

Victorian Paediatric Rehabilitation Service model of care



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Introduction

The Victorian Paediatric Rehabilitation Service

The Victorian Paediatric Rehabilitation Service (VPRS) began in October 2005 with inpatient and ambulatory services at The Royal Children's Hospital. Inpatient and ambulatory services began at Southern Health's Monash Medical Centre campus in June 2007. Eastern Health, Bendigo Health Care Group and Barwon Health will start services during 2007-08, with further service expansion to occur across Victoria in the future.

The VPRS specifically caters for children and adolescents who, as a result of injury, medical/surgical intervention, or functional impairment, will benefit from a program of developmentally-appropriate, time-limited, goal-focused multidisciplinary rehabilitation. This includes children and adolescents with acquired conditions that can benefit from a defined period of rehabilitation, such as following an Acquired Brain Injury (ABI). It also includes children and adolescents with either congenital or developmental-based conditions, following a specific event or surgery, that are amenable to a defined period of rehabilitation. The VPRS will build on and integrate with existing paediatric and rehabilitation service platforms.

While it is acknowledged that there may be gaps within the overall paediatric health service system, it is not the role of the VPRS to fill these service system gaps. The VPRS will focus on the provision of specialist rehabilitation services for children and adolescents, from high complexity clients through to moderately complex clients. Lower complexity clients may or may not require specialist VPRS intervention. Specifically, the VPRS will not deliver:

- early intervention
- developmentally-based services
- maintenance services
- primary and community services.

However, where appropriate, the VPRS may refer to, and receive referrals from, agencies that deliver these services.

The vision for the VPRS is:

- Victorian children who need specialist rehabilitation will be able to get the level of service they need, when they need it, in the most appropriate location, no matter where they and their families live.
 - child-and-adolescent-centred and family-focused clinical care
 - evidence-based, best practice
 - integrated continuum of care from hospital to community
 - appropriate linkages with other services.

The principles underpinning this vision are:

- to provide the most appropriate care for the client
- to support a child-and-adolescent-centred and family-focused model of care
- to encourage and support continuity of client care
- to encourage appropriate transition from inpatient and ambulatory settings and optimise community reintegration.

Development of the VPRS

The Paediatric Rehabilitation Reference Group was responsible for overseeing the development of the VPRS. The aim of the reference group was to develop a model of care and policy framework for the delivery of coordinated statewide specialist paediatric and adolescent rehabilitation services (both inpatient and ambulatory) in Victoria, taking into account the principles outlined above. The Terms of Reference for the reference group are now completed and the Paediatric Rehabilitation Governance Group will oversee the governance and future development of the VPRS.

Model of care working group

A model of care working group was established in June 2006 with representatives from the Royal Children's Hospital, Southern Health, Eastern Health, Barwon Health, Bendigo Health Care Group, Transport Accident Commission, Melbourne Citymission, Transition of young adults clinics and the Department of Human Services. The model of care working group initially reported to the Paediatric Rehabilitation Reference Group and, following this, to the Paediatric Rehabilitation Governance Group.

The tasks of the working group were to develop a discussion paper for the model of care that would enable the provision of a statewide specialist paediatric and adolescent rehabilitation service in Victoria, for consideration by the Paediatric Rehabilitation Reference Group. This has included:

- advising on, and contributing to, the evidence base that will underlie the model of care
- defining the components of the model of care, including principles, objectives, and core aspects
- developing role delineation criteria for inpatient and ambulatory services
- identifying the role of outreach services and relationships with local providers.
- identifying key linkages with ongoing community support providers
- preparing a discussion paper for the VPRS model of care for consideration by the Paediatric Rehabilitation Reference Group.

This document

This model of care document describes the components of the paediatric rehabilitation model of care to be developed in Victoria. It outlines the context of the document, the components of the model of care and relationships and roles to be developed. It should be noted that regional areas may wish to make modifications to the implementation of this model to suit their needs.

The Paediatric Rehabilitation Reference Group has endorsed the model of care document, in principle. The Paediatric Rehabilitation Governance Group will oversee any further development of the model of care. This document will be reviewed every 12 months.

Section 1: The context

Policy context

The VPRS model of care will be developed within a framework provided by relevant Department of Human Services' policies. These include:

- *Review of Victorian paediatric services – Department of Human Services response (2003)*
(<http://www.health.vic.gov.au/metrohealthstrategy/response-paediatric.pdf>)

The *Review of Victorian paediatric services* (2002) identified issues and gaps in the provision of paediatric rehabilitation services in Victoria. It recommended that a statewide specialist paediatric and adolescent rehabilitation service be developed, and the *Department of Human Services Response to the review* (2003) accepted this recommendation.

- *Care in your community* (2006)
(http://www.health.vic.gov.au/ambulatorycare/downloads/care_in_your_community.pdf)

Care in your community provides a strategic framework for planning and delivering integrated health services, with an emphasis on providing people with care in their own community wherever it is safe and effective to do so.

- *Metropolitan Health Strategy* (2003) and forthcoming updates
(<http://www.health.vic.gov.au/metrohealthstrategy/index.htm>)

The *Metropolitan health strategy* provides a framework for service and capital planning in Melbourne.

- The *Sub-acute Ambulatory Care Services (SACS) framework* and associated guidelines (forthcoming) (<http://www.health.vic.gov.au/subacute/sacs/index.htm>)

The *SACS framework* will provide guidance on the integrated provision of community-based rehabilitation and specialist assessment and management services.

- *Better access to services: a policy and operational framework* (2001)
(<http://www.health.vic.gov.au/pcps/publications/access.htm>)

The *Better access to services: a policy and operational framework* describes the reasons service coordination is being undertaken and outlines the principles that guide service coordination.

- *Victorian service coordination practice manual* (2007)
(http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual.pdf)

The *Victorian service coordination practice manual* defines the practices, processes, protocols and systems that support service coordination across Victoria.

The evidence context

The development of the VPRS model of care was informed by the best available evidence, including:

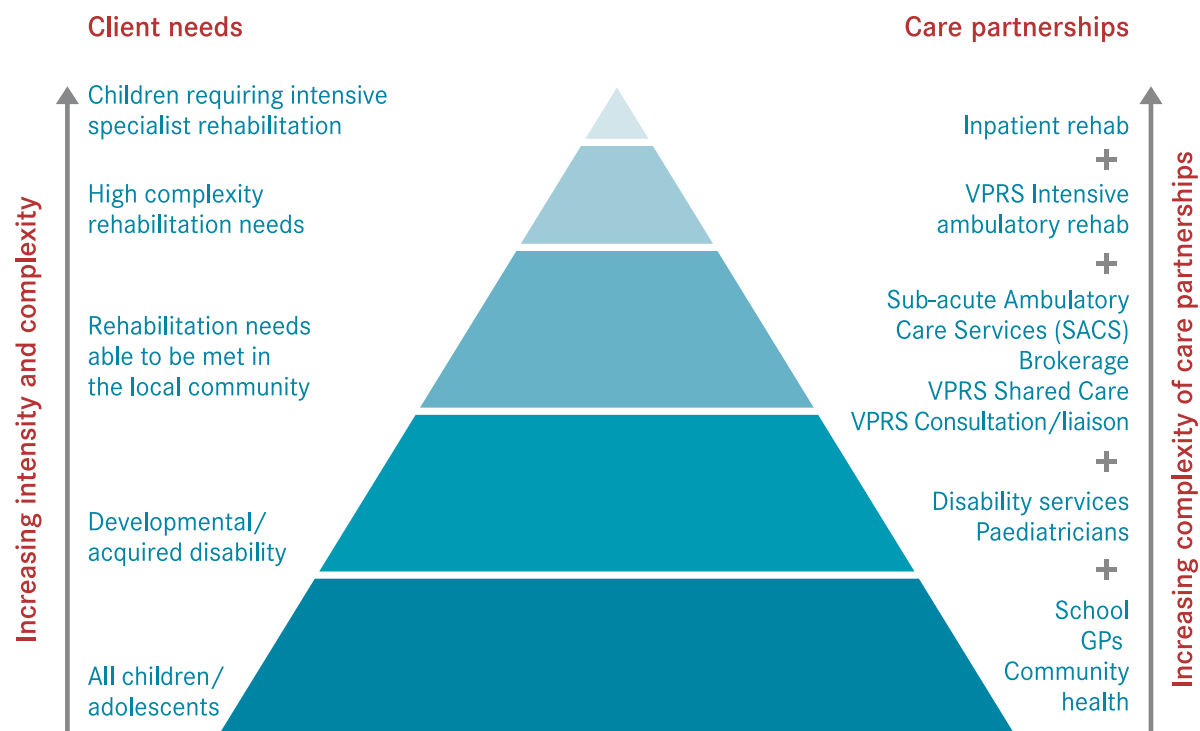
- review of interstate and overseas paediatric rehabilitation service delivery models, including a literature review of best practice for paediatric rehabilitation service delivery models
- data about service utilisation
- information gathered through consumer consultations (Consumer consultations to inform the development of the Victorian Paediatric Rehabilitation Service Final Report 2007)
- documentation produced by similar and related services, including:
 - Melbourne Citymission documents
 - Western Metropolitan Region paediatric ABI case management referral pathway for children and young people who do not have complex ABI needs
 - Western Metropolitan Region paediatric ABI case management referral pathway for compensable children and young people (0-18 years)
 - Western Metropolitan Region paediatric ABI case management referral pathway (non-compensable) for children and young people (0-18 years)
 - Paediatric ABI services list – Southern Region (draft document)
 - Department of Human Services' Disability Division: identifying the needs and possible service responses for children and young people with ABI and their carers
 - Queensland Paediatric Rehabilitation Service documents
 - Statewide Paediatric Rehabilitation Service, Queensland Health evaluation report (August 2000)
 - Statewide Paediatric Rehabilitation Service, Queensland Health evaluation report – supplementary report prepared for Queensland Health (December 2000)
 - An investigation of Paediatric rehabilitation systems of care in North America – Churchill Fellowship report by Lynne McKinlay
 - Sample patient journeys for complex ABI and cerebral palsy
 - Southern Health Paediatric Clinic or Service profiles.
 - King, G., Tucker, M., Balwin, P., Lowry, K., LaPorta, J., & Martens, L. (2002) 'A life needs model of paediatric service delivery: Services to support community participation and quality of life for children and youth with disabilities'. *Physical & Occupational Therapy in Paediatrics*, 22(2), 53-57.
 - Paediatric rehabilitation service delivery in North America – Brainwave and Rosemary Derham Travelling Scholarship report by Jane Galvin 2006

- Stroke Care Strategy for Victoria (Department of Human Services, 2007)
- Clinical Services Capability Framework (Queensland Health, 2004)
- NSW guide to the role delineation of health services, third edition (NSW Health 2002).
- Visit to Queensland Paediatric Rehabilitation Service – report by Fiona Gorrie, 2006
- Canadian Paediatric Rehabilitation and Trauma Services visit report by Lyndal Hickey, 2006
- Visit to National Institute of Rehabilitation, Paris – report by Dr Anna Mandalis, 2006
- Visit to Children’s Trust – report by Dr Anna Mandalis, 2006.
- Visit to Astrid Lindgren Children’s Hospital, Karolinska Institute, Sweden – report by Dr Anna Mandalis, 2006
- Transport Accident Commission clinical justification flow chart
- Rural and regional case studies from Bendigo Health, Barwon Health and Eastern Health
- Service model for paediatric rehabilitation – The Royal Children’s Hospital, Melbourne, June 2005 – Dr James Rice.

The service system context

The VPRS will focus on the provision of specialist rehabilitation services for children and adolescents, from high complexity clients through to moderately complex clients. Lower complexity clients may or may not require specialist VPRS intervention. Through a regional coordination approach, the VPRS will help coordinate the care experience across service system boundaries for children who require specialist rehabilitation. Through secondary consultation, shared care, education and mentoring, the VPRS will also provide access to specialist paediatric rehabilitation expertise for other service providers.

The VPRS will be integrated with, and build upon, existing rehabilitation and paediatric service platforms. As a child's rehabilitation needs become more intensive and complex, more services will share the partnership of providing their care

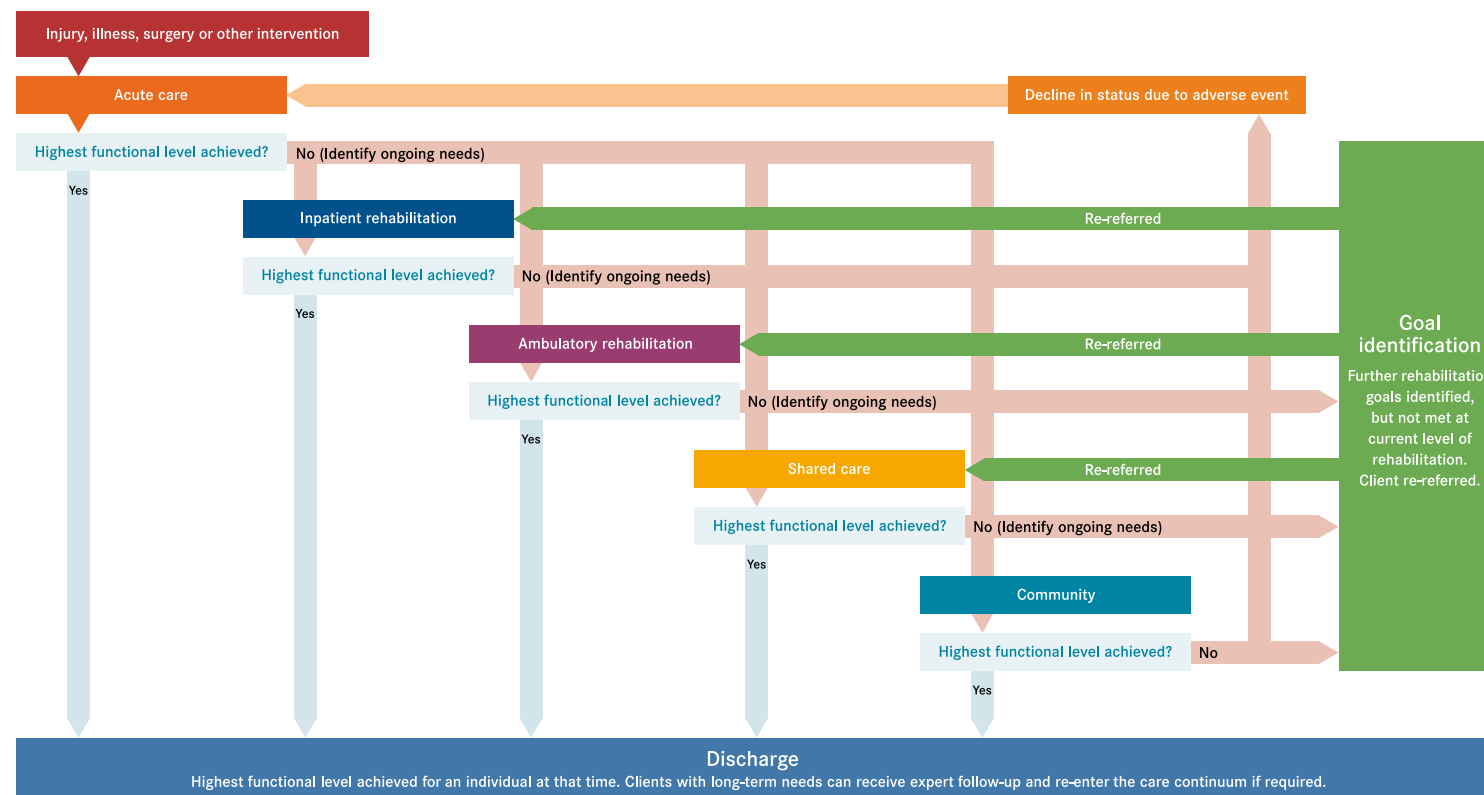


The clinical context

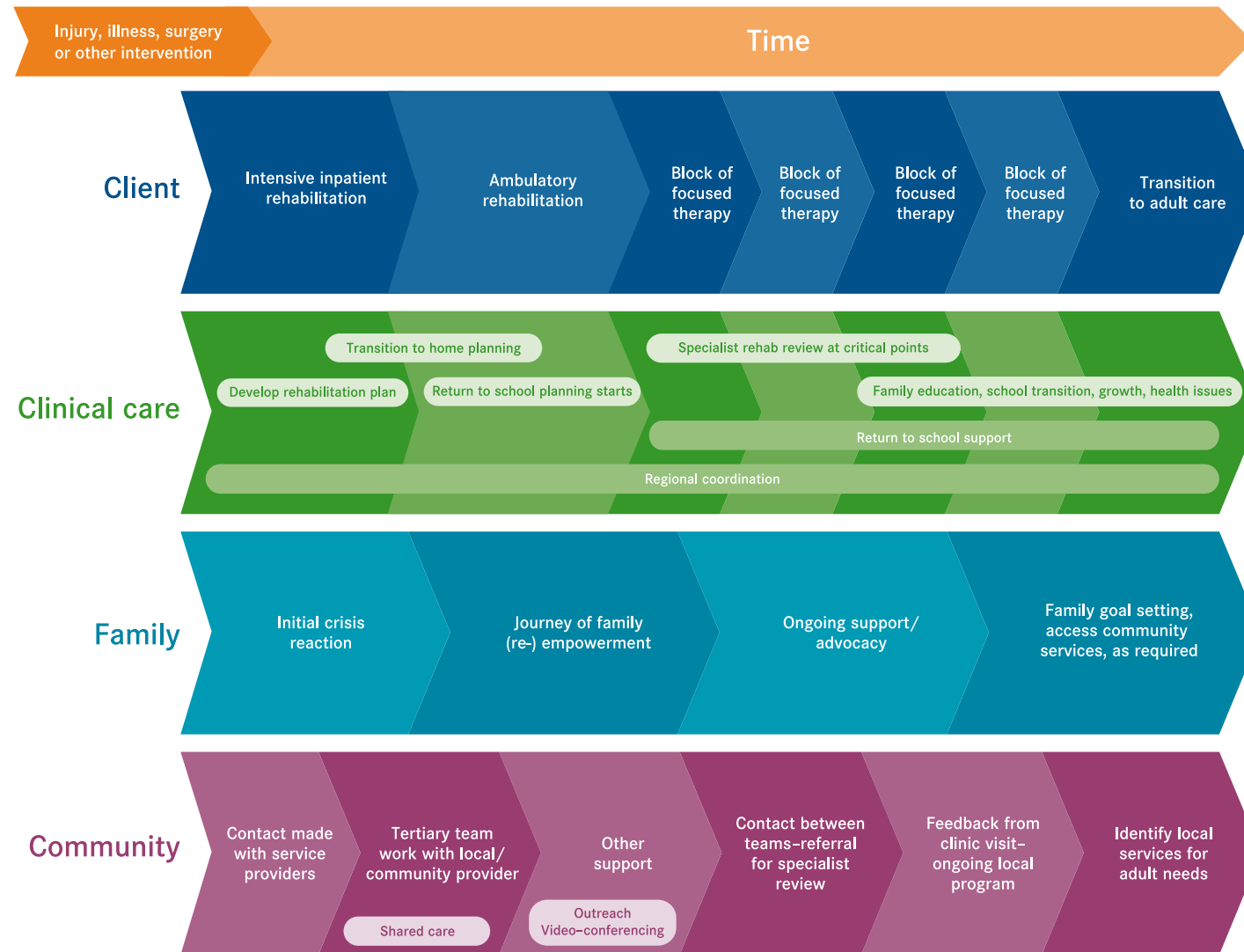
Paediatric rehabilitation continuum of care

Rehabilitation is the combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to their highest possible level of function. It utilises functional and social models rather than a predominantly disease-based model of care.

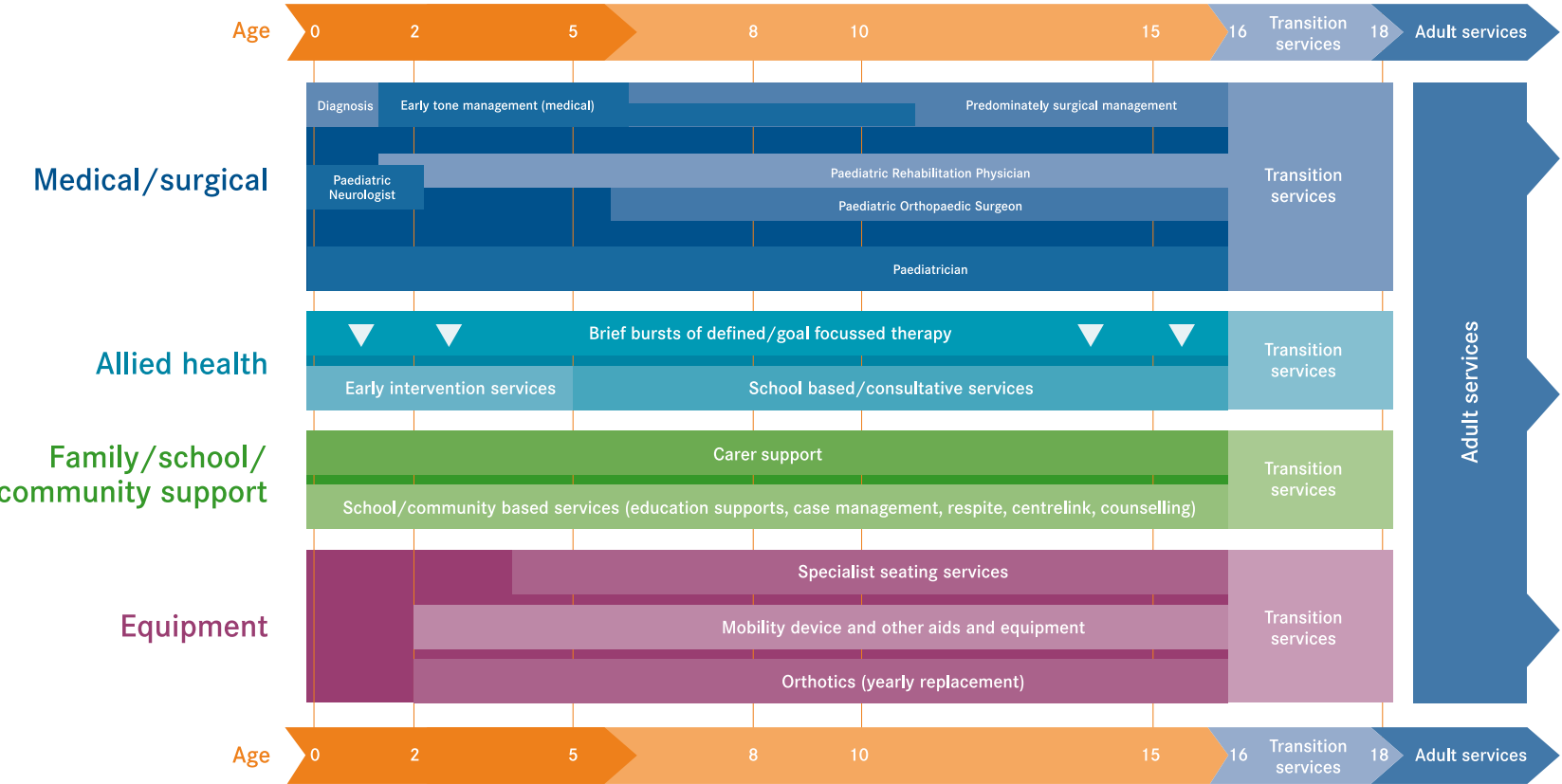
Paediatric rehabilitation uses generic principles of functional intervention but incorporates the essentials of growth and development as part of expert child health knowledge to ensure that care is child-focused and family-centred. Services need to provide a continuum of care that ensures coordinated referral and discharge pathways with community providers, and that those with long-term needs receive expert follow-up, particularly around critical points of transition.



Dimensions of the paediatric rehabilitation journey – acquired event focus



Dimensions of the paediatric rehabilitation journey – cerebral palsy/physical disability

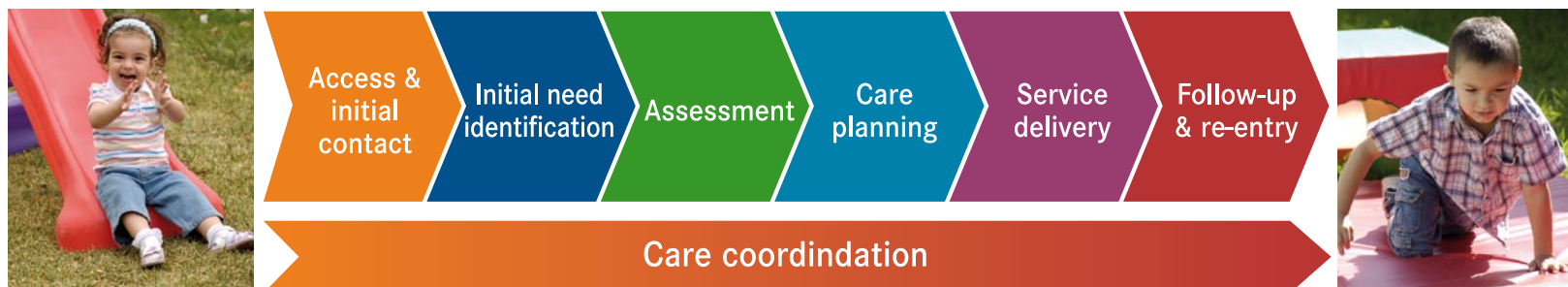


Section 2: Model of care

The client journey through the service system

The VPRS model of care outlined in this document is conceptualised in terms derived from the Victorian Service Coordination Practice Manual. Using the manual as a guide to designing and describing the client journey through paediatric rehabilitation will enhance the ability of the VPRS to communicate with other service providers, and to develop ways to work in partnership with them.

To map out a complete model of care for paediatric rehabilitation however, the model of care working group felt it was necessary to add some additional categories to those in the practice manual. These are **Service delivery** and **Follow-up and re-entry**.



Access and initial contact

Information

A communication strategy should be developed, including a VPRS website, to provide information about the service. Information about the service should be available from emergency departments, general practitioners (GPs), paediatricians, and schools. It is expected that VPRS staff will have a role in actively promoting community awareness of the service.

Staff working within the VPRS will have a role in providing education to other health professionals, including information regarding key conditions likely to require rehabilitation. This education may include university training for health professionals.

Initial contact

Children requiring rehabilitation (or their families) may contact the service at a number of different sites. Initial contact is likely to be at a hospital emergency department, but may be via other hospital wards, general practitioners, allied health providers, paediatricians and other service providers.

Some families may directly contact the VPRS when they become aware of the service. Contact with the VPRS may be information seeking only, or may lead to an initial need identification process and, if indicated, referral to an appropriate service provider.

Referral

Once the initial contact is made, referral to the VPRS should be a clearly defined process, with a defined point of entry and a defined intake process in place. The Victorian Service Coordination Practice Manual provides a framework for service coordination, however referral processes should be further specified by VPRS standard procedures and protocols. It is acknowledged that there may be some variation between sites.

The service coordination tool templates should be used to ensure consistent referral documentation across the service. The VPRS should develop any further tools required for sharing client information between service providers.

After a referral has been received, feedback should be sent to the referrer and to the client and family regarding the referral outcome.

Initial need identification

Initial need identification consists of an initial screening process, broadly determining the child's need for service provision, with consideration of priority, risks, eligibility and the type and breadth of services required. It is not a diagnostic process and does not encompass clinical assessment, however, it can involve provision of information to the family to enable them to make an informed decision.

In some cases, a child may be referred to the VPRS after initial contact and initial need identification have occurred elsewhere in the service system. In this case, the initial need identification within the VPRS would include consideration and verification of the information provided in the referral.

Appropriate screening tools for the VPRS should be identified or developed, and used at the point of initial need identification.

Assessment

An initial assessment of a client should occur once the initial need of the client has been identified, a referral has been made to the VPRS and the client has been accepted into the service.

An assessment is a clinical process that can be used to set goals, determine appropriate interventions, determine other services required and make appropriate referrals with the consent of the client and family. An initial assessment ensures that the current and ongoing needs of the client and their family are identified and documented.

The assessment of the client may be undertaken by a single discipline or be interdisciplinary, depending on the complexity of the client's needs. A client with more complex problems may require an interdisciplinary assessment, whereas a client with less complex problems may require only a single discipline assessment. In some cases a single discipline assessment may lead to referral on to other disciplines for further assessment.

Where possible, the assessment should be timely in relation to receipt of the referral. The timeliness of the assessment will depend on the identified need of the client. The triage process in relation to client assessment should be fair and equitable, with prioritisation based on need.

The assessment should remain client focused and be appropriate for clients with culturally and linguistically diverse (CALD) backgrounds. The VPRS and other external service providers should access interpreter services where appropriate and ensure staff are trained in the use of these services.

Where possible, recognised assessment tools should be used for the assessment. This will improve consistency of practice within the VPRS and may also reduce the duplication of assessment as the client moves through the system. Statewide outcome measures should also be developed.

Care planning

The client's care plan will be a shared vision for the client, their family and service providers in achieving the best possible health and wellbeing outcomes for the client. The service providers may include VPRS staff, the client's GP, paediatrician, and any other external service providers.

The care plan should be developed in partnership with the client and their family and be based on the client's identified needs. It should set out a clear management plan for the client, with the needs of the family also considered. The client and their family should be provided with a copy of the care plan and it should also be provided to other relevant parties.

The care plan should be goal focused and developed with set timelines in place. There should be regular reviews of the care plan by the treating team and the client and their family to ensure goals and timelines are re-evaluated. The care plan may involve treatment by only one discipline or may require input from a number of team members. The care plan should clearly document any partnerships that are required.

Access issues, such as the geographical location of the client and family and their ability to access the required services, should be considered in developing the care plan. Other factors such as the client's medical issues, ability to participate in activities, links with the child's school and community and other family aspects should also be considered. Where appropriate, the care plan should have a developmental focus. It should be evidence based and clinically justifiable. When the client is an adolescent at 14-16 years of age, planning for transition into the adult health service system must be included as part of the care plan.

Due to the complex needs of the clients accessing the VPRS, care coordination may be required as part of the care plan. All VPRS clients should have a key contact person within the treating team. The regional VPRS coordinator who can work with the various local service providers will also enhance care coordination. The VPRS key contact person will work closely with the regional coordinator (See *further information regarding the key contact person and VPRS regional coordinator in Section 3: relationships and roles*).

Service delivery

There may be a number of different service providers delivering paediatric rehabilitation services.

Service provider	Description	Examples
VPRS tertiary provider	Tertiary-level paediatric service provider. Providing specialist inpatient and ambulatory paediatric rehabilitation services.	Royal Children's Hospital Monash Medical Centre, Southern Health
VPRS local provider	Health service providing ambulatory paediatric rehabilitation services.	Eastern Health Bendigo Health Care Group Barwon Health
External service provider	Service provider that may be able to provide some paediatric rehabilitation services, either as part of their core service or with brokered VPRS funds.	Community Health Service SCOPE Yooralla Education Services

The type of service delivery that a client receives may be influenced by a number of factors:

Complexity of the client's needs

The complexity of the client's needs should be considered when determining the most appropriate type of service delivery for a particular client. Clients with highly complex needs may require VPRS care coordination and VPRS service provision at a tertiary centre or through a shared care model with a local VPRS provider. Clients with moderately complex needs may require VPRS care coordination and VPRS service provision at a tertiary centre or local VPRS service provider with, or without, outreach support or shared care. Low complexity clients may or may not require regional coordination and VPRS service provision may be via a local VPRS service provider or an external service provider.

Timing of the intervention

The timing of the intervention will affect the type of service delivery for a client. Clients may experience their first contact with the VPRS soon after their initial episode/incident or it may be some time following the event.

Clients will often have more complex needs in the earlier stage of their rehabilitation and have less complex needs as time passes. However, clients with an acquired brain injury (ABI) can appear less complex initially and then become more complex with time. Cognitive, social and behavioural issues are known to increase over time and may not be identified at the time of initial diagnoses. As such, the timing of the intervention may or may not coincide with the complexity of the client's needs.

Critical mass

For clinical staff to gain expertise working in paediatric rehabilitation, there must be a large enough number of appropriate clients admitted to the hospital/centre (a critical mass). This will present some difficulties in rural and regional areas where client numbers will tend to be small and infrequent. In some areas regular staff training may be required to maintain this skill level, and to regularly refresh staff skills and knowledge. This may be accessed through a mentoring program, the provision of outreach support or other mechanisms. It could include some client-specific training prior to a particular client accessing the service.

Type of service delivery

VPRS clients will have access to a variety of types of service delivery. Inpatient services will be provided at a tertiary centre by staff employed directly by the VPRS. Ambulatory services may be provided by staff from a specialist VPRS tertiary centre or by staff from a local VPRS service provider or external service provider.

Inpatient services

Inpatient services will be provided at the Royal Children's Hospital and Monash Medical Centre Southern Health, and will be designated as Level 1 Rehabilitation Services. Further work regarding sub-acute role delineation is to be undertaken within the Department of Human Services, which will inform future role delineation and service planning for the VPRS.

The inpatient setting is a resource intensive service setting. For a client to require access to an inpatient service they should meet one or more of the following criteria. They should:

- require a service environment with rapid access to diagnostic and medical support
- require an intensity of service that necessitates an inpatient stay
- have high care needs, which surpass the family's capacity (physical, social, emotional) to directly care for their child (this may change as the client improves or the family learns to care for their child)
- be reasonably acute; following surgical/procedural/medical/other major event
- experience fatigue, requiring rest management
- have geographical reasons why it may be very difficult to receive the intensity of the service required as an outpatient (for example, lack of scope of required services locally)
- have safety requirements, or will be at risk if discharged
- require access to other services such as specialist care with regular reviews required.

In some cases a client may meet the criteria for inpatient rehabilitation but the client and family may choose to have care in an ambulatory setting. Decisions regarding the most appropriate type of service delivery should be made on an individual basis.

In order to provide the VPRS inpatient service, there are specific infrastructure and workforce requirements.

Specific infrastructure requirements include:

- a child friendly environment including play spaces
- access to developmentally appropriate equipment
- access to paediatric specific therapy, for example, music therapy, play therapy and equipment
- school support/liaison for long stay patients
- psychological support.

Specific workforce requirements include:

- 24-hour medical availability (with expertise in paediatric management)
- bedside nursing support
- direct access to a paediatric rehabilitation consultant, including on-call
- experienced allied health staff such as physiotherapy, occupational therapy, speech pathology, social work, neuropsychology, education advisors and access to other staff as required
- access to the required expertise on a daily basis.

Ambulatory services

Ambulatory care can be delivered in a range of settings. These may include:

- hospital
- community centre
- community
- client's home
- school environment
- other recreational settings.

Ambulatory care can range from intensive regular treatment to less intensive treatment with a focus on community integration. Ambulatory care may be provided by staff from a specialist VPRS tertiary centre or by staff from a local VPRS service provider or external service provider.

Ambulatory care should be delivered in the most appropriate treatment setting for the client. The context and relevance of the treatment for the client and the needs of the family should be considered when deciding where treatment should be provided. Where possible, the options should be presented to the family and they should be empowered to make a choice. The safety of the health care team and that of the child should also be considered when deciding the setting of the ambulatory care service.

Outreach services

Outreach services will form an important component of the model of care for the VPRS. For the purposes of this document, outreach is defined as a partnership model that sits at the interface between VPRS tertiary centres and VPRS local providers or external providers. This model involves the provision of support to local service providers particularly regarding high complexity/low incidence cases in regional areas, where a low critical mass of children does not allow for the maintenance of specialist skills. The main intent of outreach services are to provide specialist services closer to a client's home and build capacity in the local community.

There are two main components of an outreach model. The first component is specialist outreach clinics held in regional areas, and the second component is individual visits to facilitate discharge or transition.

Specialist outreach clinics

Provision of specialist outreach clinics involves a VPRS tertiary team providing specialist reviews in a regional area. The clinics may be held periodically at defined intervals or may follow a request from a local provider. Where appropriate, the clinics will provide an opportunity to upskill VPRS local providers and local external providers.

Individual outreach visits

Individual visits by VPRS staff from a tertiary centre to a regional area can facilitate transition of a client from a tertiary inpatient or ambulatory setting to a local service provider. These visits are usually based around a particular client, with the tertiary centre providing individual visits to assist with facilitating transition and knowledge transfer.

Roles of the teams involved in outreach services

The tertiary team providing an outreach service is expected to:

- liaise with the local service provider when clients are discharged from an inpatient or ambulatory setting at a tertiary centre to a local service provider. This includes establishing if outreach services will be required
- provide clinical support, advice, mentoring or training of healthcare staff
- where appropriate, develop education workshops for local VPRS and other service providers, such as schools and community services, based on identification of needs by local providers.

The local service providers are expected to:

- request support from the tertiary team, where required, when a client has been transitioned from a tertiary centre
- request support of the tertiary team at other times when support is required to manage the needs of a client, even if the client has not previously attended a tertiary centre
- identify their learning needs and how these can best be met and communicate this to the tertiary provider.

If a client has been transitioned from a specialist tertiary centre, the regional coordinator may initially have a role in linking the client with the local service provider. The regional coordinator may be involved in establishing any local outreach clinics and coordinating various staff to attend.

There is also an expectation that VPRS clinicians will develop a clinical network across the service. This network should involve collaboration and communication between different VPRS service providers. Outreach support will form a natural extension of this clinical network. This will ensure a level of consistency across the service, upskilling of local service providers and the development of specialist skills across Victoria.

Shared care

Shared care implies that care of a client is shared between health services or sites. Care may be shared between a major tertiary centre and a local service provider and implies that both services are involved in active client management. A client may receive most of their services through a local provider but return to a tertiary centre for periodic reviews or management of a more complex issue that requires particular expertise. Alternatively, a client's therapy may be shared between the tertiary VPRS centre and the local provider whilst the local provider is developing skills, or in order to ensure the client receives the intensity of therapy they require.

Shared care, and the communication required between services providers to ensure collaborative client management, will provide another avenue for knowledge sharing and upskilling of local service providers.

Brokerage

Brokerage can be used to provide additional services to a client, particularly while waiting to access care in mainstream services. Brokerage can also provide interim supportive care that enables a client to stay at home. At present, it is anticipated that brokerage will be required at some stages of the client journey to ensure the client is optimally managed. However, service gaps requiring brokerage can be used to inform future service planning and there is an expectation that sub-acute ambulatory care services, and the skill base developed in community-based rehabilitation, will form a strong platform to support the development of paediatric rehabilitation in the future.

Brokerage may be indicated when:

- there is a clinical need
- there is risk to the health and welfare of child and/or family without the brokered service
- the brokered service provides supportive care that enables a client to stay at home
- additional services are required that cannot be provided within the existing staffing profile of the service provider.

In order to be successfully utilised, brokerage should be:

- flexible
- used to meet a specific, identified need
- used for a defined period of time
- used to fill service gaps
- used while clients are on a waiting list for another service.

There may be times when it is preferable for clients to receive their rehabilitation through a brokered external service provider if they are already linked in with that provider, such as an education or disability service provider (See *further information regarding links with external service providers in Section 3: relationships and roles*).

The following issues should also be considered when brokering services:

- clinical governance
- duplication of the existing service system
- cost shifting
- credentialing of external service providers.

The Department of Human Services is currently reviewing brokerage models. The outcome of this review will inform the development of brokerage models for the VPRS.

Follow up and re-entry

A child may require follow up and re-entry into the VPRS at critical points of transition throughout their life. There are established critical points of transition during a child's life where follow up and re-entry into a service is most likely, such as starting primary or secondary school. However, services should be able to follow up clients at any point in time if the client or their family feel it is required.

The client and their family should have a known point of contact for follow up and re-entry into the rehabilitation process. Often the regional coordinator will be this point of contact. However, in some cases a client's GP or paediatrician will be responsible for monitoring the client (See *further information regarding the VPRS regional coordinator, general paediatrician and GP in Section 3: relationships and roles*).

The complexity of the client's needs should be considered when determining the most appropriate model of service delivery if they re-enter the service.

Section 3: relationships and roles

Service and clinical support

Clinical decision making

Due to the complexity of the VPRS client group, staff support during the clinical decision making process will be an important aspect of the service. Service coordinators from different clinical streams or service streams should be appointed to support clinical decision making within that area and, where appropriate, clinical pathways should be developed.

Clinical decision-making can be supported by:

- joint treatment and assessment sessions, drawing on the skills of more experienced staff and creating an environment for information sharing
- mentoring of junior staff by more experienced staff
- mentoring of local VPRS service providers by tertiary VPRS staff
- case conferencing, which provides an opportunity to discuss a client's treatment options
- outreach clinics and visits
- shared care arrangements.

Education support

Participation in ongoing professional development, research and education will be a key requirement for all VPRS staff. As the VPRS is a statewide service, resources will need to be shared across the service. Education can be delivered in a variety of settings and using a variety of modalities including face-to-face education sessions, videoconferencing and online options.

Education should be valued by service providers with support available for the development of education tools and to attend appropriate education sessions. Appropriate post-graduate qualifications for staff need to be identified and supported. Relationships should also be built with universities around allied health training, as appropriate.

Resource sharing

Resource sharing refers to the sharing of protocols, procedures and tools, as well as sharing of human resources. The development of common protocols, procedures and tools will help to ensure consistent practice within the VPRS and will avoid unnecessary duplication across sites.

While some site-specific protocols may be required, where possible there should be consistency across all services within the VPRS.

The development of joint appointments across different service providers within the VPRS will assist with sharing of human resources. This will enable the specialist skills of practitioners to be shared across different service providers. This may also enable the creation of more substantial positions across a number of sites, rather than only small part time roles.

The development of rotating positions will increase skill development in the area of paediatric rehabilitation within the health system. This will enable supported positions to be developed with the aim of skilling up staff who rotate through the positions.

Research

Research will be an important part of the ongoing development of the VPRS and is a core component underlying the model of care. Collaborative research projects will be conducted across the various service providers within the VPRS. The VPRS will take a lead role in research to enhance the specialist knowledge and skills of the service, contribute to the evidence base and establish VPRS as a national and international leader in the area of paediatric rehabilitation. This may also encompass affiliations or adjunct positions with local and international universities and research institutes.

Technology

Technology can be utilised to assist with VPRS client management. This may include videoconferencing or teleconferencing to allow access to health professionals with specialist skills, particularly in areas where direct access to expertise is limited.

Technology can assist clients who have accessed the VPRS to be monitored and followed up as required. This may include the use of information management systems to monitor the time period since the initial admission and flag appropriate points for follow up.

Technology will play an important role in resource sharing and will enable the development of a virtual VPRS community and a centralised register of resources. This will facilitate the development of a clinical network for the VPRS.

Program coordination and linkages

Links with external service providers

The VPRS does not aim to duplicate services, but rather to enhance local service platforms and develop partnerships. As such, relationship building between VPRS service providers and external service providers will be an important aspect of service development.

The interface with other specialist paediatric and rehabilitation service providers, such as non-government organisations (including SCOPE and Yoralla), other disability services and education services, is an important aspect of the model of care. The VPRS should not duplicate scarce allied health resources and roles but, where appropriate, link in with these services.

In some cases, where clients are already linked in with a local external service provider such as non-government organisations, disability services or education services, these services may be the most appropriate place for a client to receive a defined period of rehabilitation following an event or surgery. Brokerage, via the local health service, can be used to fund these agencies to deliver rehabilitation for a defined period when it is in the best interests of the client and can be adequately delivered by the service.

Provision of outreach services by specialist VPRS tertiary staff should be available to external service providers, where appropriate. External service providers should receive education regarding the role of the VPRS and any necessary support and education should be provided following the transition of a client from a tertiary centre back to the external service provider.

Care coordination

Key contact

A designated key contact person from the treating team should be allocated to each VPRS client. This key contact person is responsible for completing the care plan for the client and for coordinating the care of the treating team. The key contact is the first point of contact for the client's family and is responsible for communication of relevant information. The key contact is responsible for the discharge or transition summary when the client moves from one area of the VPRS to another, or is referred to another service.

Regional coordinator

There will be a VPRS regional coordinator in each metropolitan region and each regional area. They will coordinate the various local service providers whilst a child is receiving rehabilitation services and will aim to facilitate continuity of care for children and their families during the rehabilitation process to ensure a seamless service. The coordinator will ensure a smooth transition for children into rehabilitation services and from rehabilitation services into longer-term community-based services and disability services, where appropriate.

The regional coordinator will:

- provide expertise regarding local paediatric service providers in the region
- coordinate referrals to local community service providers for children who require rehabilitation
- coordinate local service provision for children requiring rehabilitation services
- regularly liaise with local providers of disability and community-based services to ensure up-to-date knowledge of all local services provided, including the type of services provided, referral criteria and current waiting lists
- determine and coordinate the support needed to enable the successful transition of clients from inpatient rehabilitation services to ambulatory services and from ambulatory services to community-based or disability services
- provide a point of contact for families with children requiring rehabilitation services or who have had rehabilitation services in the past and require re-entry into the VPRS.

Paediatrician

General paediatricians are involved in coordinating the medical, social and psychological needs of children with functional impairment. Children with a significant injury who have required inpatient rehabilitation in a tertiary hospital should be referred to a general paediatrician as part of their discharge plan. The paediatrician is then responsible for the ongoing medical care of the child in the community.

The paediatrician will have a role in monitoring of the client and, in some cases, in initiating their re-entry to the VPRS. If required, general paediatricians should be able to access a secondary consultation with a paediatric rehabilitation specialist.

General Practitioner

Clients with less complex needs may not require the involvement of a regional coordinator or a paediatrician. In these cases, the client's GP will be responsible for their care coordination. Even in cases where the regional coordinator or general paediatrician is involved in the coordination of the client's rehabilitation, the client's GP will have a general role in the client's medical management and should be kept informed of their progress and outcomes.

