with non-progressive brain disorders'.

A CPIP UK Network has now been established with representative paediatric physiotherapists from each of the APCP Regions plus a representative paediatric orthopaedic surgeon and paediatrician. The Network will meet twice a year to share information, support each other and establish links between regions.

Each region is committed to establishing a Regional Steering Group to drive the implementation of CPIP in its area. The UK Network is already working collaboratively with the British Academy of Childhood Disability (BACD) and the British Society for Children's

Orthopaedic Surgery (BSCOS) to raise the profile of the CPIP amongst paediatricians and paediatric orthopaedic surgeons.

Outcome measures

Improving the quality of healthcare is top of the agenda in all four UK countries, resulting in an increased focus on methods of measuring the quality of clinical practice and service delivery. In this context, standardised validated clinical outcome measures sit within a suite of different types of tools and indicators used to measure the quality of provision of patient care.

The value placed upon child centred, accurate, appropriate and timely outcome measurement is demonstrated in the professional body standards and is expected to be a key attribute of professional practice. Using standard, validated outcome measures in clinical practice is an explicit requirement of the CSP's [Quality Assurance Standards](#). 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 also provided in this document.

The APCP have published an online tool to facilitate this process – [Paediatric Outcome Measures Database](#).

Patient reported outcome measurements ([PROM's](#)) have signalled a significant change of emphasis and a desire to measure the impact of healthcare interventions from the patient perspective. The government's NHS white paper [Equity and Excellence: Liberating the NHS \(2010\)](#) states a clear ambition from the Department of Health that PROMs and PREMs (patient-reported experience measures) are utilised 'wherever practicable'.

What does this mean for children and young people?

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 operate under the remit to find the best intervention for the child, family and social situation

Moving and handling

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 and the welfare legislation. It is mandatory that all paediatric physiotherapists employed in the health service attend moving and handling training.

In paediatric practice it is important to consider the posture that the therapist or carer has to adopt, the equipment they have to work with, as well as the 'load' they are handling when carrying out therapeutic interventions, as well as the repetitive nature of the tasks.

All proposed intervention should be fully assessed for potential risks to either the child, therapist or the carer and if a risk is identified and cannot be avoided during the therapeutic activity then the 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 that 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 (commonly referred to as TILE):

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 such as: moving and handling training, safe systems of work (e.g. moving and handling assessments and plans), use of safer moving and handling principles, use of equipment or adaptation of the proposed intervention. 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 intervention.

Risk assessment is an ongoing and dynamic process and should be reviewed at a minimum annually or when there is any significant change in the child, therapist, task, equipment or environment. This could mean adjustments within a therapeutic task or session as well as regular formal review of advice.

Caring for dependent children may involve regular repetitive manual handling. The child as a 'load' may be mobile, flexible, possibly unwell or in pain, sometimes resisting, non-compliant and potentially unpredictable. Sensory deficit can have an impact on the child's ability to function. Movement, sensory processing, perception, communication and the environment in which handling and therapeutic activities take 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 or comply and thus increase the risks when handling. As a result the way a child is approached can influence the success of moving and handling techniques.

Delegation is commonplace within paediatric physiotherapy practice and paediatric physiotherapists have a duty of care not only to the child, but also to themselves, to the people they work with, and to parents and carers.

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.

Health and Safety Regulations include:

- [Health and Safety at Work Act 1974](#) – this act forms the basis of all health and safety law and sets out duties for employers and employees and covers all aspects of health and safety in the workplace

- [Control of Substances Hazardous to Health 2002](#) –this legislation states that 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 \(RIDDOR\) 2013](#) – these regulations state that 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 \(1999\)](#) – these regulations place an obligation on employer who employs five or more employees to actively carry out a risk assessment of the work place 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 2002](#)- these regulations 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 \(LOLER\) 1998](#) – these regulations state that 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.

Welfare Regulations include:

- [Human Rights Act 1998](#)- This came into effect in Oct 2000 and acts as a vehicle for bringing in the European Convention of Human Rights into UK Law. Human Rights Act takes 16 of the fundamental human rights in the [European Convention on Human Rights](#) and pulls them down into UK Law. This covers rights such as the right to life, to liberty, to family life, freedom of expression and to not be subjected to slavery
- [Equality Act 2010](#) - An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to

enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

- [Children Act 2004 –](#) This Act provides the legal basis for how social services and other agencies deal with issues relating to children. These guidelines have been laid down so that all individuals who are involved in the looking after children, be it in the home, the work place, school or other locale are aware of how children should be looked after in the eyes of the law
- [Education \(ASL\) \(Scotland\) Act 2004 \(updated 2009\) –](#) this created a framework for providing additional support for learning to children who need it.

Useful resources

- APCP [Paediatric manual handling – guidance for paediatric physiotherapists](#) 2010
- The Chartered Society of Physiotherapy. [Guidance on Manual Handling in Physiotherapy](#). 2014
- Mandelstam M. Manual handling in health and social care: an A-Z of law and practice. London: Jessica Kingsley; 2002.
- [Rapid Upper Limb Assessment Guide](#)
- [Rapid Entire Body Assessment Guide](#)
- [Moving and Handling Policy](#). Health Education England 2013
- [Moving and Handling Guide for Disabled Children and Young People](#). Scottish Government and Capability Scotland. 2012
- Manual Handling of Children – Pat Alexander and Carole Johnson, Manual Handling of Children – Professional Series Volume 2 A National Back Exchange Publication 2011.

- A Carer's Guide to safer moving and handling of people. Backcare -The Charity of Healthier Backs
- The Guide to The Handling of People 6th Edition (2010)- BackCare in collaboration with the Royal College of Nursing and the National Back Exchange.
- The [All Wales NHS Manual Handling Training Passport and Information](#) scheme 2007

What does this mean for children and young people?

Paediatric Physiotherapists should advise how to carry out physical management strategies, in home, school and community environments, giving clear instructions on how to safely manage the child and how to carry out therapeutic programmes.

Health and wellbeing

The health and wellbeing of the people living in the UK are high priorities for government. 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 e.g. [Children and young people continuing care](#).

The CSP [corporate strategy](#) 2017-2020 focuses on transforming health & wellbeing, maximising independence and empowering populations to help self-manage conditions, as well as developing influencing skills within members to help shape service design. This strategy will aid staff in reflection of current service models within paediatrics, and help reshaping services to best address family needs and meet future demands.

Each country in the UK has a website which outlines the issues relating to public health and can be a valuable resource for further reading.

- [Public health - England](#)
- [Public Health Agency – Northern Ireland](#)
- [Scottish Public Health Network – Scotland](#)
- [Public health - Wales](#)

For children and their families there is a huge opportunity for physiotherapists to support the ongoing health and wellbeing of the younger population. Physiotherapists can become engaged in a proactive approach in acting preventatively, early intervention and enable children and families in participation. There is scope to foster inter-agency collaboration for better health outcomes and to empower the family to be confident in self-management. This requires listening skills and empathy for the whole family. An understanding of the local environment and its specific challenges for a family can make a significant difference in how much or how little the child can participate in play or family activities. The APCP recognises that participation (involvement in life situations) is a fundamental health outcome for children and families. We encourage therapists to: (i) include a strong focus on participation outcomes in their goal-setting with families, (ii) use the ICF-CY to consider all potential factors influencing participation outcomes, for example environmental and personal factors as well as body structure and function factors, and (iii) engage in local and national opportunities for collaboration on participation outcome measurement.

Sharing information with parents, children and young people in an appropriate manner is essential, including outcomes and bad news.

The physiotherapist should be key to facilitating engagement with other organisations e.g. voluntary (third sector), transport, sports and leisure activities. Lack of appropriate transport is known to be a significant factor that perpetuates the feeling of exclusion and a loss of quality of life ([SPARCLE](#)). SPARCLE stands for the Study of Participation of Children with cerebral palsy Living in Europe. SPARCLE wants to find out about children who have cerebral palsy in different countries.

The [International Classification of Functioning, Disability and Health](#), known more commonly as ICF, is a classification of health and health-related domains. As the functioning and disability of an individual occurs in a context, ICF also includes a list of environmental factors. ICF is the WHO (World Health Organisation) framework for measuring health and disability at both individual and population levels. ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 as the international standard to describe and measure health and disability.

The ICF can provide a common language and framework for documenting functional changes associated with physiotherapy intervention. It also changes the negative focus of disability and tasks someone cannot do to the positive abilities of the individual and their participation. A research study in 2011 looking at the [impact of using the ICF framework as an assessment tool for students in paediatric physiotherapy](#) showed that using the framework encouraged clinical reasoning and an improved holistic approach to identifying the child's needs and wishes.

Sport and exercise

In addition to the health and fitness benefits of sports and physical activity, participation in sport can have a positive effect on confidence and self-esteem. Paediatric physiotherapists are in a key role to encouraging children to participate in sport and whatever level they would like to, and foster a lifelong enjoyment of exercise. The APCP website has a comprehensive [web-based resource](#) signposting families/ professionals to information about disability sports and local opportunities.

It is recognised that people with disabilities are underrepresented in physical activity and sports and there is a drive to improve access for all, an example of this is Active Living: No Limits 2011. This is a strategic Action Plan to improve the health and well-being for people

with a disability in NI through participation in sport and active recreation. The vision for the plan is that everyone with a disability has an equal opportunity to access sport and active recreation leading to a healthier and more active lifestyle.

Locations and settings

Where possible, children should have access to their physiotherapy in the setting most appropriate for their assessment, treatment and ongoing support, and that 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, developmentally appropriate environment for children and young people (CYP) to have their assessments, interventions and ongoing support, and meet the child's needs and developmental potential.

The paediatric physiotherapist should also take account of their personal safety and adhere to local lone working policies when planning assessments or treatment sessions.

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.

It is recommended that all paediatric services should collaborate for timely and effective communication between primary, secondary and tertiary care, integrating care around each child's specific needs and delivering a planned and co-ordinated care pathway. This was highlighted in the [Kennedy report 2010](#) -Getting it right for children and young people.

Children may be seen in public, private or voluntary sectors and it is essential anyone treating the child liaises in the best interests of the child. Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient and should not have NHS treatment withdrawn or refused because they also have private care. Patients have a right to choose where they seek treatment, and in some cases this can

result in patients seeking and receiving concurrent treatment in both the NHS and private sectors.

In principle the choice that a patient makes in having additional private provision should not cause a problem, but sometimes it does, and for a number of different reasons such as poor communication or organisational boundaries. The guidance paper from the CSP entitled [Concurrent and Subsequent Treatment](#) explores some of these issues in detail. In addition those working in the private sector may find the CSP information paper [Thinking of Private Practice](#) also covers some of these issues.

Hospices for children

There are over 40,000 children living with life limiting diseases. [Together for Short Lives](#) works together with other organisations to support the development of best practice and provision of children's hospice services across the UK. The number of children living with a life limiting condition is [steadily increasing](#), particularly in the 16-19 age group. This suggests that the growing need for support associated with these conditions is being driven by longer survival times rather than a rise in the incidence of disease.

Life-limiting conditions ([LLC](#)) in children have been defined as conditions for which there is no reasonable hope of cure and from which children will die. Life-threatening conditions are those for which curative treatment may be feasible but can fail, such as cancer.

The hospices provide physical and emotional support in a home from home atmosphere and provide specialist staff and equipment to support play as well as medical care. The role of the hospice includes care for the child and for the family, including bereavement counselling.

What does this 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 year's settings, children's own homes, hospices, social care respite provision, mainstream schools and special schools, leisure and sports facilities.

Working in partnership with children, families and other service providers

Parent Empowerment

Empowerment is the capacity of an individual to take control of their circumstances, exercise power and achieve their own goal, in order to help themselves and maximise the quality of their lives. Seeking control over one's life by taking action to get what one wants.

Becoming a parent can be a time full of joy and anticipation. Prior to the birth of the baby, parents think about what the child will look like, the sports he or she will play. When the child is born, the parents think in terms of normal development, parenting is a great challenge and parents do not plan for a child with special needs. They often find themselves very unprepared, afraid and angry.

The transition from feeling helpless and overwhelmed to believing in and acting on their ability to parent a child with special needs is an ongoing process for most families. ([Turnbull, Turnbull, Erwin, & Soodak 2007](#)).

[Empowering parents](#) is about giving the parents the skills, resources and ability to ask themselves 'what does my child need from me right now' and having the right environment to allow them to do this.

The most effective support services are those where parents are involved in achieving better control over their lives and the development of their child. It is where the parents can come up with their own ideas and think up credible solutions. To achieve this, professionals should be empathetic rather than formal or authoritative, purposeful but open, encourage not criticise.

As physiotherapists, it is important that we empower parents from early on. Parents are expected to be involved in all aspects of their child's care including the delivery of all aspects of physiotherapy. Parents are asked to consent to physiotherapy and then expected to implement home exercise programmes (Novak & Cusick, 2006). The approach should be collaborative; this means meeting the family's preferences through excellent communication and teaching skills. The physiotherapist needs to understand the family, cultural differences, wider socio-economic factors and the abilities of the parents (Case-Smith & Nastro 1993). For physiotherapy intervention in the home to be effective, the families need to be competent, willing and supported. The physiotherapist must be able to build a trusting relationship, facilitate learning, trouble shooting and recognising where parents require additional external support.

'If the experiences of parents are positive, they are more likely to engage and comply in the delivery of physiotherapy programmes and demand less from the service provider.'
Deborah Wilson BSc (HONS) MSc MCSP [APCP Journal V5N1 2014](#)

Breaking bad news/ difficult conversations

'Physiotherapists are not particularly involved in breaking bad news – such as telling people that they have a terminal illness. But we are very much involved in picking up the pieces after people have had that sort of news and dealing with the worries and concerns that often come up.' [Chris Barton](#)

Paediatric physiotherapists may have to work with families who have only recently been given bad news, or have been given this news some way in to the working relationship with the physiotherapist. This may be a diagnosis of a long term disability or a life limiting condition. Some healthcare practitioners can overlook the psychological aspects of the family and focus too much on the physical or medical issues. The way in which a family is first given the news that their child has a long term problem are words they never forget and can plunge the family into a confusing and previously unknown world. [Research](#) shows that the manner in which the family is told affects both the way they adjust to the situation and the wellbeing of their child. The paediatric physiotherapist needs highly developed skills in managing communication of a distressing nature and managing difficult conversations and regular supervision and support should be established concerning this. Children have the right to know why they are attending for physiotherapy appointments. However, children are not always told by parents or professionals directly about their diagnosis and this can lead to a lack of important information available for the child to understand their difficulties and what support is available to them. Physiotherapists can sensitively and openly help parents and children talk, reduce the fear around being different and positively empower to seek solutions and promote independence.

It is important to recognise that supporting families through these situations can affect the emotional well-being of the therapist as well. The role of the paediatric physiotherapist is frequently emotionally demanding and can cause feelings of loss, grief, guilt and demoralisation as well as attachment issues especially with inadequate team support.

Managing expectations

Everyone working with children and young people who have additional needs or disabilities should support them to prepare for adult life and help them go on to achieve the best outcomes in employment, independent living, and health and community participation. When a child is very young, or additional needs are first identified, families need to know that the greater majority of children and young people, with the right support, can find work, be supported to live independently, and participate in their community. Health workers, social workers, early years providers and schools should encourage these ambitions right from the start. They should seek to understand the interests, strengths and motivations of children and young people and use this as a basis for planning support around them.

It is also essential that physiotherapists manage a family's expectations with regard to eventual outcome, likely frequency of intervention and longer term management. A frequent contentious issue, or cause for complaint is the frequency of intervention. Parents often feel that therapy is reduced as children get older, without understanding this is due to a lesser need rather than a reduction in resources. It is important from the beginning the therapist is honest with the family as to what they feel the child needs in the way of input with an explanation of how input may change according to the child's need or developmental level. It is important to discuss the possible rate of skill acquisition and how it may slow down as the child gets older. It is also important to discuss the possibility of loss of skills with age and growth and discuss the process of puberty which often has a marked impact on a child's abilities during rapid periods of increase in height and weight. It may be advantageous to have these discussions from early on and to continually reinforce it as the child grows.

Goal setting

Goal setting is essential in providing a focus to therapy and to ensuring a family centred evidence based approach. [Goal setting](#), refers to the identification of, and agreement on a target which the client, therapist or team will work towards over a specified period of time for the purpose of rehabilitation. Goal setting and goals are an effective means of both understanding and changing human behaviour. Clear and functional goals enhance motivation, leading to improved outcomes. Implementing a family centred approach within a goal setting framework emphasizes parental involvement in decision-making, collaboration, and partnership, acceptance of the family's choices, and empowerment. Several goal setting tools may be utilised to this end; SMART goals, the GAS or the ICF model.

SMART is an acronym commonly used in setting healthcare related goals and reminds one to provide clarity about each goal.

Specific	A specific goal is detailed and focused, contains enough detail to clearly define what you want to achieve. Everyone should know exactly what is to be achieved.
Measurable	A measurable goal is quantifiable and includes concrete criteria for measuring progress. Measuring progress helps you stay on track. Everyone should know when the goal has been achieved.
Achievable	An achievable goal has to have a fair chance to be met. Try not to make goals too easy, they should be challenging enough to move forwards and everyone should know that it has been achieved.
Realistic	A realistic goal is practical and achievable within the defined timelines. The goal must express an objective you are willing and able to work towards. A goal should stretch you, but not so far that you will be discouraged before you even start.
Timed	The goal has a definite deadline for completion and realizes the limits of available resources.

Group intervention

The use of group sessions both to share information with parents and carers, educate in terms of management of their child’s condition and to also deliver child specific treatment should be utilised as deemed appropriate. The impact of this approach on managing demand and meeting patients assessed needs may be useful in demand and capacity modelling.

Group intervention may be used in conjunction with charitable, community or voluntary sectors. The group could be used to facilitate self-management, transition or independence/ integration.

Children selected for group work should be of similar abilities or with similar conditions and the group should have a positive impact on both the child and the parents/carers.

Some children may not be suitable for group work.

Equipment

The benefits and purpose of equipment are in many respects self-evident. When appropriate equipment is provided in a timely manner it may allow children to access their environment, communicate with others and take part in developmentally appropriate activities that they would be unable to do without these devices. 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 equipment such as standing frames, walking aids, postural management or orthotics. However it is important to have an understanding of a wider range of products available to ensure the most effective provision within available resources. Equipment needs can be a sensitive topic for families so full collaboration and explanation is imperative to support compliance.

Community equipment services play an important part in helping people to develop their full potential and to maintain their health and independence. Equipment for children with long term physical problems is becoming more advanced, expensive and is constantly changing. Each Trust should have a robust system and process in place for the identification and procurement for the most suitable item to meet the child's assessed need. Equipment desirable from a child's or parent's perspective that is not recommended or deemed clinically appropriate for the child by the physiotherapist may not be funded by the local authority or Trust. A wide range of equipment and adaptations can now be provided from local, national or voluntary organisations. Additional resources may be found through organisations such as [Disabled Living](#) and their specialist [Kidz](#) exhibitions.

A recent report by the [Newlife Foundation for Disabled Children](#) '*has exposed a catalogue of failures in the provision of essential equipment for disabled and terminally ill children*' Newlife is calling on government, local authorities and health providers to ensure unmet need for equipment is better measured in the future. This is based on their 2007 campaign [It's Not Too Much To Ask](#).

Early intervention

'Early Intervention is an approach which offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending. It covers a range of tried and tested policies for the first three years of children's lives to give them the essential social and emotional security they need for the rest of their lives. It also includes a range of well-established policies for when they are older which leave children ready to face the challenges of each stage of childhood and of passage into adulthood – especially the challenge of becoming good parents to their own children.' [Early Intervention: The Next Steps](#)

[The Next Steps](#)

Early intervention for paediatric conditions has long been championed in literature. How paediatric physiotherapists interpret 'early intervention' and apply it clinically is essential in supporting and educating the family towards managing their child's condition. Building resilience and the family bond is an important element of the early physiotherapy intervention. From the analysis of effective practice, supported by research findings and international experience of what works, five '[golden threads](#)' of essential practice became apparent. These are the best start in life, language for life, engaging parents, smarter working- better services, knowledge is power.

Paediatric physiotherapists are frequently one of the first AHP's to be involved with a child, and can remain involved for their entire childhood. Early intervention focuses on helping babies and children learn the basic physical skills that typically develop during the first three years of life such as reaching, rolling, sitting, crawling and walking.

For some children it is known at birth, or even before birth, that early intervention will be essential in helping the child reach their potential. For other children who have a relatively routine entry into the world, it may be identified that they are developing more slowly, experience setbacks, or develop in ways different from expected. The term 'developmental delay' is important in early intervention, broadly meaning that a child is delayed in one or more areas of skill acquisition. Physiotherapists will help families understand how to meet their child's needs, create opportunities for children to develop motor abilities through play, find resources in the community that are suited to the family's needs and transition the child into preschool or school at the appropriate time.

The Common Assessment Framework for children and young people (CAF) is a shared assessment tool used across agencies in England, some authorities have now developed this tool and it is also known as other names such as Early Help Assessment. It can help

professionals develop 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 / Early Help Assessment is an important tool for preventative services. The Assessments have been designed specifically to help professionals assess needs at an earlier stage and then work with families, alongside other professionals and agencies, to meet them. The provision of early help services must take a pro-active approach to working with children and families. It aims to help the early identification of children and young people's additional needs and improve integrated working by promoting co-ordinated service provision to meet those needs. Paediatric physiotherapists need to be aware of this approach as many parts of working with children interlink with it. Every area will have its own slightly different forms and processes. Efforts should be made to re-engage adolescent children to ensure they get support at the earliest opportunity.

The [Team Around the Child](#) (TAC) is a co-ordinated approach to service delivery and is easily understood by families and paid workers. Key people, who already provide practical support to the child and family, are trusted by the parents and feel comfortable in their relationship, agree to join together regularly in the child's TAC meetings. The purpose of these meetings is to tell each other about the approach they are using, agree what the needs of the child and family are and create a unified action plan that integrates all strands of support, no matter which agency or person is providing them. This plan is reviewed and modified as necessary at successive TAC meetings. The child's TAC is kept small so that it does not become a case conference in which parents might be overwhelmed, disempowered and afraid to speak. In children with physical delay or difficulty, a paediatric physiotherapist is frequently a partner in this team.

Local authorities that have established TACs for their vulnerable children have usually done so as a collective enterprise between health, education, social services and perhaps the voluntary sector. This does not however happen everywhere and is often not commissioned so there will be many local variations. Rather than leave individual TACs to cope on their own, senior managers have created a post of 'TAC Co-ordinator' or 'TAC Manager' to support TACs and secure for them the resources they need. TAC Managers hold authority within their own agency and must then adapt to the horizontal landscape of multi-agency collaboration.

A Team Around the Family (TAF) is how multi-agency service provision is organised under the Common Assessment Framework (CAF). The main functions are to: Bring together children, young people, parents and practitioners; Provide a small, individualised team for the

child/family; Ensure parents/carers and children/ young people have an equal role in agreeing goals and actions to meet those goals; Ensure parents/carers needs are recognised and their central role in meeting the needs of the child/young person is acknowledged. The meeting should be as small as practically possible, so that the child/young person and family members do not feel overwhelmed.

[Accountable care organisations](#) (ACOs) are under active development in a number of areas of England. They are a response to growing financial and service pressures and work to put in place new care models that integrate services previously provided separately. ACOs have attracted interest as one way of overcoming fragmented responsibility for the commissioning and provision of care in the NHS. They are a practical expression of [‘place-based’](#) working under which NHS organisations and their partners agree to collaborate in order to meet the needs of the population they serve.

The [Early Years Foundation Stage \(EYFS\)](#) sets standards for the learning, development and care of children from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes.

The [Early Years Foundation Stage \(EYFS\) framework](#) supports an integrated approach to early learning and care. It gives all professionals a set of common principles and commitments to deliver quality early education and childcare experiences to all children.

As well as being the core document for all professionals working in the foundation years, the EYFS framework gives mums and dads confidence that regardless of where they choose for their child’s early education, they can be assured that the same statutory commitments and principles will underpin their child’s learning and development experience.

Northern Ireland- The Early intervention Transformation Programme (EITP) aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches. The EITP has a number of strands giving children the best start in life, early intervention services aligned to family support hubs and programmes to support children and families impacted by adversity

Scotland - The Early Years Framework and this highlights the importance of all national and local agencies, the third sector and independent sector working together to deliver improved outcomes for children. The Framework identifies the ten key elements of transformational change in the early years – these are:

- A coherent approach.
- Helping children, families and communities to secure outcomes for themselves.
- Breaking cycles of poverty, inequality and poor outcomes in and through early years.
- A focus on engagement and empowerment of children, families and communities.
- Using the strength of universal services to deliver prevention and early intervention.
- Putting quality at the heart of service delivery.
- Services that meet the needs of children and families.
- Improving outcomes and children's quality of life through play.
- Simplifying and streamlining delivery.
- More effective collaboration

School Years

All children have a right to be educated in an environment which supports their additional needs. This principle is enshrined in legal process (e.g. Child and Families Act England)

However there is wide local variation in how this is achieved. There may be provision within mainstream education settings, or special schools. Frequently physiotherapy services have a regular presence in schools, using skill mix and working with education and other professionals to support the pupil's development. Whilst working within a school setting you will also be required to comply with local education policies and procedures. Physiotherapy advice may be particularly influential in facilitating the correct support in the absence of an EHC plan, when the additional needs are mainly due to physical disability.

It is the role of paediatric physiotherapists to teach physical management programmes to educational and welfare staff and delegate school staff to continue to facilitate gross motor skills, postural management and mobility. Many children require physical management programmes to enable their access to education, integration and socialisation. There are

further details on delegation on the CSP website entitled '[Supervision, accountability and delegation of activities to support workers](#)'.

Local authorities in England have a duty to publish a [Local Offer](#), setting out in one place information about provision they expect to be available in their area across education, health and social care for children and young people in their area who have SEN or are disabled, including those who do not have EHC plans. These will vary from one area to another but the Local Offer has two key purposes:

- To provide clear, comprehensive, accessible and up-to-date information about the available provision and how to access it, and
- To make provision more responsive to local needs and aspirations by directly involving disabled children and those with SEN and their parents, and disabled young people and those with SEN, and service providers in its development and review

Transition

Transition 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' [J.E McDonagh](#).

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.'* [R.W Blum](#)

Transition has been recognised as an important standard of care in several major policy documents:

- [Getting the right start: national service framework for children, young people and maternity services: standard for hospital services \(2003\)](#),
- [National service framework for children, young people and maternity services: core standards \(2004\)](#)
- [Every child matters: change for children \(2004\)](#).

- [Transition: moving on Well \(2008\)](#)
- [NICE guidance- Transition from children's to adult's services for young people using health or social care services](#)

The NICE guidelines were written to support commissioners, managers and individual practitioners to develop and implement best practice for this time to ensure continuity of care, self-management as much as is able and independence for the young people with a long term condition. It is important to view the child and their care as a holistic package as all areas of their life impact on their compliance to care. The teenage years are particularly important to lay the foundations for future management. Local areas will have their own policies on age for transition.

Careful planning and delivery of treatment is essential to facilitate a young person's independence and successful transition to the adult world. [Shaw et al](#) suggest 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. The key to successful treatment is empowerment of the young person thus instilling a sense of responsibility and ownership of their disability or 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.

Shaw et al also suggest that 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 and that 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.

Transitional care packages need to be:

- Multi-dimensional holistic care – addressing all areas of a young person's life;
- Co-ordinated (multi-disciplinary) and individualised;
- Supportive – seeing the same healthcare professional at each appointment;
- Developmentally appropriate;
- Age appropriate – facilities and information.

Shaw et al and [McDonagh et al](#) identified the importance of 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 from age 13-14 as stated in NICE guidelines. 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.

Useful resources:

[Child and Maternal Health Intelligence Network – Transitions to adulthood](#)

[Transition Information Network Website](#)

[Pathway to Getting a Life](#)

[Preparing for Adulthood](#)

[APCP Transition Guidance](#)

[Children and Families Act 2014](#)

Summary

It is not possible to reflect every facet of paediatric physiotherapy practice within this document. The links embedded will enable further detail to be discovered, and the importance of direct work as a clinician, and/or within research cannot be underestimated. Working in paediatrics encompasses all of the core skills of physiotherapy, and enables a wide variety of career development and opportunities within the speciality.

It is a privilege to be able to make a difference to babies, children, young people, families and others using this particular knowledge, enabling them to develop, thrive and reach their full potential.



There can be no keener
revelation of a society's soul than
the way in which it treats its
children.

Nelson Mandela

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This document has been produced after an initial review of literature and where there is a lack of evidence, a consensus of expert opinion is agreed, correct at time of publication