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SHEFFIELD HALLAM UNIVERSITY

FACULTY OF HEALTH AND WELLBEING

MSc PHYSIOTHERAPY

ADVANCING PROFESSIONAL PRACTICE

(PAEDIATRICS)

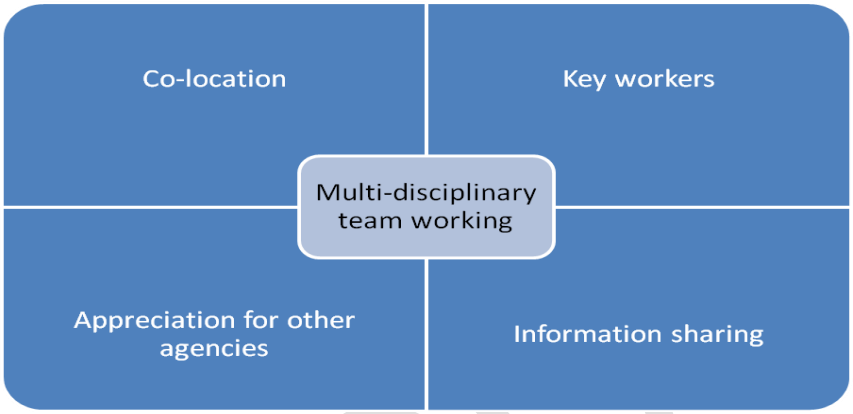
LEVEL 7 – EXPLORING CLINICAL PRACTICE

EXPLORING THE CONCEPT OF CO-LOCATION WITHIN SERVICES FOR CHILDREN WITH COMPLEX DISABILITIES

WORD COUNT - 2736

Introduction

Co-location of services is defined as professionals from health, social services and education working together in the same location and there is evidence it benefits staff and children according to Doyle, 2008, p27, who described it as one facet of multi-disciplinary team (MDT) working.



This study aimed to explore the concept of co-location by…

- Critically evaluating literature on co-location concept/practice
- Critically evaluating service provision in a co-located paediatric centre, exploring the pros and cons
- Contextualising co-location from all perspectives, ranging from national policies to individuals
- drawing justified conclusions about the appropriateness/feasibility of co-location for effective service delivery to disabled children
- considering the implications for clinical management within my own setting

Situational Analysis

The Centre is Health Board-owned serving a large mixed socioeconomic/rural/urban district of 3 boroughs, sited on donated land in a largely affluent area, contrasting with English centres typically located in disadvantaged areas (GREAT BRITAIN, 2013). This is significant because of the association between childhood disability and

deprivation (Blackburn, Spencer and Read, 2012).

The centre was a 20 year project, replacing the previous CDC and drew heavily on its Charitable arm: involving professionals and families/children in the design. The result was described by The Children/Young People's Ambassador as unique…

> "allowing [users]….to fight the difficulties they face in a truly wonderful bright updated centre, allowing them to prosper and reach their full potential emotionally, socially and physically while having fun and interacting with the many fantastic staff there. Having received treatment since the age of 4 and seen both systems and centres, I can truly say that this is special"

It initially hosted Physiotherapy/Occupational/Speech Therapy and Social Services, but has since developed other services, with additional visiting professionals (see Appendix) and an active out of hour's sports/leisure service. This service integration is underpinned by the legislative framework of Welsh Assembly Government and NHS Wales priorities (2005b, p4; 2012a, p9; 2012b, p14).

<u>The shared vision</u>

The goal was to be child-centred and disability-specific rather than geographically-specific, especially focussing on early support. The Hackney Ark Centre was used as a benchmark.

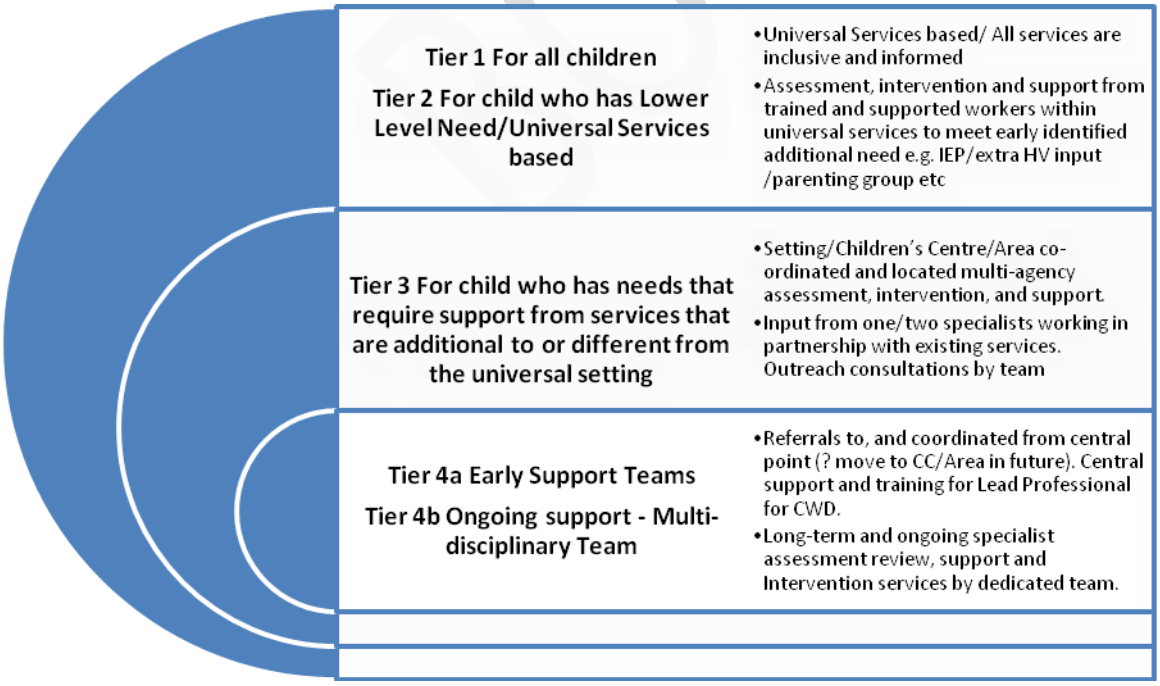
<u>Management Structure</u>

An executive group meet to provide strategic leadership, with a diverse membership reflecting the co-located services of Local Authority, Health Board, voluntary sector, parent's forum and Charitable Arm. An operational team also meet to discuss day to day issues with Service managers.

The Physiotherapy Service

The team consists of a Team Leader, Band 7's, rotational Band 5 and Physiotherapy Technician team. They treat a variety of conditions including neurological, respiratory and orthopaedic presentations and have the use of a hydrotherapy pool, gym and treatment rooms. Interventions range from hydrotherapy, Ponsetti, mobile gait analysis, core stability/gym exercise programmes and are delivered by all bands.

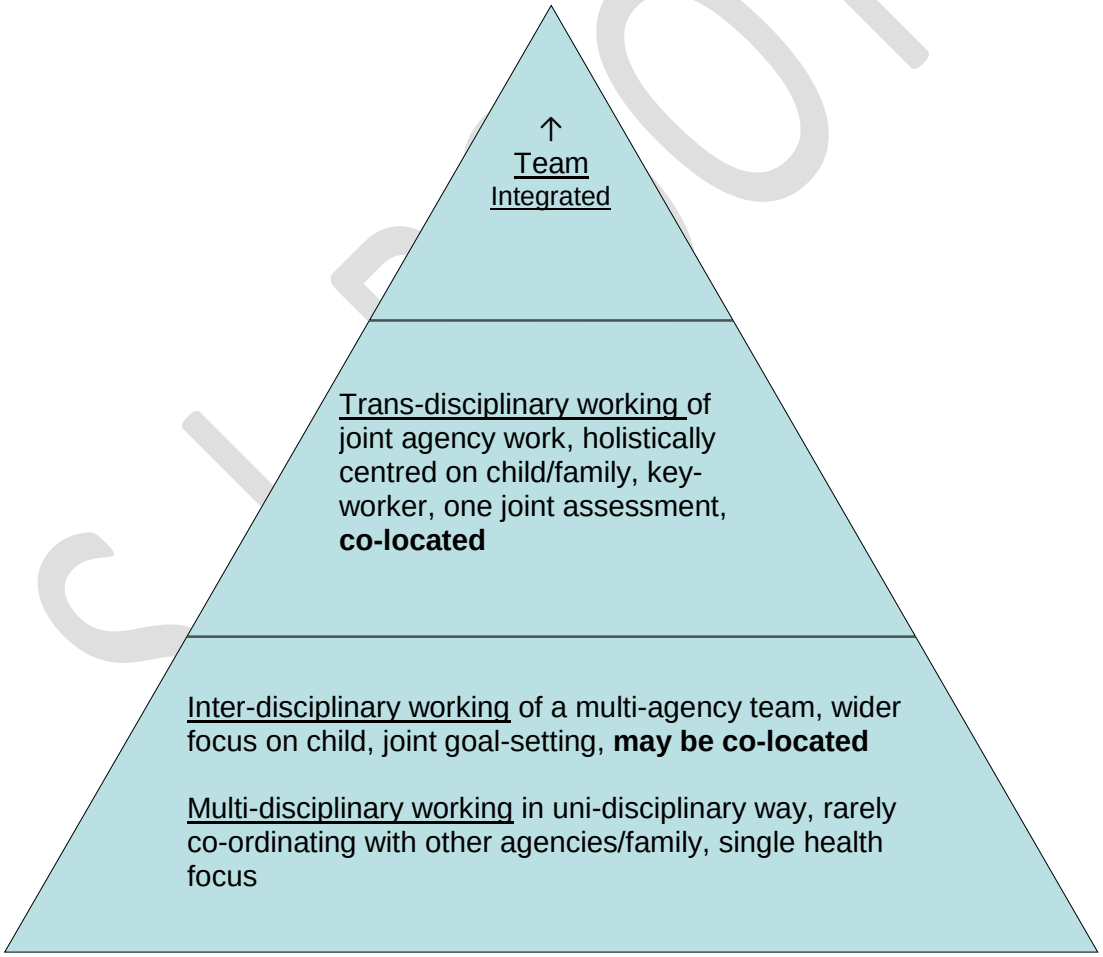
Some children have more enduring conditions/greater complexity requiring a different approach, involving ongoing support from as many as 20+ professionals. Integrating services for these children in 'Tier 4b' has felt to be most desirable in achieving the best outcomes for them (Watson, Townsley and Abbott, 2002) and



(Text from Children With Disabilities Framework Tameside, 2007, p14)

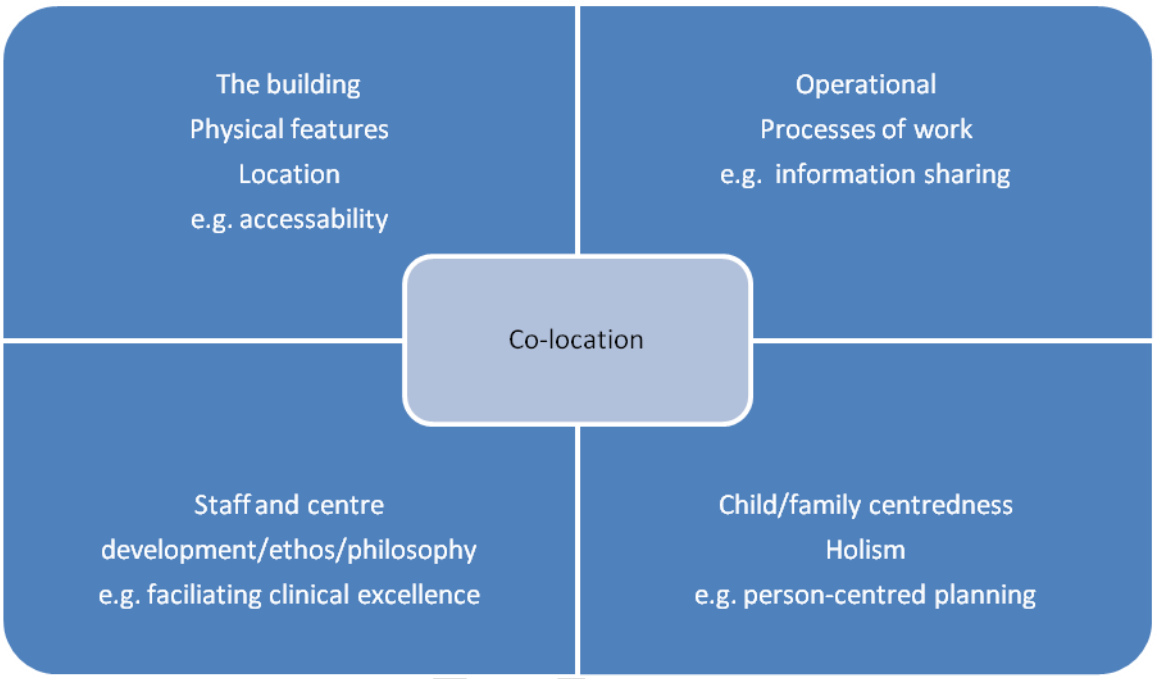
has been legislatively promoted over the past decade (Great Britain, 2010, p26) e.g.

the 2004 Children's Act/National Service Framework (Great Britain, 2004), formation of Children's Trusts and Children's Plan (Great Britain, 2007). However, separate funding streams/methods/governance within institutional/professional silos has hindered this (Bachmann, 2000, p257; Stout et al, 2009, p7). Notwithstanding this, co-location has been the preferred way to integrate teams (Gilbert, Tough and Wilson, 2010; Hudson et al, 1997, p28; King and Meyer, 2005, p477; Wheatley, 2006, p21, 22) and attain the transdisciplinary working, most likely to confer benefits to families (Watson, Townsley and Abbott, 2002, p374).



Evaluation

Shadowing, observations and semi-structured interviews were combined to capture the lived experience of co-location from a variety of staff, parents and volunteers (Clouston, 2003). Following this a number of largely positive themes emerged, which were loosely categorised as follows…



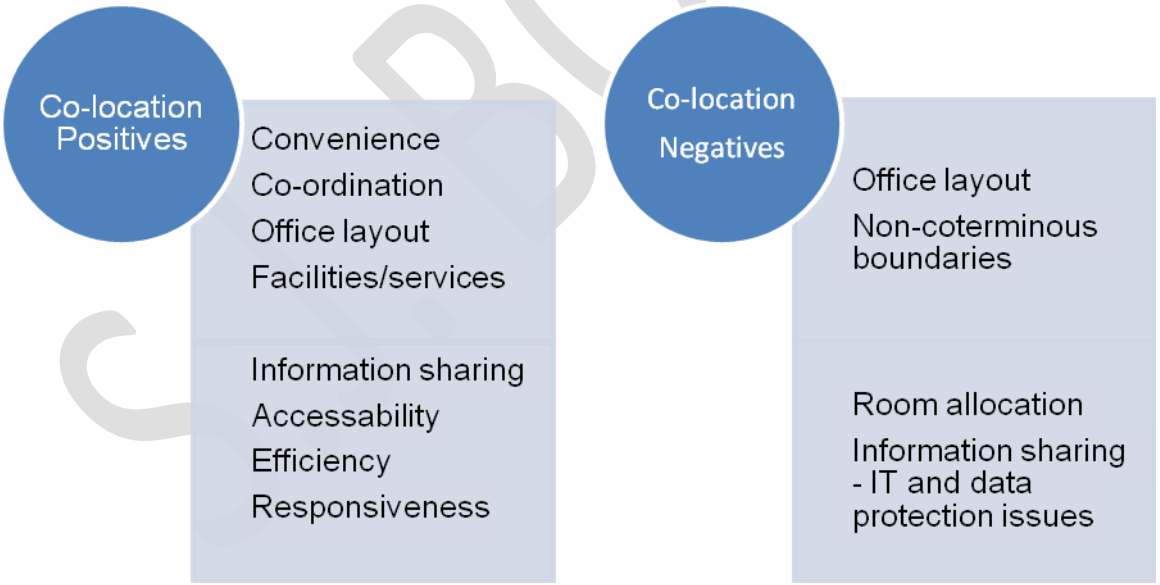
Most respondents had positive experiences of co-location, but when probed more as to why, it was obvious that co-location seen in isolation was a sterile concept; it only had value as it facilitated many other aspects of inter-disciplinary working. To simply be physically located in the same building or even on the same floor was meaningless. As Sloper, 2004, p574 found, centre-based delivery does not necessarily ensure joint service delivery and…

> "this research has shown that simple co-location of services does not lead to more or better collaboration" (Strogilos et al 2011, p815).

As might be expected within a diverse group of services there was an experiential spectrum - for some co-location had transformed practice and in others it had

enhanced existing good practices and cemented relationships/established alliances (Sloper, 2004, p576). However some felt disempowerment and a sense of loss through being relocated miles away from key co-workers and coping against the stress of recent organisational change (Bachmann, 2000, p 257) and staff turnover. Within families' responses, it was impossible to separate their enthusiasm for the co-location concept from their admiration of the premises in which co-location happened. This was due to their experiences at the previous centre and accessing services at the main hospital site. They variously described the new centre as 'fantastic', 'marvellous' and a 'godsend'. The physical building/features were hugely important and ease of parking was an area highlighted repeatedly.

Logistics/building



Convenience (Doyle, 2008, p27) and co-ordination were universally associated with co-location, e.g. for families as a one-stop shop (Abbott, Watson and Townsley, 2005, p234) with a range of services (Bachmann, 2012, p262) to save time/travel

costs (Doyle, 2008, p27). Although combining appointments wasn't always possible, e.g. the orthotist only attended one day per week, it is recognised that highly specialized services such as this will be spread across a number of sites for reasons of efficiency as 'part-time co-locators' (CSIP, 2005, p16; Great Britain, 2013a, p6), however planning one common day per week could improve team cohesion; and in any case, there is a finite number of appointments a child could be tolerate in one visit.

Communication and information sharing was frequently mentioned as a major benefit of co-location (APCP, 2012, 17; Children's Service in Partnership, 2005, p14) both in terms of timeliness (CSIP, 2005, p18; Carter, Cummings and Cooper, 2007, 532), e.g. producing reports quickly for emergency foster care placements or gathering the MDT easily for meetings. As Stout et al, 2009, p17 states.

> "Clearly co-location of the workforce is linked with the drive for excellent communication. Co-locating interagency staff in the same office, wherever possible, [means] that communication is easy and frequent and shared learning takes place automatically".

and quality, because face to face was better than emails, e.g. the monthly new referrals meeting, informal exchanges in the shared staff room (Department for Education, 2013, p3) and the open plan office design making staff accessible. The design had also originally envisaged mixing professional's desks to reinforce joint working, but the actual layout was profession-based, which did assist profession-specific peer support, but did not have the advantages afforded by the hot-desking used within our office.

> "My view is that the only way to really get people working together is to put them in the same building together…. [previously] people have made various commitments to sharing information and so on, but it doesn't make much difference. We need to literally move in with our health partners (SSD manager)" (Hudson, 1997, p28.)

A pertinent example, familiar from my own setting (where Physiotherapy and Occupational Therapy office-share) is child protection, since disabled children are known to be at greater risk of abuse, where enhanced local intelligence is facilitated by co-location. Nevertheless, even when physically co-located, information sharing can be problematic due to confidentiality issues and incompatible IT systems (Stout et al, p14).

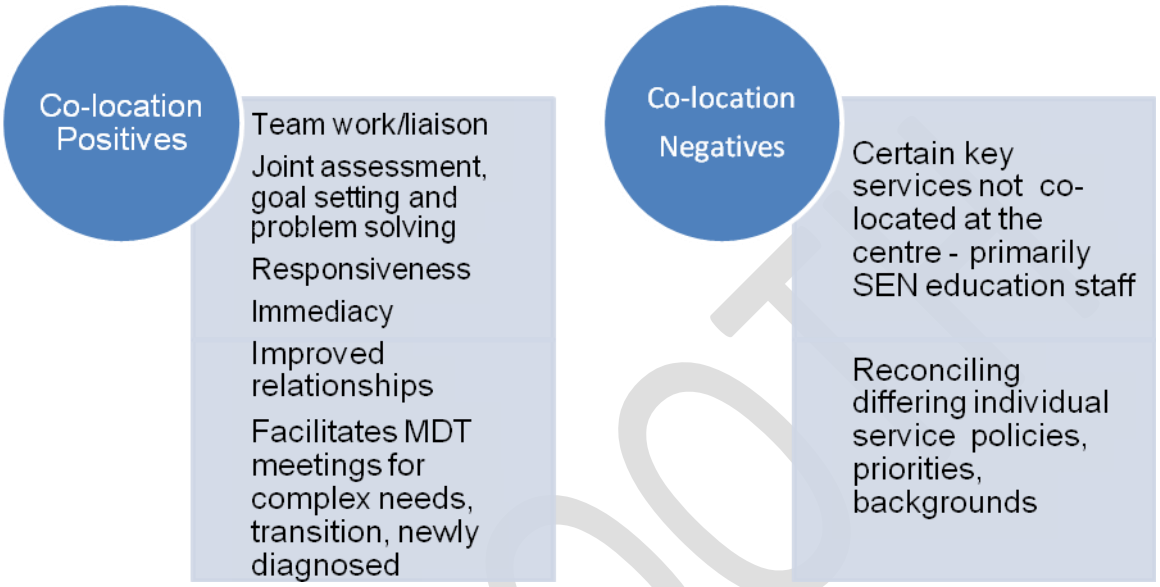
For families, especially, where you are co-located counted, their appreciation of the building and its accessibility was hugely important and accords with Carter, Cummings and Cooper 2007, 527, Welsh Government and NHS Wales, 2012a, and the evaluation of Children's Centres (Great Britain 2013b, p4). They were prepared to travel beyond their locality to access specialist services.

One identified source of friction in a co-located setting was around room allocation and 'ownership' of facilities, an indicator of covert inter-professional issues, but not insurmountable, as trust is built through modest joint actions and more staff become 'boundary crossers' described by Stuart, 2011, p4-5.

Co-location was found to be negative when agency boundaries were non-coterminous, e.g. Bachmann (2000, p257) found that Children's Trusts worked best

where the Local/Health Authorities had coterminous boundaries.

Operational/processes of work

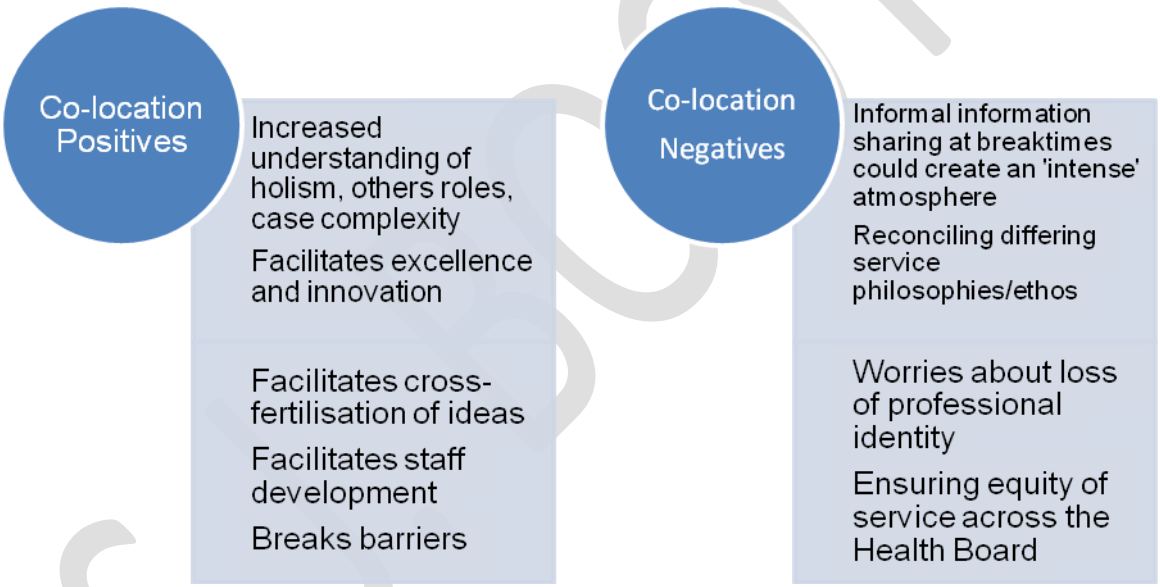


Staff felt co-location meant they could give better quality care and were a more effective team, e.g. better access to families, more use of common processes, saving money and time, similar to findings in the Swindon Study (Gilbert, Tough and Wilson, 2010). They highlighted the care-coordinator role (Tameside, 2007) as facilitated within a co-located setting, especially for complex joint planning/co-ordination at transition points (APCP, 2012, p17; Greco et al, 2006, p451).

The future legislative context here is the Special Educational Needs reform consultation (Welsh Government, 2012a/b), which embeds the production of a joint Individual Development Plan (IDP) by multiple agencies and co-location was highlighted as a way of assisting this. This single plan has integrated headings, e.g. 'challenges' and 'strengths' rather than separate profession reports. It is what families want, but remains a challenge all agencies are working towards, also

mirrored in my setting with combined EHC Plans replacing SEN Statements. Similarly, joint assessment (OFSTED, 2012; Wiltshire Council, 2013) and goal setting was felt to be facilitated and used resources more effectively (Xyrichis and Lowton, 2008, p141). The only identified negative was the lack of key education staff on site and Abbott, Townsley and Watson, 2005, p161 had also found them to be the least accessible partner.

<u>Ethos/philosophy/staff and centre development</u>



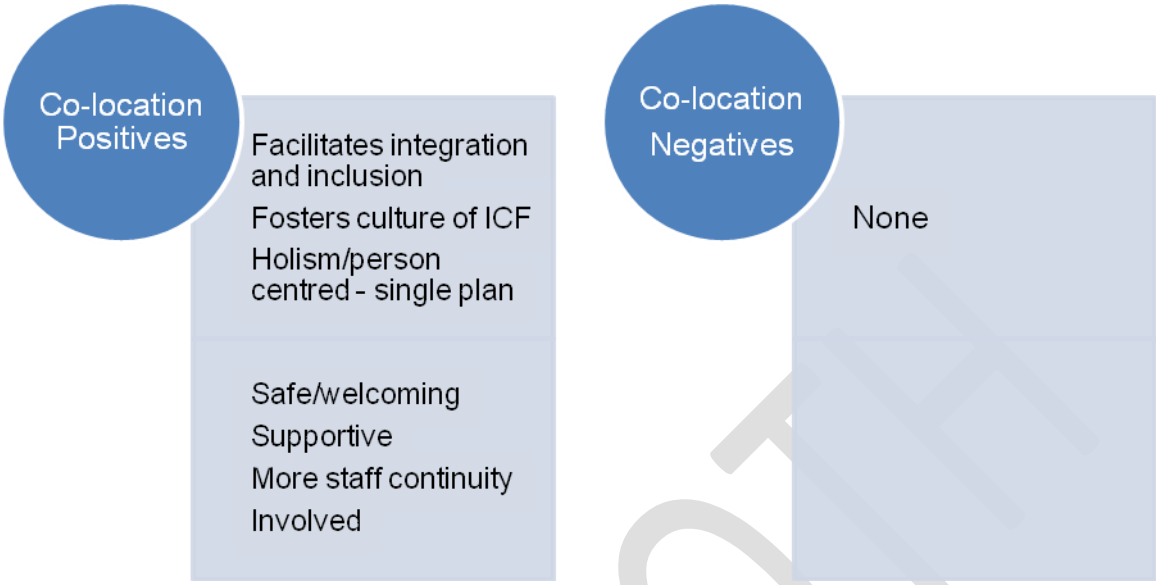
Interpersonal staff relationships, team building and staff/family relationships are inextricably linked with co-location and regular team meetings were felt to foster these (Doyle, 2008, p28; Abbott, Townsley and Watson, 2005, p155, 160, 161; Xyricihis and Lowton, 2008, 143), this resulted in more service co-ordination with mutual respect/trust (Wheatley, 2006, p26) and awareness/appreciation/understanding of other's roles (Caan, 2000, p90). In fact

Gannon-Leary, Baines and Wilson, 2006, p670, felt these relationships were as important as interorganizational ones. Joint training was suggested as a way of team-building, using the cross-cutting theme of child protection and has been used within my service; this would be especially pertinent since multi-agency child protection inspections are due to commence in 2015 (Community Care, 2013).

A culture of continuing improvement was identified through co-location and subsequent cross-fertilisation/'interprofessional seepage' (Gannon-Leary, Baines and Wilson 2006, p671) and innovation was faciliatated as professional barriers were broken down. Some staff recognised this personal 'role enhancement' occurring (Caan, 2000, p90).

Interestingly only one person highlighted potential loss of professional identity within the setting; this would indicate staff felt secure in their roles and/or that transdisciplinary working (e.g. where professional roles have been expanded and released, including joint commissioning and pooled budgets - Great Britain, 2011; Welsh Assembly Government and NHS Wales, 2005b, p65) was not happening. Transdisciplinary working can be professionally challenging for those trained on uni-disciplinary pathways (McConkey, 2002, p6; Stuart, 2011, p2-3), and can bring confusion, e.g. in discussions had about which model of disability should be pre-eminent in this setting. Fortunately the ICF model espoused by Rosenbaum and Gorter, 2011, used in my own setting, was highlighted as a useful paradigm that embraces all agencies, including the sports/leisure services.

Child/family centred/holism



Staff felt the co-location of sports/leisure services promoted holism (Xyrichis and Lowton, 2008, p141) and with the addition of Council staff, enlarged the 'team around the child' principle (Department for Education, 2012, p4), as well as being socially inclusive. In my setting the service partners with the local disability sports association for this function.

A legislative driver is the National Service Framework (Welsh Assembly Government, 2005a, 5.25) stating the importance of the MDT, in involving families as active partners in goal setting and person-centred planning (Great Britain 2013c). Although parents did not specifically mention goal setting, they did feel more involved, acknowledged the child friendliness, peer/emotional support and welcomed the thought that had gone into making provision for siblings and child/family forums (Contact a Family, 2013). This involvement is espoused within Welsh Assembly Government and NHS Wales documents, 2006, p7; 2011, p9; 2012a, p11; 2012b,

p11. Families also reported an increase in continuity of care and accessibility of professionals in a co-located setting (Hudson et al, 1997, p 28; 1999, p17; and Xyrichis and Lowton, 2008, p141).

Conclusion

Services work in an interdisciplinary way within the co-located centre and the philosophy/priorities/policies of individual service managers towards the allocation of resources and work still plays a huge role, notwithstanding the fact that their services are co-located.

The big question is whether fully integrated services under single management are either desirable/necessary/feasible. It would start a new phase of work, which in itself would present many challenges. Full service integration is a long-term, complex project, involving structural and cultural change for organisations and individuals. However, parents and professionals report that multi-agency work in co-located teams alone, brings real improvement to understanding of roles, better joint working and an improved response to requests from families" (Wheatley, 2006, p27).

The last words lie with the Centre's Young People's Ambassador…

> "The centre has come a long way in 2 years, but there is a massive potential and a continuing evolution"

and Centre manager….

> "we are gradually evolving a culture and ethos of multi-agency working that will be sustained"….the child and their interests is what unites us all"

Reflection (see Appendix)

I wished to explore the concept and practice of co-location more deeply following an earlier module. During the module, my understanding of the concept and practice of co-location have been deepened, as I have had opportunity to listen to the lived experience of all, practice the narrative approach, collect/thematically-organise qualitative data, locate an evidence base for co-location and considered the legislative backdrop to service provision.

I critically explored the implications of co-location for patients/services (Etherton, 2013, p31) and reflected on how embracing this service model would benefit…

- me
- my patients
- my service/organization

I better understand the links between co-location and integration levels/service delivery paradigms/models such as holism, ICF and the team around the child because I can see how physical co-location plays a part in this, but I can also see how it is not the only factor and how so many other factors play a role in being truly integrated.

I appreciate better that this client group is complex, as are interprofessional relationships and the tensions/agendas/differing priorities present when agencies come together to work jointly.

The impact of co-location on families, in particular their feelings about the building was revealing and made me think about the quality of my own centre.

Reflecting on future application in my setting, at this time my Trust is undergoing restructuring, which may result in the re-location of my service to an as yet unknown destination and separation from the Occupational Therapy Service, with whom we currently share an office. I can therefore justify continuing the co-location of Physiotherapy and Occupational Therapy Team in the same office because it assists service integration and therefore improves the patient experience, e.g. our use of joint assessments in bi and tri-clinics.

Within the context of financial constraints, I cannot replicate the physical building and its many benefits in my setting, as the centre emerged from a specific set of circumstances. However, I can use my portfolio to apply transferable principles about co-location and multi-agency working to my present setting, e.g. justifying the existing co-location, collaboration and future expansion of services within special schools (McConkey, 2002, p6; Strogilos et al, 2011; APCP, 2012).

Lastly, I can suggest that we ought to be more co-located, by including the SLT's working with this paediatric client base, especially with the advent of the reform of special educational needs and Children and Families Bill 2013 (Wiltshire Council, 2013), since it embeds the production of a joint Education, Health and Care Plan (EHCP) by multiple agencies working together and co-location was highlighted as a way of assisting this.

Action Plan for Continuing Professional Development

Objective	Action	Barrier(s) to implementation	Time frame
Share knowledge gained during the module with Paediatric Physiotherapy team and Paediatric Occupational Therapy team	Prepare an In-service PowerPoint presentation on the topic of co-location and related concepts of multi-agency working, including how the 'Team Around the Child' and ICF can be used as all-embracing concepts to draw agencies together; and looking ahead to the forthcoming joint plans required for children with special needs (EHCP) in the Children and Families Bill 2013.	Availability of all team members to attend	During Autumn In-service Training schedule, within 8 weeks
Justify continuing the co-location of Physiotherapy and Occupational Therapy Team in the same office and the later addition of SLT	Lobby our Consultant Paediatricians, with a coherent argument that is justified by reference to the portfolio and its academic articles, as they are key players in the process and have influence on senior management staff. Presentation at meeting of newly restructured Family Division team to make the case	None Gaining access to this forum to present a case Lack of profile of our service amongst teams serving more acute areas of the Trust and the competing demands of other services for base accommodation Financial situation of the Trust	8 weeks 10 weeks
Project work to justify the existing co-location, collaboration	Discuss with Paediatric Physiotherapy Team Leader to pilot the introduction of a community orthotic clinic	Staff time to instigate project and collect/evaluate data Obtaining permission	6 months to pilot including evaluations

and expansion of services within special schools	within a Special school for children attending mainstream schools and evaluate its effects on waiting times and on patient's, therapist's and families satisfaction compared to its present location in the Appliances Dept at the Hospital. The study could represent an audit for our Team	to pilot the project from Senior Trust Managers	

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Appendix A

Summary of professionals/staff/volunteers encountered

Had the opportunity to shadow, sit in on clinics, talk with…

Paediatric Physiotherapists
Paediatric Physiotherapy technicians
Paediatric Occupational Therapists
Paediatric SALT
Paediatric Nursing staff - Consultant Nurse in Child Health
Paediatric medical staff
Audiology staff in Children's Hearing Impaired Clinic
Teachers of the Hearing Impaired
Orthotist
Portage worker
Play therapist
Activities co-ordinator
Youth workers (Council)
Sports Development Workers (Council)
Music Therapist

Medicinema co-ordinator
Social Services staff – Social Workers and Care co-ordinators from 2 different areas served by the centre
Family Information Officer support staff
Family Liaison officer
Support staff
Volunteers/fundraisers from the Charitable appeal arm
Centre manager
Parents/families

Thematic analysis of raw data – positive and negative

Logistical

POS One stop shop and all appointments/facilities in one place, e.g. less time taken out of work for parents (AMBASSADOR) (PARENT) (PHYSIO) (OUT OF HOURS PLAY/ACTIVITY STAFF) (VOLUNTEER) e.g. orthotics (including rectifications), PT and OT Better for family life (PARENT) e.g. provision of mobile gait analysis avoids need to travel further afield for gait analysis (PHYSIO)

POS AND NEG good to have all services on one site, e.g. orthotic clinic, but orthotist only in one day per week, which may not coincide with other professionals (ORTHOTICS)

POS AND NEG Potential to co-ordinate appointments is good, but children might not be able to cope with multiple assessments/treatments in one visit (SLT) Need to streamline appts more to enable single visits (MANAGER)

POS Informal contacts possible when child is visiting to attend a different clinic (SLT)

POS Building features - Accessibility for parents, e.g. previous building physically inaccessible. Physical facilities benefit children/families (INFORMATION/LIAISON OFFICERS) (CARE CO-ORDINATOR) Building is airy and light (PAEDIATRICIAN), quality of the facility noted, presence of quiet rooms (PARENT) bright and colourful (AMBASSADOR)

POS and NEG Open plan office layout can make it difficult to focus on a writing a report due to being interrupted and constantly available (CARE CO-ORDINATOR) (SLT) (PORTAGE), but positives outweigh negatives (SLT) (PORTAGE)

Office originally envisaged complete mixing of professionals, but this way means professionals can give profession-specific peer support, e.g. important to those who previously worked as sole practitioners (OT)

NEG Being on one floor, still not as good as being in one room (SOCIAL WORK DEPT)

NEG Location on the edge of a geographical boundary, making long/difficult journey for those in the north of the area (PAEDIATRICIAN) and non-coterminous boundaries between different services (PHYSIO) site not centrally located within the patch they are responsible for (OT) and geographically detached from other services relevant to children (SOCIAL WORK DEPT)

POS good for car users with great parking (AMBASSADOR) (MANAGER), compared to the hospital (PARENT) (CARE CO-ORDINATOR) and motorway links (AMBASSADOR), not so much for public transport

NEG Logistical issues around room/space allocation

POS AND NEG 'IT' issues and data protection when different agencies, e.g. Health and Social Services are sharing information (*FORWARD IN PARTNERSHIP FOR CHILDREN AND YP WITH ADDITIONAL NEEDS)*

IT sharing difficult- no uniform data monitoring (MANAGER). Joint notes (OT)

POS Familiarity with the building (OUT OF HOURS PLAY/ACTIVITY STAFF) (PARENT)

POS Convenience for families (OUT OF HOURS PLAY/ACTIVITY STAFF)

POS Decreased travel time (AMBASSADOR) and Better use of time (OUT OF HOURS PLAY/ACTIVITY STAFF)

<u>Operational/processes of work</u>

POS Professionals work better together, better liaison (NURSING) (PORTAGE)

(PARENT) (PAEDIATRICIAN), especially in complex cases (OT) helpful, effective, efficient, enhances practice (SOCIAL WORK DEPT)

POS Joint goal setting (PHYSIO) (PORTAGE)

POS Joint problem-solving via liaison with another profession (PHYSIO) (PORTAGE)

POS Joint decision making (*FORWARD IN PARTNERSHIP FOR CHILDREN AND YP WITH ADDITIONAL NEEDS)* (SOCIAL WORK DEPT) (PORTAGE)

POS Hub and spoke model (NURSING)

POS Liaison with play and activities co-ordinator would enable feed into disability sports opportunities (PHYSIO)

POS Care co-ordinator role and work is facilitated and becomes very important (CARE CO-ORDINATOR) (AUDIOLOGY) and needs to continue to develop (MANAGER)

POS Better information sharing generally (INFORMATION/LIAISON OFFICERS) (CARE CO-ORDINATOR) (SOCIAL WORK DEPT) and better quality (PORTAGE) informal and informal (SLT), e.g. on child protection which can be dealt with appropriately and immediately (SLT), each profession adds a piece of the jigsaw to give a holistic view of the family. A job of education still to be done on child protection, but just being located together in the same building is raising awareness (SOCIAL WORK DEPT)

POS Responsiveness e.g. getting professionals out to deal with difficult families and situations quickly, e.g. children going into foster care and needing speedy assessments/reporting (SOCIAL WORK DEPT) instant updates, quick answers (SOCIAL WORK DEPT) (PAEDIATRICIAN) (PORTAGE) decreased length of lines of communication (INFORMATION/LIAISON OFFICERS) (PARENT) (SLT) Faster follow up (PARENT) Immediacy of other services (OT) (CARE CO-ORDINATOR) (MANAGER)

POS More approachable (SOCIAL WORK DEPT)

POS increased frequency of treatment (PARENT)

POS Better quality information shared, face to face better than emails which is better for staff and families and facilitates getting to the heart of the matter (CARE CO-ORDINATOR) (PAEDIATRICIAN) e.g. better linking of health and social services (CARE CO-ORDINATOR) (SOCIAL WORK DEPT) more linking up (OT) better relationships with other professionals to betterment of the child (SOCIAL WORK DEPT)

POS Increased understanding of the holistic approach (INFORMATION/LIAISON OFFICERS) (PARENT)

POS Increased time efficiencies for both families and staff, quick results (INFORMATION/LIAISON OFFICERS) (SLT) (PORTAGE) streamlining (CARE CO-ORDINATOR)

POS Facilitates gathering everyone for MDT/operational meetings/centre meetings/case conferences, including drawing those in who are not normally based on the site, so providing a focal point (INFORMATION/LIAISON OFFICERS) (SOCIAL WORK DEPT) (NURSING) e.g. support group involved in waiting room at

hearing impaired clinic (AUDIOLOGY) e.g. joint meetings between SS OT and Health OT and joint training/clinics with CAMHS (OT) (CARE CO-ORDINATOR) (SLT)

e.g. CDT monthly new referrals meeting – deciding what interventions are required in multi-faceted cases – involved Ed Psych, Paediatrician, OT, PT, SLT

Child protection would be ideal cross cutting topic for joint training (SOCIAL WORK DEPT) could reduce silo working (PORTAGE)

However heavy workloads/time pressures and part-time working/agency staff can get in the way, but supplying reports helps (CARE CO-ORDINATOR). e.g. MDT good for safeguarding cases, which take precedence over everything and the health component, is an important part of cases involving disabled children

POS Facilitating transition and early years support/newly diagnosed support (MANAGER) (INFORMATION/LIAISON OFFICERS) especially important in 0-5's with complex needs, who may have 20+ professionals involved(CARE CO-ORDINATOR) e.g. counsellor services to help with family support (MANAGER)

POS Facilities/activities on same site to enable signposting to out of hours activities and onward to up skill for integration into mainstream activities/disability sports, establishing club links and with disability sports development officer (OUT OF HOURS PLAY/ACTIVITY STAFF)

POS Fostering link between therapies and out of hours activities, common ground and areas of overlap on gross motor skill sets (OUT OF HOURS PLAY/ACTIVITY STAFF)(MANAGER)

POS Team work and partnership work fostered, e.g. joint staffing by council play and sports development officers alongside the host charity staff, e.g. passport to play information sharing tool (OUT OF HOURS PLAY/ACTIVITY STAFF) Better team working and integration (CARE CO-ORDINATOR) (PARENT)

NEG Absence of certain services still to be added to the mix (CARE CO-ORDINATOR) e.g. LEA inclusion officers was highlighted as it would assist in educational liaison (OT) e.g. SLT closely work with education staff, as they are not co-located this means lots of meetings off site

Educational liaison – issues around getting time off school to attend daytime appointments at the centre (PARENT)

Ethos/philosophy/staff and centre development

NEG Atmosphere can be intense because of breaktime chats about clients, managed by going off site if required (CARE CO-ORDINATOR)

POS Facilitating clinical excellence (PHYSIO) (PORTAGE)

POS Facilitates cross-fertilisation between teams, e.g. leading elements of training day for other professions (SLT)

POS Staff development facilitated in the post, as there has been better scope to harness their talents/skills within a co-located setting, e.g. registered nurse who is also a CARE CO-ORDINATOR (CARE CO-ORDINATOR) e.g. increases disability focus of staff (OUT OF HOURS PLAY/ACTIVITY STAFF)

POS Increased understanding of the holistic approach and awareness of each other's professional roles (INFORMATION/LIAISON OFFICERS) (SOCIAL WORK DEPT) (PORTAGE) breaking down barriers between professions and stereotypes around health professionals (SOCIAL WORK DEPT) e.g. Physical presence of another professional (Clinical Psychologist) and also intention to refer (OT)

Has a levelling effect on the profile of professions, taking into account the opinions of all professionals involved with a child (SOCIAL WORK DEPT)

NEG Concern about professional identity being watered down (SOCIAL WORK DEPT)

POS Increased understanding of the complexity and number of professionals involved with particular individual families (INFORMATION/LIAISON OFFICER)

POS Original vision based on work done with parents/families/children and yp (AMBASSADOR),

POS Becoming a focal point for services, centre for delivery, e.g. ASD support group re-located here at their request (INFORMATION/LIAISON OFFICERS)

POS Out of hour's activities requested by families can be delivered out of the centre (INFORMATION/LIAISON OFFICERS)

POS Facilitates innovation, e.g. maximising use of the centre for supervised contact by Social Dept practitioners (reducing travel time for practitioners) (SOCIAL WORK DEPT)

POS Centre has come a long way in 2 years, but still massive potential and continuing evolution (not revolution), avoiding complacency (AMBASSADOR) (MANAGER) Gradually evolving a culture/ethos of multi-agency working that will be sustained (MANAGER) Need to ensure that as centre evolves and forges ahead that the Health Board ensures that the service offer remains equitable for those families served by other facilities (MANAGER)

POS AND NEG – The philosophy/priorities/policies of Managers of individual services towards allocation of resources and work still plays a huge role (CARE CO-ORDINATOR) (MANAGER) e.g. uniformity in discharge policies and how this is communicated to families (MANAGER) notwithstanding co-location, which is but one strand. Personalities and philosophy are big influence on the success/failure of integration.

It is recognised that staff will respond differently to being co-located, their cultural backgrounds will be different and it will be more of a change/challenge for some than others, e.g. need for internal security within the building (MANAGER)

Other factors include joint funding/commissioning of posts (OT)

OTHER FACTORS HAVE AN IMPACT The context of re-location/recent organisational changes (merger of services still ongoing) have impact (SOCIAL WORK DEPT), still coping with lots of recent change as a service and as individuals, new staff (CARE CO-ORDINATOR) (OT) (MANAGER)

Austerity – background of cuts to benefits has increased need/demand for services

Child/family-centred/holistic approach (not dominated by the 'medical' aspects of care)

POS Co-location fosters culture of the ICF, with right mix of professionals and social opportunities, the right medical attentions and social awareness to match every child's strengths and limitations, staying close to the original goals (AMBASSADOR) My child attended different groups, e.g. hydrotherapy, bike skills and ball skills (PARENT). Addresses the tension between Medical Model and Social Model of Disability (SOCIAL WORK DEPT)

POS Familiarity with the building due to multiple same site appointments means children less inhibited (OUT OF HOURS PLAY/ACTIVITY STAFF) (AMBASSADOR) a safe place (MANAGER)

POS Holistic approach fostered (OUT OF HOURS PLAY/ACTIVITY STAFF)
The child and their interests is what unites us all….moving beyond treatment care to embrace holistic services for families (MANAGER)
A very pleasant atmosphere, not a hospital and not frightening for children (VOLUNTEER)
welcoming waiting room with playworker/toys for siblings and child (PAEDIATRICIAN) (MANAGER) less daunting, de-medicalised (AMBASSADOR) welcoming with facilities for siblings (PARENT) Being greeted (MANAGER) Child-friendly (SOCIAL WORK DEPT)

POS Including Out of hours activities in the centre's offer…peer support for families and kids (AMBASSADOR)

help reduce parental isolation, family support groups, e.g. face2face initiative (MANAGER)

improve socialisation of children who are home schooled assist family dynamics and provide respite to families (MANAGER)

give opportunities to siblings (MANAGER)

support families with newly diagnosed children/young people (OUT OF HOURS PLAY/ACTIVITY STAFF

POS More staff continuity than the hospital (PARENT)

POS Families involved through Children and Young Peoples' Forum, Parents Forum and use of questionnaires (Information Centre)
Families massively important and communicating with them very important (AMBASSADOR),

POS Better than the hospital (CARE CO-ORDINATOR) (PARENT)

POS Person-centred planning, e.g. use of the IDP with headings that are not profession specific, but use integrated headings such as 'what's working', 'what's not working', 'challenges', 'strengths', 'important to', 'best way to support me'; also where its relevant – home, school or work life (PHYSIO TEAM IN SERVICE TRAINING SESSION)

POS Reducing duplication of reports (PHYSIO TEAM)
Parents want a single plan – it's a big challenge and all agencies need to be around the table, which we are still working towards. All will need to sign up and enforce this (MANAGER)

POS Multi-agency working draws in mainstream youth clubs from outside the centre for specific events to aid integration, socialisation of children, increasing self esteem of children (OUT OF HOURS PLAY/ACTIVITY STAFF)

Quotes
"Fantastic" (OT) (PARENT)
"Brilliant" (PORTAGE)
"Marvellous, compared to what we had before", "great facilities" (PARENT prepared to travel 40 mile round trip to access the facilities)
"Child friendly" (PARENT)
"A godsend, better than attending at the hospital" (PARENT – orthotic clinic)
"Less isolated" (SLT) (PORTAGE)
"Unbelievable" "Amazing" (OUT OF HOURS PLAY/ACTIVITY STAFF)
"Makes a difference to families" (OUT OF HOURS PLAY/ACTIVITY STAFF)
"we couldn't do what we do without good networks" (SOCIAL WORK DEPT)

"has changed the way they practice (NURSING) (PORTAGE)
"conditions are not fixed but managed, so parents say what's important is the child has a life…having fun is important" (MANAGER)
"allows me to do my job as it was always intended…Portage is all about joint working and working holistically" (PORTAGE)

Colour codes/staff groups/govt initiative

AMBASSADOR
AUDIOLOGY
CARE CO-ORDINATOR
INFORMATION/LIAISON OFFICERS
MANAGER
NURSING
ORTHOTICS
OT
OUT OF HOURS PLAY/ACTIVITY STAFF
PAEDIATRICIAN
PARENT
PHYSIO TEAM
PORTAGE
SLT
SOCIAL WORK DEPT
VOLUNTEER
FORWARD IN PARTNERSHIP FOR CHILDREN AND YP WITH ADDITIONAL NEEDS

Reflective Journal (last day in the centre on 9.7.13)

Very useful day as I draw the threads together and interviewed some key people at the centre, including the centre manager and Consultant Nurse; also the final feedback session with my clinical supervisor. The Consultant Nurse is undertaking a study similar to mine albeit on a much bigger scale, over a period of years and lottery funded. It was a great opportunity to bring my evaluative thoughts together and bounce my ideas about co-location off her. The over-riding thought being that co-location is only valued as it facilitates other mechanisms of integrative working; in fact simple co-location can be a very sterile concept and people remain operating in their uni-disciplinary silos. Respondents are saying it's not a case of co-location is

better, but co-location is better because it facilitates a), b), c) etc. The reality is highly complex…co-location is one important factor and a means to the bigger prize, i.e. multi-agency and integrative working to secure the best outcomes for children with disabilities and their families.

Also discussed the forthcoming reform of special educational needs and how that might impact on the centre and its services. More discussion about the ICF and how it can be used to unite services in a common enterprise, when you have many services operating from one site. The centre manager brought perspective about what unites all these teams…the child and their interests and a confirmation of how the centre is currently operating and at what level of integration, together with thoughts for the future and the exciting possibilities. I could see how full integration/single management would be attractive to families in reducing the number of professionals they would have to deal with, but just can't see how it could work with the level of specialist function required here within the workforce, e.g. the highly specialist skills of the Band 7's in the physio team; you wouldn't expect a nurse to cast an AFO or an orthotist to deal with enteral feeding issues etc. When you drill down, these roles are just too specialist for a generic worker to undertake. In practice being multi-disciplinary with loads of joint working definitely seems more workable, sensible and realistic

I have a variety of data from many different sources, but think it's beginning to fall into categories around a) logistics/building; b) operational processes; c) deeper culture type issues, such as ethos/philosophy and staff/centre development; d) the holism areas.

My thoughts are now turning to how I can use this insight in my own setting, where the context is our Trust restructuring, office move and possible separation from Occupational Therapy. My stay here has convinced me that we must stay together, in fact we ought to be co-locating more to improve the service to our children and families. The spread of services located here in this centre is ground breaking; aside from education not being present, but maybe the co-location of an all age special school on the site would represent true utopia! The fact that this centre came into being after a 20 year journey indicates there must have been a commitment on the part of senior managers towards meeting the needs of children with disabilities and their families and to the staff who seek to serve them. In providing them with this brilliant facility, it speaks volumes about the value they place on the staff/service and the importance they assign to this client group within the overall health economy.

Due to financial constraints, a centre of this kind it is unlikely to occur within my setting and I have to work with that and within those confines. However there has been investment within education with 2 new special school builds; I know we work well as a team in my special school and I can see how this could be fostered still further, perhaps by introducing a mainstream orthotic clinic to run after school.

Appendix A

SHEFFIELD HALLAM UNIVERSITY – FACULTY OF HEALTH AND WELLBEING

Postgraduate Physiotherapy Programme: Clinical Practice Final Report Form

Module title: Exploring Physiotherapy Practice N^{o} of clinical hours 60 (actual = 63.25 hours).

Learning Outcome	Met	Partially Met	Not Met	Comments
LO1: Demonstrate on-going professional development through the analysis and evaluation of a clinical scenario **30%**	√			Summary: Reflecting on the topic of co-location of services and how it affects clinical management and service delivery for children with disabilities in a setting that contains diverse service providers, but who all have the child in common. What it means for the day to day practice, as well as strategically. Recommended Aims for CPD: Application of learning on the topic of co-location in relation to my own on-going professional development/own setting in order to improve my own practice and that of my team.
LO2: Critically evaluate service provision within the selected placement setting in the context of the global healthcare environment **30%**	√			Summary: Evaluated both physiotherapy service provision and that of other services, including other health professionals/out of hours/social services/visiting professionals/charitable arm in relation to concept of co-location. Then beginning to contextualise this concept within health outcomes of the host NHS organization and other relevant legislative contexts derived from both health and education. Identifying those initiatives that support co-location Recommended Aims for CPD: Application of learning on the topic of co-location in relation to my own on-going professional development/own setting in order to improve my own practice and that of my team. Understanding and applying the legislative context from my own area of the UK
LO3: Critically reflect upon the development of clinical management skills in relation to the placement experience **30%**	√			Summary: Understanding how co-location alters clinical management and service delivery Recommended Aims for CPD: Application of learning on the topic of co-location in relation to my own on-going professional development/own setting in order to improve my own practice and that of my team, e.g. core stability class and exercise group.

LO4: Present detailed and innovative action plans to support professional development in relation to the placement experience **10%**	√			Summary: Action plans forming that make the case for co-location of services, along with its associated linked concepts of multi-agency working. Understanding how it links to other concepts, e.g. team around the child, self-management and ICF-CY
				Recommended Aims for CPD: Applying the action plan to my own setting, justifying co-location of services and linked multi-agency working in a children's centre and within special schools in order to successfully manage long-term paediatric conditions and showing how it is underpinned by current legislative initiatives

STUDENT: Susan Booth **MENTOR: Caroline Havard**

PLACEMENT SITE: Children's Centre **DATE: 9.7.13**