2022 Elizabeth Casson Memorial Lecture – Q&A

Optimising Performance, Clinical and Economic Outcomes in Occupational Therapy Service Delivery

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Thank you for submitting questions during the livestream of my lecture on 28th April 2022. I have grouped the 26 questions (in blue) under different headings (in red) as they are related. The headings are arranged in a sequence related to the content of my lecture. I may answer (in black) several questions together and provide references (in green) accordingly. It is beneficial to read other sections for further information related to the questions relevant to your learning and practice.

A. WHERE AND HOW TO START

Q1. I am unsure where to start with using these tools for service improvement and development. What is a good starting point?
Q2. How to approach this with managers who aren't occupational therapists and who won't have seen this lecture?
Q3. How can we influence non-OT managers to prioritise much of what was mentioned?

The first starting point is to view my lecture again. You can also read the article of my lecture once it is published in the British Journal of Occupational Therapy. After that, use the RCOT 2022 Casson Lecture Self-Directed Learning Toolkit to expand and apply the information. In this toolkit, there are directive and non-directive questions to help you to reflect on the learning and relate it to your service and practice.

If you are working in a team, you can do a group reflection as a whole service. Then the facilitator guide will be useful to lead a discussion of the Lecture with colleagues.

The strategies I covered in my lecture are relevant to other disciplines as well. So, if your line manager (who is not an OT) and other colleagues who have not seen this lecture, you can recommend them to watch the recording of my lecture on Youtube (https://www.youtube.com/watch?v=8Mu_Dk7GgDk) and also share my article published in the British Journal of Occupational Therapy.

If you want to influence them to embark on service improvement, it is better if you have done your reflection first and identified areas that you would like to work on and get support from them. In terms of priority, it is important to sort out the structure, processes, and model of service delivery as the foundation for development in other areas. You also need to use the guidance set in the Professional Standards for Occupational Therapy Practice, Conduct and Ethics published by the RCOT in 2021.

Remember, Rome was not built in a day. Pursuing service improvement requires patience, persistency, time, effort, the technical knowledge required as well as support from frontline staff and senior management.

RCOT (2021). Professional standards for occupational therapy practice, conduct and ethics. Southwark, London: Royal College of Occupational Therapists.

B. SERVICE IMPROVEMENT STRATEGIES

Q4. Most quality improvement models are based on manufacturing industry frameworks for factory floor effectiveness & efficiency, do you think these translate well to human services? I think there is data that says 30% of service improvement is sustained and 60% for QI projects.
Q5. Hi Mary 3rd year OT students in Glasgow, I was wondering if the Lean methodology is being used in Scotland also?
Q6. There are many performance criteria and benchmarks facing health service managers nowadays, what's your advice for them to meet these challenges?

In my lecture, I mentioned Lean Thinking as one of the service improvement strategies I used to improve the structure and processes of service delivery. Although Lean Thinking originated from the industry, it has been applied in health service successfully in the last 20+ years (Jones and Mitchell, 2006; Brandao de Souza, 2009). It has been proved to improve health service efficiency and productivity (NHS Confederation, 2009).

Lean Thinking is a way of streamlining the patient journey and making it safer, by helping staff to eliminate all kinds of waste and to treat more patients with existing resources (Jones and Mitchell, 2006). The whole approach brings together several strands of process improvement. It starts by defining the purpose of the process (value for the customer), then redesigns the process to deliver this value (with minimum wasted time, effort and cost). It then organises people and organisations to manage this value delivery process. It is about developing the whole staff team to problem-solve every day to pursue perfection (NHS Improving Quality, 2014).

Based on the "Lean Thinking" concepts developed in industry, the NHS Institute for Innovation and Improvement (NHS III) launched the Productive Services Series in 2008. It consists of programmes on the Productive Ward, Productive Mental Health Ward, Productive Community Hospital, Productive Leader, Productive Operating Theatre, Productive Community Services, Productive General Practice and Productive Endoscopy Unit to be used in the whole country (NHS III, 2007).

NHS organisations from the 4 nations can adopt these Productive Programmes to improve the efficiency and productivity of their clinical services. Burgess and Radnor (2013) identified that hospitals in England increasingly enhance and elevate their Lean implementation approaches in line with organisation-wide programmes and the organisation's strategy. I do not know the extent of Lean Thinking implementation in the other three nations. OTs working there will need to search the information themselves.

The NHS III also published specific applications of Lean Thinking in different aspects of service delivery. For example, services can apply lean thinking to reduce unnecessary waits in the 18 weeks pathway (NHS III, 2006). You can learn more about the Productive Series through this link: https://www.england.nhs.uk/improvement-hub/productives/

As mentioned in my lecture, I implemented the Productive Community Services Programme (NHS III, 2009) with the whole staff team in 2010. The programme is a whole management system with tools and methods that have been effectively utilised to eliminate waste and improve process flow. Tools that address workplace organisation, standardisation, visual control, and elimination of non-value-added steps are applied to improve the flow of patients' journeys. For example:-

1) Value stream mapping – identify the components of the patient journey which add value to their care, and remove waste in the processes e.g. duplicate steps, unnecessary work, lack of clear roles and responsibilities by using the techniques of "eliminate, combine, simplify and sequence". Involving patients in this process ensures the patient perspective is maintained at all times.

2) Create a better and safer working environment and standardise work by using the 7S process: sort, set in order, sweep & shine, standardise, sustain, spirit and safety.

Besides Lean Thinking, there are other service improvement strategies that can be used to improve the efficiency of the service. For example:-

- Plan-Do-Study-Act Process (Deming, 1993)
- Turning the Curve (Friedman, 2005)
- Statistical Process Control (SPC) (Qiu, 2014)
- Vanguard Method (Seddon, 2008; O'Donovan, 2014)

All these service improvement strategies can be translated well into human services to improve safety and quality, improve staff morale and reduce costs. But service improvement won't just happen on its own. It needs leadership and leaders. People are willing and able to gather colleagues around them, find out how to do it, and win senior management support. It needs managers with the vision to give staff licence to experiment. As I mentioned in my lecture - To improve the efficiency of the service, OT managers and clinicians need to develop a "lean" eye for service improvement.

To meet commissioning challenges in achieving performance, clinical and economic outcomes, OT managers or team leaders need to apply all the strategies mentioned in my lecture. Using the RCOT 2022 Casson Lecture Self-Directed Learning Toolkit will help to apply your learning from the lecture and relate it to your service and practice. If you are working in a team, you can do a group reflection as a whole service. You can use the facilitator guide to lead a discussion of the Lecture with colleagues.

Brandao de Souza, L. (2009), "Trends and approaches in lean healthcare", Leadership in Health Services, Vol. 22 No. 2, pp. 121-39.

Burgess, N. and Radnor, Z. (2013). Evaluating Lean in healthcare. International Journal of Health Care Quality Assurance, Vol.26, No.3, pp.220-235.

Deming, W.E. (1993). The new economics. Massachusetts Institute of Technology Press, p.35.

Friedman, M. (2005). Trying Hard is not Good Enough: How to produce measurable improvements for customers and communities. FPSI Publishing.

Jones, D. and Mitchell, A. (2006). Lean thinking for the NHS – a report commissioned by the NHS Confederation. London: NHS Confederation.

NHS Confederation (April, 2009). Primary Care Trust Network Briefing Issue 181: The future for community services.

NHS Improving Quality (2014). Bringing Lean to Life – Making Processes Flow in Healthcare. NHS Improving Quality – www.nhsiq.nhs.uk.

NHS III (2006). No Delays Essentials – Six things that will make a big difference to your 18 week wait (NHSIND01). Annesley, Nottingham: NHS Institute for Innovation and Improvement.

NHS III (2007). Going Lean in the NHS. How lean thinking will enable the NHS to get more out of the same resources (NHSILEAN02). Annesley, Nottingham: NHS Institute for Innovation and Improvement.

O'Donovan, B. (2014). Editorial for Special Issue of SPAR: The Vanguard Method in a Systems Thinking Context. Syst Pract Action Res, 27:1–20 DOI 10.1007/s11213-012-9247-7.

Qiu, P. (2014). Introduction to Statistical Process Control. Boca Raton, FL: Taylor & Francis Group.

Seddon, J. (2008). Systems thinking and the public sector. Triarchy, Axminster.

C. STRUCTURE AND MODEL OF SERVICE DELIVERY

Q7. Do you think it's possible for children with long-term conditions who have had such an integrated holistic service to continue having such seamless care when they become adults? How can adult services learn from a model like this?
Q8. I know there is lots of desire in the museum and gallery sector to be involved in social care. Do you think there is viability in using the 3-tiered model to train facilitators in the OT approach but delivered by a museum/ cultural venue?

The service I developed has two important components in service delivery – multi-agency integration and innovative models of service delivery. I will address the component of multi-agency integration first.

It is possible but challenging to integrate services from different agencies for both children and adults. Before embarking on this challenging journey, you will need to establish yourself to be a recognised skillful clinician and competent manager so that your voice carries weight. After that, the best way to start is to network with key stakeholders from different agencies. Networking is to establish relationships with people, break the barriers and get to know them to develop trust and share ideas. You will need to exercise your leadership skills (both soft and hard) to inspire innovation within and outside the service, influence senior management and other key stakeholders to collaborate, and get commitment to developing the service into a fully integrated and multi-agency funded service. Knowledge of different legislations and national agendas is useful to support your call for integration. It can be done as my service is a good example (Chu, 2014).

The transition from children to adult service is always a challenging time for the young person, parents/carers, and all professionals involved. Having an integrated holistic children's service will help to maximise the potential of young people to prepare them to transit to adult life and hopefully, they may need fewer input from the adult services. Practically, it is essential to have a multi-agency and multi-disciplinary transition plan started at least one year before the transition. The young persons and their families should be involved in the whole process. Good liaison between the children's and adult's services through a written transition pathway is important to ensure all supports are in place if needed. Parents and young persons should be given all the information they need for further input after they leave the children's service. If necessary, signpost them for inputs from different voluntary services and support groups locally and nationally. Also, see the answer for Q23 & Q24 for further information.

The second component is about innovative models of service delivery. In my lecture, I mentioned the 3-tiered school-based OT model of service delivery (Chu, 2013, 2015 and 2017) I adopted in 2010. This model is based on the Response to Intervention (RtI) Model used in the educational system in North America (National Association of State Directors of Special Education, Inc., 2005) and adopted by the American Occupational Therapy Association (Cahill, 2007; AOTA, 2009; Clark & Polichino, 2013). It is consistent with the concepts of the 3-tiered Public Health Model (i.e. primary, secondary and tertiary levels of interventions) (Taylor, Peckham, & Turton, 1998) and also the graduated approach recommended by the College of Occupational Therapists (COT, 2016).

This model emphasises early intervention and addresses student learning needs through universal (whole school-based), targeted (classroom-based) and intensive (individual-based) interventions before a student get too far behind or is referred to a specialist service. It can be used in mainstream and special schools to develop specific areas of function/skill (e.g. fine motor skills, handwriting skills) and support children with different disability conditions, e.g. autism spectrum disorder, and cerebral palsy (Chu, 2015 & 2017).

The concept of a 3-tiered model can also be used at the population level in both children and adult services. For example, when the National SureStart Programme for children under four years old (now the Universal Child Health Service) was introduced in 2001, I was able to secure funding for two OT posts working at two local SureStart Projects. This was the model used at the population level:-

1.	**Tier 1 - Universal Services**	
	a.	Provide training to staff and parents on different topics and programmes e.g. - Infant and toddlers who are at risk of developmental problems - Selection and use of toys to facilitate child development - Use of developmental screening tools by frontline workers - Early motor development and the use of the Nursery Motor Programme - Sensory modulation function and self-regulatory behaviour - Pre-writing skills development and training
	b.	Drop-in sessions – identify children with developmental problems and advise on sensory, perceptual and motor development, play, self-care skills training, etc.
	c.	Developmental screening and antenatal work with Midwives and Health Visitors by using different screening tools and the Brazelton Neonatal Assessment Scale, especially important for vulnerable mothers
	d.	Set up and operate a Toy Library Service
	e.	General and specific information services to staff and parents
2.	**Tier 2 – Targeted Services**	
	a.	Run therapy groups for children who are identified to be at risk of developmental problems. The format is integrating SLT, OT and play activities into a children-centred programme.
	b.	These therapy groups will also provide hands-on training to staff so that they can continue the implementation of certain groups.
	c.	Provide regular OT inputs to children with developmental problems attending different children's centres.
	d.	Provide advisory and therapeutic Inputs to established groups in the borough, e.g. parent and toddler groups organised by the PEST (a local parents group) for children with disabilities.
3.	**Tier 3 – Specialist Services**	
	a.	Specialist OT assessment and treatment of individual children, with advice and programmes written for children's centre staff and parents. Regular review and monitoring can be provided. Staff training will be on an individual base, related to a child.
	b.	Refer to other teams and other professionals for early intervention as appropriate.
	c.	Facilitate transition to school and transfer to other parts of the OT Service if necessary and also liaise/work with other services.

Therefore, OTs working in the adult services should be able to apply the concept of a 3-tiered model either for a specific group of clients or at the population level by focusing on capacity building of people around the client and empowerment of family members to provide cost-effective interventions in different settings.

American Occupational Therapy Association, Inc. (2009). Occupational therapy response to intervention leaflet. Bethesda, MD: Author.

Cahill, S. M. (2007). A perspective on response to intervention. AOTA Special Interest Section Quarterly School System, 14(3), 1–4.

Chu, S. (2013). A Model for Commissioning School-based Paediatric OT Services. OT News, February 2013, pages 38 – 39.

Chu, S. (2014). A Model of Good Practice. OT News, March 2014, pages 26 – 27.

Chu, S. (2015). Developing, Costing and Marketing School-based Occupational Therapy Service to Health and Education Commissioners – Course Manual (2nd Ed.). Derby, England: National Centre of Rehabilitation Education (NCORE), University Hospitals of Derby and Burton NHS Foundation Trust.

Chu, S. (2017). Supporting children with special educational needs (SEN): An introduction to a 3-tiered school-based occupational therapy model of service delivery in the United Kingdom. World Federation of Occupational Therapists Bulletin, DOI: 10.1080/14473828.2017.1349235

Clark, G. F., & Polichino, J. (2013). Chapter 17: Best practices in early intervening services and response to intervention. In G. F. Clark & B. E. Chandler (Eds.), Best practice for occupational therapy in schools (pp. 173–182). Bethesda, MD: American Occupational Therapy Association.

COT. (2016). Provision and commissioning of occupational therapy services for children and young people. Southwark, London: College of Occupational Therapists.

National Association of State Directors of Special Education, Inc. (2005). Response to intervention: Policy considerations and implementation. Alexandria, VA: Author.

Taylor, P., Peckham, S. and Turton, P. (1998). A public health model of primary care – from concept to reality. Public health alliance. ISBN 188-331419-0

D. OUTCOMES MEASURES

Q9. I would be interested to hear whether there are any outcome measures you have found to successfully capture participation-focused outcomes?
Q10. As you mentioned, participation is an important outcome measure that we should look into. What would you suggest for measuring participation and engagement? As it seems difficult to quantify participation in healthcare services. Are there existing scales for measuring that?
Q11. Do you have a preferred Patient Rated Outcome Measure that helps OTs (not just in paediatrics) measure the effectiveness and client participation? You reference the GAS.

There are different assessments of participation used in the OT practice. OTs are contributed to the development of some of these assessment tools.

EXAMPLES OF PARTICIPATION ASSESSMENT TOOLS FOR CHILDREN:-

1) Perceived Efficacy and Goal Setting, 2nd Edition – PEGS (Missiuna & Pollock, 2000)

This is a self-report assessment of perceived competence in everyday activities for children ages 5–9 years. Children choose activities that are challenging and motivating and set their own goals. A caregiver questionnaire is included in the assessment.

Missiuna, C., & Pollock, N. (2000). Perceived efficacy and goal setting in young children. Canadian Journal of Occupational Therapy, 67, 101–109. https://doi.org/10.1177/000841740006700303

2) Children's Assessment of Participation and Enjoyment (CAPE) and the Preferences for Activities of Children (PAC) (King et al., 2004)

The CAPE and PAC provide an understanding of the social well-being and activity performance of children and young persons with disabilities for intervention planning or measuring outcomes. These are self-reported companion measures of participation in recreational and leisure activities in out-of-school activities for children ages 6–21 years. They report on five dimensions of participation (recreational, physical, social, skill-based, and self-improvement) and provide a context of where activities take place and the child's preference for the activity. Administer either by having the client complete the record form with assistance from the parent or caregiver or by using the activity and category cards. Administration time: 15-20 minutes - PAC; 30-45 minutes – CAPE.

King, G., Law, M., King, S., Hurley, P., Rosenbaum, P., Hanna, S., Kertoy, M. and Young, N. (2004). Children's Assessment of Participation and Enjoyment (CAPE) and Preferences for Activities of Children (PAC). Harcourt Assessment / Pearson Clinical Assessment UK.

3) Child and Adolescent Scale of Participation – CASP (Bedell, 2009)

This caregiver report measures the extent how a child participates in home, school, and community activities compared with children of the same age. The CASP Youth version (2011) is available for free on Dr. Bedell's website: https://bit.ly/3vOjdYP

Bedell, G. (2009). Further validation of the Child and Adolescent Scale of Participation (CASP). Developmental Neurorehabilitation, 12, 342–351. https://doi.org/10.3109/17518420903087277

4) Assistance to Participate Scale – APS (Bourke-Taylor et al., 2009)

This is a brief assessment tool measuring the assistance that a school-aged child, age 5–18 years, with a disability requires to participate in play and leisure activities at home and in the community, based on the caregivers' perspective. This assessment tool is free and available at https://bit.ly/3xXsOhG.

Bourke-Taylor, H., Law, M., Howie, L., & Pallant, J. F. (2009). Development of the Assistance to Participate Scale (APS) for children's play and leisure activities. Child: Care, Health, and Development, 35, 738–745. https://doi.org/10.1111/ j.1365-2214.2009.00995.x

5) Participation & Environment Measure - PEM-CY (Coster et al., 2011)

This parent-report measure evaluates participation at home, school, and community alongside environmental factors within each setting for children ages 5–17 years with or without disabilities. It gives information on current levels of participation while encouraging problem-solving within each setting to support participation. It can be downloaded and completed online.

Coster, W., Law, M., Bedell, G., Khetani, M., Cousins, M., & Teplicky, R. (2011). Development of the participation and environment measure for children and youth: Conceptual basis. Disability and Rehabilitation, 34, 238–246. https://doi.org/ 10.3109/09638288.2011.603017

EXAMPLES OF PARTICIPATION ASSESSMENT TOOLS FOR ADULTS:-

1) Participation Objective, Participation Subjective – POPS (Brown et al, 2004).

The POPS was developed to gather information about both objective aspects of participation and the subjective evaluation of the level of and satisfaction with participation. The POPS is unique in the following 3 aspects: (a) it focuses solely on activities, (b) the metric is duration or frequency of activity, and (c) all measured activities are intrinsically social, part of household or occupational functioning, or recreational activities occurring in community settings. The 26 items are summed within 5 subscales: Domestic Life; Interpersonal Interactions and Relationships; Major Life Areas; Transportation; and Community, Recreational, and Civic Life, in parallel to the ICF domains.

Brown, M., Dijkers, M., Gordon, W.A., Ashman, T., and Charatz, H. (2004). Participation Objective, Participation Subjective: a measure of participation combining outsider and insider perspectives. J Head Trauma Rehabil, 19:459-81.

2) Mayo-Portland Participation Index – M2PI (Malec, 2004).

The M2PI consists of 8 items that comprise a subset of the Mayo-Portland Adaptability Inventory. This index correlates highly with the entire inventory, which in turn has well-established validity and other psychometric properties. It evaluates the degree of limitations in the areas of initiation, self-care, social contact, recreation, employment, transportation, household management, and financial management.

Malec, J.F. (2004). The Mayo-Portland Participation Index: a brief and psychometrically sound measure of brain injury outcome. Arch Phys Med Rehabil, 85:1989-96.

3) Keele Assessment of Participation – KAP (Wilkie et al, 2005 & Wilkie et al, 2006)

The KAP is a brief self-administered measure of participation restriction (contains 11 items) from the conceptual basis of participation as an individual's perception of their actual involvement in life situations. There is some evidence of sufficient measurement properties to support its potential application in epidemiological studies in older populations.

Wilkie R, Peat G, Thomas E, and Croft, P.R. (2006). The prevalence of person-perceived participation restriction in community-dwelling older adults. Qual Life Res 2006;15:1471–9.

Wilkie, R., Peat, G., Thomas, E., Hooper, H. and Croft, P.R. (2005). The Keele Assessment of Participation: a new instrument to measure participation restriction in population studies. Combined qualitative and quantitative examination of its psychometric properties. Qual Life Res,14:1889–99.

4) Participation Scale – P-Scale (Van Brakel et al, 2006).

The P-Scale is a tool for assessing problems perceived in main socioeconomic living spaces and is based on 18 items. It enables an individual to compare himself/herself with a peer who is in a similar situation in terms of socio-cultural, economic, and demographic aspects besides illness and disability. The questions in the scale measure specific aspects of ICF activity and participation domains, including learning and applying knowledge, general tasks and demands, communication, mobility, self-care, domestic life, interpersonal interactions and relationships, major life areas and community, and social and civic life.

The scale uses a 5-point grading system (0—no restriction; 1—some restriction, but no problem; 2—small problem; 3—medium problem; and 5—large problem). By summing the item scores, a total score range of 0–90 is obtained. This final score can be converted to participation constraint scores. Possible grades are no important constraint (0–12), mild restriction (13–22), moderate restriction (23–32), severe restriction (33–52), and extreme restriction (53–90).

Van Brakel, W. H., Anderson, A. M., Mutatkar, R. K. and Bakirtzief, Z. (2006). The Participation Scale: measuring a key concept in public health. Disability and Rehabilitation, vol. 28, no. 4, pp. 193–203.

5) Participation Profile – PAR-PRO (Ostir et al, 2006).

The PAR-PRO is a measure of home and community participation related to the ICF. It is a broad measure of home and community involvement for persons with disabilities with 20 items measuring the client's participation in domestic management, socialization, physical vigor, and generative activities.

Ostir, G. V., Granger, C. V., Black, T., Roberts, P., Burgos, L., Martinkewiz, P. and Ottenbacher, K.J. (2006). Preliminary results for the PAR-PRO: a measure of home and community participation. Archives of Physical Medicine and Rehabilitation, vol. 87, no. 8, pp. 1043–1051.

6) International Classification of Functioning (ICF), and the Disability and Health Measure of Activity and Participation-Screener - IMPACT-S (Post et al, 2008).

The IMPACT-S is the screener part of the ICF Measure of Participation and Activities questionnaire. It consists of 33 items in 9 scales, reflecting the 9 activity and participation chapters of the ICF. It is a reliable and valid generic measure of activity limitations and participation restrictions for people with different physical disabilities.

Post, M. W. M., de Witte, L. P., Reichrath, E., Verdonschot, M. M., Wijlhuizen, G. J. and Perenboom, R. J. M. (2008). Development and validation of IMPACT-S, an ICF-based questionnaire to measure activities and participation. Journal of Rehabilitation Medicine, vol. 40, no. 8, pp. 620–627.

7) Activity and Participation Questionnaire – APQ6 (Stewart et al, 2010).

The APQ6 is a self-report measure of vocational activity and social participation for routine use in community mental health services. It was developed from concepts of the Australian Bureau of Statistics Labour Force Surveys and Census. Field testing and consumer consultation were undertaken in New South Wales mental health rehabilitation services. The APQ6 is proposed to be used as a recovery-orientated measure focusing on vocational activity and community participation.

Stewart, G., Sara, G., Harris, M., Waghorn, G., Hall, A., Sivarajasingam, S., Gladman, B. and Mowry, B. (2010). A brief measure of vocational activity and community participation: development and reliability of the Activity and Participation Questionnaire. Australian & New Zealand Journal of Psychiatry, vol. 44, no. 3, pp. 258–266.

8) Participation Assessment with Recombined Tools-Objective – PART-O (Whiteneck et al, 2011; Bogner, 2013).

The PART-O is a set of 24 items that covered a broad range of participation content. "Objective" refers to the fact that although participation as a status can in principle be observed by an outsider (i.e. "subjective"), aspects of participation that reflect the priorities, satisfactions, and desires for change can be determined only by people with disability themselves. The content of PART-O items includes aspects of participation identified in the ICF. The items include content covering various ways people can be productive members of society (work, school, homemaking, and so on), are socially integrated (interacting with family, friends, spouses, and so on), and show community involvement (going shopping, attending church, eating out, and so on).

The PART-O was developed to examine long-term outcomes and can also be used to evaluate the effectiveness of interventions to improve social/societal functioning. The z-scores can be used to provide the basis for an assessment of progress in post-acute rehabilitation, allowing for an assessment of intra-individual differences in change across domains as well as inter-individual comparisons with the normative groups. The authors caution that the normative data is best used with individuals from similar demographic groups.

Bogner, J. (2013). The Participation Assessment with Recombined Tools-Objective. The Center for Outcome Measurement in Brain Injury. http://www.tbims.org/combi/parto (accessed May 2, 2022).

Whiteneck, G. G., Dijkers, M. P., Heinemann, A. W., Bogner, J.A., Bushnik, T., Cicerone, K.D., Corrigan, J.D., Hart, T., Malec, J.F., and Millis, S.R. (2011). Development of the Participation Assessment with Recombined Tools-Objective for use after Traumatic Brain Injury. Archives of Physical Medicine and Rehabilitation, vol. 92, no. 4, pp. 542–551.

GOAL ATTAINMENT SCALING (GAS):-

In service settings for clients with different disability conditions, measuring clients' progress towards an individual goal is increasingly important. The heterogeneity of the population often induces challenges to clinicians in identifying appropriate clinical outcome measure tools. A possible solution for measurement in heterogeneous groups is the use of individual measurement tools, one example of which is the Goal Attainment Scaling (GAS) (Kiresuk et al, 1994; Chu, 2019).

GAS is a method originally developed for adults in the mental health arena as a programme evaluation tool that facilitates patient participation in the goal-setting process (Kiresuk & Sherman, 1968; Kiresuk, 1973; Kiresuk, Smith & Cardillo, 1994). It is a generic individualised evaluative criterion-referenced instrument that can be used for the measurement of changes in individual patients and in groups of patients (Steenbeek, 2010). In the UK, some service settings have adapted the five-scale structure of the original GAS and reduced the requirement of writing 5 incremental scales for a goal to just writing the baseline and the expected level of performance. It is also known as the GAS Light version (Turner-Stokes, 2009). An excel spreadsheet or online GAS calculator has also been developed to summate goals for a client into one single GAS Score to measure the effectiveness of treatment provided.

In my service, I use GAS as the main method to measure treatment effectiveness and provide monthly outcome data to the commissioner. GAS is one of the outcome methods recommended by the NHS London. Some clinical services have the GAS template and calculator integrated into their information systems so that clinicians can use it to keep a record of treatment goals for an individual client and calculate the GAS Score.

GAS offers greater ecological validity than other standardised tests in which the relationship between test scores and real-life functioning is unclear. Goals can be individualised and are specifically designed to represent realistic expectations concerning the client's participation in different functional activities (Lee et al, 2021). It encourages collaborative goal-setting i.e. the thoughts and opinions of clients, their families, and other health service providers are important. It improves the clarity of therapy objectives for both therapists and clients. Its collaborative use reflects a person- or family-centred approach with client involvement in service delivery (Chu, 2019).

GAS is a contextually relevant measure of change that shows promise for application to intervention effectiveness research and programme evaluation (Ottenbacher and Cusick, 1993). It captures individualized progress that is meaningful to the family (Mailloux et al, 2007; Tam, Teachman, and Wright, 2008). It is potentially responsive to small changes in progress for clients with diverse diagnoses and needs (Russell, Candelaria and Addario, 2019).

CLIENT SATISFACTION:-

As stated in my lecture, clinical outcome includes treatment effectiveness and client satisfaction with the service provided. Therefore, client satisfaction with services through self-report measures is an important outcome when seeking to optimise service delivery and increase acceptance of individualized outcomes (Majnemer and Limperopoulos, 2002; Palisano, 2014).

Chu, S. (2019). Outcome Framework and Goal Attainment Scaling (GAS) Course Manual (13th Edition). England, Derby: National Centre of Rehabilitation Education (NCORE), University Hospitals of Derby and Burton NHS Foundation Trust.

Kiresuk, T.J. (1973). Goal Attainment Scaling at a county mental health service. Evaluation, Special Monograph, 1, 12-18.

Kiresuk, T.J. and Sherman, R.E. (1968). Goal attainment scaling: a general method for evaluating community mental health programs. Community Mental Health Journal, 4, 443-453.

Kiresuk, T.J., Smith, A. & Cardillo, J.E. (1994). Goal Attainment Scaling: Application, Theory and Measurement. Hillsdale, NJ: Erlbaum.

Lee, C.E., Shogren, K.A., Segal, J., Pezzimenti, F., Aleman-Tovar, J. and Taylor, J.L. (2021). Goal attainment scaling – community-based: a method to incorporate personalised outcomes into intervention research with youth and adults, on the autism spectrum. Autism. First published online: June 15, 2021. https://doi.org/10.1177/13623613211024492.

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Palisano, R.J. (2014). Editorial – Whose goals and outcomes are they? Physical & Occupational Therapy in Pediatrics, 34(1), 1 – 3.

Russell, M., Candelaria, G and Addario, B. (2019). Evaluating the Quality of Goal Attainment Scales (GAS) for Clients in Therapy. American Journal of Occupational Therapy, Vol.73, No.4, Supplement 1, August 2019.

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Tam, C., Teachman, G. and Wright, V. (2008). Paediatric Application of Individualised Client-Centred Outcome Measures: a Literature Review. British Journal of Occupational Therapy, 71(7), 286-294.

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E. REDUCING AND CALCULATING COST

Q12. Why do you privilege contact time over other activities? Care plans and risk assessments are 'documentation', too, and a well-produced one is crucial to successful outcomes. Reflection on client care, alone or with colleagues, is a vital activity (is it not?) and often takes place outside client contact.

From the Commissioning perspective, clinical services are required to provide monthly performance and output data (e.g. waiting time and waiting list, DNA rate, number of clients being seen and number of contacts produced in each month, etc.) and clinical outcome data (e.g. percentage or number of clients who have achieved the treatment goals set, client satisfaction ratings, etc.), i.e. the end-products in service delivery.

It does not mean that other supporting activities (e.g. documentation, treatment planning, team meeting, supervision, CPD, liaison with other professionals, traveling, etc.) are not important. We all know that all these background activities are essential to support effective clinical inputs to the clients and contribute to the achievement of performance, clinical and economic outcomes.

However, it is our responsibility to avoid wastage and maximise the use of resources, time, and effort by improving the efficiency of the services. That means we all need to work smartly by streamlining all the work processes to produce more Clinical Inputs Hours for direct client contacts, which in turn, reduce the cost involved.

The calculation of On Duty Hours and Clinical Input Hours demonstrated in my lecture is the first step to working out the unit cost of each direct client contact (Chu, 2011). In some areas, commissioners have set the ratio of time spent on direct client contacts and other supporting activities in service specification when setting the contract of commissioning (see the answer for Q15 below).

Once the number of 'Clinical Input Hours' is calculated, it can be used to calculate the number of client contacts that can be made by a full-time (or pro-rata) staff per year by defining the duration of contact, the unit cost, cost per care package by defining the number of clinical input hours required and also caseload for individual staff and the whole service. Please refer to my article published in the OT News (Chu, 2012) for a brief outline of all the calculation steps.

Chu, S. (2011). Calculating Costing and Productivity of Therapy and Nursing Services (3rd Ed.). Great Yarmouth, England: Kid Power Therapy and Training Co. Ltd.

Chu, S. (2012). Are you ready for World-Class Commissioning in the NHS? OT News, January 2012, pages 32 – 34.

Q13. Could you please recommend any outcome measures/samples to record / to calculate other supporting hours activities?

In the NHS information system for recording daily activities undertaken by staff, there should be functions to record time spent on direct client contacts and other supporting activities. If these data are entered into the system, you can produce pie charts to show the percentage of time spent on different activities for individual staff, groups of staff at different bandings, or the whole service. You can then work out the ratio of time spent on direct client contacts versus other supporting activities. If you don't have such a system, you can conduct a Time and Motion Study (Taylor, 2010) to work out the ratio.

The technique of "Time and Motion Study" originated from the field of industry. It is used to capture the time taken to complete a defined series of tasks so that an analysis of the processes involved can be conducted to improve productivity.

In health and other public services, the technique has been adapted and used for a long time. It is designed to capture time staff spent on direct client contacts and other supporting activities over a period of time so that strategies can be used to improve the productivity and efficiency of the service.

To capture the data, service managers need to devise a set of codes and descriptions relevant to the way the services operated with involvement from all staff. The codes for recording various activities can be devised in two main categories:

a. Time spent on carrying out **direct client contacts** (see **Table 1** for examples of codes and descriptions).

b. Time spend on **other supporting activities** (see **Table 2** for examples of codes and descriptions).

A form should be devised to record the data (see **Table 3** for an example). Each staff should complete the form for a minimum of 4 weeks continuously. Try to select a period that represents the typical work pattern of the year as close as possible.

Table 1: Examples of Codes and Description for "Direct Face-to-Face Contacts"

A1	First Assessment	Use for first contact/ assessment ONLY as it may take more time.
IC	Individual Contact	Use for direct contact with the client (not carer) after the first contact/assessment.
GW	Group Contact	Use for direct contact with a group of clients within a defined session.
PC	Proxy Contact	Denotes contact with parents/carers and individuals who have direct involvement with the client's care plan, e.g. school visits, home visits, annual review, or case conferences with the presence of teachers, parents, or carers.
M3	Co-worker	If more than one staff member is involved in any INDIVIDUAL or PROXY contacts, this code should be used for additional staff members. Ensure one staff member uses the code IC or PC and others use M3.
NC	Non-face-to-face direct contacts	Denotes contact with the client through telehealth, e.g. telephone consultation, video link etc.

Table 2: Examples of Codes and Description for the "Other Supporting Activities"

GC	General Clerical	Includes all other administrative duties not directly concerned with patients, I.e. writing minutes of meetings, policies, procedures, general ordering, filing, etc.
CM	Caseload Management	Includes all administrative duties concerned with identified patients, i.e. writing notes and treatment programmes, reports, letters, referrals, making appointments, ordering equipment, planning treatment sessions, etc.
DE	Data Entry	Includes completion of forms related to Referral Registration and Diary Sheets.
HPE	Health Promotion/ Education	Includes any health-related promotion and educational activities, i.e. health fairs, open days, exhibitions, producing leaflets, giving talks to parents, carers, or service users, etc.
L	Client-Related Liaison/ Meetings	Includes all meetings and discussion time concerned with the delivery of service for all clients and not individual client e.g. MDT Meetings.
M	Non-client Related Liaison/ Meeting	Includes all meetings and discussion time not related to identified patients/groups i.e. staff meetings/ service planning. Also includes non-patient-related 'phone calls'.
TR	Travel Time	Traveling time from base to other locations e.g. a nursery centre or home visits.
PU	Teaching/Education Received	Include any internal or external training and education received. Do not include supervision.
TO	Teaching Others	Include any internal or external training and education given to staff or other professionals.
TRS	Treatment Support	Include all preparation and clearing away time related to the use of clinic room or space.
SG	Supervision Given	Include any time spent on giving supervision, including preparatory time.
SR	Supervision Received	Include any time spent on receiving supervision including preparatory time.
MA	Miscellaneous Activities	Record any activities which do not appear to fit into the above categories.
BR	Break Times	Time allocated for short break times during working hours. Do not include a lunch break as it does not count within the working hours.

Table 3: An Example of Form for Data Collection

Staff Name: _____ **Profession:** _____
Location: _____ **Date:** _____

Please enter the codes for different activities at the end of each time slot.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:15						
8:30						
8:45						
9:00						
9:15						
……						
……						

The time interval can be 10, 15 or 20 minutes but not more than that. Services need to decide on the time interval which can capture the data more accurately. In practice, the shorter the time interval, the more accurate the data collected.

At the end of the data collection, time used for different activities should be calculated in percentages and presented in a pie chart showing a) the total percentages of time spent on "Direct Client Contacts" versus "Other Supporting Activities", and b) percentages of time spent in each supporting activity.

Data collected on the percentage of time available for direct client contacts can be used to examine the existing capacity. Data collected on time spent in other supporting activities can be analysed to reduce wastage, avoid duplication, shift more time for direct client contacts and ultimately improve the efficiency of service. Staff should be encouraged to be involved actively in this analysis to work out the best solutions for changes.

Taylor, F.W. (2010). The Principles of Scientific Management. New York: Cosimo Classics.

Q14. If I do my notes with the client present in the room, does that count as client contact or admin time? (I do not do my notes with the client in the room, but if I were judged on client time, would I change my practice?)

As a professional, we all need to be honest and conscientious in our practice. If you have already completed your clinical work, what is the reason for keeping the client there while you are just doing your case notes? By extending the contact time, you will just make that contact more expensive. So, you are not more productive as you are still making one contact. The activities for direct client contact and other supporting activities should be clearly defined and recorded separately. Otherwise, it will not provide a true picture of the capacity of the service.

Q15. Love the detail about working out the capacity of an OT service...do you have any guidance/tools on how you establish what the clinical to non-clinical ratio should be? Perhaps relative to the Band of staff?

Nationally, certain professional groups already have a relatively consistent ratio of time for direct client contact and other supporting activities. For example, the ratio in Podiatry Service is around 80:20, while in MSK Physiotherapy Service is about the same. Unfortunately, because of the diversified nature of OT work, we do not have a national picture of the ratio. In some areas, the commissioners will set the ratio in the service specification and demand service to work accordingly.

In the service I managed before, for staff working in clinics, the ratio is about 50:50. For staff working in children's centres and special schools, the ratio is about 60:40 as the caseload is consistent over a longer period. For staff working in mainstream schools, the ratio is about 40:60 as more time is spent traveling between schools.

For different bandings of staff, the ratio can be different. In the service I managed before, there were 1 Band 8c Service Manager, 5 Band 8a Clinical Specialists, 11 Band 7, 9 Band 6, 1 Band 4 OT Technician, and 2 Admin staff. Band 8a and Band 7 staff tend to have a slightly lower ratio as they have additional responsibilities in management, service development, and supervision of staff. For my post, I did 50% management and 50% clinical work. For the 50% clinical work, the ratio of direct client contact versus other supporting activities is 60:40.

As different OT services operate differently, it is difficult to set a standard of the ratio. To establish an acceptable ratio, you will need to analyse the data available and streamline all the supporting activities to improve the efficiency of the service (see answer for Q12 & Q13). You can then justify the ratio to the commissioners by providing your analyses and steps taken to improve the efficiency of the service. It is a matter of balancing quantity versus quality.

F. COST-EFFECTIVENESS AND ECONOMIC EVALUATION

Q16. When would you do a cost-benefit/utility analysis instead of a cost-effectiveness one?

Economic Evaluation is the comparative analysis/evaluation of two or more interventions in terms of their cost and consequences. The most fundamental/basic concept of economic evaluation is that both the costs and benefits of all the available options are taken into account. In the literature, there are five types of economic evaluations being identified. I am not an expert in all types of economic evaluation. I can however provide a brief description of the five types. If you are working with a health economist, you can consult him/her on the application of different types of economic evaluations in healthcare. You can also refer to the references below for further information.

Cost-Effectiveness Analysis (CEA) is a form of comparative economic analysis in that cost is measured against the effectiveness of the intervention (effectiveness is the final consequence). The consequences of the comparing interventions may vary here (different than cost-minimisation analysis where the outcomes of interventions were identical). However, these consequences can be expressed in common natural units like life-years gained, saved years of life, etc., or improvement in functional status (units of cholesterol, blood pressure, etc.). The limitation of this analysis is that it is difficult to compare the interventions with differing natural effects. For example, interventions that are focused on looking at life-years saved cannot be compared with other interventions which are focusing on improving physical functioning.

Cost-Utility Analysis (CUA) is a specific type of cost-effectiveness analysis. In this method of analysis, the cost incurred in the intervention is measured against the "utility" related to health. Utility refers to the Quality Adjusted Life Years (QALY) and Disability Adjusted Life Years (DALY). This method is specially used when there are multiple objectives of the programme and when both quality of life and quantity of life are important to know. It is also used to make policy-level decisions.

Cost-Benefit Analysis (CBA) evaluates two or more interventions in terms of their relative costs and outcomes. In this method of evaluation, the cost of the intervention is compared with the benefit incurred from the intervention. Both costs and benefit is measured in terms of monetary units. The net benefit is measured as Net benefit = Benefit – Costs. Therefore, if the benefit exceeds the cost incurred during the intervention, the intervention should be continued.

Cost-Minimisation Analysis (CMA) compares the costs of two or more interventions that are all assumed to have identical outcomes and health effects. The intervention incurring the lowest cost is then chosen. It should be strictly noted that the intervention can only be conducted when the outcomes of the comparing interventions are the same. Evidence that each intervention produces comparable outcomes must be demonstrated using evidence from the literature or tested as part of the analysis.

Cost-Consequence Analysis (CCA) evaluates two or more interventions in terms of their relative costs and outcomes, where the outcomes are not summarised in a single measure, and multiple outcomes of interest are reported. This type of analysis requires that investigators provide a descriptive profile of the costs (e.g., hospital costs, out-of-pocket expenses) and outcomes (e.g. impact on health and economic consequences) of one or more interventions.

Drummond, M.F., Sculpher, M.J., Claxton, K., Stoddart, G.L. and Torrance, G.W. (2015). Methods for the Economic Evaluation of Health Care Programmes (4th Edition). Oxford: Oxford University Press.

Ngorsuraches, S. (2008). Defining types of economic evaluation. J Med Assoc Thai, 91 Suppl:S21-7.

Turner, H.C., Archer, R.A., Downey, L.E., Isaranuwatchai, W., Chalkidou, K., Jit, M. and Teerawattananon, Y. (2021). An Introduction to the Main Types of Economic Evaluations Used for Informing Priority Setting and Resource Allocation in Healthcare: Key Features, Uses, and Limitations. Front. Public Health 9:722927. doi: 10.3389/fpubh.2021.722927

Watson, D.E. (2000). Evaluating Costs and Outcomes – Demonstrating the Values of Rehabilitation Services. Bethesda, MD: AOTA Press.

Watson, D.E. (2002). Chapter 9: Evaluating the Evidence – Economic Analysis. In: M. Law (Eds.). Evidence-based Rehabilitation – A Guide to Practice. Thorofare, NJ: SLACK Incorporating.

Q17. Good Occupational Therapy often takes time - how do we capture the longer-term cost savings to demonstrate the need for the upfront "expensive" cost of OT?

This is an extremely difficult area of research trying to demonstrate the impact of OT inputs on the longer-term savings. There are many confounding variables to be considered and controlled. As most clients who receive OT inputs will also have inputs from other services, it is difficult to claim that the improvement in the client's health status is mainly or only contributed by OT. Another challenge is to measure the cost-saving over a long period. I have not come across any OT research studies in this area. However, as a profession, we should aim high but probably better focus on research or programme evaluation that we can manage and we need to focus now as we do not have enough cost-effectiveness studies on different OT interventions. Therefore, the collaboration between OT researchers, managers, and health economists is an important step to build more data on the cost-effectiveness of OT services.

Q18. What do you think is the role of big data in helping health economics analysis? Do you think OT can make use of big data in improving OT service or practice?

Big data is a massive amount of information on a given topic. Big data includes information that is generated, stored, and analysed on a vast scale — too vast to manage with traditional information storage systems. Many industries use big data to learn about their customers and tailor their products or services accordingly. In health care, big data sources include patient medical records, hospital records, medical exam results, and information collected by healthcare testing machines (such as those used to perform electrocardiograms).

Big data collection and analysis enable doctors and health professionals to make more informed decisions about treatment and services. For example, doctors who have big data samples to draw from may be able to identify the warning signs of a serious illness before it arises. Treating disease at an early stage can be simpler and costs less overall than treating it once it has progressed.

The two main problems we have in the UK are related to the National IT system and also the lack of data related to health economic analyses, not just in OT but also in many other related healthcare services. In 2005, the NHS Connecting for Health was formed to deliver the NHS National Programme for IT which aimed at moving the NHS towards a single, centrally-mandated electronic care record for patients and to connect 30,000 GPs to 300 hospitals, providing secure and audited access to these records by authorised health professionals. Community services were also included in the programme. Hit by technical problems and contractual wrangling, it was effectively disbanded by the government in 2011. As a result, it is impossible to access the massive amount of data stored in different NHS IT systems and benefit from it.

In theory, OT can make use of big data to improve OT clinical practice and service delivery. However, besides the problem related to the IT system, the second problem is related to the small number of economic evaluations conducted by OTs and other related healthcare services. Although the source of big data outside NHS information is available, there is not much we can draw on to improve OT service and practice from the perspective of economic evaluation. Therefore, in my lecture, I echoed the messages from other OT researchers (Sampson et al, 2014; Green and Lambert, 2016; Weatherly and Davies, 2021; Hand et al, 2022) to focus our effort to conduct more health service research, including economic evaluations.

Green, S. and Lambert, R. (2016). A systematic review of health economic evaluations in occupational therapy. British Journal of Occupational Therapy, June 16, 2016 0308022616650898.

Hand, B. N., Li, C.-Y., & Mroz, T. M. (2022). Health services research and occupational therapy: Ensuring quality and cost-effectiveness. American Journal of Occupational Therapy, 76, 7601170010. https://doi.org/10.5014/ajot.2022.761001

Sampson, C., James, M., Whitehead, P. and Drummond, A. (2014). An introduction to economic evaluation in occupational therapy: cost-effectiveness of pre-discharge home visits after stroke (HOVIS). British Journal of Occupational Therapy, 77(7), 330–335.

Weatherly, H. and Davies, C. (2021). Editorial – Economic evaluation of OT services: guidance and opportunities. British Journal of Occupational Therapy, Vol.84(6), 329-331.

G. OT TRAINING AND CONTINUING PROFESSIONAL DEVELOPMENT

Q19. Dr. Chu if we want occupational therapists to engage in service improvement and cost-effectiveness do you think it is the responsibility of the professional bodies to offer free courses to its members on this? Because your lecture suggested there is not enough robust data collected in occupational therapy services and knowledge of service improvement?

It is a collective responsibility of individual therapists, their managers/employers, and the professional body to promote learning and engagement in service improvement activities. Members of the RCOT should express their learning needs to see whether the RCOT can provide direction in professional development and organise appropriate training courses and other CPD activities for members. Members need to engage in various learning activities and seek out information actively. However, I cannot comment on whether courses should be free or not.

Q20. Do universities need to teach health economics to OT students?
Q21. You have made some excellent points, especially in relation to the need to measure both clinical effectiveness and economic efficiency. Do you think such considerations ought to be embedded in teaching about evidence-based occupational therapy interventions in all pre-registration programmes, or are these issues of more importance as a CPD course following qualification?

In my opinion, basic knowledge of health service management and service delivery should be covered in pre-registration programmes. OT students need to have a bigger picture of the work environment (e.g. the structure of the NHS and social care services under the local authority, etc.) and how OT services fit into it, e.g. OT services in primary care, intermediate care, secondary care, tertiary care, community care, social care, mental health services, and education.

OT students need to learn the importance of efficiency and cost-effectiveness of service, not just the effectiveness of certain treatment methods. Learning effective treatment skills is important, but they need to learn how to deliver effective treatment through an efficient service with consideration of the cost involved. Therefore, they need to learn more about the structure and processes of service delivery, e.g. commissioning and contracting, financial management, performance assessment, demand and capacity of service, staff management and development, clinical governance, and service delivery based on an OT conceptual model of practice, person-centred and family-centred care practice, model of service delivery including the use of clinical pathways, etc.

To help them to relate the basic knowledge to the work environment once they are qualified, it is important to have CPD opportunities either through an internal programme organised by the service or external training events. The RCOT and other higher education institutes could play a role to facilitate learning on specific topics, e.g. service redesign, economic evaluation.

Q22. What strategies can occupational therapists in UK statutory services have more opportunities to publish their outcomes in academic journals?

First, you need to develop your writing skills, knowledge in conducting different types of quantitative and qualitative research methods, and identify the source of research funding when you are ready to conduct a research study.

In developing writing skills, it is probably easier to start with a practice-based article by sharing clinical practice and experience in the OT News. Then you can embark on a single case study before attempting other research methods. It is important to get support and guidance from a research mentor. If you are doing it as part of a higher degree study, you can get support from your supervisor. Collaboration with an experienced researcher is another good way to develop your research skills and skill to write the manuscript submitted to academic journals. Reading journal articles is a good means to learn the writing style.

Once you have developed your writing skills and knowledge in conducting research, you will need to identify research questions needed to be answered, plan the research study, obtain support from your organisation and approval from the ethics committee and research governance committee, and apply for research grants if necessary.

It is important to focus your research related to the top 10 priorities for OT research in the UK (RCOT, 2021a; Watson et al, 2021) and also the eight outcomes stated in the new Professional Standards for Occupational Therapy Practice, Conduct and Ethics published by the RCOT (2021b).

RCOT (2021a). Identifying research priorities for occupational therapy in the UK – what matters most to the people accessing and delivering services? Southwark, London: Royal College of Occupational Therapists.

RCOT (2021b). Professional standards for occupational therapy practice, conduct and ethics. Southwark, London: Royal College of Occupational Therapists.

Watson, J., Cowan, K., Spring, H., MacDonnell, J. and Unstead-Joss, R. (2021). Identifying research priorities for occupational therapy in the UK: A James Lind Alliance Priority Setting Partnership. British Journal of Occupational Therapy, Vol.84, Issue 12, pages 735-744.

H. CLINICAL AND PROFESSIONAL PRACTICE

Q23. In providing advice to Education, Health and Care Plan, does it have to be service centred - meaning what the service can offer or should it be client centred - what the child needs/child focused?

In the old statutory assessment of SEN and also the new SEND Code of practice related to the 2014 Children and Families Act, it is always our professional duty to state what the child needs rather than what the service can provide. The principles underpinned the current SEND Code of Practice are active participation from parents/carers and young people, better outcomes for all involved, better joint working through multi-disciplinary and multi-agency collaboration, coordinated assessment and planning which is holistic, outcome-focused, person/family centred, transparent, with clear accountabilities and creative solutions to achieve the defined outcomes.

A coordinated assessment and planning process is one in which parents/carers and practitioners pull together and use this to identify their desired outcomes for the child or young person and their family. This process will be the basis for the development of a single support plan - the Education, Health and Care Plan (EHCP). It will cover all areas of need and all relevant agencies will contribute to it.

The EHCP will identify the agreed priority of each of these outcomes in education, health and social care and set out how they will be achieved. The plan will cover the contribution of the family and all relevant agencies and set out clear responsibilities and accountabilities with timescales. As OT service covers the child's needs in education, health and social care, the child's OTs need to be involved in all the processes actively (Chu, 2014).

As my service is fully integrated, the case OT will contribute information on the child's needs in education, health and social care. It will be more cost-effective as only one OT is involved in the whole process of coordinated assessment and planning, rather than 3 OTs from different agencies.

Chu, S. (2014). Reform of the special education needs system. OT News, June 2014, 26 – 27.

Q24. How do you make the most of an Education, Health and Care Plan from 21-25?

EHCP can continue to support young people up to the age of 25 if the Local Authority considers that the young person needs more time to complete their education or training. It supports successful preparation for adulthood and transition to adult services. Therefore, transition planning is an important process for OTs to work on (see suggestions on the transition from children's to adult's services discussed in Q7 & Q8).

The case OT will need to liaise with staff from colleges or educational settings which could be outside the catchment area. If necessary, a visit will need to be carried out to conduct an environmental assessment, collaborate with teaching staff and set up OT programmes to be integrated into the new educational environment.

The extension of the age to 25 does impose a demand on the already stretched resources in the OT service for children. OT manager or team leader will need to examine the demand and negotiate additional funding from the NHS Commissioners and the Local Education Authorities to fulfill this additional statutory duty.

I was able to secure funding from the CCG by providing data for additional NHS provisions related to the number of young people moving to the adult service because of their EHCP. For the educational inputs, as OT is recognised to be an educational provision in our area, additional funding will be provided by the Local Education Authority on a case by case basis.

Q25. How can data improve the relationship between social work and social care OT in Adult Services?

It is difficult to answer this question without knowing what kind of data you are referring to and what the issues in the working relationship are. No matter what are the issues, working collaboratively is the key factor to be considered to provide coordinated inputs to the clients and help to achieve better outcomes.

Q26. I am an OT in a community neurology service. We are as AHP trying to develop an OT who is reluctant to do upper limb assessments in the PTS home. How might you go about starting to motivate the OT to start doing Upper limb assessments, therefore, improving the OT profile in the team?

First, you need to find out the reasons why the OT you mentioned is reluctant to carry out an upper limb assessment at the patient's home. Is it because of the lack of knowledge and skills to conduct an upper limb assessment? Or is it because the OT does not want to do a home visit to conduct a face-to-face assessment because of Covid? If it is related to the first reason, then you will need to help the OT to acquire appropriate knowledge and skills either by attending external post-graduate training courses or through in-house CPD training. The service will need to decide what kind of assessment procedures and record forms to be used e.g. standardised tests, task-based assessments, or both. You can also arrange an experienced OT to conduct the assessment with the OT through demonstration and practice with each other and then with patients. If the reason is related to Covid, you will need to explore it further and consult Occupational Health, Human Resources, or the relevant department on this.