Royal Cornwall Hospitals
NHS Trust

Referral to the Paediatric Orthopaedic Physiotherapy Service Clinical Guideline

V6.1

August 2024

1. Aim/Purpose of this Guideline

1.1. This guideline is for use by health professionals to ensure referral of paediatric orthopaedic patients to appropriate services.

1.2. This guideline applies to anyone wishing to make a referral to the Paediatric Orthopaedic Physiotherapy service, e.g., GPs, Health Visitors, other physiotherapists, consultants.

1.3. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. **Infants**

2.1.1. Developmental Dysplasia of the Hip (DDH)

Infants referred with risk factors or positive clinical findings for DDH following the New Born Examination or NIPE will be seen within 4-6 weeks of age at the Infant Hip Screening Service at RCHT.

2.1.1.1. **Refer Infants with the following clinical signs:**

- Positive Barlow or Ortolani tests.
- Asymmetric Gluteal skin folds.
- Leg length discrepancy.
- Unequal/tight hip abduction when the hip is flexed to 90 degrees.
- Hip clicks.
- Plagiocephaly.

- Positional and Fixed Talipes.
- Torticollis or sternomastoid tumour.

2.1.1.2. **Risk Factors for referral include:**

- Positive family history of DDH or Hip Instability.
- Multiple pregnancy.
- Oligohydramnios.
- Breech or Transverse position at delivery.
- Breech or Transverse position at or after 36 weeks of pregnancy (irrespective of presentation at birth).
- Parental Concern.
- Infants with other skeletal abnormalities.

2.1.1.3. **How to Refer:**

- Internal referrals should be booked on Maxims – “Neonatal Hip Screening Service”.
- External referrals should be sent on ERS to the Referral Management Service.
- Please note: The Infant Hip Screening Clinic aims to see all external referrals within 4 weeks of the referral date.
- Infants up to the age of 12 months with clinical signs or risk factors of DDH should be referred to the screening clinic. Any child older than this must be referred to the Paediatric Orthopaedic Consultant Team.
- Urgent Referrals – Please book through ERS or Maxims and email claire.hawkins11@nhs.net.
- For queries regarding bookings please contact the Orthopaedic Booking Office on 01736 758892.
- For any other queries please contact the Orthopaedic Secretaries on 01872 253430.
- Babies requiring the application of a Pavlik harness are referred to the Paediatric Orthopaedic Physiotherapy Team by the ultra-sonographer and their progress is monitored with ultrasound until the child is approximately one year. They are then referred to the Paediatric Orthopaedic Consultant Team where they are reviewed with x-ray, and they may require periodic review as indicated.

2.1.2. **Fixed/Congenital Talipes Equinovarus (CTEV)**

Any child with fixed talipes equinovarus should be referred urgently to the Paediatric Orthopaedic Physiotherapy Service. Internal referrals should be made on Maxims by selecting 'Neonatal Orthopaedic Physiotherapy Outpatient Referral.' External referrals should be made via electronic Referral System by selecting 'Physiotherapy, MSK Paediatric Orthopaedic RAS.'

2.1.2.1. Any queries can be emailed to rch-tr.PaedsOrthoPhysio@nhs.net

2.1.2.2. The child will not usually be seen by a physiotherapist on the ward, but they will be offered an urgent outpatient appointment within 2 weeks. If Congenital talipes equinovarus (CTEV) is diagnosed antenatally through a scan, the parents will be offered an antenatal appointment with the Paediatric Orthopaedic Physiotherapy team.

2.1.2.3. The ward team should notify the Paediatric Orthopaedic Outpatient Service when the child is born by referring via maxims drop down menu 'Neonatal Orthopaedic Physiotherapy Outpatient Referral.'

2.1.2.4. The Paediatric Orthopaedic Consultant does not need to routinely be informed of babies with fixed talipes or other congenital foot problems as the Paediatric Orthopaedic Physiotherapy team will refer on, as necessary.

2.1.3. **Obstetric Brachial Plexus Palsy**

2.1.3.1. A child presenting with suspected brachial plexus palsy should be referred urgently by selecting 'Neonatal Orthopaedic Physiotherapy Outpatient Referral' on Maxims.

2.1.3.2. Or external referrals should be sent via eRS, selecting 'Physiotherapy, Musculoskeletal System (MSK), Paediatric Orthopaedic Referral Assessment Services (RAS)'.

2.1.3.3. The child will not usually be seen by a physiotherapist on the ward, but they will be offered an urgent outpatient appointment within 2 weeks. **The Erbs Palsy Group 'Caring for your Baby' information booklet should be provided to the parent / carer before discharge, so they are confident holding, washing, dressing, and undressing their child. You can obtain these by emailing** rch-tr.paedsorthophysio@nhs.net**, or by contacting the Erbs Palsy Group directly.**

2.1.3.4. An X-ray of clavicles is required to exclude fractures prior to discharge.

2.1.3.5. The upper limb Consultant Orthopaedic Surgeon RCHT does not need to routinely be informed of new babies with Obstetric Brachial Plexus Palsy as the Paediatric Orthopaedic Physiotherapy team will refer on, as necessary.

2.1.4. Upper Limb Abnormalities

Referral to Consultant Plastics and Hands Surgeon Rebecca Dunlop via Maxims (Trauma Hands) or eRS (Elective Hands). Any queries can be emailed directly to Rebecca at rebecca.dunlop@nhs.net.

2.1.5. Lower Limb Deficiencies

2.1.5.1. Refer directly to the Plymouth Prosthetic Rehabilitation Service either by phone on 01752 434200 or email livewell.plymouthprosthetics@nhs.net.

2.1.6.1. For a child who presents with positional deformities e.g., positional talipes (equinovarus or calcaneovalgus,) metatarsus adductus, internal referrals should be made on Maxims by selecting 'Neonatal Orthopaedic Physiotherapy Outpatient Referral'.

2.1.6.2. External referrals should be made via eRS by selecting 'Physiotherapy, MSK Paediatric Orthopaedic RAS'.

2.1.6.3. Any queries can be emailed to rch-tr.PaedsOrthoPhysio@nhs.net but referrals must be made as above.

2.1.6.4. The patient should also be referred for neonatal hip ultrasound (see 2.1.2).

2.1.7. Plagiocephaly (flattening to one side of the head)

2.1.7.1. Early referral is essential to the Paediatric Orthopaedic Physiotherapy Service.

2.1.7.2. Internal referrals should be made on Maxims to 'Physiotherapy Paediatric Orthopaedic Outpatient Service'.

2.1.7.3. External referrals should be made via eRS by selecting 'Physiotherapy, MSK, Paediatric Orthopaedic RAS'.

2.1.7.4. Referrals after 12 months of age have very limited potential for improvement.

2.1.7.5. A hip scan referral should also be made simultaneously for all infants with plagiocephaly.

2.1.8. Torticollis

2.1.8.1. Refer as soon as identified to the Paediatric Orthopaedic Physiotherapy Team. External referrals should be made via eRS by selecting 'Physiotherapy, MSK Paediatric Orthopaedic RAS.'

2.1.8.2. Hip scan referral should also be made simultaneously for all infants with torticollis.

2.1.8.3. Brachycephaly (flattening of the back of the head only)

2.1.8.4. These patients do not need to be referred to physiotherapy. General advice on regular repositioning should be offered.

2.2. Toddlers and Older Children

2.2.1. Flat Feet

2.2.1.1. Most children when learning to walk do so with a wide stance and flat feet. Heels may be in a valgus position.

2.2.1.2. Flexible flat feet in children is a normal variant up until the age of 8-10 years[1].

2.2.1.3. Please see the CFT (Cornwall Foundation Trust) Podiatry department guidelines for the treatment of paediatric flexible flat feet for more guidance.

2.2.1.4. The Association of Chartered Paediatric Physiotherapists has produced leaflets on normal variants which are available on their website (https://apcp.csp.org.uk/parent-leaflets).

2.2.1.5. **Asymptomatic** flexible flat feet do not require treatment but an advice leaflet entitled 'Flat feet in young children' is available that can be given in primary care if there is parental concern. The link is available on the referral management system website.

2.2.1.6. **Symptomatic** flexible flat feet in children are appropriate for referral depending on age. See table below:

Category	Information
Normal neurology Able to easily (and bilaterally) go up onto tiptoes (age appropriate) Arch present on tip toe No tightness on ankle dorsiflexion No painful symptoms No poor function, e.g. tripping / falling Absence of associated syndromes e.g. Down's, Marfan's, Ehlos Danlos, hypermobility syndrome	No treatment required. Referral to physiotherapy or podiatry is not appropriate. If there is parental concern, consider issuing the flat feet advice leaflet from the link on the referral management system.
Abnormal neurology	Refer to Acute Consultant Paediatricians RCHT
Arch not present on tip toe Asymmetrical flat foot Significant pain affecting activities of daily living.	Refer to Consultant Orthopaedic Surgeon

Category	Information
Normal neurology Tightness on ankle dorsiflexion Difficulty rising onto tip toes Marked tripping / falling Pain in knees or hips Painful feet in child **under 6 years of age**	Refer to Paediatric Orthopaedic Physiotherapy Service via Maxims 'Physiotherapy Paediatric Orthopaedic Outpatient Service'
If child 6 years of age and older and any of following: Pain in feet / ankles / shins only Skin pressure lesions of feet / ankles Excessive medial shoe wear causing poor function	Refer to the Podiatry Department (Cornwall Foundation Trust)

2.2.2. **Curly Toes /Overlapping Toes**

'Curly toes' are common in infancy and characterized by flexion and external rotation of the lesser toes. Most will resolve spontaneously and are asymptomatic. There is no evidence that physiotherapy can be used to treat curly toes.

- Asymptomatic curly toes - no treatment required.
- Pain, redness, callous formation, difficulty finding footwear - refer to Cornwall Foundation Trust Podiatry Department for a musculoskeletal assessment by ticking 'Musculoskeletal reason' on service referral form.
- 5th toe overriding 4th toes and difficulty with footwear – refer to the Paediatric Orthopaedic Consultant Surgeon.

2.2.3. **Genu varum / Genu valgum**

2.2.3.1. Before the age of two, most children will have slight symmetrical bowing of the knees and ankles when they stand. Between the ages of two and four, children may develop genu valgum and a standing inter-malleolar distance of approximately 6 centimeters is considered normal. Genu valgum normally corrects itself by approximately the age of 6 years.

2.2.3.2. Management guidelines:

- Asymmetrical genu varum / genu valgum - refer to Paediatric Orthopaedic Consultant.
- Concerns regarding excessive symmetrical genu varum / genu valgum - refer to Paediatric Orthopaedic Consultant.

2.2.4. **Outtoeing**

2.2.4.1. Assess the child once walking is well established i.e., walking independently for 6 months.

2.2.4.2. Asymptomatic symmetrical outtoeing can be a normal variant caused by either external tibial torsion, proximal femoral retroversion, or a combination of the two.

2.2.4.3. Outtoeing may be symptomatic or asymptomatic. There are a number of differential diagnoses that may present with an outtoeing gait (e.g., Perthes, DDH, slipped upper femoral epiphysis).

2.2.4.4. Management guidelines:

- Sudden onset out toeing trauma or insidious onset - urgent referral for X-ray and urgent orthopaedic review.
- Asymmetrical out toeing - refer to Paediatric Orthopaedic Consultant.
- Symmetrical out toeing associated with pain in hips, knees, or feet - refer to Paediatric Orthopaedic physiotherapy team RCHT via Referral Management Service.
- Symmetrical out toeing asymptomatic – referral not required.

2.2.5. **Intoeing**

2.2.5.1. Assess the child once walking is well established e.g., walking independently for 6 months.

2.2.5.2. Intoeing may be due to metatarsus adductus, internal tibial torsion or femoral anteversion. Children with metatarsus adductus should be referred to the Paediatric Orthopaedic physiotherapy team (see table below).

2.2.5.3. Internal tibial torsion is a normal variant up to 7 years of age3 and may be symmetrical or asymmetrical. Femoral anteversion is a normal variant up to 10 years of age4 and is generally symmetrical.

2.2.5.4. Physiotherapy is not indicated for asymptomatic normal variants and cannot prevent the tripping often associated with intoeing. However, there is often parental concern. Therefore, a leaflet entitled ‘Intoeing Gait’ is available via a link on the referral management system or by emailing rch-tr.paedsorthophysio@nhs.net.

2.2.5.5. If as a health practitioner you remain concerned, please email the Paediatric Orthopaedic Physiotherapy Team on rch-tr.paedsorthopysio@nhs.net to discuss if a referral is appropriate or contact the Paediatric Orthopaedic Physiotherapy Admin Team if urgent (01736 758846).

Category	Information
Curved lateral border of the foot. (Assess by holding a pen/pencil along the lateral border). 	Curved Lateral Border of the foot indicates Metatarsus adductus. Refer to the Paediatric Orthopaedic Physiotherapy Team RCHT via eRS if external referral or use Maxims drop down menu. 'Physiotherapy Paediatric Orthopaedic Outpatient Service' for internal referrals.
Asymptomatic intoeing with straight lateral border of the foot and symmetrical hip range of movement.	No treatment required. Parents can be issued with the advice leaflet "Intoeing Gait" available via the link on the Referral Management System.
Asymmetrical hip rotation or abduction.	Refer to Consultant Paediatric Orthopaedic Surgeon
Intoeing associated with foot, knee, or hip pain.	Refer to Paediatric Orthopaedic Physiotherapy Team via eRS for external referrals or for internal referrals refer via Maxims drop down menu 'Physiotherapy Paediatric Orthopaedic Outpatient Service.

2.2.6. **Tip toe walking**

2.2.6.1. Many children will tiptoe walk when first starting to weight bear and first starting to walk. Persistent tiptoe walking, once walking is fully established, may be a symptom of a neurological disorder or may be associated with tight tendo achilles.

2.2.6.2. **Assess the child once walking is well established, i.e. child walking independently for minimum 6 months.**

2.2.6.3. **A neurological assessment / screen must be included for any child presenting with tip toe walking and documented on any referral. Referrals to physiotherapy will be returned where neurological status is not documented. See below:**

2.2.6.3.1 Abnormal lower limb neurology with unilateral tiptoe walking – refer to consultant Paediatrician at RCHT.

2.2.6.3.2 Tightness of Tendo Achilles / limited ankle dorsiflexion with normal neurology - Refer to Paediatric Orthopaedic Physiotherapy Team via eRS for external referrals or for internal referrals refer via Maxims drop down menu 'Physiotherapy Paediatric Orthopaedic Outpatient Service.

2.2.6.3.3 **Normal** Neurology +/- tightness etc. - Refer to Paediatric Orthopaedic Physiotherapy Team via eRS for external referrals or for internal referrals refer via Maxims drop down menu 'Physiotherapy Paediatric Orthopaedic Outpatient Service.

2.2.7. **Back Pain**

2.2.7.1. There is an increased likelihood of serious pathology in the under-20-year age group. There are a number of red flags specific to paediatric back pain.

2.2.7.2. Specific Red Flags in Paediatric Population:

History:

- Pre-pubertal children especially <5 years.
- Recurrent or worsening pain causing functional disability significantly affecting activities of daily living.
- Early morning stiffness and/or gelling.
- Night pain.
- Fever, weight loss, malaise.
- Postural changes: kyphosis or scoliosis.

Examination:

- Fever, tachycardia.
- Weight loss, bruising.
- Lymphadenopathy or abdominal mass.
- Altered spine shape.
- Vertebral or intervertebral tenderness.
- Limp or altered gait.
- Neurological symptoms.

Reference: Davis PJC, Williams HJ (2008) 'The investigation and management of back pain in children', Arch Dis Child Educ Pract Ed, vol 93, pp 73-83.

2.2.7.3. Children presenting with any of the red flags above should be referred to the Acute Paediatrician Outpatient Service via Maxims referral or eRS. NB See note re spinal deformity below (3.4).

2.2.7.4. Children (0-18) with back pain (without spinal deformity and without red flags) requiring physiotherapy input.

2.2.7.4.1 The referral must state that the patient has been screened for paediatric back pain red flags and cleared or the referral will be rejected.

2.2.7.4.2 Children under the age of 10 years - refer to 'Physiotherapy - Paediatric Orthopaedic Outpatient Service' via Maxims or eRS.

2.2.7.4.3 Children age 10 years and over - refer to 'Physiotherapy - MSK Outpatient Service' via maxims or eRS. Or if your practice has an in-house physiotherapist refer to them.

2.2.8. **Spinal deformity**

2.2.8.1. Children presenting with possible spinal deformity (scoliosis or kyphosis) and with NO other red flags:

2.2.8.1.1 Children presenting with possible scoliosis and NO other red flags should have whole spine AP standing X-Rays arranged. If there is additional kyphosis (and this clinical information has been included on the request), lateral views will also be included as standard. If scoliosis is identified, the radiology team will arrange any additional x-rays required.

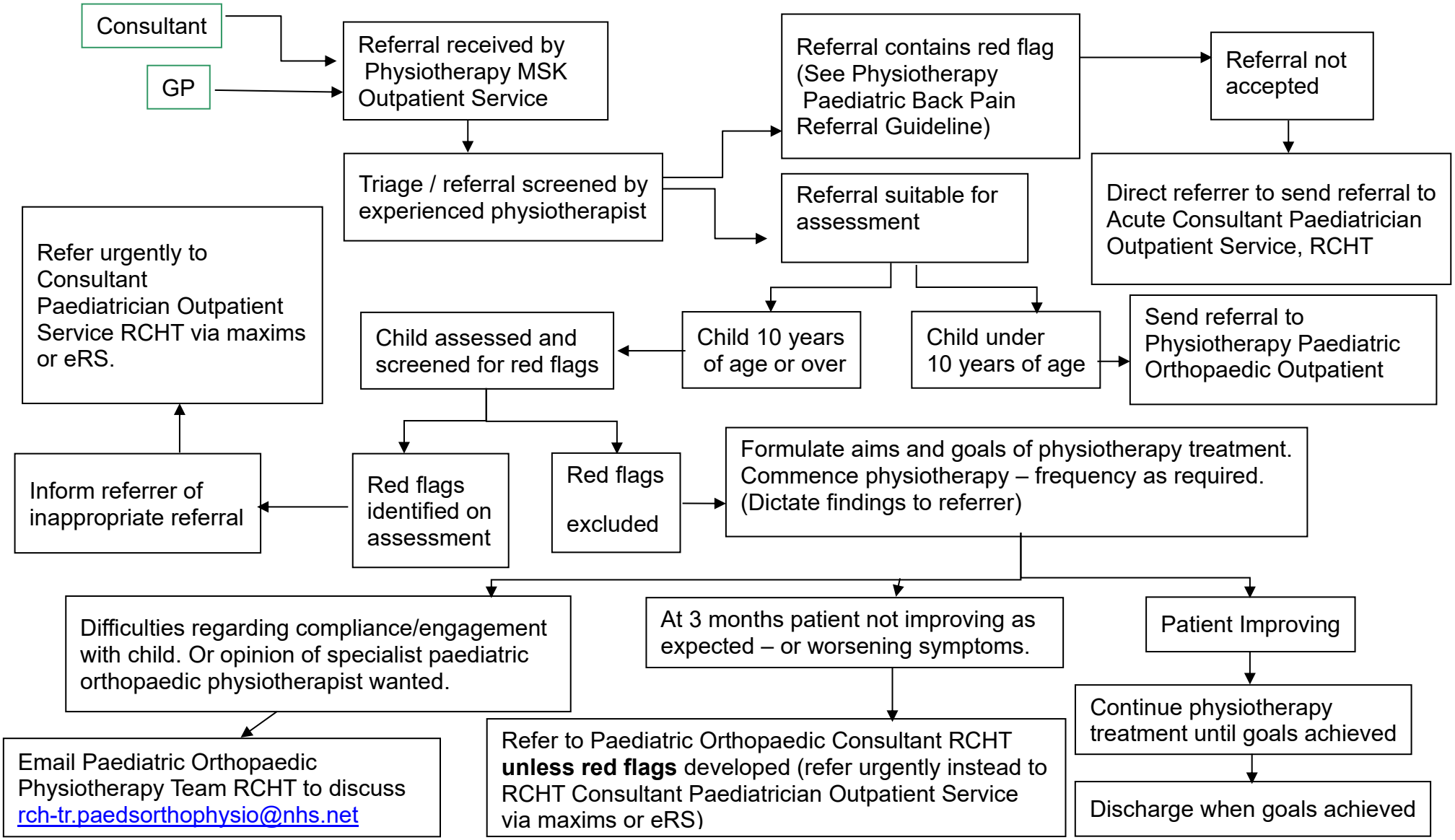
2.2.8.1.2 If Scoliosis or Kyphosis is identified on X-ray **ALL** cases should be referred to The Paediatric Spinal Deformity Service, Princess Elizabeth Orthopaedic Centre, Exeter for their assessment to ensure appropriate management depending on curve magnitude shown on X-Ray. This may be surveillance, physiotherapy, spinal bracing, or surgical management.

2.2.8.1.3 Children 0-18 who have a known diagnosis of scoliosis (have seen the paediatric spinal deformity team) and require physiotherapy input should be referred to 'Physiotherapy - Paediatric Orthopaedic Outpatient Service' via maxims or ERS.

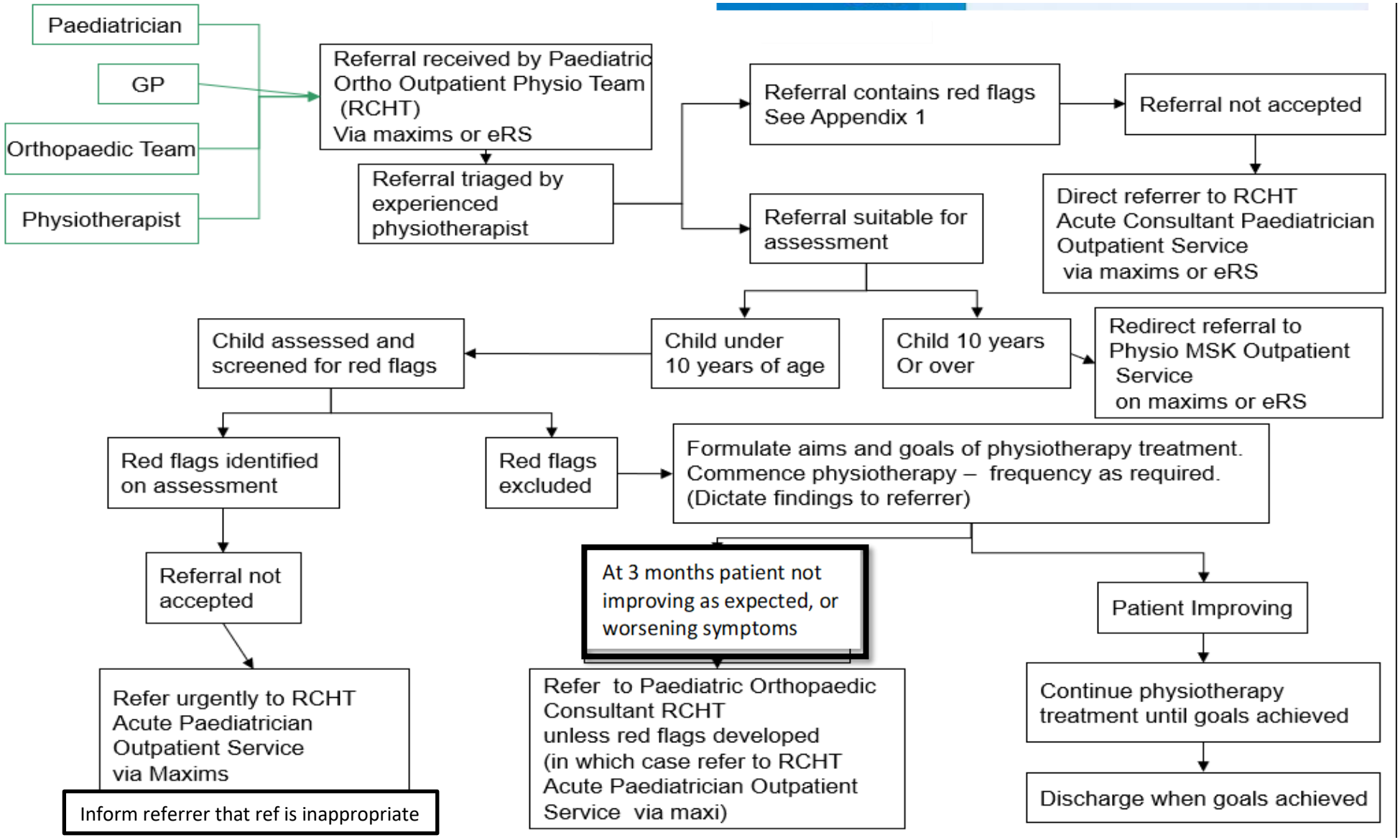
2.2.9. **Flow charts for physiotherapists triaging, assessing, and treating paediatric back pain**

To ensure the patient sees the appropriate health care professional at the appropriate time see flow charts 1 and 2 below.

Flowchart 1 - For physiotherapists working in the Physiotherapy MSK Outpatient Service – Paediatric Back Pain Referrals



Flowchart 2 - For physiotherapists working in the paediatric Orthopaedic Outpatient Service



3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Appropriateness of referrals received by the multi-disciplinary Paediatric Orthopaedic Physiotherapy team.
Lead	Clinical Leads, Paediatric Orthopaedic Physiotherapy Service.
Tool	Compare each referral received with this guidance. Audit and review tool using patient documentation.
Frequency	Each referral received will be monitored.
Reporting arrangements	Proforma response to be sent to referrer detailing reasons for return of referral.
Acting on recommendations and Lead(s)	Therapy Manager (Specialist Outpatient Operational Manager) to address persistent non-conformance (if identified) with the appropriate line managers.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within one month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Referral to the Paediatric Orthopaedic Physiotherapy Service Clinical Guideline V6.1
This document replaces (exact title of previous version):	Referral to the Paediatric Orthopaedic Physiotherapy Service Clinical Guideline V6.0
Date Issued/Approved:	May 2024
Date Valid From:	August 2024
Date Valid To:	July 2027
Directorate / Department responsible (author/owner):	Michelle Jackman, Clinical Lead Physiotherapist
Contact details:	01872 253824
Brief summary of contents:	Guidance for those wishing to refer to the Paediatric Orthopaedic Physiotherapy Service.
Suggested Keywords:	Paediatric orthopaedics, intoeing, outtoeing, flexible flat feet, normal variants, genu varum, genu valgum.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Dual Chief Nursing Officer / Deputy CEO RCHT
Approval route for consultation and ratification:	Therapies Senior Management Team Meeting
Manager confirming approval processes:	Clare Rotman
Name of Governance Lead confirming consultation and ratification:	Becky Osborne
Links to key external standards:	National Service Framework for Children, Young People and Maternity Services. Care Quality Commission Outcome 4 – Care and Welfare of People who use services.

Information Category	Detailed Information
	Click through to document
Related Documents:	1 Cappello T, Song KM (1998) 'Determining treatment of flat feet in children', Current Opinion in Pediatrics, vol 10, pp 77-81. 2 Staheli L (1989) Fundamentals of Pediatric Orthopaedics, 3rd Edition, London: Lippincott Williams and Wilkins. 3 Staheli L (1983) 'Intoeing and Outtoeing in Children', The Journal of Family Practice, Vol 16, no 5, pp 1005-1011. 4 Davis PJC, Williams HJ (2008) 'The investigation and management of back pain in children', Arch Dis Child Educ Pract Ed, vol 93, pp 73-83. Paediatric Back Pain Referral to the Musculoskeletal Physiotherapy Service at the Royal Cornwall Hospitals Trust Policy (on intranet). Association of Paediatric Chartered Physiotherapists (APCP) Guide to Good Practice for Physiotherapists Working with Children (2007). Click through to document APCP Advice Publications – "Flat Feet in Young Children" (2019), and "Intoeing Gait" (2015). APCP Advice Publications – "Head Turning Preference and Plagiocephaly" (2011). Department of Health publication - Birth to Five (2016) – Chapter 4 "How Your Child will Grow". Click through to document.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Physiotherapy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
20 October 2011	V1.0	Initial Issue	
14 October 2012	V2.0	Alteration of Consultant names to generic Orthopaedic consultant. Alteration of referral pathway to paediatric orthopaedic physiotherapy (now via Referral Management Service). Addition re routine hip scans. Alteration to curly toes 5th overlapping 4th. Addition to outtoeing referral criteria re trauma Insertion of picture of lateral border of foot. Under intoeing section.	Sarah Harvey
11 May 2016	V3.0	Alteration of consultant names to generic titles. Alteration of timescales to reflect change in service delivery and relevant clinical updates including related documents.	Alex Coker, Acting Service Lead
19 November 2019	V4.0	Alteration of Consultant names to generic Orthopaedic consultant. Update details of Ultrasonographer. Podiatry Department and Prosthetic Centre. Updated relevant clinical updates including related documents. Addition of Paediatric Orthopaedic Physiotherapy Referral table.	Michelle Jackman, Paediatric Orthopaedic Lead Physio
December 2022	V5.0	Full review. Transferred into latest Trust template. Updated information on referral routes. Highlighting that referrals for tip toe walking will be returned where a neurological status is not documented.	Sarah Harvey, Paediatric Orthopaedic Physio
May 2024	V6.0	Replacement of back pain guidance with new guidance taken from the amended 'Referral of Children with Back Pain to Physiotherapy Services at RCHT and CFT Clinical Guideline'.	Sarah Harvey, Paediatric Orthopaedic Physio

Date	Version Number	Summary of Changes	Changes Made by
August 2024	V6.1	Page 11 para 2.2.7.4.3 amended to state: 'Age 10 years and over - refer to 'Physiotherapy - MSK Outpatient Service' via maxims or eRS. Or if your practice has an in-house physiotherapist refer to them.'	Sarah Harvey, Paediatric Orthopaedic Physio

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Referral to the Paediatric Orthopaedic Physiotherapy Service Clinical Guideline V6.1
Directorate and service area:	Clinical Support / Therapies / Physiotherapy
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sarah Harvey, Paediatric Orthopaedic Physio
Contact details:	01872 253824

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Minimise inappropriate referrals to the Paediatric Orthopaedic Physiotherapy Service.
2. Policy Objectives	Ensure patients are seen by the most appropriate clinical service.
3. Policy Intended Outcomes	Reduced incidence of inappropriate referrals.
4. How will you measure each outcome?	Analysis of referrals received.
5. Who is intended to benefit from the policy?	Paediatric orthopaedic patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Paediatric Orthopaedics Consultants at RCHT. Disablement Services. AHP Therapies Clinical Governance Forum. Therapies CQAG.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sarah Harvey, Paediatric Orthopaedic Physio.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Summary of Referral Guidelines

Flat Feet	
Able to easily (and bilaterally) go up onto tiptoes (age appropriate). Arch present on tip toe. No tightness on ankle dorsiflexion. Normal neurology. No painful symptoms. No poor function, e.g. tripping / falling. Absence of associated syndromes e.g. Down's, Marfan's, Ehlos Danlos, hypermobility syndrome.	No treatment required. Referral to physiotherapy or podiatry is not appropriate. Consider issuing advice leaflet "flat feet in young children" available from the link on the referral management website.
Abnormal neurology	Refer to Consultant Paediatricians RCHT
Arch not present on tip toe. Asymmetrical flat foot. Significant pain affecting activities of daily living.	Refer to Consultant Paediatric Orthopaedic Surgeon RCHT.
Tightness on ankle dorsiflexion. Difficulty rising onto tip toes. Marked tripping / falling. Pain in knees or hips. Painful feet in child **under** 5 years of age.	Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
If child 6 years of age and older and any of following: Pain in feet or ankles /shins. Skin pressure lesions of feet / ankles. Excessive medial shoe wear causing poor function.	Refer to the Podiatry Department (CFT).

Curly Toes	
Asymptomatic curly toes.	No treatment required.
Pain, redness, callous formation, difficulty finding footwear.	Discuss referral with Cornwall Foundation Trust Podiatry department.
5th toe overlapping 4th toes and difficulty with footwear	Refer to Consultant Orthopaedic Surgeon.
In-toeing	
Curved lateral border of the foot. (Assess by holding a pen/pencil along the lateral border).	Curved Lateral Border of the foot indicates Metatarsus adductus. Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
Asymmetrical hip rotation or abduction with the hip at 90 degrees flexion.	Refer to Consultant Paediatric Orthopaedic Surgeon RCHT.
Intoeing associated with foot, knee, or hip pain.	Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
Out toeing	
Asymmetrical out toeing.	Refer to Paediatric Orthopaedic Consultant.
Symmetrical out toeing associated with pain in hips, knees, or feet.	Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
Normal Neurology.	Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
Tip-toe Walking	
Abnormal lower limb neurology.	Refer to the Consultant Paediatricians RCHT.
Tightness of Tendo Achilles / limited ankle dorsiflexion with normal neurology.	Refer to Paediatric Orthopaedic Physiotherapy Team.
Normal Neurology.	Refer to the Paediatric Orthopaedic Physiotherapy Team.
Back Pain	
Paediatric Specific Red flags present.	Refer to Acute Consultant Paediatricians RCHT.
Scoliosis or Kyphosis without other red flags.	Refer to Spinal deformity Service Exeter.
Absence of red flags. (Age under 10 years).	Refer to Physiotherapy Paediatric Orthopaedic Outpatient Service.
Absence of red flags. (Age 10 years and over).	Refer to Physiotherapy Musculoskeletal Outpatient Service RCHT/CFT.

Specific Red Flags in Paediatric Population:

History:

- Pre-pubertal children especially <5 years.
- Recurrent or worsening pain causing functional disability significantly affecting activities of daily living.
- Early morning stiffness and/or gelling.
- Night pain.
- Fever, weight loss, malaise.
- Postural changes: kyphosis or scoliosis.

Examination:

- Fever, tachycardia.
- Weight loss, bruising.
- lymphadenopathy or abdominal mass.
- Altered spine shape.
- Vertebral or intervertebral tenderness.
- Limp or altered gait.
- Neurological symptoms.

Reference: Davis PJC, Williams HJ (2008) 'The investigation and management of back pain in children', Arch Dis Child Educ Pract Ed, vol 93, pp 73-83.