Osteopathy in an interdisciplinary paediatric clinic
‘Crawling around a ball-pit doing treatment’

Newly elected iO Council Member Fiona Greer shares with us her insights into and the challenges she faced, whilst being the Clinic Director of an interdisciplinary paediatric clinic.

You used to work in a interdisciplinary paediatric clinic. Could you tell us a little about who you worked with and your contribution as an osteopath to the team? I was the Clinic Director of a large private children’s therapy clinic, we saw a combination of clients either paying all of the fees or with a combination of charity funding. We also worked in schools on specific Educational Healthcare Plan (EHCP) delivery. Along with a senior occupational therapist, we built the service after working remotely but collaboratively on a couple of clients. Our caseload saw a lot of children with complex physical and emotional needs. We had two osteopaths, three occupational therapists, three play therapists, an educational psychologist, a clinical psychologist, strength and coordination specialist, a senior speech and language specialist, and two therapy technicians. This was quite a senior team with senior practitioners (band 8 or 9) in every service to provide supervision and support. My osteopathic associate involved herself with all the other clinicians and shadowed as much as she could. This meant that there was an osteopath available most days.

How did potential patients learn about the clinic? Most clients came to us through word of mouth although we developed specific relationships with charities such as Seabability and AVUK. We also had a special link with the Boparan Trust who funded many of our clients for a course of therapy who were otherwise unable to fund the whole amount. We felt it was important to engage with our local services. We partnered with a local community centre to help them design and structure a sensory after school programme for children with special needs, we also set up a newborn baby screening service with a midwife who was a newborn examiner so that we could help support new parents in the community.

How did the osteopathic treatment and care ‘interact’ with the other healthcare professionals? Parents filled in an in depth questionnaire before booking in which we would triage and discuss the therapy priority. Often I would join in on the initial occupational therapist (OT) or speech and language therapist (SLT) assessment and then provide additional in depth input to the musculoskeletal observations in the report. Clients would usually be booked in for a separate osteopathic assessment and treatment, which would be used to compliment any other therapy intervention. It was not unusual for me to be crawling around a ball pit doing treatment while the OT was directing a session of planning or movement strategies, or just getting hands on during an SLT session. The psychiatric services had closed door sessions so I would always have a separate session with these clients but this would be specifically transitioned and then the practitioners would discuss the case outside the session. There was a lot of free flow between practitioners in the sessions.

For a lot of the clinicians I worked with I had to sell the potential benefits initially, I had to be very careful not to promise too much but still sound like a credible option for therapy — this could especially challenging, especially where there was any NHS input. I would talk about the potential of osteopathy in supporting the musculoskeletal health and gradually they started to see the results for themselves. We didn’t ever claim to ‘cure or fix’ children, a lot of the time osteopathy was really useful to support the body during intensive or long-term therapy. Now these clinicians now say that they would not consider a long-term treatment plan without some osteopathic intervention and support as part of it.

On an ongoing basis I have started TheCliniciansCollective.org, which is an interdisciplinary professional development and support network for paediatric clinicians in Greenwich. We get together regularly to discuss conditions and case examples, we also look at frameworks for referrals and I am always promoting osteopathy within these frameworks.

We have already partnered with Look Hear to roll out a similar model in Reading and although it still in the early stages this will hopefully provide more opportunities for osteopaths in this area. This collaboration came about as a result of previous contacts and shared clients with in an appreciation of the value of osteopathic intervention.

How would you describe the value of osteopathic treatment compared to conventional therapies? As a practitioner I learned so much from the other clinicians, I became more confident in what I didn’t know! I have developed a wider lens to my practice allowing me to be more confident to refer when necessary, or speak to others about my treatment aims and approaches promoting osteopathic intervention.

It becomes more and more apparent that we are often working on the same mechanisms but using different terminology. It gives you better language to talk to other disciplines if you can use familiar therapy terminology in a language they understand.
I could leave the room and knock on another therapists door and ask for a second opinion. This was really useful, especially for any specific developmental or treatment queries. Conversations would happen over coffee where I could ask advice or discuss therapy strategies and also propose possible osteopathic intervention.

The practitioners found that overall therapeutic change was accelerated, it also felt that we were specifically tailoring the treatment to what that child needed and able to reflect on those changes more deeply. Parents really appreciated the collaborative approach; often they are cared for by lots of different specialists who are not in communication.

Above all I really enjoyed the collaborative sessions, I was being challenged, they motivated me to learn more and they were often fun!

Is this a model that could be replicated? What advice would you give others on the potential to work is this model?

Yes, absolutely. I think this model can be replicated. It’s the collaborative dialogue with the clinicians that is important, whether you are doing it in the same building or within a trusted network of clinicians, once you have consent to share information and the parents understand your approach you can be very successful working in a close team around the child.

Have the confidence in the uniqueness of how we work and the unique principles of how we support health. I have attended TAC meetings in schools (team around the child) and meetings with the adoption agencies which are not usual roles for osteopaths. I have had to be careful how best to promote the value of osteopathic care. What I have found is that most other healthcare professionals are very interested but often have little or no knowledge of what we do. All these exposures improve awareness of osteopathic intervention. The more of us doing, the more we all benefit.

In the clinic I ran the monthly in house CPD programme where we would discuss specific conditions/topics and then we would discuss relevant case studies. These are easy to replicate and had great feedback and supported the collaborative model.

Currently I work in a large mental wellbeing charity, this is mostly a psychiatric service with a specific children’s service. I am not often in the same building as the other clinicians who I am working with collaboratively at the moment so my professional network and contact is very important. It takes a bit more time but I feel that’s a huge strength of osteopathic care.

I set up the The Clinicians Collective to continue to work this way. If you don’t have the physical proximity of the shared clinic space the next best thing is to have a shared knowledge structures and strong clinician referral networks.

We also had monthly supervision for all our employees, this is how you get experienced, motivated teams. We had it booked out in the diary for one hour on a monthly basis. It was a chance for clinicians to talk through anything they felt they needed help with or just to pick your brain for more knowledge!

What are the challenges of this type of practice?

There are definitely challenges to working in this way. With strong ASA limitations in how we word our paediatric practice marketing we have to be careful about what we promise. It’s important to use a shared language so that other clinicians can understand more about what we do.

When there is a complex need for therapy this can get expensive privately. It is important to be upfront about this with clients. We used funding opportunities for clients who could prove they were unable to pay. There are many charities that will give funding for a course of treatment. This allows a freedom to tailor the therapy progression specifically to need and adjust as the need changes.

You want the clinic to be the hub. Ideally there would be lots of collaborative clinics dotted around but these are complex to run and expensive to initiate. We were set up in a lot of schools for in-house OT, SLT and Psych. provision. This took many of our practitioners out of the clinic, which on reflection is not ideal for the clinic.

Osteopathy is not a named therapy on an EHCP which means we cannot provide services to improve child health; I am hoping this is something I can help change through my involvement with the iO. SLT, OT and Physio, are all named therapies who are able to access this individual funding and provide therapy intervention.

The greatest challenge working in this model is the difference in level in paediatric training and support within our profession. Basic competencies in paediatrics is a contentious subject in our profession but its challenging to be taken seriously in paediatric healthcare if we can’t guarantee an appropriate level of knowledge and skill. This acts as a barrier to accessibility for osteopathic care in paediatrics which needs addressing.

There are a lot of highly experienced practitioners in the UK and we all need to work together and engage with other paediatric specialists. We may not engage everyone but if we keep having the conversations and promoting ourselves hopefully it will continue to improve.

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