Allied Health Professional case studies: Health inequalities

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Help Kids Talk – a community-wide initiative that aims to give every child the best start in life by prioritising speech, language and communication development

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Description

Help Kids Talk is a project within Early Intervention Lisburn (EIL) which is led by the Resurgam Community Development Trust (lead partners are the South Eastern Health and Social Care Trust (SEHSCT) Speech and Language Therapy Team and Early Intervention Lisburn).

The Help Kids Talk vision is that “everyone will work together to help kids talk”.

The project is a community-wide initiative and aims to ensure everyone who has any responsibility for a child prioritises speech, language and communication development whether you are a parent, grandparent, childminder or work in an organisation that provides services for children.

By prioritising early intervention and speech, language and communication, there will be a positive impact across all areas of a child’s life including: educational attainment, mental health and wellbeing, social relationships and employability later in life.

Context

Help Kids Talk aims to give every child the best chance in life by prioritising speech, language and communication development.

The purpose of Help Kids Talk is to:

- help children and young people to be the best they can be
- make it everyone’s responsibility
- make a difference together

Main priorities are:

- Highlighting options of support
- Working together

- Learning for all
- Improving the quality of services

Help Kids Talk was co-designed following the extensive research report ‘the Best for Every Child’ (Courtney, 2012) which highlighted the issues children and young people faced growing up in Lisburn. At that time, 74% of young people were leaving the post primary sector (excluding Wallace and Friends) without 5+ GCSEs (including English and Maths). In 2013, a prevalence study carried out by the SEHSCT Speech and Language Therapy team indicated that 32% of children entering primary one in 9 schools in Lisburn had a mild to severe speech, language, and communication problem, of which, 74% were boys from disadvantaged areas (Jordan & Coulter, 2016).

Method

There are 4 main strands to Help Kids Talk:

1. 12 key messages were developed to support speech, language and communication. The ‘message of the month’ is circulated via email and social media as guidance to parents, caregivers and those working with children.

2. Basic Awareness Training was developed and is delivered on a monthly basis online. This aims to raise awareness of the importance of speech, language and communication for everyone who has any responsibility for a child. In the Basic Awareness, the 12 key messages are linked with Kate Cairns Associates five to thrive building blocks to highlight the connection between infant mental health, brain development and communication development. Further training is in the process of being co-designed and co-produced.

3. The ICAN (Speech and Language UK) programme, ‘Early Talk Boost’ is available in 11 playgroups and nurseries in Lisburn. It improves children’s attention and listening and their understanding of words and sentences. It also improves speaking and communication.

4. The ICAN programme, ‘Talk Boost’ is available in 14 primary schools in Lisburn. It can boost children’s ability in conversations, sentences, storytelling and social interaction by an average of 9 - 18 months.

Help Kids Talk is a partnership led jointly by the SEHSCT Speech and Language Therapy team and Early Intervention Lisburn. It is based on the successful ‘Stoke Speaks Out’ model of delivery which was set up in Stoke-on-Trent to help the high number of children with speech difficulties, by training parents, carers and families. After a seven year journey, the project was officially launched in March 2020. It is currently funded by Lisburn and Castlereagh City Council.

The steering group is comprised of representatives from community, voluntary, statutory and private sectors including: Public Health Agency, SEHSCT, Northern Ireland Childminding Association, Libraries Northern Ireland, Barnardo’s, Sure Start and staff from the local schools and nurseries.

There are connections with parents and carers through 37 partners (early years’ settings, playgroups, nurseries, and primary schools), social media, training, and a parent representative group.

Throughout the planning, implementation and development of Help Kids Talk, there has been a strong emphasis on co-design and co-production. The steering group and the parent representative group members have provided valuable insight and experience to inform the decision-making process. This co-production has strengthened the project and ensures we are achieving our overall vision of everyone working together to provide better outcomes for our children and young people.

The project collates data on:

- social media engagement and growth – this is collated on a monthly basis through Twitter, Instagram and Facebook analytics so we can measure what posts are relevant for our audience and measure the reach of the project through social media platforms
- number of people attending Basic Awareness training and the difference it has made – this is collated using a registration form, a training database and an online survey
- number of children and number of settings who have completed targeted programmes (Early Talk Boost and Talk Boost) and the difference it has made – this is collated through an ICAN and Help Kids Talk report at the end of every academic year

Measuring outcomes at population level for early intervention is difficult however there is a commitment from partners across all sectors to provide sustainable support to ensure our children and young people have the best chance in life.

Outcomes

Social media

Help Kids Talk has over 3000 followers across Twitter, Instagram and Facebook (**79% increase** since August 2020)

Social media feedback:

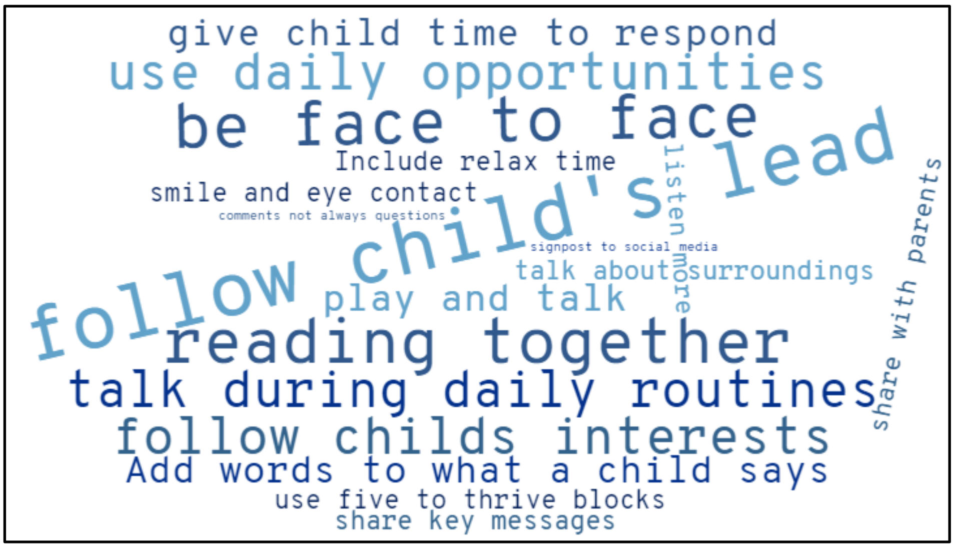
- *"I love reading all the insta posts as at 16mths my son was literally saying nothing so I felt myself reading all your posts about speech and development and was able to relate to a lot of them…he is now stringing sentences together*!"

Basic Awareness Training

725 individuals have attended Basic Awareness training since January 2020. Before training, **48%** participants rated themselves as mostly confident/confident supporting speech, language, and communication, this figure rose to **80%** after training.

Feedback following Basic Awareness training:

- *"I cannot thank you enough for creating that course last night. You were so engaging and everything I learned I have been implementing already at home and in playgroup"*
- *"I can now show these slides to hubby to show him I haven't completely lost it when I sing about her nappy as we change it"*
- *"This presentation highlights the importance of constant chat with wee ones and encourages everyone to develop talking skills"*



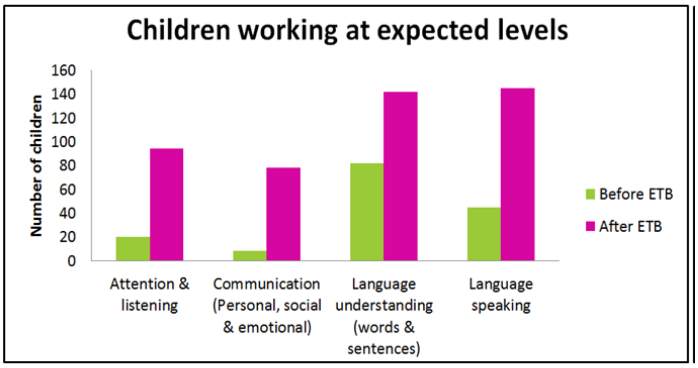
Word cloud showing strategies participants will use to support speech, language and communication skills following Basic Awareness.

Targeted programmes

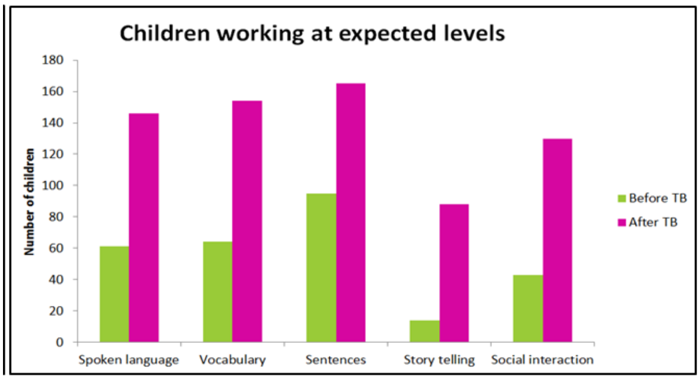
Just under **400 children** have received targeted support to support their speech, language, and communication. The graphs* below show the impact this has made for those children (*based on 203 children who have completed Early Talkboost and 179 children who have completed Talkboost from September 2016 to July 2021; this includes some pilot work pre-launch).

Help Kids Talk partners are supported to embed speech, language and communication support into their core work. In doing this, we create sustainable support for children's communication development. The link between infant mental health and speech, language and communication is a priority within the project. Creating better opportunities for bonding, attachment and communication leads to long term positive impacts for children's mental health and wellbeing.

Early Talk Boost



Talk Boost



Investment in the provision of training and resources to our partners ensures children receive intervention as early as possible and reduces potential future education or healthcare costs. For example, a child in one of our local nurseries was identified as a candidate for special educational needs (SEN) provision. His speech, language and communication skills were supported by nursery staff, he completed Early Talk Boost and was given a place in a mainstream primary school. In primary school, he continued to receive support for his speech, language and communication and completed Talkboost. As a result, the child has remained within mainstream education and has not required a place within SEN provision.

Key learning points

Help Kids Talk developed a bottom-up approach by bringing together partners from across community, voluntary, statutory and private sectors to collectively plan and make shared decisions to improve outcomes for children and young people.

This partnership-working has moved organisations from working in silos to working together and will provide long-lasting benefits to those living within our local communities.

Sustainability has been a driving force right from the beginning of the project and all training and support provided is looked at through the implementation within core provision.

Further aims have been identified, eg the development of a project like Help Kids Talk to help and support all children in need including ethnic minorities and children with a disability such as autism, learning difficulties.

References and useful links

Courtney, R. (2012) *The Best For Every Child Report*

Jordan, J.A. & Coulter, L. (2016) Individual Differences in

Speech and Language Ability Profiles in Areas of High Deprivation. *Child Care in Practice*. Available from: doi: 10.1080/13575279.2016.1188759

http://www.stokespeaks.org

https://fivetothrive.org.uk

https://ican.org.uk/training-licensing/i-can-programmes/early-talk-boost/

https://ican.org.uk/shop/talk-boost-ks1-intervention-pack/

http://www.facebook.com/helpkidstalk/

http://twitter.com/HelpKidsTalkNI

Orthoptic Public Health example. Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Domiciliary Orthoptic Assessments for patients unable to attend the Hospital Eye Service after a stroke or who have a neurological disorder

Understanding the problem

Domiciliary visits are common practice in therapy professions such as occupational therapy, physiotherapy and speech and language therapy following stroke and other acquired brain injuries, enabling patients to have a smooth transition from hospital back into their homes, and giving those with limitations to attending hospitals the ability to access services.

In Warrington and Halton, patients who are discharged home from hospital who need ongoing therapy have up to 6 weeks of continued therapy from the Early Supported Discharge (ESD) team of occupational therapists and physiotherapists, and are then referred onto the community neurotherapies team.

Up to 60% of stroke patients have a visual complication which may persist when they leave hospital. If pre-existing visual problems are taken into consideration, this increases to 72% of patient (Rowe, 2016). Many patients with Parkinson's Disease (PD), Multiple Sclerosis (MS) or who have other neurological conditions may also have visual and ocular disorders such as diplopia (double vision) related to their condition. These visual problems can affect their ability to perform activities of daily living, increase their risk of falls, and affect their emotional well-being.

Across the country unfortunately Orthoptic assessments are not routinely offered at home, with assessments normally limited to ward based testing and outpatient clinics. This is not an equitable service for all patients and no reasonable adjustments are made for patients unable to make it to the hospital. The patients who are house bound have assessments limited to optometrists and sensory support teams, leaving them without a Specialist Orthoptic assessment for diagnosis and management of their condition.

Since March 2015, Orthoptists employed by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHHFT) offer and provide Orthoptic assessments at home for those patients who cannot attend an outpatient clinic and would otherwise be left untreated and unsupported.

Aims and Objectives

1. To provide equitable access to orthoptic assessments for all patients who require the service in the Warrington, Widnes and Runcorn area.
2. To spread awareness of the service to encourage other orthoptists to offer the service elsewhere in the country.
3. To meet Royal College of Physicians Guidelines for stroke (2016) providing clinical pathways for ongoing support after discharge.

Method and approach

Since March 2015 Orthoptists have been part of the stroke service within WHHFT. They undertake both ward-based and outpatient assessments, and home visits. Patients with an identified barrier to attending the hospital for an outpatient appointment are offered an assessment and treatment at home by an Orthoptist.

The service has been well received from patients and colleagues in multiple disciplinary teams (MDT), and we have built good relationships and also receive referrals from Parkinson's nurses and MS nurse teams locally.

In 2018 we conducted a small retrospective audit of patients seen for an orthoptic domiciliary assessment and collected feedback from service users and colleagues in the ESD team.

Patients in which there is a barrier to attending hospital are offered a home visit. They include;

- Patients with transport issues such as family not yet equipped to bring them to hospital, those who find the journey too tiresome due to their condition, or those who are bedbound and an assessment at home is more important in their normal environment
- Patients with a cognitive impairment who find the busy and complex hospital environment distressing.
- Those patients in care homes as giving assessments and advice at the care homes is a large part of a patient's rehabilitation and adaptation to their visual impairment.

Results and evaluation

We completed a small retrospective audit of orthoptic home assessments from 1st September 2017 – 31st August 2018.

Out of 402 patients seen by the orthoptic stroke and neurological team 22 patients had a home visit (5.4%). 20 of the patients had a diagnosis of Cerebrovascular Accident, 1 Parkinson's Disease, 1 MS.

The average age at time of assessment was 78.8 years.

17 of the patients required only one home visit. This was because of improving or declining health, or as they had recovered and did not require follow up.

The visual impairments found were;

- visual field defects (11)
- visual inattention (7)
- eye movement problems/double vision (7)
- nystagmus (4)
- visual perception problems/visual hallucinations (2)

All patients received targeted advice relating to their condition, including a personalised vision passport and leaflets. Where appropriate the advice was extended to the wider MDT especially in the case of care homes, and to the patient's family. Three patients had their diplopia (double vision) treated with prisms at home. Two patients were registered as sight impaired without attending the hospital, giving them access to services they required. Six patients had ongoing visual field and visual inattention therapy continued at home following their discharge and therapy on the stroke ward. We made onward referral for 10 patients (45%) to domiciliary optometrists, visual impairment teams, and the ophthalmology department for those who needed assessments from other services. If this service would have been unavailable, the patients would have had assessments from domiciliary optometrists and visual impairment teams, with telephone support from Orthoptists, however the specialist support, assessment and treatment options from an Orthoptist would have not been possible without home assessments.

During this audit we collated comments from patients and colleagues experiences of the service;

- "Great service…great that sight was taken into consideration at intermediate care home after discharge and feedback given to family who live far away and the next care home in Norfolk. I recommend the service".

- "We couldn't have got to hospital, if that option wasn't there, there was no other option".

- "It was a huge help. She was very immobile at the time and it was very difficult when we tried to get to hospital in an ambulance".

- "Service has been extremely helpful and helped with other aspects of my rehabilitation".

- "Her eye problem was picked up very quickly…everything has been done to make her life easier including referral to assisted living team. Can't fault the service, personnel or attention given to Mum".

- "It helps us as therapists to better treat our patients if we know they have received a thorough assessment of their vision…I can look at the leaflet you provide which summarises your findings. This helps us be able to plan functional assessments and treatment more effectively…allows the patient to be seen in their familiar environment; giving them opportunity to discuss more realistic problems and difficulties."

Key learning points

Offering this service ensures that patients have equitable access to Specialist Orthoptic assessments and treatment. It aligns orthoptic services with other therapy teams working with patients with a stroke, or other neurological impairment.

Ensuring the orthoptists have a lone worker policy and risk assessment in place and any risks attached to the home are communicated.

Plans for spread

1. To continue to advertise the service locally in order for all those who require the service to have access to it.
2. To share this example of good practice so that other orthoptists can evolve their practice to respond to the changing needs of the patients (NHSE, 2017), developing in-reach support models of rehabilitation (NHSE, 2014), and to continue to step outside traditional boundaries to transform care (NHSE, 2017).

References

NHS England (NHSE) (2014). Five Year Forward View. London: NHS England.

NHS England (2017). AHPs into action: using allied health professionals to transform health, care and wellbeing.

Public Health England (2015). A strategy to develop the capacity, impact and profile of allied health professionals in public health 2015-2018. London: Public Health England and the Allied Health Professions Federation.

Rowe, F. Hepworth, L. Hanna, K. Howard, C (2016). International Journal of Stroke , Vol. 11 (Suppl. 4), pp.7-8

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The added value of art therapy practice within maternity and perinatal parent-infant mental health

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Practice description

Art therapy within maternity and perinatal parent-infant mental health (PPIMH) is a developing area of practice in the UK (Hogan et. al, 2017). This therapy uses artmaking to explore emotional difficulties such as anxiety in pregnancy or postnatal depression. It focuses on improving relationships between parents and their babies up to twenty-four months. A systemic and psychologically dynamic approach ensures a broad therapeutic space for exploring family environments and the deeper transgenerational relationships between parents and their baby's developing personality (Jones, 2019). This model reflects the philosophy of the department where this study was conducted.

Arts in PPIMH features in government reports, such as the Creative Health Inquiry Report (2017) and Arts in Health Evidence-based Interventions (WHO, 2019). The vitality featured in art therapy complements the cultural, socio-economic, and neurological diversity of this demographic. The physical and mental changes that come with pregnancy invite a holistic approach including the arts, mindfulness, and yoga. All have been found to have good economic outcomes for perinatal mental health (Bauer et. al., 2016). The kinesthetic qualities of artmaking (see Elbrecht, 2013) can help subdue emotional and psychological distress resulting from deeply traumatic perinatal experiences. Its sensory methodology helps to regulate attachment transmissions by providing a bi-directional space that encourages bonding and reflective function (Bruce, 2020).

Pandemic context

One in five mothers experience a spectrum of anxiety and depression during the perinatal period (Creative Health Inquiry Report, 2017). A post-pandemic report suggests this figure is now higher (Babiesinlockdown, 2021). The pandemic has also impacted fathers/partners. Women from disadvantaged socio-economic backgrounds are three times more likely to suffer perinatal illness than others in the UK. Black minorities and Asian populations have been most severely affected by the pandemic (Papworth et al., 2021). In 2017, perinatal depression was estimated to represent a long-term cost to UK society of £8.1 billion per annum (Creative Health Inquiry Report, 2017). There has since been an increase in the availability of perinatal services across some parts of the UK, but isolating effects of lockdowns have been particularly stressful for vulnerable women with babies (Papworth et al., 2021). Stigma is a significant barrier to seeking help. It is therefore likely that many perinatal illnesses remain untreated (Broadhurst et al., 2017). Some women are afraid to accept help fearing their baby may be removed from their care or they will be judged as not *good enough* parents (Papworth et al., 2021). Jones aptly uses the phrase '*illness of trust*' (Jones, 2021).

Study context

A six-month art therapy service review was completed within the author's PPIMH department in 2017. The aim was to help commissioners and professionals understand the benefits of art therapy in this field. Service user feedback was analysed. The findings were later published (Bruce & Hackett, 2020). It is summarised here with a focus on wider determinates and health improvements from including art therapy within perinatal mental health services.

Referrals to the department came from professionals working within the field. The annual referral rate was 1100 at the time of the review. Art therapy was a one-day-per-week service. Referrals were discussed at weekly multi-disciplinary team meetings. Twelve referrals were accepted for art therapy during the review period. Nine led to face-to-face assessments. Presentations included symptoms of anxiety, perinatal depression, posttraumatic stress disorder and self-harming behaviours. Parent-infant bonding issues were predominant. Some women were pregnant, others had babies up to ten months old. Five were from ethnic minorities, four were white British. English was a second language for four women. One used an interpreter. Three families received social care. Five were from low-income, temporary, or overcrowded households. Therapeutic support was offered to fathers. One requested it. Partners were encouraged to attend a father's group run by the department. Five women received psychiatric services. Seven attended community groups with their babies whilst pursuing art therapy.

Method

Interventions for the nine women and babies took place in the department's creative therapy room. This was made to feel bright and cheerful. The windows looked out onto green shrubbery. The service also arranged home appointments. Parent-infants were offered weekly ninety-minute sessions. Forty-eight of sixty-eight sessions were attended. This was above average for the department at the time of the review. Intervention length ranged from six-weeks to beyond twelve months. Sessions began with yoga or mindfulness exercises followed by time for artmaking. Art materials were available and could be used freely within the space. The floor was the most common place for activity. This invited mother-baby interaction when a baby was present.

The process of artmaking sometimes aroused memories that reminded women of their own adverse experiences of being parented. This could be a concern, but often generated opportunities for the therapist to help the parent unpack what was recalled, encouraging inter-relational repair and positive moments of mother-baby connection. Session-by-session risk management was paramount in treatment planning. Mothers' own words were used to describe desired intervention outcomes. Six-weekly reviews helped parents recognise how well they were progressing. This promoted resilience in parenting ability. Interventions were delivered by a fully qualified art therapist with post-graduate qualifications in infant mental health.

Service-user experiences

Two questionnaires were designed to facilitate the service review. These were self-reporting and used to gather views and experiences of the nine women. The British Association of Art Therapists' research officer was consulted in developing the questionnaires. PPIMHS Strategic & Clinical Lead guided the sensitive quality of the questions for this population. The first included twelve closed questions asking about general experiences of the art therapy service. Answer choices included *very* *true*, *partly true,* or *not true*. The second included ten questions about the women's therapeutic experiences. This aimed to capture moods and feelings recalled from the intervention. A selection of twenty *feeling* words such as *afraid, worried, anxious, relaxed, comfortable,* and *calm* appeared on the sheet. Women could circle words that most accurately matched their feelings before and after the intervention. Room was left for additional comments on each sheet. Eight of nine mothers returned completed questionnaires.

Table 1 highlights the proportion of women who measured *very true* in relation to aspects of their general experience (questionnaire 1). Table 2 highlights the proportion who measured *very true* in relation to aspects of their therapeutic experience. Table 3 highlights the women's most circled *feeling words* in relation to *their* therapeutic experience (questionnaire 2).

No. of mothers	Statements in relation to mothers' general experience of the art therapy service
7/8	I feel that the person who saw me / me and my baby listened to me
7/8	It was easy to talk to the person who saw me / me and my baby
5/8	I have been given enough explanation about how art psychotherapy can help
7/8	The creative art therapy room is comfortable
7/8	The art materials were appropriate
2/8	It is quite easy to get to the place where the appointments are held

Table 1.

No. of mothers	Statements in relation to mothers' therapeutic experience
4/8	Art therapy provides or provided me with an alternative way of communicating.
4/8	During art therapy I felt my mood change for the better following session 1.
3/8	During art therapy I felt my mood change for the better following session 3.
5/8	During art therapy I felt my mood change for the better following session 6.
4/8	The review(s) during the art therapy intervention was/were useful.
6/8	Art therapy is helping or has helped me to understand myself and my problem(s) better.
3/8	Art therapy is helping or has helped me to understand my baby's needs and improve my relationship with my baby.
7/8	The room/environment is helping or has helped me to feel comfortable about sharing my thoughts and feelings.
6/8	The art materials are helping or have helped me to express how I feel.

Table 2.

No. of mothers	Most circled feeling *words from questionnaire 2*
6/8	Before: *worried, anxious, and afraid*
5/6	After: *stable, relaxed, comfortable, and calm*

Table 3.

The results demonstrated that women felt their views and anxieties were considered. Six of eight thought art therapy helped them grasp an understanding of their problems. This ratio suggests that art therapy may offer a generous section of the public a more relaxed way of speaking about their troubles. Half of the women said they appreciated being offered an *alternate way of communicating*. This suggests that art therapy may offer marginalised sectors of the population diverse and inclusive ways to feel valued and understood, particularly if English is not their first language. Feeling understood increases resilience and confidence. This has potential to impact on other aspects of women's lives, for instance in developing creative abilities or pursuing new ways of developing careers balanced with parenting. Half the women experienced positive mood changes following initial sessions. Mood changes may have been influenced by prescribed medication. Three women claimed that art therapy helped them understand their baby's needs. Whilst women didn't always perceive bonding and attachment as a central issue, some said that they did not want to parent their babies in the way that they had been parented. Their drawings reflected this and helped them to see things from their baby's perspective. This can also substantiated by the women's written feedback. Empathy and compassion for others is impactful for society. It can positively affect the health and well-being of future generations. Attendance at parent-infant groups and/or other treatments received concurrent to art therapy could have prejudiced these views. Circumstantial and broader environmental factors may also have influenced change. Samples of women's feedback included:

"drawing gives me memories to put right [in the mother's mind] *and help*[ed]*…me and my baby…it helps me think about my baby's feelings"*

"making things relaxes my anxiety"

"It [art therapy] *jogged me back into thinking 'I can cope without a service'."*

"I looked forward to…art therapy."

These examples suggest women found the art therapy space relaxing. A place where feelings could be held, and anxiety reduced, promoting trust, positivity, and resilience. Women said they felt inspired to find alternative ways to combat anxiety, such as joining craft groups, or spending more time walking in nature. These healthy life-style choices helped one woman become less reliant on services, thus providing an example of reducing wider socio-economic costs.

One woman attended weekly art therapy sessions with her baby over a six-month period. She willingly granted permission to publish her personal story, keen for others to benefit from this approach. Vignette one describes the woman's perception of her background and how this influenced her current mood relating to her baby. The second summarises positive changes gained from the therapy. The final vignette features her responses to a third questionnaire developed to guide an interview approximately six months after the intervention. Vignettes capture her views and experiences of art therapy and the effect this had on her relationship with him. A pseudonym is used here.

Vignette one

In the first months of art therapy, Sandra used drawings to describe how her parents suffered from addiction to alcohol. She was often shut in a bedroom for hours at a time and spoken to in a humiliating and derogatory way. She said, this made her childhood feel frightening and confusing. She described suffering from depression. As a teenager she attempted suicide. Sandra accepted this art therapy intervention shortly after the birth of her fifth baby. She also admitted to suffering depression during previous pregnancies.

The therapist noticed that Sandra hardly looked at her baby during session one. Baby lay quiet and still whilst Sandra spoke of feeling *"lost, isolated and worse than ever before"*. She said how hard it was to feel positive about her baby. Sandra used clay to create the image of a baby (Figure 1).

Figure 1.

Pushing her efforts aside, she said she felt *"useless".* In a different session she scratched an image of herself hidden in a box. The box lay beneath her "*overpowering"* father whose face she *"couldn't think about"*. Sandra appeared unaware of how these memories affected her feelings and prevented her from encouraging her baby to thrive. The therapy enabled her to discuss how she may have unknowingly wanted her baby to feel robbed of affection, like she had felt robbed.

Vignette two

During month three, Sandra began making connections between her images and her childhood suffering. She grew more trusting of the art therapy process. Her confidence increased. She began using whole arm movements to draw across an expanse of paper on the therapy room wall. Sandra created a cohesive visual story of the *"rubbish"* she said was "*suffocating her mind*". She exercised her imagination, creating space to think of how her baby could be stimulated. Their relationship became increasingly animated. She began prioritising his needs. He gradually reached for toys, like Sandra reached to draw with her hands.

Vignette three

During the subsequent interview, Sandra said *"having someone listen and witness my story in a non-judgmental way helped me learn to trust"*. She reflected on images made during the intervention and described how her self-understanding had helped her feel more able to meet her baby's emotional needs. She said this shift came through her hands [kinaesthetic] and through the space available to *"sick out her feelings in art therapy".* She spoke of the "*joy*" she now sought internally and the hope she held for her baby's future.

Outcomes and learning

Research into perinatal parent-infant art therapy is limited (Bruce & Hackett 2020, Hogan et al, 2016). However, this study offers an example of how the cost of perinatal depression to UK society could be reduced. Bauer et al. suggest that increased access to treatment for common maternal mental health problems could provide a net benefit of half a billion pounds (2022). Further studies are needed to examine the reliability and validity of art therapy within this field. Nevertheless, these findings reveal the importance of considering the mental health and well-being of parents and their immediate environment in developing their baby's personality. This innovative approach forms a creative space for parents and babies to thrive together while considering inter-relational repair. This inclusive and diverse approach may also positively contribute to intergenerational health improvements in individuals, communities, and wider society.

As part of the NHS Long Term Plan for perinatal services, the Trust where the review was conducted successfully bid to develop a community maternal mental health service to reach women suffering from posttraumatic stress disorders and perinatal traumas such as sub-fertility, miscarriage, still birth, traumatic birth and loss of a baby through removal by social care (https://www.england.nhs.uk/2021/04/dedicated-mh-services/). Art therapy is being integrated into its forward-looking strategy. This is also reflected in the development of other community teams across England.

References

Bauer, A., Knapp, M. & Adelaja, B. (2016). Best practice for perinatal mental health care: the economic case recommendations. *Personal Social Services Research Unit (PSSRU): London School of Economics.* Available at: https://www.pssru.ac.uk/pub/5226.pdf (Accessed: 9th April 2022).

Bauer, A., Tinelli, M. & Knapp, M. (2022). *The Economic Case for Increasing Access to Treatment for Women with Common Mental Health Problems During the Perinatal Period*, Care Policy and Evaluation Centre, London. Available at: https://www.lse.ac.uk/cpec/assets/documents/CPEC-Perinatal-Economics-2022.pdf (Accessed: 9th April 2022).

Babiesinlockdown, (2021). Best Beginnings, Home Start & Parent-Infant Foundation. Available at: https://babiesinlockdown.files.wordpress.com/2021/11/no_one_wants_to_see_my_baby.pdf (Accessed: 9th April 2022).

Broadhurst, K., Mason, C., Bedston, S., Alrough, B., Morriss, L., McQuarrie, T., Palmer, M., Shaw, M., Harwin, J. & Kershaw, S. (2017). Vulnerable Birth Mothers and Recurrent Care Proceedings, Final Summary Report. *Lancaster University and Centre for Child & Family Justice*, 3rd October. Available at: https://www.nuffieldfoundation.org/sites/default/files/files/rc-final-summary-report-v1_6.pdf (Accessed: 9th April 2022).

Bruce, D. (2020). ‘Cases on the border: perinatal parent-infant work involving migrants, video analysis and arts psychotherapy’. In: *Therapeutic Arts in Health, Pregnancy Birth, and new Parenthood* by S. Hogan, (Ed.). Jessica Kingsley Publishers: London https://www.taylorfrancis.com/books/e/9781003027607/chapters/10.4324/9781003027607-16

Bruce, D. & Hackett, S. S. (2020). Developing art therapy practice within perinatal parent-infant mental health. *International Journal of Art Therapy,* https://doi.org/10.1080/17454832.2020.1801784

Creative Health Inquiry Report (2017). All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry Report, *Creative Health: The Arts for Health and Wellbeing*., *6.1, Perinatal Mental Health, 6.2, Gestation and Birth, 6.3, Early Childhood Development*, July. Re-evaluated from ‘Fair Society, Healthy Lives’ 2010 report. Available at: https://ncch.org.uk/uploads/Creative_Health_Inquiry_Report_2017_-_Second_Edition.pdf (Accessed: 9th April 2022).

Elbrecht, C. (2013). *Trauma Healing at the Clay Field, a sensorimotor art therapy approach*. London: Jessica Kingsley Publishers.

Hogan, S., Sheffield, D. and Woodward, A. (2017). ‘The value of art therapy in antenatal and postnatal care: A brief literature review with recommendations for further research’, *International Journal of Art Therapy,* 22:4 169 – 179.

Jones, A. (2021). *‘Illness of Trust’*. Presented at The Pandemic and Beyond: how professionals can respond to babies’ needs and support parenting practice which enables infants to thrive. *International Training School for Infancy and Early Years (ITSIEY)* conference, Anna Freud Centre: London. (Unpublished, copyright training material delivered 22nd April).

Jones, A. (2019). ‘When working therapeutically with a baby’s father is not possible’. In: *Working with Fathers in Psychoanalytic Parent-Infant Psychotherapy* by T. Baradon, 2019 (ed.) pp. 50 - 63. Routledge: London and New York.

Papworth, R., Harris, A. Durcan, G., Wilton J. & Sinclair, C. (2021). Maternal mental health during a pandemic, A rapid evidence review of covid-19’s impact. Centre for mental health. Available at: https://www.mindwisenv.org/media/2387/frcentreformh_maternalmhpandemic_fullreport.pdf (Accessed: 9th April 2022).

W.H.O. (2019). *Health Evidence Network Synthesis Report 67. What is the Evidence on the role of the arts in improving health and well-being? A scoping review.* (p.12: 2.1.2 and 2.1p 34) Daisy Fancourt, Saoirse Finn. Available at: https://apps.who.int/iris/bitstream/handle/10665/329834/9789289054553-eng.pdf (Accessed: 9th April 2022).

Art therapy in a range of gallery-based arts interventions for the wellbeing of parents and infants

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Description

‘Art at the Start’ is an ongoing project offering a range of arts-based interventions to promote the mental health and wellbeing of parents and their infants (aged 0-3 years). We have a particular focus on reaching families vulnerable to poor attachment relationships and who may be facing multiple deprivations and mental health difficulties. These target groups are also likely to be under-represented within cultural spaces. It is a collaborative research project between University of Dundee and Dundee Contemporary Arts (DCA), led by an art therapist. The art therapist delivers a spectrum of approaches to improve parent and infant wellbeing within the gallery space. These include art therapy sessions to support poor attachments and mental health through targeted referrals, public messy play sessions to encourage families to engage in interactive play through shared art making and art boxes for use at home to support vulnerable families during COVID-19 lockdown.

Context

The wellbeing of parents and infants in the early years has profound implications for the health of both parent and child. Positive interactions in attachment relationships promote infants’ emotional well-being, capacity to regulate, sense of self and brain development (Belsky, 2001) while there is growing recognition of the importance of parental mental health on the attachment process (Murray et al, 2010). An estimated 10-20% of women develop a mental health condition whilst pregnant or in the first year of a baby’s life which, in addition to the impact on the mother, will likely impact upon their capacity to form optimal attachment relationships. Pre-existing mental health conditions such as anxiety or other social circumstances such as isolation or domestic violence can also impact upon early attachments.

In the locality in which we work, families face multiple disadvantages. These include a higher percentage of first-time mothers under 19 than the national average, more parents living with long-term physical or mental health issues and an estimated 30.1% of children in Dundee live in households that experience both low income and material deprivation. These additional stressors impact on the wellbeing of the parent-infant dyad. Crucially there are currently no psychological therapies available for perinatal mental health locally, so we wanted to enhance the available provision.

Dyadic interventions can help to improve early relationships and mental well-being and improvement to the quality of attachment relationships may have a mitigating effect on the impact of poor post-natal mental health. There is promising evidence for the use of art therapy in the context of dyadic intervention, for parents and infants together (Armstrong & Ross, 2020).

Our project aims to build strong attachment relationships by maximising the opportunities for parents and infants to have positive interactive experiences together during art making and by supporting mental wellbeing. By embedding an art therapy service within a gallery, a public building with visible creativity and a social community space, and by providing a spectrum of art-based activities, the art therapist is better able to meet the needs of a diverse range of families. We can offer the support that is most appropriate to a family's needs; for those who are vulnerable this may be containment and support, while others may just need the encouragement and space to engage in art making with their child. At both ends of this spectrum we are seeking to enhance wellbeing through dyadic art making.

Parent-infant art therapy groups support dyads to engage in playful art making together which helps encourage positive interactions, whilst giving therapeutic support to parental wellbeing, encouraging attuned responsive parenting, and increasing behaviours which build secure attachments. Messy play sessions open to all parents and infants aged 0-3 years encourage engagement with the gallery and more shared art making, giving parents ideas and infants new experiences and potential for connection through art making. The Home Art Boxes support families while we are unable to see them in person by providing materials and encouragement for parents to try art making with their infants at home.

Method

- **Art therapy groups** focus on parents and infant dyads aged 0-3 who may be vulnerable to low wellbeing and to attachment difficulties, referred by health visitors, family nurses, social workers and voluntary agencies. We offer 12-week group art therapy in the gallery, with around 8 dyads in a group, focused on supporting them to engage together and using the new art experiences as a way to build their communication and the parent's attunement and responsiveness. They have space to make art together and to reflect. The therapist provides containment, both in practical terms by holding the boundaries of the sessions and in psychological terms by helping to manage difficult emotions that arise. The art therapist may need to scaffold interactions for an infant if a parent is not managing at that time, while redirecting towards positive dyadic interactions. The art process itself is central, with the joint making helping to draw the dyads together into interactions with a shared focus of engagement. Exploring new materials together gives numerous opportunities to encourage parents to reflect back how infants may be feeling and to be responsive.

(All images in this case study are included with permission from parents/guardians)

- A second strand runs for the general public, offering gallery based **messy art making sessions for ages 0-3 years and their parents**. These open sessions draw upon current exhibitions as a jumping off point for creative exploration. These are not intended to be therapy, but they do draw on the learning from the art therapy strand of the project to develop activities which best encourage positive interactions between parent and child. These sessions have an added benefit of offering art activities that parents and children who have attended a block of art therapy may wish to move on to. We are undertaking outreach by running further art activities within the community with marginalised groups as a way of broadening participation in these public sessions. These include sessions for a number of voluntary organisations who work with women from Ethnic Minority communities, refugee women and families facing deprivations.

- A third strand of **Home Art Boxes** has been added to our activity in the wake of the coronavirus pandemic to work with families remotely. While we were putting regular creative activities online for families to access, we were aware that these may not reach our target families where the impact of digital exclusion during the pandemic has only exaggerated inequalities in children and families' access to the arts. As well as online arts content relying on families having the financial security to possess sufficient digital access, some of this activity potentially requires having a range of arts-and-crafts materials at home. Even when this is not a requirement it may still be a perception, putting off families who face deprivations. In addition to physical resources, the use of online arts content requires less tangible resources within the family unit; significantly an adult needs to have capacity (both in terms of time and mental wellbeing) to make it available for children. Knowing that families were struggling with low wellbeing over this time, particularly those with pre-existing vulnerabilities (Gassman-Pines, 2020), we began a project to support families by delivering Home Art Boxes. These contained art materials, information on why art making is beneficial and instruction worksheets to guide them through a series of creative ideas with variation for age and stage, aimed at enhancing opportunities for playful parent-infant interactions. Families who would benefit from this are referred by health or voluntary agencies where there are worries about the wellbeing of a parent and infant and it is felt that the relationship could be supported by encouragement to play together through art making at home. In addition, many of the families referred would not be able to access the art materials themselves due to financial constraints. The Art Boxes give parents practical help by providing resources alongside the encouragement to give it a try. This increases their opportunities for positive playful interactions and can help them feel connected to each other and supported by the project.

Outcomes

We use a mixed methods approach to collecting outcomes data as we operate across a range of contexts, from referred families where we have several months of involvement to families who we see as members of the public for a one-off session.

The questions we ask vary across the activity; in art therapy sessions we look to evaluate clinical outcomes, whereas in public sessions we are interested in more general improvements in parents' engagement in creative play with their children. Each aspect of the project is informed by the others, thus the attachment outcomes from art therapy sessions have influenced the activities offered in the art boxes, and activities with positive feedback from parents at public sessions may inspire activity suggestions within art therapy. Researching outcomes is integral to our project and we have ethics approval from the University of Dundee.

- Our collection of quantitative data from **art therapy** uses pre and post intervention measures on perception of the relationship and on parental wellbeing as well as analysis of video footage of interactions from the first and last session to look for changes in behaviour. Outcomes from our piloting of the art therapy groups were positive with a significant increase in parental wellbeing and in positive attachment focused behaviours (Armstrong et al, 2019).

  In our current research stage (2018-2022), we have run sessions for 51 dyads, expanding to compare outcomes from art therapy groups with standard services over a four-year period. We collect qualitative feedback through questionnaires. There is a focus in responses on their increasing confidence with play and mess and on the benefits of meeting others. Asked what they valued, participants gave fun, bonding and mess as repeated themes, and that sessions were relaxed. Most said they would continue making art and there were repeated comments about not wanting to end, which we hope reflects parents valuing the group rather than feeling as if the work had not come to an end.

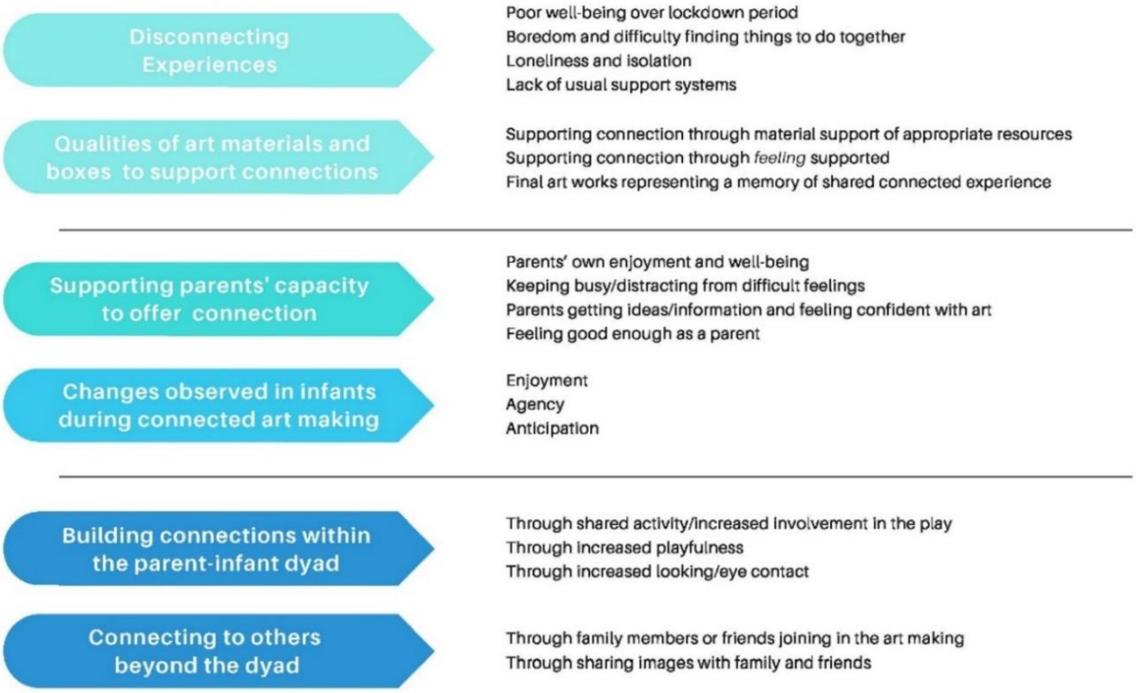
  > *"It has had a very positive effect on my general wellbeing"*
  >
  > *"I'm more confident in going out"*
  >
  > *"[positives have been] having a purpose once a week, gaining confidence in playing with my baby"*

- For the **public messy play sessions** our preliminary feedback showed that families were making return visits and valued the opportunity to make a mess and the relaxed atmosphere. In our observations as facilitators we saw families coming back and saw parents surprised by how much their infants could engage with art making, several babies having their first experience of paint in the sessions.

  > *"A chance to go out, socialise, learn, develop motor skills and have fun"*
  >
  > *"playful environment with lots of new things to try"*
  >
  > *"my baby painted for the first time! It is not easy to make space for that at home since it gets so messy and we have carpets"*

  We have moved to gather more targeted quantitative feedback on connection to infants and confidence to try these kinds of activities through the use of scaling questions and this data analysis is underway.

- The **Art Boxes** contained feedback cards that participants could return (54 received, a 35% response rate), and a sub-sample of 20 participants and referrers were followed up for interview. The preliminary findings of this are recently published (Armstrong & Ross, 2021). Results showed that the Art Boxes encouraged positive interactions between young children and their parents through the art making (table 1).



Disconnecting Experiences	Poor well-being over lockdown period Boredom and difficulty finding things to do together Loneliness and isolation Lack of usual support systems
Qualities of art materials and boxes to support connections	Supporting connection through material support of appropriate resources Supporting connection through *feeling* supported Final art works representing a memory of shared connected experience
Supporting parents' capacity to offer connection	Parents' own enjoyment and well-being Keeping busy/distracting from difficult feelings Parents getting ideas/information and feeling confident with art Feeling good enough as a parent
Changes observed in infants during connected art making	Enjoyment Agency Anticipation
Building connections within the parent-infant dyad	Through shared activity/increased involvement in the play Through increased playfulness Through increased looking/eye contact
Connecting to others beyond the dyad	Through family members or friends joining in the art making Through sharing images with family and friends

Table 1: Themes from analysis of parent interviews following art boxes (Armstrong & Ross, 2021)

Parents reported seeing their infant's increasing eye contact and looking to show them things (a sign of joint attention) as well as showing excitement when the art materials came out (a sign of anticipation). Parents said they were joining in the activity more than they normally would in play with toys as they felt it was something for them to do together. These kinds of connected, shared experiences are positive for infant wellbeing and can help to build strong attachment relationships so we can see that the Art Boxes helped to facilitate these experiences at an otherwise hugely challenging time for parents. We also saw an increase in parental wellbeing through doing these activities together with their child.

> *"I feel that I'm doing a good thing for my children. Where I felt, while we were at home with no things to do, that maybe I'm not doing a good job for them and that they are not getting all the things that they need to do, to try. So by doing this, I feel that I have done something for them and that makes me feel good." - parent*

Key learning points

We found that parents and infants involved in our project have appreciated the opportunity to get involved in the arts and the support offered. We saw families try new activity and interact through play. We saw **positive improvements in the interactions and confidence** of families vulnerable to attachment difficulties. This meets the Allied Health Professions (AHP) Public Health Strategic Framework (AHPF, 2019) for wider determinants of health by supporting nurturing environments for children. The project has also supported vulnerable communities as we see **increased participation with the gallery** which has broadened its reach to more diverse audiences, including families facing deprivation, families with long term mental health conditions, and families from minority ethnic communities; all are groups that can be underrepresented in galleries traditionally.

In the AHP framework (AHPF, 2019) for population healthcare, our parent-infant art therapy group has been able to offer an early intervention where there are attachment difficulties which could have a long-term **impact on children's mental health and parental recovery from perinatal mental health conditions**. We have seen that the **capacity to offer emotional containment** that comes from therapeutic training may be useful for those instances where parents became overwhelmed, struggled to keep the focus on their child, or struggled to provide safe boundaries, or in managing the group dynamics. In feedback a number of the parents explained how they did not attend 'normal' parent groups due to feelings of anxiety and judgement and that they would not previously have considered going to art events offered in the art gallery by themselves. The art therapy group offered safety for these parents to attend.

By providing a **spectrum of interventions**, ranging from those which are about participation and engagement in the arts for everyone to those which offer additional layers of support to engage with the art process for those who need it, we have been able to meet the needs of our local community. Art therapists can bring their skills and undertake work across the spectrum of Arts in Health interventions from community arts, social prescribing, and participative arts to art therapy. As art therapists most often come from an art background and all must maintain their own art practice, they are able to work at many levels from where they are in the role of artist themselves to where they need to draw on their training in psychotherapy and mental health. This **capacity to shift between levels of practice** whilst always maintaining a therapeutic understanding can help us to serve the best interests of the individuals or families that we work with.

During this project we have found many benefits from working in a gallery space. We find a real added value from the creativity of being in those spaces and we notice parents visiting the exhibitions after the sessions with their children. Arguably it also removes some of the stigma that may be felt from a referral to the art therapy groups as it is in a public space rather than one associated with health or social care. Admittedly, gallery spaces may be intimidating but we have found that having had a home visit from the art therapist this has been manageable. Perhaps attending the group will demystify these spaces for some of the parents, encouraging them to continue to **engage with arts venues in the future**. We are hopeful that the outcomes from the art boxes will also be that families feel more connection to DCA and those who have never been will engage in future. The family programme in DCA is largely free and offers parents continued opportunities to take part in art activities with their children. Given increasing evidence of the benefits of attending galleries and museums and their potential for social change (Desmarais et al, 2018) this would be an additional beneficial outcome from the project.

Having seen the increase in participation that has come out of having an art therapist based with them, DCA are now planning to embed this in the future and are actively seeking funding to create a position when our research project comes to an end. This connects to the AHP framework for Health Improvement with local capacity building for health, wellbeing, and resilience. This has also been achieved in our outreach work for community groups. We have engaged several local organisations such as the International Women's Centre, Amina, and Homestart, so are raising awareness of the benefits of art making for wellbeing amongst their staff as well as their clients.

References

1 - Belsky, J. (2001). Developmental risks (still) associated with early child care. Journal of Child Psychology and Psychiatry, 42(7), 845–859 Available at: https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/1469-7610.00782

2 - Murray, L, Fiori-Cowley, A., Hooper, R. & Cooper, P. (2010) The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. Child Development, 67 (5), pp. 2512-2526 Available at: https://srcd.onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-8624.1996.tb01871.x

3 - Armstrong, V.G & Ross, J. (2020). The evidence base for art therapy with parent and infant dyads: An integrative literature review. International Journal of Art Therapy (IJAT). 25(3), 103-118 Available at: https://doi.org/10.1080/17454832.2020.1724165

4 - Armstrong, V. G., Dalinkeviciute, E. & Ross, J. (2019). A Dyadic Art Psychotherapy Group for Parents and Infants – Piloting Quantitative Methodologies for Evaluation. IJAT. 24(3), 113-124 Available at: https://doi.org/10.1080/17454832.2019.1590432

5 - Armstrong, V.G & Ross, J. (2021) Art boxes supporting parents and infants to share creative interactions at home: an art-based response to improve wellbeing during Covid-19 restrictions, Public Health Available at: https://www.sciencedirect.com/science/article/pii/S0033350621000536

6 - Desmarais, S., Bedford, L. and Chatterjee, H.J., 2018. Museums as Spaces for Wellbeing: A Second Report from the National Alliance for Museums, Health and Wellbeing. Available at: https://museumsandwellbeingalliance.files.wordpress.com/2018/04/museums-as-spaces-for-wellbeing-a-second-report.pdf

7 - Gassman-Pines. A., Ananat. E. O., Fitz-Henley J. (2020) COVID19 and Parent-Child Psychological Well-being. Pediatrics. 146(4):e2020007294

8 - Allied Health Professions Federation (2019) UK Allied Health Professions Public Health Strategic Framework 2019-2024

Provision of Therapeutic Boxing for Psychiatric Intensive Care Unit

Description

The aim of the project was to increase access to physical activity on a 10-bed Psychiatric Intensive Care Unit (Willows). The Live Team at Highbury Hospital, worked in partnership with a Nottingham City Council project, Get Out Get Active, and local boxing initiative Evolve CIC, to provide a continuous intensive boxing course directly onto the Willows Unit.

Inpatients on the Willows Unit were offered two sessions a week of non-contact boxing skills, through a professional boxing instructor from Evolve CIC, and encouraged to continue participation at the instructor's club with increased support post discharge.

Context

Evidence shows that people with Severe Mental Illness die up to twenty years younger than the average population (NICE 2018; De Hert et al., 2011; Stubbs B et al., 2015). Physical activity could have a vital role in addressing the health inequalities experienced by people living with severe mental illness, in addressing premature mortality, in preventing the onset of comorbidities, and in improving the overall health and wellbeing of this population. (Ashdown-Franks et al., 2018).

The Live Team were initially awarded Sport England year-long project funding in September 2018, to address inpatients requests for increased levels of physical activity across multiple hospital sites within Nottinghamshire.

The boxing sessions were tailored and adapted to the meet the needs of the Willows Unit inpatients, as the Unit provides specialist support to high-risk patients from a diverse population. Our objectives for the boxing sessions were to embed physical activity on the Willows Unit; engage the whole ward team; inspire and support inpatients to continue to access boxing beyond admission; improve levels of engagement and improve mood.

As boxing sessions developed, staff observed and tried to capture the positive impact on the ward environment and identify any correlation with a decrease in violence and aggression incidents.

Method

Through a partnership with Nottingham City Council's Get Out Get Active inclusive sports project and Evolve CIC, a Nottingham estate-based boxing club, collectively we aimed not only to engage inpatient services but to maximise the benefit and connect the Willows inpatients to the wider non statutory community sport resources, and demonstrate investment and relevance in valuing our services users by providing best quality to ensure engagement.

The boxing instructor offered an outside perspective and created a different dynamic in the Willows Unit. Boxing skills and breathing exercises were included in the sessions that were offered twice a week. The instructor's approach and personality fostered good team cohesion and had a positive impact on the ward atmosphere each time they arrived, their approach appeared to normalise discharge and created opportunities for inpatients and staff to think about engaging in community boxing or general physical activities post-discharge.

Internally a whole team approach was essential to support the success of this project, inclusive of the Live Team, Willows ward management to healthcare assistants and therapy staff, all who worked collaboratively and collectively, ensuring suitable engagement and safety was maintained.

Outcomes

The impact of the boxing sessions was captured via multiple qualitive outcome measures including an electronic feedback form that sat within an inpatient's electronic note, staff interviews, individual case studies and the Incident Reporting System.

Willows ward staff reported that they observed positive changes in inpatient behaviour and were surprised at the levels of engagement from specific inpatients who had declined offers of other onward activities or social interactions with staff.

Inpatients who engaged in a boxing session were supported by staff to complete a feedback form that focused on the individual's mood pre- and post-boxing session. Results from this after every session showed an uplift in mood for all inpatients, which therefore created a positive impact overall on the ward after the session had taken place.

There were several requests from inpatients to access Evolve CIC's boxing club within the community, post-discharge from the Willows Unit. Details of the boxing club were passed on to inpatients upon this request, as well as Evolve CIC setting up a dedicated session at the club specifically for Willows service users to attend, having one service users attend the club independently amongst the public, beyond his discharge from inpatient services.

Reporting level of incidents: days of session / days not / for engaged/participants / reduced violence and aggression through relieving stressors – why and rationale? Nature of the ward, boxing negative?

Learning points

Collecting data and measuring impact poses an on-going problem and having additional training on this may have been beneficial to all staff involved. All staff and external providers agreed it was hugely successful and identified numerous benefits but this was mainly via discussion and observation with all involved. It is difficult to represent that with evidence particularly in relation to cost effective/value for money and longer-term benefits in health and prevention especially in terms of securing or ensuring this is funded.

The perception of boxing initially created its own barriers with ward staff, with serious concerns about increased risk of violence and aggression, but these were easily challenged when sessions were witnessed in action, and we learnt to anticipate this and reassure staff teams when rolling out sessions on other wards. Additionally, we found that when staff participated in the sessions alongside the inpatients, it changed the dynamic of staff and inpatients' therapeutic relationships.

On-going plans are to continue to roll out across wards, including a dementia ward. The next steps are to seek funding to enable access to more boxing sessions on multiple inpatient wards and for further funding to be sustained via the wards. We hope to further develop links to community boxing resources and support transition to community access for inpatients.

The COVID-19 pandemic did put the project on hold, but the Live Team remain committed to continuing the developments of provision of boxing sessions when safe to do so.

References

Ashdown-Franks, G., Williams, J., Vancampfort, D., Firth, J., Schuch, F., Hubbard, K., Craig, T., Gaughran, F. and Stubbs, B., 2018. Is it possible for people with severe mental illness to sit less and move more? A systematic review of interventions to increase physical activity or reduce sedentary behaviour. *Schizophrenia research*, *202*, pp.3-16.

De Hert, M., Correll, C.U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D.A.N., Asai, I., Detraux, J., Gautam, S., Möller, H.J., Ndetei, D.M. and Newcomer, J.W., 2011. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World psychiatry*, *10*(1), p.52.

NICE (2018) *Improving Physical Health for People with Serious Mental Illness (SMI)*. Available at https://www.nice.org.uk/sharedlearning/improving-physical-health-for-people-with-serious-mental-illness-smi (accessed April 2021).

Stubbs, B., Gaughran, F., Mitchell, A.J., De Hert, M., Farmer, R., Soundy, A., Rosenbaum, S. and Vancampfort, D., 2015. Schizophrenia and the risk of fractures: a systematic review and comparative meta-analysis. *General hospital psychiatry*, *37*(2), pp.126-133.

Annual Physiotherapy Review Project – Working to create an efficient, patient centered and cost-effective service to those with profound and multiple learning disabilities in the community

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Description

The Southampton City Community Learning Disability Health Team provide care to those with learning disabilities in the community. Changes within the NHS has led to adults with learning disabilities being open to the team under an 'Episodes of Care' philosophy. This results in service users only being open to the physiotherapy team when the person and, or their family/ support staff notice that there is a problem that needs addressing. Since adopting this approach the Physiotherapy team noted that in many cases service users were referred at a late stage of their current complaint. Late referral results in a person experiencing more complex care needs (e.g. dysphagia risks, respiratory care needs, chronic pain) and increases the support required from NHS services.

The Annual Physiotherapy Review project seeks to take a preventative approach, assessing and documenting changes in condition such as weight, posture, contractures and scoliosis annually. The aim being early identification of deterioration of posture and respiratory care to enable appropriate and timely support to resolve the issue. This approach is in line with NICE guidelines *Care and support of people growing older with learning disabilities* NG96 (2021). The potential benefits of this proactive annual review approach include, reducing risk of, hospital admission, increased care packages and increased equipment needs, whilst maximising the efficiency of NHS workforce resources.

Context

The project developed due to repeat referrals into the Learning Disability (LD) Physiotherapy service with examples of service users requiring new equipment (such as wheelchairs/sleep systems/standing aids) due to late identification of postural changes and or worsening contractures.

The aim of the project was to achieve early identification and treatment of postural and physical health changes in adults with profound and multiple learning disabilities (PMLD) in Southampton. This is important, as respiratory conditions remain the most significant cause of premature mortality in people with learning disabilities (Leder 2020). Poor postural management impacts on respiratory care as scoliosis will impact on rib cage deformity and lung volumes. These individuals are also often reliant on others (family/paid carers) to recognise changes to tone, contractures and spinal changes due to the level of their communication difficulties. Expressing pain can often be difficult for these individuals and is very often "under recognised and under treated" in those with learning disabilities and there is a misconception that people with a learning disability have a 'higher pain threshold' (Doody and Bailey 2007)

There were three primary objectives to be achieved through the Annual Physiotherapy Review:

- Ensure efficiency of service within the resources available
- Create a person-centered service
- Cost efficiency

It is well known and documented that people with learning disabilities are more at risk of deterioration in their health, which forms the basis of the NHS GP Annual Health Check scheme (NHS UK 2021). Heslop et al., (2014) found 'avoidable deaths from causes amenable to change by good quality health care were more common in people with learning disabilities (37%) than in the general population of England and Wales (13%)', and that people with 'more severe learning disabilities have been recognised as having shorter life expectancies than those with mild learning disabilities'.

Method

The project identified those people in Southampton with PMLD and complex physical health needs who were at risk of late identification of their complex health needs. An original caseload of 49 service users were involved with the project in 2019 (x1 RIP prior to assessment x1 moved out of area).

An assessment form was then designed based alongside the GP LD annual health check and postural care assessments. The reasoning was to identify those with postural needs but also to collect simple health data such as blood pressure and weight, as evidence has shown that GPs have difficulties completing these assessments for people with PMLD due to lack of appropriate equipment, which may then lead to late recognition of deteriorating physical health. This is also in keeping with a 'making every contact count' approach.

A detailed 12 page assessment was completed including, but not limited to:

Area assessed	Assessment/Measurement	Notes
Weight	Weighing via sit on or hoist scales	GPs often do not have access to this equipment
Height	Measuring tape with S/U lying on their bed	Where this was not possible an ulna length was taken and converted as per the 'MUST' www.bapen.org.uk
BMI	Calculation kg/m^2	
Medication/ Drug charts	Review of medication specifically pain relief and anti-spasmodic	Liaison with GP required
Skin Care	Review of pressure points and high risk of breakdown	Specific assessments around shoulder blades, sacrum and calcaneum
Blood pressure and cardiovascular function	Sphygmomanometer where able Electronic wrist cuff if unable to use sphygmomanometer	An assessment GPs find challenging due to spasticity of upper limbs. Often spasticity is reduced following physiotherapy assessment so easier to access the upper arm to complete

		assessment. Service users often lying in bed also helps aid with relaxation to complete assessment.
Respiratory	Auscultation Pulse oximetry	Auscultation will consider scoliosis and potential lung fields dependent on individual's deformities. Use of toes when unable to gain reading via finger.
Physical Disabilities	Use of OCE 'part B' range of movement with 'postural deformities' assessment chart	In line with postural findings: Review of wheelchair Review of slings Review of sleep systems Review of standing frames/walking aids
Pain	Pain noted during assessment at certain joints	As with 'medication' section review pain relief where required

An annual review was completed by a physiotherapist with these service users, discussions were held with family members/support workers in relation to the findings of the assessment and an appropriate care plan was developed with the service user and their main support team.

In 2020, the review was streamlined to a 2 page document in order to make the process more efficient, and sought to assess key subjective and objective information of the service user's condition from the past 12 months.

Assessment	Notes
Changes to health over the past 12 months	Any notable health issues that require escalating
Changes to medication over the past 12 months	Anything that may impact on physiotherapy recommendations
Wheelchair specifications and needs	Any changes noted or required
Sling specification and needs	Review slings for wearing and fraying and replace
Critical measures – specifically changes over the past 12 months	Are ranges of movement reducing over last 12 months and require intervention
Respiratory Assessment	To review service user's baseline respiratory
Weight/BMI	To review any changes and liaise with family/support team or GP if required
Postural deformity chart	To review postural management – specifically sleep systems/equipment needs

Once the assessment had been completed, it was decided whether or not the service user was suitable for discharge, or whether they were referred onto the physiotherapy caseload.

Outcomes

Outcome of the assessments:

2019

47 service users were offered an assessment as they met the criteria for the project.

Percentage	Number	Outcome
4%	1	Refused review
27%	13	Already open and receiving physiotherapy intervention
31%	15	Review complete – deemed suitable for discharge
41%	20	Physiotherapy needs identified => referral for physiotherapy intervention It is unlikely these needs would have been identified without the physiotherapy review

2020

45 service users were offered an assessment as they met the criteria for the project

Percentage	Number	Outcome	Comments
16%	7	Refused review	Mainly due to Covid-19 pandemic
15%	7	Already open and receiving physiotherapy intervention	
49%	22	Review complete – deemed suitable for discharge	
20%	9	Physiotherapy needs identified => referral for physiotherapy intervention	x 5 of these the physiotherapy team were already aware of – annual reviews were worked around this. x 4 'new referrals' found previously undetected needs at this time.

Intervention Identified from assessments:

2019			2020	
Number	Referral Reason		Number	Referral Reason
8	Specialist mobility; Standing aids (such as Quest 88) walking aids (such as buddy roamer, Meywalk) etc.		1	Specialist mobility; Standing aids
8	Postural management including sleep systems		3	Transition into adult services
4	Moving and Handling		2	Moving and Handling
			2	Sling reviews
			1	Review of exercise programme
24	**Referrals made into the wheelchair service**		**2**	**Referrals made into the wheelchair service**

Health issues that have been highlighted through the project

- Weight loss/gain – advice given and x2 referrals to GP/Dietitian
- x1 unexplained weight loss led to further investigations regarding cancer – negative following screening.
- Respiratory assessments have identified x2 chest infections prior to support staff knowledge ensuring timely intervention from GP.
- Poor activity levels secondary to physical disability – x8 service users were signposting to leisure activities to promote more active lifestyles for those wheelchair users who have limited community access to activity.
- Three examples where standing/mobility activities had stopped due to equipment failures and staff unable to work out how to solve this. Support was provided to fix/replace this equipment to re-start these activities – improvements on musculoskeletal, digestion, respiratory and cardiovascular function.
- Reduction of referrals (22 in 2019 to 2 in 2020) to wheelchair services reducing NHS costs and time for clinicians. Also improving quality of life for service users ensuring they are using appropriate seating.

Key learning points

Offering a proactive Physiotherapy annual review to those with complex physical health needs associated with profound and multiple learning disability and communication difficulties appears to result in earlier identification of postural care needs and earlier provision of equipment to prevent further deterioration of posture. Early identification and support for these needs is likely to reduce the risk of:

- Respiratory conditions resulting in reduced acute hospital admission
- Health conditions, specifically cardiovascular function and bowel management associated with physical inactivity
- Pressure sores
- Pain

Areas for improvement

Issue	What we have done
Support Staff unaware of historical recommendations	Re-sent recommendations Offered teaching if required
Concerns with lack of ‘flexibility’ with physiotherapy recommendations	Incorporated recommendations into activities of daily living as opposed to a separate ‘activity’ such as bathing, dressing etc.
Challenges to complete physiotherapy recommendations such as aquatic therapy, specialist gyms, sitting activities due to: Staffing Finances Transport	Liaison with adult services/CHC to improve issues where able. Negotiated recommendations where these issues were unable to be resolved to reduce pressure on families/support staff.

What went well?

Positive feedback received from carers and other health professionals:

- "Reassured me that I am doing the physiotherapy recommendations right!"
- "Always feel the staff are supported by the physiotherapy team – but I like that this is being more 'proactive' and not waiting for us to raise issues/concerns"
- "Such a good idea, should have been done years ago – you can pick up problems we don't notice before they get too bad"
- "A brilliant idea"
- "We know the physiotherapy recommendations are important, but this helps us ask any questions or clarify any concerns without having to call the physiotherapist out specifically"
- Feedback from a 48 hour panel following a death of a service user highlighted the excellent work and practice by the physiotherapy team and all members of the panel were supportive of the annual review project.

Challenges:

- The increase in workload in year 1 had been predicted, but still impacted on the service as referrals were also entering the service – effectively placed an additional 20 cases to our caseload in 2019.
- Getting feedback about the project from families and support staff was a challenge. Questionnaires were attempted, but not completed. A telephone follow-up was completed with many, however we recognise that the feedback may be biased towards the physiotherapy team as families/support staff may not wish to be seen as being 'negative'.
- Getting feedback from GPs has been difficult. The aim was to align the physiotherapy review with the GP annual health check to ensure they had appropriate information 1 month prior to the annual health check – this was not deemed possible.
- Covid-19 meant a delay in completing assessments in 2020 with many families refusing assessment due to shielding – telephone contact was maintained and advice was given to these families in line with the assessment that had been completed the previous year. Specifically, for those whose activities had stopped such as hydrotherapy, rebound therapy and accessible gyms.
- The Southampton Physiotherapists have been in the team for many years so have good knowledge of the service users with PMLD. Challenges will be faced by others who may not have the relevant information to start identifying those who meet the PMLD criteria this may make starting the project more challenging

Future plans to embed this initiative:

Although still in relative infancy, the number of physiotherapy referrals into the service from the annual reviews is reducing, showing that whilst the caseload increased for 1 year, the subsequent years have led to reduction in workload. Postural and health care needs are being met in a timely way, ensuring proactive intervention to those who are most vulnerable to undetected health changes in our society. Equipment and treatment have been provided to many service users that has helped improve their quality of life, whilst minimising long-term care cost to the NHS.

References

Doody D, Bailey ME (2017). Pain and pain assessment in people with an intellectual disability: Issues and challenges in practice. *British journal of Learning Disabilities*; 45: 3, 157-165

Heslop, P, Blair, P, Fleming, P, Hoghton, M, Marriott, A. and Russ, L. (2014). The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. *The Lancet*, 383(9920), pp.889-895.

National Institute for Health and Care Excellence (NICE) 2021. *Care and support of people growing older with learning disabilities* NG96. Available at: https://www.nice.org.uk/guidance/ng96 [Accessed 17 February 2021].

National Health Service (NHS UK) 2021. *Learning disabilities - Annual health checks.* Available at:

https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/ [Accessed 16 February 2021]

Oxford Centre of Enablement (OCE) 2014. ‘Management of Physical Disability 24-7 MPD’. Part B ‘Physical Profile’.

Sport for Confidence and Stay Connected:
Creating an online physical activity service

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Description

Sport for Confidence CIC is a unique and innovative organisation, which brings together occupational therapists and specialist sports coaches to provide activity-based assessments and interventions for marginalised groups across Essex. Sport for Confidence typically operates within leisure centres, but during the coronavirus pandemic the Stay Connected service was created - an online service that utilises occupational therapists and sports coaches to provided support to marginalised populations, such as disabled people and people living with long-term conditions.

Context

The Stay Connected service enables participants to access and engage with a wide range of online interest groups, low and high intensity physical activity groups, and vocational groups. The occupational therapists enhance this offer by providing additional telephone contact, occupational assessment, active listening, empathy and personalised advice. The service also works in partnership with care and community providers to enhance resilience and accessibility of existing provision, supporting them to develop and embed sustainable and inclusive online solutions.

The Stay Connected service was originally commissioned in April 2020 for 6 months, to offer immediate support to disabled people living within Essex due to the pandemic. The service proved successful, and an extension was granted. Stay Connected is a person-centred service, which focuses on meeting the needs of individuals who face barriers in initiating, accessing and sustaining contact with support services. This is because these individuals are often the most at risk of experiencing a deterioration in their mental and/or physical health, exacerbated by the requirements to socially distance, shield and/or self-isolate. These individuals are also known to encounter inequalities in sport and physical activity participation, which has consequences for their health and well-being (English Federation of Disability Sport, 2013; Sport England, 2016). The service recognises the broader context of people's lives and how this relates to their health and well-being. Therefore, assessment and support is also offered to those in a caring role (whether paid or unpaid) to reduce the risk of carer breakdown. This further supports national policy that seeks to enable people with health conditions and impairments to live an active lifestyle (English Federation of Disability Sport, 2016).

Method

The service started with telephone and email contact and developed to providing regular Zoom exercise classes alongside occupational therapy assessment and support. The following demonstrates keys stages in the service improvement:

- Started with a basic service telephone and email contact service
- Awareness raising sessions (live social media events, providers and health and social care workers)
- Strengthen existing and new partnerships and referral pathways (e.g. Enhanced Social Care Support for Adults with LD/Autism team).
- Reviewed and changed measurement to qualitative data collection only to enhance rapport building and connection with the member of staff.
- Gradually increased and adapted the offer to include: personalised support ranging from, a short phone call to regular and lengthy contacts subject to needs assessment, signposting, email contact, personalised physical activity videos, zoom sessions, resources sent/ recommended.
- Posted infographics of monthly contact via social media
- Provided a weekly zoom timetable
- Co-created resources with Team Create (includes participants with lived experienced of disability/mental health/LD) to use within sessions (e.g. 'How to start a conversation about PA')

Outcomes

- The service was initially measured using self-rated measurement tool but feedback from the participants led to qualitative measurement, using feedback and case studies.
- Total referrals April 2020 – Feb 2021: 1157
- Current Caseload as of 1st March 2021: 129
- Total Zoom sessions delivered for January 2021: 41
- Total Zoom sessions delivered for February 2021: 41
- Total attendance at Zoom for January 2021: 576 interactions (average attendance of 14)
- Total attendance at Zoom for February 2021: 668 interactions (average attendance of 16)
- Average 0 – 10 rating given by participants on service provided: 9.7

There are many examples of what has changed, including:

- **Increased access to physical activity** (e.g. 5 days a week rather than 2x week in prior to covid)
- **Challenged assumptions** around people with a learning disability/Autism using digital platforms, we have enabled participants connect with new and old and stay connected with all.
- **Increased opportunity** for people to make independent choices about what activities they want to join. A choice of 14 different sessions a week was something that was not previously an option for the majority.
- Enabled participants to **safely try different sports and activities** they may not have tried before- enabling us to grade their exposure online and work towards them trying new things face to face in the future.
- Provided participants with **structure and routine**

Client feedback:

"This service has been helpful / useful by just knowing they are a phone call away in this difficult time of lock down uncertainty… keep up your amazing work! I am grateful to you all for your help and support and the belief you all have in me to achieve and grow as a person".

Family feedback:

"My son has Down's syndrome and attends a Sport for Confidence session; the therapists have kept these going each week via Zoom. This has allowed him to keep in touch with everyone, which given his additional needs he would not have been able to do… the variety of activities is great… the care and attention put in by the therapists is outstanding".

"Everyone at SfC has been amazing, all the team are so caring. My son is a completely different person since participating in the Stay Connected service."

Carer Feedback:

"The team have made me feel part of the 'outside world indoors" Thank you.

Provider feedback:

"We have been given lots of suggestions and physical activity information. Our client has now been offered a fantastic Video Carephone thanks to Stay Connected and they have been supporting one of our clients regularly".

The extension and how the service is evolving suggests the service is respected and valued by the commissioners who want it to remain. The consistent number of referrals suggest the service is of value to health professionals and participants.

Key learning points

- Learning to evolve with time and acting quickly, Covid has been a roller coaster ride and we have had to exhaust all our innovative creations to ensure that we can adapt to support the participants at their own pace.
- A single point of access has been a real important learning experience, something extremely valuable and as a consequence results in participants gaining efficient, sensitive and consistent support.
- Technology is difficult to navigate, however, it can be done with attention and care.
- The iterative approach we have taken has enabled us to adapt and change our approach as we go, therefore we have consistently followed check, challenge and change principles.
- It's clear there is a long term need for virtual and face to face delivery, to promote choice and independence for participants.
- To explore how this service becomes a long-term plan as part of Sport for Confidence and the participants we see.

References

English Federation of Disability Sport (2013) Microsoft Word - Active Together Report V6 (sportanddev.org) Accessed in April 2021

English Federation of Disability Sport (2016) English Federation of Disability Sport - Impact Report 2016-17 (activityalliance.org.uk) Accessed in April 2021

Sport England (2016) sport-england-towards-an-active-nation.pdf (sportengland-production-files.s3.eu-west-2.amazonaws.com) Accessed in April 2021

The development of Chatting Time Series (including Changing time is Chatting Time and Anytime is Chatting Time) – a suite of resources that support parents to interact with their babies and young children throughout the day

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Description

There are two sets of resources:

1. Changing Time is Chatting Time is designed for antenatal parents and parents of babies:
   - Video 1 Changing time is Chatting Time – how to smile, talk, laugh and sing with your baby
   - Video 2 Your Words Work Wonders – Tips for Chatting with Your Baby
   - Parent information session containing information about baby brain development, how to smile, talk, laugh and sing with your baby throughout the day and why this makes a difference to their brain
   - Parent information session in 6 bite size 3-4 minute videos
   - Parent leaflet with Changing Time songs and QR code for the videos

2. Anytime is Chatting Time is designed for parents of children from around 12 months to 3 years:
   - Video 1 Anytime is Chatting Time – how to smile, talk, laugh, sing and share stories with your child
   - Video 2 Your Words Work Wonders – Tips for Chatting with Your Child
   - Parent information session containing information about baby brain development, how to smile, talk, laugh, sing and share stories with your child throughout the day and why this makes a difference to their brain
   - Parent information session in 6 bite size 3-4 minute videos
   - Parent leaflet with Anytime song and QR code for the videos

Chatting Time resources are used in all Sure Starts in Belfast Health and Social Care Trust (BHSCT) area (and now regionally across NI) to increase parents' understanding about how their baby's brain develops and their role in this. They also give parents practical advice on how to increase interaction with their child throughout the day.

The resources mentioned can be accessed at:

https://view.pagetiger.com/chatting-time-resource-guide/v1

Context

One of Sure Start's overarching objectives is to improve language skills of children in Sure Start areas and so help end the intergenerational cycle of language deprivation. In Sure Starts in BHSCT area, around 70% of children entering the Developmental Programme for 2-3 year olds have delays in speech, language and communication. The role of the Sure Start SLT is to improve the language skills of children living in Sure Start areas by increasing the relevant knowledge and skills of those most proximal to the child i.e. parents, Sure Start staff, and members of the community. To be most effective, this capacity building needs to begin antenatally. Working with antenatal parents and parents of young babies were new areas of work to some in the newly recruited (late 2016) team of Sure Start SLTs.

The need was therefore identified for a set of resources that:

1. supported SLTs to begin work with antenatal parents and parents of babies
2. Provided user friendly tools for Sure Start SLTs and Practitioners to give consistent messages to parents (of children antenatal to 3 years) in an accessible and helpful way
3. Gave information about brain development and the importance of talking to your baby in a way that was easy to understand and easy to communicate to others
4. Packaged information in a simple accessible way
5. Supported parents to interact with their children in ways that promote emotional security and the development of language

Method

Changing Time is Chatting Time (CTCT) was first developed by the BHSCT Sure Start SLT team in 2017 to support Sure Start SLTs as they moved into a new area of work with antenatal parents and parents of babies. It provided Sure Start SLTs and other Sure Start staff with a tool that enabled giving consistent health promotion messages in a clear and concise way. CTCT increases parents' understanding of why talking to their child is so important. The resources also give them simple concrete guidance on how to do this as well as tools (songs) and modelling (videos). Early outcomes from staff and parents (see below) indicated that CTCT was supporting staff to give information to parents and supporting parents to interact differently. Therefore in 2018 the need was identified to develop a similar resource for parents of slightly older children 12-36 months. At this time, we had the opportunity to be involved in a co-design project with a group of parents from East Belfast Sure Start in partnership with Save the Children. This gave us the opportunity to:

a) Get parents' help in revising CTCT

b) Get parents' insights and guidance in developing a new resource which became Anytime is Chatting Time (ATCT)

The parents in the East Belfast Group had valuable insights into what is helpful for parents and what isn't helpful, so it was important that this group of parents had a role in the revision of CTCT and the development of ATCT. They were able to advise on what is helpful to them in their understanding of brain development and what would support them in developing 'serve and return interactions' and 'contingent talk' (Matthews et al, 2016)[1] which are identified in research as critical factors in language development.

The result of this collaboration with parents was the completion of the suite of resources outlined above – some changes were made to CTCT and ATCT was developed using insights from the parents as our guide. The parents had the opportunity to appraise the changes to CTCT and the new ATCT resource and make further changes before it was completed.

Outcomes

Aim 1 – to support SLTs to begin work with antenatal parents.

Before CTCT, Sure Start SLTs were involved in working with antenatal parents in 2 out of 9 Sure Starts.

Currently Sure Start SLTs are involved in working with antenatal parents in 9 out of 9 Sure Starts.

86% of SLTs reported increased confidence in sharing information about brain development with parents. The one SLT who did not report increased confidence had already significant experience in this area e.g. was a Solihull trainer.

Aim 2 - Provide user friendly tools for Sure Start SLTs and Practitioners to give consistent messages to parents (of children antenatal to 3 years) in an accessible and helpful way.

Aim 3 - Give information about brain development and the importance of talking to your baby in a way that was easy to understand and easy to communicate to others.

Aim 4 - Package information in a simple accessible way.

These aims were not evaluated separately. Rather, the outcomes can be inferred because:

- CTCT is now used in all 38 Sure Start across Northern Ireland
- Use of ATCT is currently being introduced across all 38 Sure Starts in Northern Ireland
- Following the introduction of CTCT, Practitioners (SLTs and other Sure Start Practitioners) reported giving information about brain development and early interaction more frequently
- Parent outcomes for CTCT and ATCT (below) report behaviour change

Aim 5 – Support parents to interact with their children in ways that promote emotional security and the development of language.

Parent outcomes are being gathered in 3 ways (as per Royal College of Speech and Language Therapists (RCSLT) Framework: Measuring Outcomes outside individualised care June 2021)[2].

a) Quantity of information shared
b) Parent report of behaviour change as captured by parent questionnaire
c) Individual examples of change as captured by staff observations and parent stories

Quantitative data is difficult to obtain due to the nature of the service area and the subjectivity but our qualitative data from our parent feedback shows behaviour change in those parents who responded to questionnaires (see b) below):

a) Quantity of information shared:
    - CTCT video views – 2712
    - Your words work wonders (baby) video views – 736
    - ATCT video views – 2542

- Your words work wonders (toddler) – 668
- CTCT information embedded into work of all 38 Sure Starts
- Bite size videos shared via YouTube or WhatsApp in all Belfast Sure Starts (CTCT with antenatal parents and parents of babies; ATCT with parents of children in Developmental Programme for 2-3 Year Olds ie approx. 300 parents per year)
- Chatting time Staff Resource Guide on Page Tiger – 421 visits spread consistently since it was first published indicating that it is still being used

b) Parent report of behaviour change (from questionnaire responses 'what would you tell another parent?'):
CTCT – ***"understanding the upper brain and lower brain. So concentrating on keeping the baby calm. talking also in sing song way which definitely catches his attention more now".***
"calmer babies engage more. lots of communication can be done by singing and talking to them in a sing song way. they will pay more attention and start engaging with coos and this will help further in developing their speech"
"Singing and talking more to my baby and she smiles and makes noises back"
ATCT – what would you tell another parent?
"How something quite simple like singing while driving, can help engage your child"
"That its surprising how much I told my child what he liked and (when I follow his lead) ***he actually has his own point of view and his own likes"***
"Give them one on one time and properly listen and have conversations about them and their interests and it will pay off 10 fold"

c) Examples of change reported by others: CTCT
Midwife fed back that some parents have talked about how the changing time songs 'really work'- they help 'calm down' the baby and make changing time more enjoyable.
Family Support Worker reports 'I have noted a change in parents with whom I have completed CTCT with the feedback being they are all singing to their babies now and some reading to their babies. It started conversations with parents where they said 'I didn't know you could read to a small baby 'which lead to a book talk and information on books etc. Mums reported that they have put the songs on the wall beside the nappy changer to aid them.'
Family Support Worker reports 'At Infant Massage, one Mum said that she has been singing the "Change your nappy, here we go" song to her wriggly six month old when changing him. He loves it and said it also really calms her down and it is less of a battle for both of them! At the end of the session we all sang it as we dressed our babies and nearly everyone joined in (without the handout), so they must be singing it at home'.

Key learning points

- Parents are most likely to do something if it makes it easier to get through the day (insight given by East Belfast parents in co-design group). Singing songs makes nappy changing easier and so parents do it. There are also some parent reports of transferring this behavior to other stressful situations.
- Giving the information in a conversational way (using the illustrations from the parent session folder) rather than 'giving a talk' engages parents better. Information is best received when delivered by someone the parents have a trusted relationship with.

- Parents are very interested in brain development and how they can influence this in a positive way (see an example above about a parent comment re upper brain and lower brain) but they want tools to help them do this. This has resulted in further co-productions and the development of the Sure Start Chat with Me books.
- Bite size videos were introduced during lockdown and were positively received by parents who reported doing things differently as a result (see ATCT behavior change comments above). Staff found it easier to open up discussions with parents when the parents had already watched the Bite Sized videos.
- As a result of this feedback from staff and parents, Chatting Time training for staff was developed by the Sure Start SLTs and a working group of Family Support Workers. Chatting Time training is developed to help Sure Start staff explore how to embed the key messages from Chatting time into all areas of work with parents rather than just delivering a parent information session. Example of Family Support Worker feedback
  "We are thinking about parent/child relationships, more specifically the connection using ATCT language. We are developing processes within our planning to help embed this language into our programme as a way of using a shared language to discuss attachment and bonding"

References

1. Matthews, D, McGillion, M & Pine, J (2016). EYFS Best Practice - All about…contingent talk. Nursery World, 25, 17-20.
   Available at https://www.nurseryworld.co.uk/features/article/eyfs-best-practice-all-about-contingent-talk
2. Royal College of Speech and Language Therapists RCSLT (2021). Measuring outcomes outside individualised care. Available at:

   https://www.rcslt.org/members/delivering-quality-services/outcome-measurement/outside-individualised-care/

Communication first: people experiencing street homelessness

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Description

Change Communication provides speech and language therapy to people experiencing homelessness.

In March 2020 Jake (pseudonym) was accommodated via the Everyone In programme. This programme aimed to protect rough sleepers from the coronavirus pandemic by providing emergency accommodation and support. A charitable trust seeking to address isolation amongst people experiencing homelessness during the pandemic funded Change Communication to support people accommodated by the Everyone In programme. Jake's keyworker in the emergency accommodation contacted Change Communication to request help with Jake's communication difficulties. The Speech and Language Therapist (SLT) worked with Jake to identify the communication issues and used the findings to support other organisations to understand the extent and impact of these needs.

Context

Change Communication helps people experiencing homelessness, and the organisations that support them, talk, listen and achieve their goals. These goals may include working together on housing resettlement plans, understanding rights and responsibilities or being able to express needs clearly.

There is very little understanding within the homelessness sector of how communication skills develop, may be different or damaged during the life course and how they can be supported. However, people who are homeless are more likely to have communication needs than the general population (Andrews and Botting, 2020). Communication difficulties are a barrier to accessing healthcare with experts by experience stating services need to provide enough time to really listen, show patience and support meaningful participation in healthcare encounters (Luchenski et al, 2018). One third of homeless deaths are from causes that are amenable to treatment (Aldridge et al, 2019). Change Communication therefore aims to identify and support communication needs so that health inequalities are reduced amongst people experiencing homelessness. This includes highlighting the legal right to accessible communication from publicly funded health and social care services under the Accessible Information Standard.

Method

Project engagement

Change Communication introduced their work and provided communication awareness training to services taking part in the Everyone In programme. This facilitated appropriate referrals from support workers and helped support workers encourage clients to attend appointments. All clients and many support staff were unaware of the role of an SLT and so the SLT explained the service using relevant information, e.g. if a client had a brain injury the SLT outlined how this may affect communication.

Project flexibility

The SLT met clients in their emergency accommodation to complete assessments. This in-reach face to face model was welcomed by clients and support staff because it was easier for clients to attend appointments and less time consuming for staff. For the SLT it also provided a COVID risk assessed confidential space with staff support in case of any queries or difficulties.

Project delivery

Both informal observation and formal standardised assessments were used over one to six appointments as needed. Clients could attend with another person or support organisation if they wished. At times the SLT provided telephone advice or attended appointments at the request of services to facilitate communication about complex matters, e.g. during health assessments.

Outcomes

Jake attended four appointments with Change Communication. These appointments included assessment, reviewing results with Jake, providing Jake and support staff with strategies to increase effective communication, and a case closure meeting. Prior to accessing the emergency accommodation Jake had missed five appointments with a non-healthcare service because he had not understood what was happening in the meeting and did not feel he could ask questions.

A Care Act assessment was supported by the SLT following a request from the assessing Social Worker who recognised their duty under the Accessible Information Standard. This led to a fully informed assessment which identified a range of care needs.

Jake was referred to a wellbeing service. This service changed their usual method of introduction to the client following advice from the SLT. Usually a telephone call would be made in the first instance, but this deprives the client and staff of visual communication cues. Instead video was used to facilitate first contact and Jake immediately agreed to meet the service. Making these communication adaptations reduced inequity of access to the wellbeing service.

Jake has remained accommodated after an extensive period of street homelessness. Crisis (2021) state that preventing homelessness saves £9250 per person per year. Additionally, quality of life benefits were experienced by several clients in contact with the SLT service. Comments included meeting the SLT as “getting my day off to a good start”, being “encouraged” to hear positive things about their communication and feeling “charismatic” for a change.

The SLT clinical report outlined Jake's strengths and these findings were not consistent with a query over an alternative condition suggested by other organisations. This helped organisations focus on appropriate assessment, management and treatment. For the first time Jake was able to talk about his communication needs and how they made him feel. Whilst Jake still experienced difficult emotions about his communication, he had a better understanding of the situation and a range of support strategies that he utilised in multiple appointments with different services.

Key learning points

What worked well?

The provision of assessment, coaching and therapy with an SLT was of benefit to both Jake and the services supporting him.

What would you have done differently?

Appointments with the SLT were requested and provided on an ad hoc basis during this project. The SLT would now provide a regular weekly session on site so that relationships with staff and clients could be informally developed. Where this has been tried with other services it has led to better understanding of the role of SLTs, more inter-disciplinary working and connections with local NHS allied health services.

What future plans do you have?

Jake had no health diagnosis that would have allowed access to NHS SLT services under current criteria in the local area. Change Communication is contacting NHS SLTs and commissioners to explore how the speech language and communication needs of people who are homeless can be better identified and met by the NHS which, in turn, will support reductions in homelessness and health inequalities.

References

Aldridge R.W., Menezes D., Lewer D. *et al.* (2019) "Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England", Wellcome Open Research **4**:49 https://doi.org/10.12688/wellcomeopenres.15151.1

Andrews, L. and Botting, N. (2020), "The speech, language and communication needs of rough sleepers in London", International Journal of Language and Communication Disorders, Vol 55, Issue 6, pages 917-935. https://onlinelibrary.wiley.com/doi/full/10.1111/1460-6984.12572

Crisis "The Cost of Homelessness" available at: https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/cost-of-homelessness/?gclid=EAIaIQobChMIx46V9NnV7wIVFoFQBh0hTQZvEAAYASAAEgKX0_D_BwE Accessed: 29 March 2021.

Luchenski S., Maguire N., Aldridge R.W. et al (2018) "What works in inclusion health: overview of effective interventions for marginalised and excluded populations", The Lancet. Vol 391, Issue 10117, pages 266-280.

A Nutrition Education and Cooking Intervention in a UK Foodbank

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A case study exploring the practicalities and experiences of implementing a healthy diet skills programme in a foodbank setting.

Background

There has been an exponential rise of foodbanks in the UK over the past decade. In 2008/09 25,899 people received 3 days emergency food from UK foodbanks, this rose to 1,084,604 people by 2014/15 (1). The leading UK foodbank charity, The Trussell Trust, is a Christian organisation distributing food to those in need out of local church rooms or community centres. To address the foodbank clients' broader needs, a 'more than food' approach has emerged aiming to improve health and wellbeing and advance social circumstances. As part of the 'more than food' approach Coventry Foodbank and Coventry University in partnership working applied for funding from Lottery Awards for All to fund for one year a graduate part-time dietitian to design and deliver a cooking and nutrition course.

This intervention was deemed necessary as food insecurity is a growing concern in the UK with 8.4million individuals (13%) food insecure in 2014 (2). The diets of foodbank clients usually fall short of healthy eating recommendations as they are unable to acquire or consume an adequate quality or sufficient quantity of food (3). Coventry Foodbank wanted to be able to provide practical skills and knowledge regarding healthy eating and cooking at a low cost to supplement the foodbank parcel they were giving to clients.

The aims of the intervention were:

- To communicate health messages in an appropriate way to support dietary and lifestyle change

- To explore the role of a dietitian in a UK foodbank
- To test the feasibility of delivering a nutrition intervention for foodbank clients and to measure change in nutrition knowledge, food choice and confidence of healthy eating and cooking

Practice Development

A two-week nutrition education and cooking intervention was delivered in a UK foodbank by a dietitian. The population was defined as foodbank clients accessing support at Coventry Foodbank. The intervention involved 2 x 2hour sessions, split into one-hour nutrition education and one hour on cooking fresh vegetable soup. The focus of the intervention was on ‘Soups for Revival’ as this was a stipulation of the funding grant. It was felt that soup was a simple nutritious meal to use as a starting point to improve skills and knowledge.

All foodbank distribution centres had posters for advertisement. The intervention took place at four of the busiest foodbank centres. The kitchen facilities at these venues were basic and sometimes portable cooking equipment was taken to the venue. Recruitment took place for 2 weeks and following this the intervention was delivered for 2 weeks. Recruitment took place whilst clients received soup and a roll whilst waiting for their foodbank parcel. Giving out the soup and collecting the empty mug created the opportunity to recruit onto the programme.

The length of the course was agreed with different stakeholders. Recommendations from research highlighted the challenge of delivering an intervention in a hard to reach group within longer timeframes (4). Two weeks was felt to be an attainable course length that would reach a wider audience. At the time of delivering the intervention there was a local 9 week ‘cook well eat well’ council-run course being delivered, so clients were also able to be signposted to this course.

The content of the nutrition intervention was developed from existing interventions and available resources. This included:

Week 1: learning about The Eatwell Guide, food budgeting tips and reducing food waste. The first week tomato soup was made. When making the soup there was the opportunity to discuss cooking tips and get to know one another.

Week 2: meal ideas using ingredients given at the foodbank, understanding food labels and physical activity ideas. The second week the soup made was chosen by the group during the first session. The nutrition information was tailored to foodbank client’s needs and resources. For example, one foodbank client only had a kettle and no other cooking facilities therefore some of the content was adjusted accordingly to meet their needs. Clients attending both weeks received a hand blender, recipe cards and ingredients to make the soup at home. The resources were used as an incentive to sign up to the course and encouraged participants to make the soup at home instilling new behaviours.

Measuring Impact

An intervention-specific questionnaire was completed pre and post intervention, to measure change in nutrition knowledge, food choice and confidence. Knowledge was measured by asking foodbank clients the recommendations for physical activity, fruit and vegetable intake and questions on The Eatwell Guide. Food choice options related to budgeting and shopping were measured by identifying and ranking statements such as 'writing a shopping list' as: already do it, will try to do it and not for me. Confidence was measured by ranking a variety of variables on a 5-point Likert scale, such as 'preparing healthy meals from the foodbank parcel'. Feasibility was measured through client's uptake and attendance rates. A Wilcoxon test, McNemar paired sample test, and 2-tailed paired sample T-test were run on the data. 95% confidence intervals around the mean change was presented and statistical significance was accepted at $P<0.05$.

42 foodbank clients completed the intervention, and on average there were 2-4 foodbank clients on each course. Only 2 foodbank clients (5%) did not complete the intervention. The low dropout rate (5%) demonstrated acceptability of the intervention. Attrition from recruitment of the intervention to attendance was high (42%). The mean age of participants was 36 years (±12 s.d.), 70% were female and 68% identified as single.

Following the intervention there was an increase in clients' knowledge of the recommendations for physical activity (55%) and The Eatwell Guide (40%) ($P<0.001$). Foodbank clients knew the recommendations for fruit and vegetable intake pre intervention, but their intake was low; on average 2 portions per day. Many of the food choice statements used to determine budgeting and shopping habits, were already observed, for example buying value brands ($P>0.285$) and 'using tinned/frozen fruit and vegetables' ($P>0.614$). Confidence was identified as the most improved measured variable. Across all variable's confidence increased with statistical significance, for example 'How confident do you feel in planning meals?' ($P<0.001$).

Learning

Positive features of the intervention:

- There was a low dropout rate between week 1 and week 2 of the intervention (95%).
- Improvements were noted in nutrition knowledge and confidence.

- Many of the clients stated that their cooking confidence had increased, and they were planning to try to cook more meals at home.
- Many participants reported that they enjoyed the social aspect of the course.
- At recruitment, offering homemade soup and a roll engaged potential participants and provided a nutritious meal whilst they were waiting for their foodbank parcel.
- Incentives to participate were well received, they encouraged attendance and empowered foodbank clients to instil new behaviours.
- Feasibility has been tested for the role of dietitians' in UK foodbanks.
- The dietitian provided an advocate role to other services within the foodbank network, for example referring on to the job club.

Challenges of the intervention:

- Advertising and recruitment of the intervention to the target population took a significant amount of time for the dietitian.
- Many people signed up for the intervention but did not attend. Of the 96 people recruited for the intervention only 42 (42.7%) attended.
- Transporting the cooking equipment between venues.
- Foodbank clients seeing improving health as important. Many of the foodbank clients had other important factors to address in their life such as housing and finance. Attending the programme was a low priority.
- A part time dietitian role meant that not all foodbanks within the Coventry Foodbank network were able to be targeted. It was also challenging to complete the objectives of the role in the time available.
- Relying on volunteers to support delivery of the intervention as not always were they able to help due to other commitments.
- Limited evidence base in the subject area.

Recommendations:

- On the spot interventions may work better instead of asking clients to return on a future date. For example, delivering a health promotion topic as a stand which foodbank users are encouraged to access as they are waiting for their foodbank parcel. There could be different topics delivered each week, that are put on a repeated cycle, examples could be cheap but healthy snack ideas, getting your five a day and increasing fibre in the diet.

- The clients supported are facing extreme hardship so it is important to understand what would be helpful in times of crisis. For example, by providing a key take home message and keep nutrition knowledge and terminology basic to increase engagement, as baseline knowledge was low.
- Adding recipe cards to food parcels using ingredients enclosed would also be a simple yet effective intervention as many foodbank users feel unsure what to do with the ingredients they are given. This is something some but not all foodbanks do.
- Text messaging to be used as the main method of communication to remind foodbank clients about the intervention.

Conclusion

The intervention identified that a dietitian working within a foodbank is a feasible and worthwhile asset and produced similar findings to other published research (5). The intervention made an important contribution to the foodbanks 'More than Food' model. Improving confidence to prepare healthy meals is important to support behaviour change and should be a key focus in interventions like this. This case study highlights the evolving role of an allied health professional in the community setting developing on existing assets such as community buildings and volunteers.

'Food is a simple medium through which powerful positive change can take place within our community'

References

1. The Trussell Trust (2016) *Latest Stats* [online] available from <https://www.trusselltrust.org/news-and-blog/latest-stats/> (accessed January 2016)
2. Taylor and Loopstra (2016) *Too Poor to Eat: Food Insecurity in the UK* [online] available from < https://foodfoundation.org.uk/wp-content/uploads/2016/07/FoodInsecurityBriefing-May-2016-FINAL.pdf > (accessed January 2017)
3. Dowler, E., Kneafsey, M., Lambie, H., Inman, A. and Collier, R. (2011) *Thinking about 'food security': engaging with UK consumers* [online] available from < http://wrap.warwick.ac.uk/37633/1/WRAP_Dowler_CPH_consumer_views_food_security_full_july11.pdf > (accessed January 2016)

4. Flynn, M., Reinert, S. and Schiff, A. (2013) 'A Six-Week Cooking Program of Plant-Based Recipes Improves Food Security, Body Weight, and Food Purchases for Food Pantry Clients' *Journal of Hunger and Environmental Nutrition* 8 (1), 73-84
5. Butcher L, Chester M, Alberle M, et al. 'Foodbank of Western Australia's healthy food for all'. *British Food Journal* 2014:116:1490-1505

Art Psychotherapy in the community. Addressing health inequalities through Social Prescribing - an Asset Based Community Development (ABCD) approach

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Description

The Art Room @ is an art psychotherapy practice run by the third sector charity LS14 Trust. It is designed to support people within their community addressing the impact their lived experiences brings to bare on their mental and physical wellbeing. Working in partnership with local community members, and strategic partners to form a range of locally driven initiatives including creative arts in health projects, addressing the wider determinants of health inequalities. Combining the Social Prescribing model and Asset Based Community Development (ABCD) approach as part of this psychotherapeutic intervention, supports clients to bring about sustainable behavioural change in addressing health inequalities for themselves and the local area.

Context

The Art Room @ is situated in the Killingbeck and Seacroft ward in Leeds.

The health profile (2019) for this ward indicates it has a GP registered population of 27,175 and ranked the fourth most deprived area in Leeds. GP recorded conditions for 2019 indicates a significant number of the local population have a diagnosis of obesity, COPD, diabetes, as well as both common and severe mental health conditions (Observatory Leeds, 2019) such as depression, anxiety, psychosis, personality disorders and trauma, including managing and maintaining physical wellbeing of diagnosed conditions.

The Art Room @ is a free service providing local and accessible psychotherapeutic support to adults aged 18+ living in Leeds who experience high levels of health inequalities. This service offers a 12 week course of group or 1-1 sessions for clients to explore, come to terms with, draw conclusions from and learn to find new ways of coping with their mental and physical health and overall wellbeing.

Art psychotherapy uses art materials as its focus for expression and communication, enabling individuals to use art to creatively express themselves. Art therapy is a part of therapy in many psychiatric conditions. Art psychotherapists are registered with the Health Care and Professional

Council (HCPC) and are one of the 14 Allied Health Professionals who provide a range of services in connection with healthcare both in the NHS and community settings.

Method

The Art Room @ adopts an Asset Based Community (ABCD) approach to community development (Nesta, 2020). Initially the service was set up as a pilot project in 2015 delivered by a trainee Art Psychotherapist who was also an LS14 Trust volunteer, funded by the local Council Housing Advisory Panel (HAP). The success of the service has grown year on year and is now contracted by Leeds City Council through Live Well Leeds (LWL) to deliver this programme over a 5-year contract ending in 2023.

The referral process is predominantly based on social prescribing from a range of different pathways, i.e. GP social prescribers, LWL, statutory and third sector, personal recommendations from community members and self-referrals. Social prescribing aims to holistically address the needs of an individual enabling them to take greater control of their own health.

Social prescribing – addressing people's needs in a holistic way

GPs and other health care professionals can refer people to a range of local, non-clinical services, supported by a link worker or connector

GPs and other health care professionals can refer people to a range of local, non-clinical services.

Figure from: Public Health England (2018). *Health matters: community-centred approaches for health and wellbeing*

In excess of 50 referrals are received in any one year and approximately 40 clients a year engage in the programme. Average attendance is approximately 74% over the course of a 12-week programme. The project currently employs one art psychotherapist for 3 days per week.

The service is based in a community building with a café space offering a range of engagement opportunities in creative arts in health activities, community development, volunteering, training programmes, access to digital inclusion and agencies addressing social and economic need. People receive support holistically and seamlessly across their life course, enabling therapy to become an inclusive option for all at any point during their lives.

Evidence suggests that psychosocial pathways are integral to health inequalities and as such should be the focus of consideration in contributing to the reduction of inequalities, including addressing social determinants of health, early intervention, and developing a comprehensive pathway across the life course as a whole (Public Health England, 2017).

The symbiotic relationship between art therapy and arts in health programmes, in particular, and social prescribing, allows people to engage in community life, balance access to support services when needed and take part in social activities for enjoyment and pleasure. Social prescribing allows a two-way flow both in and out of the therapy, allowing clients to go beyond the therapy space and continue to further develop behavioural change.

Outcomes

To date a range of improvements have been recorded ranging from:

- Maintaining work life balance,
- Strengthening family relationships and widening social networks,
- A reduction in: substance dependency, prescribed medication, self-harm, suicidal thoughts and ideations, social isolation,
- An increase in: volunteering and employment, engagement in wellbeing activities, referrals to financial support services such as housing and councillor surgeries, engagement in further education opportunities.

Star Recovery is the evaluation tool and uses point score differences as a measurement of outcomes. By far the most effective illustrative evaluation, in this services experience, is personal client narratives. Greenhalgh (2016) cites narrative as “an essential tool for reporting and illuminating the cultural contexts of health” and “used appropriately, stories can complement more conventional forms of research.”

One such client, Andrea (pseudonym) 57 years old. From attending art therapy in 2015, referred through GP social prescribing experienced stress, anxiety and an underlying undiagnosed stomach complaint. Andrea was referred through her local GP social prescriber. At the end of therapy she recorded a point score increase of 3 in confidence and self-esteem, 2 in relationships, 5 in area of work. Andrea progressed from art therapy to volunteering, further education and training, has become self employed as a community aromatherapist, no longer requires medication and no longer under a hospital consultant. Andrea says her journey to recovery began in taking part in art therapy which offered opportunities beyond the therapy room in the same place, illustrating that “Community-centred ways of working are important for all aspects of public health, including health improvement, health protection and healthcare public health” (Public Health England, 2018).

Key learning points

The LS14 Trust became the host organisation for the Ward Covid Response Hub during 2020/21. The community, through the collaboration of all organisations involved, is beginning to see positive effects of this way of working.

Overtime it would be beneficial to scale-up a whole-system community-centred approach, a ‘challenge’ cited by Public Health, that many localities face (Public Health England 2018). There is the potential to develop a ward-wide wellbeing engagement strategy developed at local level encompassing a variety of support services and engagement activities including a range of therapy services, including all arts therapies modalities, such as drama, music, art, dance and movement, including environmental and talking therapies. Aiming to embed a model of therapies working alongside arts in health and socio-economic support and health care services, developed by and with community members.

It is clear the Art Room service addresses, to some degree, health inequalities and the public health model. A healthy number of referrals continue to be maintained through social pre scribing. Approximately three quarters of those referred go on to receive a programme of support during therapy. Beyond therapy a number of clients continue to benefit as they are referred to additional services or engagement opportunities.

There are gaps in referrals that would benefit from collaborative working with other AHPs and health professionals both at local PCN and Trust levels. Referrals from Occupational Therapists, Community Mental Health Teams (CMHT), Community nurses, Therapeutic Nursing Team, Dieticians, Paramedics as examples. The aim would be to co-ordinate and design art therapy groups that encompass a psychoeducational approach, developing patient understanding of their conditions, build confidence and autonomy to elicit behavioural change. Working with groups recently diagnosed with an illness, experiencing chronic pain, recovering from surgery, living with mental health, people in the ECV category and improving better health outcomes, reducing dependency on services for non-clinical conditions as examples.

Return on investment (ROI) has not yet been undertaken. It can be seen that aspects of ROI are present. This would be an area of focus service development, strengthening future commissioning opportunities. The infographic below demonstrates the impact of the Arts on social and health determinants in addressing health in equalities.

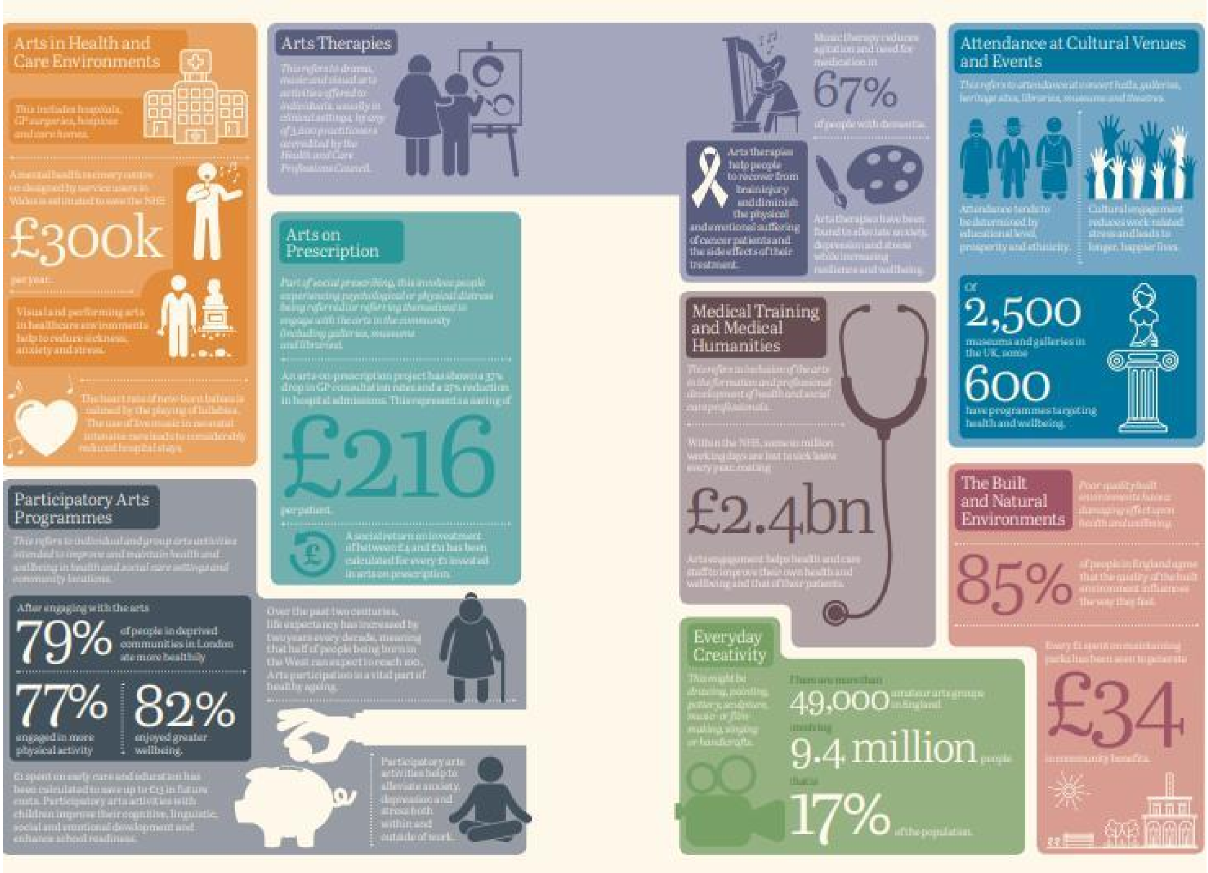

Figure from: Culturehealthandwellbeing.org.uk. (2014) *All-Party Parliamentary Group on Arts, Health and Wellbeing*

An expansion of the service with more practitioners across all modalities of therapy would provide diversity enabling people to engage in therapy suited to their needs, addressing the NHS Long Term plan to personalise recovery pathways that bring about personal and community growth by holistic, systemic change in addressing health inequalities.

Longitudinal research would be beneficial to explore sustainability of behavioural changes made in the art therapy programme. Working with clients over a timeframe between 12 weeks to five years, using robust arts therapy based evaluation and research. Demonstrating how art therapy can contribute to addressing health inequalities through a community-based approach is, I suggest, the way forward.

References

Culturehealthandwellbeing.org.uk. (2014). *All-Party Parliamentary Group on Arts, Health and Wellbeing*. [online] Available at: https://www.culturehealthandwellbeing.org.uk/appg-inquiry/.

Greenhalgh, T (2016). Cultural contexts of health: the use of narrative research in the health sector. [online] Available at: https://apps.who.int/iris/handle/10665/326310

Health profile overview for Killingbeck and Seacroft ward. (n.d.). [online] Available at: https://observatory.leeds.gov.uk/wp-content/uploads/2019/04/Killingbeck-and-Seacroft-Ward-April-2019.pdf.

Nesta. (n.d.). *Asset-Based Community Development for Local Authorities*. [online] Available at: https://www.nesta.org.uk/report/asset-based-community-development-local-authorities/.

Public Health England (2017). *Psychosocial pathways and health outcomes*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/psychosocial-pathways-and-health-outcomes.

Public Health England (2018). *Health matters: community-centred approaches for health and wellbeing*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing.

Forgotten Feet – Helping Homeless Feet

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Introduction

Forgotten Feet was set up in 2013 by podiatrist Deborah Monk, to provide a foot care service to the homeless, socially isolated and vulnerable people. By working alongside existing homeless charities, the service is easily accessible to the target population. The main objective is to alleviate pain and suffering where possible, to be non-judgemental, and show compassion.

One of the most important aims was to establish a growing network of like-minded podiatrists to run Forgotten Feet clinics, often with the help of Foot health practitioners, covering as many towns and cities as possible. The founder was inspired to do this after seeing the plight of homeless people in the town she worked in, often in pain and discomfort heading into the homeless centre. Therefore, armed with the necessary skills, Deborah launched the first clinic in August 2013, running every four to six weeks. From this humble beginning, many other clinics were set up, seeing a great network expansion and Forgotten Feet becoming a registered charity in 2018.

The rationale behind starting this charity was recognising the prevalence of painful, untreated foot and lower limb conditions in around two thirds of the homeless population (To et al, 2019); and indeed the health inequalities whereby those with the least means and most needs are least able to access podiatry. In order to address this, the care received is free at the point of service and available to anyone who frequents a homeless centre. Another important point is that of footwear, often completely worn out or ill-fitting leading to painful foot conditions. Some people can only access clothing banks, if at all, for shoes, often accepting or selecting inappropriate footwear. Along with treatments it's often necessary to replace footwear and issue socks. Many rough sleepers have reported not being able to remove shoes or socks for weeks or months, and in the winter months they get wet and cold giving rise to conditions such as trench foot, bacterial and fungal skin infections, frost bite, gangrene and ulceration. Simple biomechanical issues are also dealt with, and orthotics can be issued if necessary, depending on supplies.

Cellulitis can be a problem seen in the lower limb especially amongst drug users who inject, early intervention can save life. With practices like skin popping on the increase, cellulitis and other serious infections or conditions will be more prevalent – Skin popping is basically a subcutaneous deposition of illicit drugs, intended to slow absorption and reduce the risk of an overdose. If infections are noted and pointed out, the service user is likely to take notice, and obtain medical advice and/or antibiotics from a local GP drop-in centre or A&E department, reducing the likelihood of hospitalisation, (Saporito et al, 2018).

How the service works

The clinics are run on a regular basis, each clinic determined by the availability of volunteers who kindly give their time. All volunteers are qualified and insured, most of them from the private sector. The supplies (instruments, consumables, medicaments, socks and shoes) are sent from Forgotten Feet storage, all of which are donated, or purchased with funds raised. There is an open-door policy, appointments aren't usually necessary unless there is a great demand at a session; in which case the more urgent cases are prioritised by the staff. The service can be run almost anywhere, though dignity is best preserved in a quiet area or separate room. This opportunity for intervention allows sign posting to other services if needed, with many centres having contact numbers for helplines – for example 'Rape Crisis'. Everything required for a treatment session is supplied by Forgotten Feet. In establishments or venues with a room that can accommodate it, a podiatry couch and work station can be supplied.

It is important to break down barriers and build trust in order to get continuity of treatment where possible. Barriers to healthcare can be a hurdle to overcome, but some centres have observed that many service users are happy to see a podiatrist, and in doing so are more likely to engage with other healthcare services. A friendly informal attitude is adopted without pressure for too much information from the service user in order to put them at ease. Fear of disclosure and retreating behaviours are often seen, as well as real and perceived communication difficulties (Davies et al. Med J Aust 2018). As a minimum, a name and date of birth is taken, other information is often given during that treatment or at subsequent visits. Another barrier can be a clinical uniform; this is overcome by asking volunteers to wear a blue polo shirt with a Forgotten Feet logo. In doing so, this identifies volunteers as professionals but is notably less intimidating to service users than a clinical uniform. Other barriers to healthcare include service users having to make formal appointments or having to visit a clinical setting which can be daunting. This may be physically difficult with regards transport and costs, if it's not easily accessible (Chrisp, 2021).

Impact and outcomes

Since its inception in 2013 by its solo founder, before the pandemic in 2020, Forgotten Feet had 89 clinics distributed around the UK, and 320 volunteers running sessions every 4 – 8 weeks. At these sessions an average of 8 people would be treated, amounting to a conservative estimate of 5,542 treatments being carried out and of those around 20% would be returning clients.

Early anecdotal data shows this service is preventing potential hospital admissions, as early intervention is detecting infections before they require more serious treatment.

Hospital admission via A&E in an ambulance for one day costs the NHS £1,102, (Kings Fund 2019) when multiplied by the individual contacts this amounts to a potential saving to the NHS of £6,187,284; although money has never been the focus, this incidental saving is a real benefit to the NHS.

Very little has changed with regards to how Forgotten Feet is implemented, other than raising awareness of problems. Promoting Forgotten Feet in a positive light helps to demystify and dispel common prejudice around homelessness. The opportunity to share stories and challenges faced by service users helps to make an often hidden community more visible.

Feedback has been very positive; this example gives the perspective of volunteer coordinator at Maggs Day Centre, Worcester (2016), quote:

'*Forgotten Feet have made remarkable progress in improving the health and wellbeing of our service users over the time they have been engaging with us. Perhaps the most interesting measure of the beneficial effect Debi is having lies in the attitude of the service users. When the initiative started few people were putting themselves forward for help. As the service has gained more credence this situation has reversed, there is now an appointment system in place to cope with the high demand for help. This is perhaps the most telling indicator of success in that there is a clear perception among the service users that their difficulties are being resolved.*

Forgotten Feet has enabled some service users to alleviate the symptoms of painful and long-term neglect of their feet allowing them to emerge from a cycle of despair. Others have benefitted by finding the remedial action has moved them from being medically unfit for work into the fit for work category. A third group have found the treatment and attention has helped them in developing a more positive view of life so ameliorating their mental health difficulties.

Perhaps the most profound effect has been in restoring service users' faith in medical services, if they see the benefits of engaging with podiatry then it is a small step to get motivated to engage with dentists for example.

In summary, engagement with Forgotten Feet has had a range of positive outcomes from the direct improvement of feet to the alleviation of mental health problems with the added benefit of making it more likely for service users to engage with other medical services.'

Key learning points

Forgotten Feet clinics are a valuable source of CPD for all volunteers; it broadens the practitioner's scope of practice, exposing them to conditions not normally encountered in general private practice. Information is disseminated to volunteers about conditions they may encounter, usually through the social media group. Volunteer safety is important, therefore treatment guidelines, safety precautions and guides to risk assessments are sent to everyone, and generally the advice is to work in pairs where possible. Many clients are drug/alcohol users, knowing this, volunteers are very careful to protect people's identities when sharing sensitive information or case studies. Being adaptive and thinking on one's feet is a skill often acquired, as it's necessary to consider the consequences of any treatment given due the environment some of the service users have to endure. Mental health issues are often encountered, some can be complex and challenging, information is available and learning how to deal with a diverse range of characters is very useful. Of the service users it is estimated that 49% have mental health issues, 39% are drug users, or in recovery, 27% have or are recovering from an alcohol problem, 73% have physical problems of which 41% are long term and 30% have had a criminal conviction (Bubb-McGhee et al, qni.org.uk).

Challenges faced by Forgotten Feet have been greatly exacerbated by the pandemic. Many volunteers have not resumed, and some venues have closed permanently. Raising money has also been difficult during this time, as has promoting the charity and attracting potential volunteers.

Many homeless charities have approached Forgotten Feet for help with their clients, unfortunately unless they are near an established clinic this isn't feasible. In some locations such as Birmingham, the NHS have retracted their homeless service, now the need is greater than ever, especially in the major towns and cities.

Some useful learning outcomes include that of how to engage the hardest to reach, who often have very painful feet but are mistrusting and cautious. In some centres, food vouchers are given after they have received podiatry treatment, or a free hot breakfast. Food is often a great incentive. Listening rather than talking, showing interest and encouraging clients to talk about themselves is helpful. 'Approach and retreat' – approach, give a pair of socks, then retreat, this helps with introduction in a passive manner. Podiatry is a useful tool for intervention within the harder to reach homeless community.

Future plans to embed this service include encouraging student podiatrists on board, either to help with fundraising activities or final year placements. By promoting the charity at conferences, it is hoped more volunteers will come forward. In addition, new ways of ensuring better volunteer retention need to be explored. It is hoped in the near future that a reliable means of collecting raw data can be established with the cooperation of the volunteers.

References

Bubb-McGhee M, Rhodes L, Homelessness and the Criminal Justice System. https://www.qni.org.uk/resources/homelessness-criminal-justice-system-2/ (online, Accessed 17.12.2021).

Chrisp, P., 2018. New Draft Guideline To Help Reduce Health Inequalities In People Experiencing Homelessness https://www.nice.org.uk/news/article/new-draft-guideline-to-help-reduce-health-inequalities-in-people-experiencing-homelessness (Accessed 17.12.2021).

Davies A, Wood LJ. Homeless health care: meeting the challenges of providing primary care. Med J Aust 2018 Aug 3;209(5):230-234. Doi: 10.5694/mja17.01264. https://pubmed.ncbi.nlm.nih.gov/30157413/

The Kings Fund: Key Facts and Figures about the NHS (2019) https://www.kingsfund.org.uk/health-care-explained (online, Accessed 11.01.2022)

Saporito, R., Pineiro, M., Migden, M., Silapunt, S. 2018. Recognising Skin Popping Scars, a Complication of Illicit Drug Use. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6070054/(Online (Accessed 17.12.2021).

To JM, Brothers TD, Zoost C (2016) Foot Conditions among homeless persons: a systematic review. PLoS ONE 11 (12): e0167463: 10.1371.

Nutrition Skills for Life®(NSFL): Providing quality assured nutrition skills training for community workers and support for the development of community food and health initiatives

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Description

NSFL is a programme of nutrition training for health, social care and third sector workers, developed and co-ordinated by dietitians working in the NHS in Wales. Working with local communities and partner organisations, ***NSFL*** aims to build community capacity to access a healthy balanced diet, a major determinant of health, wellbeing and quality of life.

NSFL trains frontline workers, volunteers and peer leaders to promote healthy eating by incorporating evidence-based food and nutrition messages into their work. There are two key aspects to the programme;

1. Accredited nutrition skills training for community workers to help them to competently cascade nutrition messages and to support those working in community settings to provide healthy/nourishing food and drink options e.g. in nurseries, play groups, after school clubs, residential homes and care settings for older adults.

2. Co-production of healthy eating initiatives with community groups. This can include offering accredited practical cooking skills, nutrition skills or weight management courses depending upon identified need. All courses are accredited by the Welsh awarding organisation, Agored Cymru, enabling people to gain credit for learning; a potential route into further learning and employment opportunities.

Context

Launched in 2006, funded by Welsh Government and evaluated by Glyndwr University[1], ***Nutrition Skills for Life®*** operates in all seven NHS Health Boards in Wales.

Nutrition Skills for Life® aims to build capacity of communities to support healthy eating and prevent malnutrition.

The objectives are to:

- Increase the capacity of the community workforce in Wales to inform and support communities in healthy eating and prevention of malnutrition

- Develop a standardised approach for accredited nutrition training across Wales, promoting consistent nutrition messages and contributing to preventing nutrition related disease
- Support the development of healthier environments and improved access to nutritious foods through training and professional advice
- Support local action e.g. supporting development of local community food initiatives ensuring they are evidence based
- Support local partnerships to raise the profile of nutrition and help to achieve better outcomes in relation to nutrition and health for their population
- Focus on lower socioeconomic/hard to reach groups
- Focus on 0-25's and vulnerable older people

Poor diet is a risk factor for obesity and other chronic conditions such as type 2 diabetes, hypertension, cardiovascular diseases including heart disease and stroke, respiratory problems, joint problems, lower back pain, and some cancers e.g. breast and colon cancer. In Wales 61% of adults are overweight or obese, including 25% obese[2]. More than a quarter of 4-5 year olds are classified as overweight or obese (26.4%) including 12% obese[3]. Obesity is steadily increasing with greater prevalence among lower socio-economic groups. Prevalence of obesity in 4-5 year olds is 6% higher in those living in the most deprived areas. This rises to a 13% difference in adults. High Body Mass Index (BMI) is the leading risk factor for Years Lived with Disability (YLD). The top 3 risk factors are directly linked to diet and obesity[4].

Method

Dietetic services in Wales experienced increasing demand from partner organisations for quality assured nutrition training. The development of the health care support worker role and national programmes in Wales including Flying Start[i] and Families First[ii], provided significant opportunities to train the wider workforce in nutrition. The development of a national nutrition skills training programme would provide a standardised, consistent, evidence-based approach to meet this increasing demand. Utilising dietetic expertise to train and support community workers to cascade evidence-based nutrition messages would reach more people than the dietetic service would be able to do alone.

During 2005, Public Health Dietitians in NHS Wales worked in partnership with Welsh Government, Agored Cymru and community workers to plan, develop, deliver and evaluate an accredited nutrition skills training programme. Since launching in 2006 a range of standardised learning, teaching and assessment resources including tutor facilitation manuals, learner workbooks and evaluation tools have been developed for all courses. This 'once for Wales' approach avoids duplication and benefits from economies of scale in line with prudent health care principles. The training model successfully supports implementation of nutrition elements of national schemes including the Healthy and Sustainable Pre School Scheme, Designed to Smile oral health projects, Welsh Network of Healthy Schools Scheme, Corporate Health Standard and the implementation of the Best Practice Guidance for Food and Nutrition for Childcare Settings[5] and in Care Homes for Older People[6]. ***NSFL*** has achieved recognition as a model of good practice at local, national and UK wide level*. It has been successfully embedded into national programmes in some areas e.g. Flying Start and Families First and is firmly embedded in Welsh Government strategic priorities e.g. digitalisation of ***NSFL*** is a commitment within the Welsh Government's renewed priorities for ***Healthy Weight: Healthy Wales 2020-2022***[7].

Outcomes

External evaluation was undertaken by Glyndwr University from 2006-2010. Since then annual reports are submitted to Welsh Government. The Results Based Accountability approach to programme performance monitoring is used to monitor the extent to which ***NSFL*** programme objectives are being met and to ensure a standard all Wales approach.

Performance measures have been identified by Public Health Dietitians in Wales and data is collected using standard evaluation questionnaires and databases.

Evidence of impact between April 2018 and March 2019 includes:

- **91** Level 2 accredited courses were accessed by **902** staff
- **174** Level 1 nutrition skills courses were accessed by **1150** members of the community
- **157** non accredited training sessions were accessed by **2839**
- **100%** staff attending Level 2 courses rated the course as good (**16%**) or excellent (**84%**)
- **100%** staff attending Level 2 courses reported they would recommend the course to others
- **99%** individuals attending Level 1 courses rated the course as good (**13%**) or excellent (**86%**)
- **97%** staff accessing Level 2 courses gained credit for learning
- **84%** individuals accessing Level 1 courses gained credit for learning
- **99%** staff completing Level 2 CFNS training reported feeling confident (**72%)** or very confident (**27%**) to deliver the Level 1 accredited course
- **91%** reported learning something new about food and nutrition as a result of attending Level 1 course
- **88%** reported making changes to what they eat as a result of attending Level 1 course
- **94%** reported making changes to what their family eat as a result of attending Level 1 course
- **79%** reported eating more fruit and **70%** eating more vegetables as a result of attending Level 1 course
- **83%** reported eating less fatty /fried foods and **84%** less sugar/sweet foods as a result of attending Level 1 course

Key learning points

- We have worked nationally as a profession, avoiding duplication, sharing good practice, and collaborating to continually update and develop standardised, national nutrition learning and teaching resources.

- Working in partnership with an awarding body -Agored Cymru- enables learners to gain credit for learning and has ensured the quality and integrity of the programme is maintained.

- Continued to develop to support new initiatives e.g. the infrastructure has supported the roll out of other programmes utilising the same model i.e. 'Foodwise for Life' structured weight management programme and the School Holiday Enrichment Programme (SHEP).

- Maximised opportunities for partnership working with other organisations and initiatives to strengthen the nutrition component e.g. Flying Start, Welsh Network of Healthy Schools Scheme, Healthy and Sustainable Pre School Scheme.

The programme stalled during 2020 due to the Covid-19 pandemic. With physical distancing requirements likely to continue for some time we needed to transform our accredited traditional face-to-face training to online teaching and virtual face-to-face delivery to continue to reach communities to support healthy eating.

The Welsh Government has committed to *'Invest in fully digitalising the all Wales* ***Nutrition Skills for Life®*** *programme, enabling continuation, through virtual delivery, of all community-based initiatives including Foodwise for Life, Foodwise in Pregnancy and Community Food and Nutrition Skills programmes'.*

Our future priorities are:

- Ensure every child has the best start in life by optimising nutrition in the first 1000 days.
- Ensure the early years and childcare workforce and those caring for older people have the knowledge and skills to be able to improve nutrition and hydration for those they care for.
- Embed healthy eating into the school curriculum by training others to deliver nutrition and food skills training for children and young people, including the School Holiday Enrichment Programme.
- Widen access to accredited Level 1 nutrition, practical cooking skills and weight management course enabling more people to gain credit for learning.

The programme is on track to be fully digitalised by April 2021. This will provide renewed opportunities to further integrate nutrition skills training into local and national initiatives in Wales and to have far wider population reach.

References

1. Carnwell, R., Baker, S., Parry, O. and Kennedy, L. (2009). *An Evaluation of the All-Wales Dietetic Capacity Grant Scheme: Final Report*. [online] *An Evaluation of the All-Wales*. Available at: https://glyndwr.repository.guildhe.ac.uk/id/eprint/2911/1/fulltext.pdf [Accessed 21 Feb. 2022].
2. National Survey for Wales 2019-20: Adult lifestyle. (2020). Wales: Welsh Government.
3. Child Measurement Programme 2017/18. (2019). Wales: Public Health Wales.
4. Health and its determinants in Wales. Informing strategic planning. (2018). Public Health Wales.
5. Food and Nutrition for Childcare Settings. Best Practice Guidance. (2019). Wales: Welsh Government.
6. Food and Nutrition in Care Homes for Older People. Best Practice Guidance. (2019). Wales: Welsh Government.
7. Healthy Weight: Healthy Wales Taking forward the 2020-22 Delivery Plan: Renewed priorities for 2020-21. (2020). Wales: Welsh Government.

* Winners of the UK wide Bevan prize for "Health and Wellbeing 2014"
Winners of an NHS Wales Award in the category of "Promoting Better Health and avoiding disease 2014"
http://www.wales.nhs.uk/sitesplus/901/news/33500
Winners of Cwm Taf University Health Board "Health and Wellbeing Award 2013
Finalist in the Royal Society of Public Health- Health and Wellbeing Awards 2017
https://www.rsph.org.uk/about-us/news/health-wellbeing-awards-2017-shortlist-announced.html

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[i] Flying Start is a Welsh Government funded programme and is available in targeted areas supporting all families to give children aged 0-3 year 11 months a Flying Start in life.

[ii] Families First is a Welsh Government funded programme designed to improve outcomes for families with children & young people aged 0-25 years. It places emphasis on early intervention, prevention and providing support for whole families, rather than individuals helping families become confident, nurturing and resilient.

Slow cooking for communities, Northern Ireland

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Introduction and context

In February 2019, the Cook it! Team in partnership with North Ballymena Community Cluster (NBCC) group devised a cross community project "Slow cooking for communities" in the Dunclug & Doury Road areas in Ballymena. The NBCC aims to "increase social cohesion within the North Ballymena Area, reducing anti-social behaviour and sectarianism and increasing community confidence and wellbeing" [1]. Dunclug was identified as one of the most deprived super output areas within Mid and East Antrim for four of the seven domains including health and disability, income, education, skills and training and crime and disorder, resulting in them reaching the top 10 multiple deprivation list [2].

Evidence shows those living in deprivation are 47% more likely to be obese than those living in non-deprived areas [3]. Obesity is a significant health concern in Northern Ireland with 65% of adults being overweight or obese.

The National Diet and Nutrition Survey Northern Ireland shows that food energy from saturated fat exceeds the recommended maximum level, by 15-20% in children aged 4 years upwards and 20-27% in adults. Excessive amounts of saturated fats are linked with cardiovascular disease [4].

Conversely, AOAC fibre intake (American Association of Analytical Chemists method) and fruit and vegetables intake, did not meet recommended levels [5].

An interactive cooking class was the chosen programme design as research has shown that this type of intervention can improve confidence with cooking as well as improving dietary intake [6]. It was felt slow cooking was a convenient and cost-effective way to encourage families to cook from scratch whilst reducing reliance on processed convenience foods and takeaways. These foods tend to be higher in saturated fats and salt, and red and processed meats in excess is linked to an increased risk of colorectal cancer [7].

Method

An open invite was sent via WhatsApp and word of mouth by a NBCC community worker to two housing areas within the NBCC catchment area. An informal coffee morning was set up to allow participants to find out more about the project, get to know the Cook it! team, choose their favourite recipes and if desired, to sign up to the programme.

Four weekly interactive sessions lasting 2 hours were delivered by a Registered Dietitian covering theory on food safety, how to use a slow cooker, general healthy eating principles, sustainable diets, sugar, and fat. We used the British Dietetic Association's environmentally sustainable diet project, 'One Blue Dot' to demonstrate how sustainable eating can also be cost effective and good for one's health. A group activity demonstrating how useful store cupboard items can be in creating multiple dishes was included. Visual displays demonstrating the sugar and fat content of foods was discussed with participants.

During each session, the group prepared a recipe as a team. At the end of the session, they were encouraged to taste the recipe - a batch pre-prepared by the Cook it! Team. Participants who did not own a slow cooker, were provided with one funded by NBCC. Ambient ingredients were provided for each attendee to encourage replicating the recipe at home. The Cook it! team decided against providing high-risk foods, such as beef or poultry to minimise the risk of food poisoning.

A WhatsApp group was set up and managed by NBCC, to encourage group interaction and social cohesion. Each participant received a copy of the Causeway Coast and Glens Borough Council Slow Energy Efficient recipe book [8] and some kitchen utensils.

An intervention specific questionnaire was carried out pre and post programme, using remote devices from Turning Technologies. This allowed responses to be kept anonymous.

Outcomes

Despite the small pilot size, this programme showed promising results. Following the programme participants reported a 57% increase in cooking from scratch, 100% participants felt confident using a slow cooker and using a slow cooker once a week or more. 80% of participants reported making healthy changes to their diet and reported improved awareness of healthy eating. Takeaway consumption reduced from 86% of participants purchasing 2-4 times per week to 80% having takeaways once or less per week, with the remaining 20% having takeaways no more than twice per week. There was a reduction in the use of processed foods. At baseline, 43% of the group consumed processed foods daily, this reduced to 100% consuming these foods twice or less per week, following the programme. A study by Mills et al (2017) supports home cooking for health.

"…eating home cooked meals more frequently was associated with better dietary quality and lower adiposity" [9].

Fruit and vegetables intake did not change with 100% of the group consuming 0-2 portions per day.

Participants from both communities attended and interacted well with each other, sharing ideas on WhatsApp and working together.

A focus group at eight months post initial intervention revealed:

- 100% of participants would recommend the programme and the use of a slow cooker to their friends/family.

- 50% of participants have used their slow cooker at least 1-2 times per week since attending and the remainder used it at least a few times.
- 57% reported consuming takeaways once or less per week.
- 57% reported consuming processed foods once or less per week.
- 100% found the sessions interesting and enjoyed learning more about food and nutrition.
- The group enjoyed practical cooking, food sampling and interactive displays.
- No one used the Causeway Coast and Glens Slow Energy Efficient recipe book.

Key learning points

The group reported enjoying the short interactive educational sessions on healthy eating, followed by a practical cooking session. A slow cooker is not required for everyone and participants indicated they would have attended irrespective of the provision of a slow cooker, therefore the need for this could be checked at registration. Ambient ingredients did not have the positive impact of encouraging the recipe replication at home, therefore we would review the provision of these items in future.

A printed recipe book was provided to each member. However, from feedback these were not used. Supplying a PDF version via the group WhatsApp or use of online resources would save cost and would be more environmentally friendly. Participants suggested a series of ‘fake-away’ recipes would be useful to include in future recipe books.

It is widely accepted that the cause of obesity is multifactorial but participants provided feedback they would like to know more about portion sizes and calories .[10] Although obesity rates in this group were not reviewed, this desire to increase knowledge of portions sizes and calories is encouraging, given the link with larger portion sizes and increased energy intake.[11]

Follow-up at 8 months showed the sustained use of the slow cooker. However, we did not review the type of recipes being prepared in the slow cooker. This would have been useful to review to understand more detail on the types of food prepared.

This pilot was presented to and reviewed by our regional colleagues in the Public Health Dietitians group in Northern Ireland and has since been adapted into a train-the-trainer model, with training sessions being delivered virtually and knowledge passed on to groups, including those from socially deprived areas, throughout Northern Ireland.

References and additional links

1. The Charity Commission for Northern Ireland (2014) North Ballymena Community Cluster. Available at: https://www.charitycommissionni.org.uk/charity-details/?regid=100224&subid=0 (Accessed on 12/12/2021)

2. Northern Ireland Statistics and Research Agency (2017) Northern Ireland Multiple Deprivation Measure
   Available at: https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017 (Accessed on 12/12/2021)

3. Department of Health (2020) Health Survey NI First Results 2019/20. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-19-20.pdf(Accessed on 12/12/21)

4. The National Institute for Health and Care Excellence health (2010) Cardiovascular disease prevention (PH25), Chapter 1. Available at: https://www.nice.org.uk/guidance/ph25/chapter/1-Recommendations (Accessed on 12/12/2021)

5. National Diet and Nutrition Survey (NDNS RP): Results for Years 5 to 9 (2012/13 - 2016/17) (combined) and time trend and income analysis Years 1 to 9 (2008/09 - 2016/17) Available at: https://www.food.gov.uk/research/national-diet-and-nutrition-survey-ndns/national-diet-and-nutrition-survey-ndns-report-for-northern-ireland (Accessed on 12/12/2021)

6. Hasan B, Thompson WG, Almasri J, Wang Z, Lakis S, Prokop LJ, Donald D. Hensrud, Kristen S. Frie, Mary J. Wirtz, Angela L. Murad, Jason S. Ewoldt & M. Hassan Murad (2019) The effect of culinary interventions (cooking classes) on dietary intake and behavioral change: a systematic review and evidence map. BMC Nutr 5, 29 (2019). https://0-doi-org.brum.beds.ac.uk/10.1186/s40795-019-0293-8

7. Public Health England (2010) Scientific Advisory Committee on Nutrition Iron and Health. Norwich. TSO. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/339309/SACN_Iron_and_Health_Report.pdf (Accessed on 12/12/2021)

8. Causeway Coast and Glens (no date) Slow Energy Efficient Recipe Book Available at: https://www.causewaycoastandglens.gov.uk/live/health-and-built-environment/environment-health-and-well-being/wellbeing/improving-wellbeing-through-food/slow-energy-efficient-cookbook (Accessed on 12/12/21)

9. Mills S, Brown H, Wrieden W, White M, Adams J. Frequency of eating home cooked meals and potential benefits for diet and health: cross-sectional analysis of a population-based cohort study. Int J Behav Nutr Phys Act. 2017 Aug 17;14(1):109. doi: 10.1186/s12966-017-0567-y. PMID: 28818089; PMCID: PMC5561571.

10. S M Grundy (1998) Multifactorial causation of obesity: implications for prevention. The American Journal of Clinical Nutrition, Volume 67, Issue 3 https://doi.org/10.1093/ajcn/67.3.563S

11. M. Barbara E. Livingstone, L. Kirsty Pourshahidi, Portion Size and Obesity, Advances in Nutrition, Volume 5, Issue 6, November 2014, Pages 829–834, https://doi.org/10.3945/an.114.007104

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The Orthoptic visual processing difficulties (VPD) clinic during covid-19 lockdown. The affectivity of telephone consultation implementation rather than face to face visits

Kathryn Whitfield, Advanced Orthoptist

Description

At Warrington and Halton NHS Teaching Hospital Orthoptists have been providing telephone consultation opportunities to parents of children who are struggling with their learning due to possible visual processing difficulties.

Orthoptists are health care professionals with a degree in Orthoptics. They diagnose and treat a variety of differences and one extended role is in helping children with visual processing difficulties (VPD).

VPDs are characterised by a difficulty interpreting what the eyes see. It involves looking at how a young person struggles with reading and strategies that can be implemented to help them. For example, some students will lose their place when reading and skip words which interferes with their comprehension. Some children will get visual distortions of print despite excellent visual acuity. Other children may struggle with an aspect of visual perception such as their visual memory.

The cohort of children discussed below are new patients who would normally be seen and assessed for visual difficulties that may be interfering with their reading ability. These children were all referred into the service using the detailed referral sheet, by teachers or health care professionals prior to Covid-19. During lockdown, all children were being schooled at home either by the school via zoom, or by their parents. The VPD team wanted to help those children to feel more comfortable when reading and enable them to have the tools and strategies to help each child access the curriculum equally to their peers.

Context

The aim of the study was to assess whether telephone consultations would be as effective in diagnosing visual processing difficulties. Would the information gained without an actual face to face assessment allow Orthoptists to make a sound conclusion and offer appropriate advice?

The Orthoptist would then later see the child face to face and gain a qualitative understanding of the impact the virtual assessments had on the learning skills of the patient.

A full, detailed history was taken from the parents and that information was used to form a picture of likely difficulties. Strategies and advice were then offered to compensate for these possible difficulties and exercises that would target specific areas of improvement. For example, Orthoptists were able to reassure parents who were frustrated with their child's progress and reassure them that those difficulties may be related to a visual processing difference. This enabled a supportive environment for the child as the parents then understood that it was a treatable issue rather than a behaviour choice.

The VPD team provided an opportunity for a healthy conversation to take place such as addressing sleep or diet issues and offering signposting for advice.

All the advice, strategies and exercises were those used in the clinic. They were easy strategies to implement at home, for example making a reading ruler or window from paper to help the child to keep their place, changing the background colour/font size and style of the computer screen or playing games to help the child improve their visual perception skills.

The referrals into the Orthoptic VPD clinic are from educational settings across our local areas of Halton, Warrington and Widnes. The list of new patients who had been referred in the months March, April, May and June were collated onto an accessible spreadsheet. The parents of each patient were contacted and offered the opportunity to talk about their referral and a telephone consultation was done then or booked for a future date when convenient. The same questions were followed and advice was targeted dependent on the parent's and the child's answers and original referral. A lot of the time the phone was on speaker and the Orthoptists was able to have a full discussion with the whole family.

The aim of the assessments was to help children who would be working from home and finding it difficult. The Orthoptists wanted to make sure that the children were well supported in their educational setting. Another aim was to reduce the workload when the team were able to see routine patients again. The VPD team wanted to make good use of the quietest period when they were not able to see non-emergency patients face to face.

Method

Training of the 6 Orthoptists with the extended specialist role of VPD clinicians, to undertake virtual assessments took place during individual face to face or virtual meetings and was led by the lead of the service, Kathryn Whitfield. A standard operating procedure was implemented and reviewed by the team. Any difficulties were addressed and modified. Prior to completing telephone consultations, the clinicians watched Kathryn doing these virtual assessments and guidelines for reports to school were drawn up and continually modified. The assessment was based on a full history that is completed at every child's first visit which enables the clinician to gain a full detailed picture of likely difficulties. The history sheet that we complete is standardised and we know the strategies that work for each area of difficulty following years of audit and service improvement.

Kathryn Whitfield is also the co-lead of the British Orthoptic Society clinical advisory group for VPD so this information was discussed on the members forum of the website. This information was made available for other clinicians to follow if requested.

The VPD clinicians telephoned the parents of children who were referred into the Orthoptic visual processing difficulties clinic. During questioning about the general health of the child they ask lots of questions which are clinically relevant to learning and vision such as diet and sleep. Prior to referral into the clinic the class teacher or school special needs coordinator completes a detailed questionnaire about the child's learning. For example, do they lose their place frequently when reading? The Orthoptist discussed the specific school concerns and discussed what the parents had noticed, and together, came up with strategies to help the child. Parental permission was obtained to write a report and copy it to school, with every consultation. The advice could then be continued at school once the child returned and until they could safely return for a face to face Orthoptic clinic appointment.

There had been a small use of telephone consultations prior to lockdown. VPD Orthoptists previously asked that parents contact us if they wished, before appointments, to discuss any issues over the phone. This was purely at parental request due to sensitivity of the child when discussing past family history such as those children who are adopted.

Outcomes

There is no current patient quantitative evidence of the impact of these telephone consultations but the verbal feedback from the parents has been excellent so far. One quote from a parent was “the reading ruler that you suggested has had a huge impact on my son’s learning and understanding since I spoke to you”. In the clinic the lead of the VPD team performs yearly audits to provide evidence that the clinics are achieving the goals of helping children to read more effectively and therefore access the curriculum despite learning difficulties. The audit for 2021 is looking at patient and school satisfaction so when this time comes it would be hoped that despite not being able to see patients face to face, the Orthoptists were still able to provide an accessible and worthwhile consultation.

In December 2020 the VPD team lead sent out a questionnaire to all the schools in the area asking them what they felt the impact of the Orthoptic Visual Processing Difficulties clinic has on the learning of the child prior to and during lock-down. It was explained what the team had been doing during lock down to ensure that patients were being cared for. Feedback from schools was excellent. Schools are happy that they receive detailed reports, including suggestions on how to support these vulnerable children.

At the end of every consultation questions were taken. The majority of the time, the team were thanked for their advice and strategies and the feedback has been brilliant. Results from the December questionnaire sent to schools has shown that 100% of schools so far are happy with the service that is provided.

During a time when activity was low for patient contact, the VPD team were able to keep appointment activity up for this Orthoptic service. Once able to see patients face to face again, the VPD team continued with the telephone consultations to take a full history. This meant that the appointment time could be reduced to allow time to clean the room between patients and allow a greater number of patients to be seen. Rather than a new patient appointment being 1 hour it was reduced to 45 minutes allowing an additional patient slot to be created thereby increasing productivity.

Key learning points

The Orthoptic VPD team were initially very keen to start with the NHS ‘Attend Anywhere’ innovation. They found that the telephone consultations worked so well that they wanted to continue with them post-lock-down which they did. It cut down the face to face time that was spent with patients and during the initial post Covid climate this was reassuring to staff and patients. This was done for a 3 month trial period.

New patient slots were allocated to telephone consultations with a 30 minute time limit. These patients were then later seen on a 45 minute face to face appointment slots. Feedback from patients and staff was initially good but there was increasing frustration from parents who wanted the full assessment.

Following a VPD staff meeting when these changes were discussed, it was decided to change the referral process. Instead of the history being discussed via a series of verbal questions, the team have asked schools and parents to complete this at home on paper, send it in to the lead of service and it will be discussed at the appointment which has gone back to an hour long face to face appointment slot. Telephone consultations have been abandoned at this time as there is no replacement for face to face assessments now that clinics are back running to full capacity. The new referral tool enables the Orthoptist to have full information prior to the assessment and the appointment time can be clinically utilised with physical assessments involving observation of the patient.

The difficulty was in keeping the consultation time down. As there were no visible cues to the parents that they were running out of time, they often spent a long time discussing their concerns about their son/daughter on the phone.

There was a 3-month trial of combining face to face and telephone consultations but following team discussion, the VPD team decided to change the referral process as mentioned above to cut out the need for the telephone consultation. It was useful when there was no alternative, but there is no substitution for a full face to face assessment which allows correct utilisation of physical assessments as well as the non-verbal cues and nuances that are so important for the wholistic clinical assessment.

References

British and Irish Orthoptic Society

Arts therapy leadership activates creative resources which promote individual, team, and community growth in mental health settings

Nicki Power, Head of Arts Therapies for Bedfordshire & Luton, East London NHS Foundation Trust

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Introduction

The arts therapies include art, dance-movement, drama and music therapy. These four creative professions use non-verbal psychological therapy to support people to make changes in their lives, which can improve both mental and physical wellbeing. The active ingredient in the arts therapies is the art form. Using play and experimentation, the person accessing arts therapies can: explore choices through artwork, trial a different version of themselves in role-play, find their voice with musical improvisation and learn to listen to their physical needs through movement.

While the arts therapies are a specialist and complex intervention[1] in clinical settings, as an allied health profession, arts therapists have a range of transferrable skills which can be activated in leadership roles to support the equally complex agenda of public health.

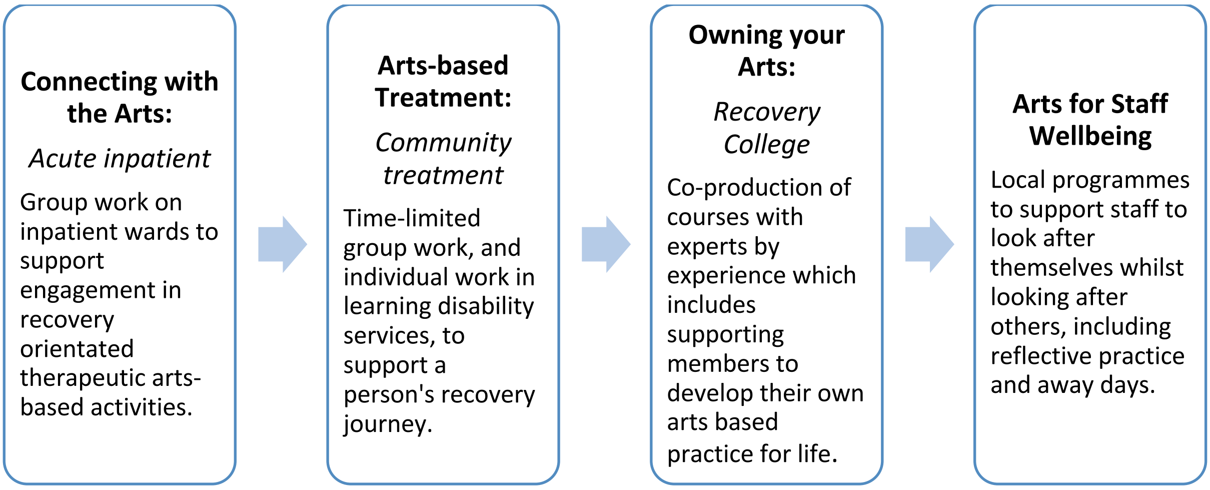
Alongside ensuring that the team deliver effective and timely clinical services in secondary mental health settings, my role as Head of Arts Therapies requires more to reduce local health inequalities in Bedfordshire and to focus on preventative rather than reactionary healthcare. As a leader, I modelled my creative values in action to empower the arts therapies team to do the same. Through collaborative working, we not only maximised our small arts-based resource but built capacity and confidence in other parts of the system with healthcare professionals, experts by experience and local cultural assets.

Context

Bedfordshire has a population of 670,000. As a county it is predominantly rural, with some of the most affluent communities living alongside some of the most deprived areas in the UK. For example, 43% of Luton Borough lies within the top 30% of the most multiply deprived areas in England[2]. Additionally, there is great cultural variety across Bedfordshire, with Luton being one of the most culturally diverse parts of the UK[3]. These geographic and socio-economic factors pose significant challenges for healthcare delivery, but also potential opportunities for celebrating cultural diversity.

The arts therapies team in Bedfordshire and Luton delivers a county-wide service across adult mental health, specialist learning disability and community health services provided by East London NHS Foundation Trust (ELFT). Each of the four arts modalities are represented in our team. However, the arts therapies resource is limited, with the equivalent of four whole time posts serving the entire county.

Under ELFT's Trust-wide arts therapies strategy, clinical interventions are provided across a broad range of services, both inpatient and community, to a varied adult population (figure 1). Locally, we have also included support for NHS staff, both clinical and non-clinical, as an essential part of this arts-based strategy.



Connecting with the Arts:

Acute inpatient

Group work on inpatient wards to support engagement in recovery orientated therapeutic arts-based activities.

Arts-based Treatment:

Community treatment

Time-limited group work, and individual work in learning disability services, to support a person's recovery journey.

Owning your Arts:

Recovery College

Co-production of courses with experts by experience which includes supporting members to develop their own arts based practice for life.

Arts for Staff Wellbeing

Local programmes to support staff to look after themselves whilst looking after others, including reflective practice and away days.

Figure 1: Arts Therapies Service provision in Bedfordshire & Luton, ELFT

This system-wide vision recognises "the benefits that the arts can bring to health and wellbeing"[4] as a recovery tool and in promoting psychological resilience beyond NHS service use. In parallel, our team has sought to provide continuity of care across mental health services so that people can access the arts at any stage of their recovery. To achieve this level of impact several factors drive our work, these are:

- Collaborative working maximises the use of our arts therapies resource which includes transdisciplinary inpatient working and coaching experts by experience to deliver their own recovery college courses.
- Building capacity and confidence in other parts of the system through using arts-based interventions with a strengths-focussed recovery approach for staff, service users and the public creates better outcomes for everyone.
- Clinical service delivery built on quality improvement principles enables a nimble response when providing county-wide services, increasing equity and accessibility, meeting demand in a timely and context sensitive manner. This includes piloting novel interventions in wider teams and introducing group-based delivery in learning disability services.

Arts Therapies working across traditional healthcare barriers

My leadership style is participative, I know that I cannot implement large-scale transformation without my team being active change agents. As a quiet leader[5], listening is essential, in my silence I can hear opportunities for future collaborations and lean-in to difficult conversations, averting potential resistance. To successfully deliver the arts therapies strategy, in line with ELFT's public health priorities, I have prioritised the following:

1. Developing clinical leadership in the arts therapies team

Each member of the team has unique skills and valuable experience, together our creative voice can empower others. Building individual confidence and competence involves working across levels of capability through coaching and supervision, given as part of my leadership role. This included investment in talent through supporting autonomous professional practice and academic development which benefits the team and wider arts therapies. Creative experimentation through solution-focussed learning and working with uncertainty models authentic leadership for the team.

2. Strengthening the current clinical service provision through evidence-based practice

Communication, both verbal and non-verbal, lies at the heart of the arts therapies. Similarly, communication within an organisation is essential in understanding the multifaceted role of the allied health professions.

In our team, we began by holding our service accountable, through producing quarterly reports which included contact data with service users and staff, outcome measures and experience data. This enabled us to meet key targets and to celebrate successes. Additionally, we reduced barriers to accessing the arts therapies through strengthening referral pathways and widening participation across different client groups.

Each arts-based intervention is underpinned by quality improvement methodology, fostering a growth-orientated team culture. Increased visibility for the arts therapies has confirmed our role as valid contributors to multi-disciplinary mental healthcare.

3. Adopting a flexible approach to arts-based interventions to engage a range of stakeholders

Employing our therapeutic and arts-based skills flexibly enables the arts therapies to operate beyond the traditional confines of the clinical therapy room. The arts work across many levels. For example, we can facilitate challenging conversations through metaphor or role play. We can enable diverse groups of professionals and service users to each find a voice and feel heard through creative play. These skills not only provide psychological safety when exploring complex or controversial issues but foster more holistic solutions to issues of organisational change.

Some examples of specific work programmes that the arts therapies team have collaborated on are:

- Service Design

  A transdisciplinary steering group was set up, to develop a radical vision of barrier-free healthcare, for people with persistent physical symptoms and functional syndromes. This necessitated engagement across organisational levels, from borough director to service user. Additionally, we reached across geographic and traditional service barriers to include primary care and other provider organisations across the whole of Bedford Luton Milton Keynes (BLMK) Sustainability and Transformation Partnership (STP).

  An art therapist used a model of visual mapping (figure 2), which enabled all voices to be heard, to distil the strengths in the current system and identify areas for improvement. Through this process discussion of complex areas such as discriminatory language and the psychological impact on clinicians of this work were explored. Visual system mapping accelerated the journey towards personalised care for this client group, through recognition of the strengths in the system and collaboratively designing a better vision.

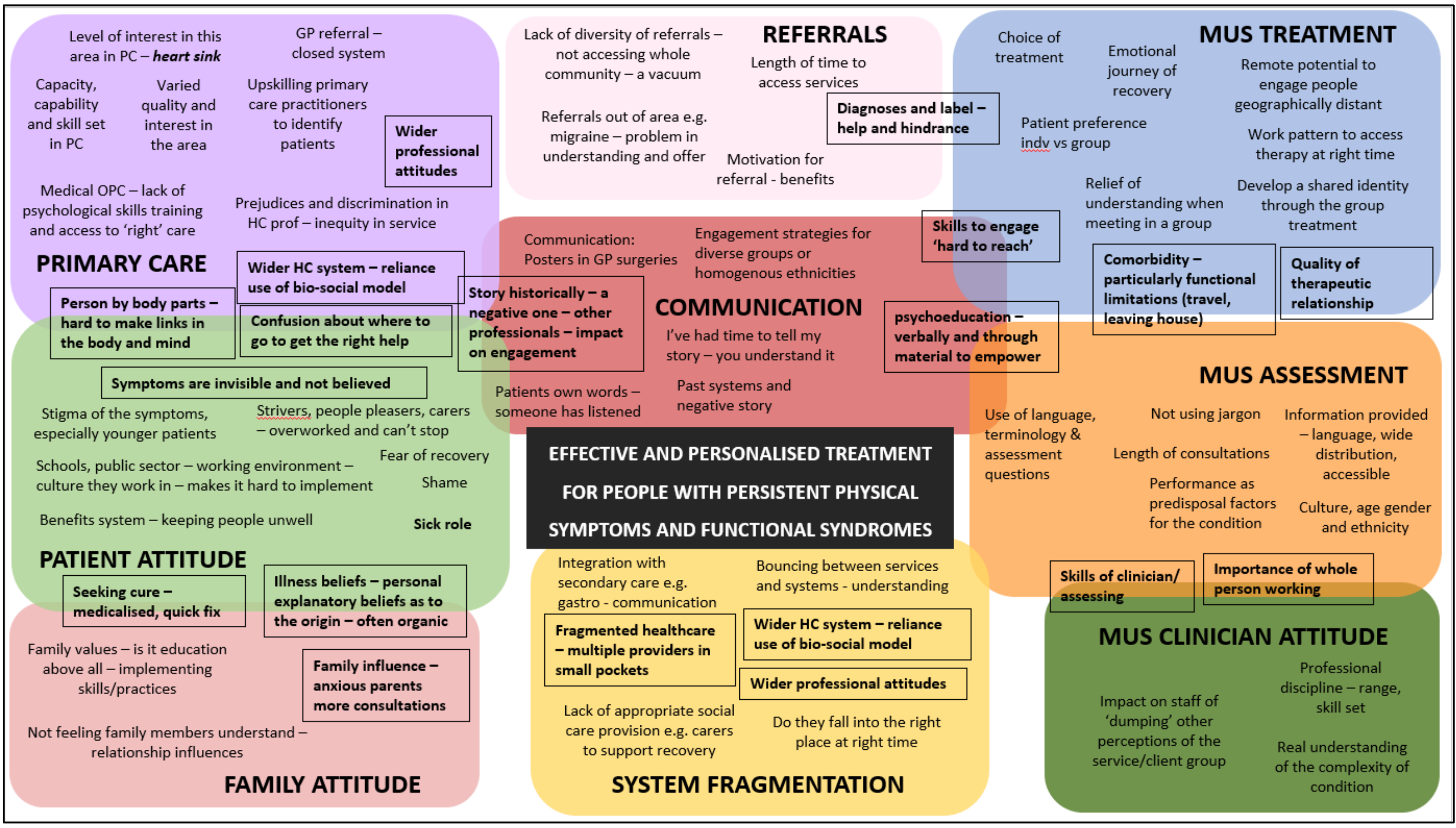


Figure 2: Thematic map of the barriers and facilitators in service access and use
(please note MUS stands for Medically Unexplained Symptoms, this is one term used to describe people who experience persistent physical symptoms and functional syndromes such as Fibromyalgia, Chronic Fatigue or some Musculoskeletal conditions)

- Staff Support

It is widely known that staff experience is an antecedent to patient experience in healthcare. Teams which are well structured in organisations with a supportive culture, not only achieve higher staff retention and fewer sickness absences but demonstrate reduced patient mortality and readmission rates with increased patient satisfaction[6].

The arts therapies draw on this evidence when caring for the person in the professional. We recognise the emotional impact of caring work in mental health services. We offer a multi-intervention approach which includes: structured debriefing after critical incidents; contracted arts-based team reflective practice; and during the pandemic tri-weekly creative breakout sessions. Using the arts enables difficult conversations to occur without blame and facilitates a team's own recovery resources through creative expression.

- Strengths-focussed Psychological Support

People with a learning disability face a range of complexities when seeking support for their physical and mental health. There is a greater likelihood of comorbid diagnoses[7] and communication challenges, alongside referrals originating from support staff not the person themselves[8].

We developed a 4-session arts therapies assessment group[9] to activate service users' personal resources, support them to advocate for their needs and to make an informed choice about accessing psychological therapy. For some, this is all they needed, others enter non-verbal psychological therapy with a greater awareness and motivation to change. In parallel we engage the person's support team to maximise therapeutic success and understanding.

- Recovery College

  The arts therapies wing of the recovery college has seen co-production partnerships between experts by experience, that is, people with lived experience of mental health conditions and arts therapists, grow in unprecedented ways. Following a successful pilot programme with dramatherapy[10], psychoeducational courses are now part of our routine practice. Group members have produced a recovery-focussed book, delivered training within the Trust and presented at national conferences alongside arts therapists. In partnership, the arts therapies and experts by experience have supported local community resources to reduce stigma around mental health, widen access and foster inclusive public environments which promote life-long recovery.

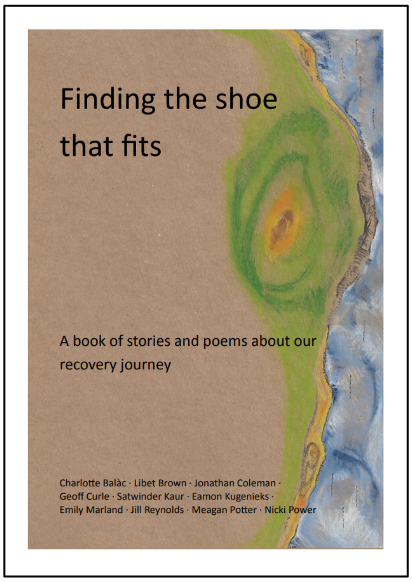


Figure 3: 'Finding the Shoe that Fits' a book about recovery made by experts with experience

Measuring success

There is no single measure of change which can accurately capture the range of interventions which we offer and continue to develop as a team. However, we use triangulation of data from a range of sources to help us build a picture of effectiveness, to identify where the arts therapies add value and to point towards future areas for development. We collect formal outcome measures, experience data and improvement suggestions from service users, staff and carers. Here are some selected outcomes from those who have accessed the arts therapies:

- Arts Therapies Team

  As well as providing direct clinical intervention, members of the team have been supported to write academic papers[11] building the evidence base for arts therapies and to develop leadership skills, for example, becoming a quality improvement coach.

- People who use mental health services

  One person who attended an inpatient group said:

  > *"Do you see how connected people seem now…before the group everyone seemed so isolated and tired…that was such a therapeutic experience".*

  Another person, who attended a recovery college course said:

  > *"Gives you self-confidence to just sing and…*
  > *to go and speak to people with similar health issues".*

  A person with a learning disability who attended individual therapy said:

  > *"I was quite poorly with anxiety and depression… as my therapy progressed,*
  > *I started to feel better in myself, and…I've really enjoyed …my [arts] therapy sessions.*
  > *They've really helped me a lot….I have the tools to help me keep the work up".*

- Staff in ELFT Services across Bedfordshire & Luton

  During the first national lockdown in 2020 the arts therapies team provided arts-based break spaces for 108 staff per month (March to July inclusive). This was a 200% increase in staff support provision. One staff member said they appreciated:

  > *"Having time away from direct clinical responsibility to share …and reconnect".*

- Wider Community in Bedfordshire

  We have created sustainable partnerships with cultural organisations such as the Higgins Museum, The Place Theatre in Bedford and The Hat Factory in Luton. This has enabled people who face stigma to access these cultural settings as equal citizens, and staff beyond mental health care have benefited from mental health first aid workshops.

  Following a film showcase, which was co-produced with young people from CAMHS services (another pilot project we supported), a member of the public who had been in the audience said:

  > *"It was a very unique and special experience …exceedingly informative and deeply moving...immensely powerful voices, speaking and singing of strength and redemption, of emergence and new beginnings. Thank you …for convincing us that a better day is always possible".*

Key learning points

- Creativity is an essential tool in service transformation. The creative process familiar to arts therapists, combined with therapeutic skills of engagement and group facilitation, make us ideal collaborators in complex change programmes.
- Just as arts therapies provide a space apart from everyday life for service users to make changes possible in their lives, this capacity can be harnessed to support staff wellbeing and team building.
- The value of systems approaches in the design and delivery of mental healthcare cannot be underestimated. Interdisciplinary work enables professions with limited resources to reach

further and maximise impact. Inclusive mental health services place the lived experience of the people accessing services firmly at the core of practice. Together, we can draw on a range of expertise and build a board skill base to strengthen our whole community's mental health approach.

- True co-production requires professionals to be led by our experts by experience. This takes time and involves learning for all. In any developing therapeutic programme, allied health professionals need to be mindful of the time and energy involved in genuinely collaborative and inclusive working.
- The arts are a vehicle to access the creative potential in the everyday. There is some need for caution when implementing arts-based interventions as part of change programmes. The potential uses of creativity are boundless, this poses a risk that we may over-stretch. Pacing and good project planning can mitigate this risk.

References

1. Medical Research Council (2019) *Guide to developing and evaluating complex interventions.* Online resource. Available at: https://mrc.ukri.org/documents/pdf/complex-interventions-guidance/ [Accessed on: 07.04.2021]
2. Ministry of Housing, Communities & Local Government (2019) *National statistics: English indices of deprivation 2019.* Online resource. Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 [Accessed on: 18.04.2022]
3. Wood, P., Landry, C. & Bloomfield, J. (2006) *Cultural diversity in Britain: A toolkit for cross-cultural co-operation.* Joseph Rowntree Foundation. Online resource. Available at: https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/1922-cultural-diversity-britain.pdf [Accessed on: 18.04.2022]
4. All-Party Parliamentary Groupon Arts, Health and Wellbeing (2017) *Creative Health: The Arts for Health & Wellbeing. Inquiry Report.* Second Edition. Online resource. Available at: https://www.culturehealthandwellbeing.org.uk/appg-inquiry/ [Accessed on: 07.04.2021]
5. Rock, D. (2007) *Quiet Leadership: Six steps to transforming performance at work*. Harper Business. ISBN:0060835915
6. Cornwell, J. (2014) *Staff care: How to engage staff in the NHS and why it matters*. The Point of Care Foundation. Online resource. Available at: https://www.pointofcarefoundation.org.uk/resource/staff-care-report [Accessed on: 18.04.2022]
7. Beail, N. (2016) *Psychological Therapies and people who have intellectual disabilities*. British Psycholgical Society.
8. Beail, N. & Jahoda, A. (2012) Working with people: Direct interventions. *Clinical psychology and people with intellectual disabilities.* Wiley-Blackwell.
9. Power, N., Bowler, P., Critchley, A. & Rothman, K. (2021) 'Time-limited Arts Therapies Assessment Groups for Adults with Learning Disabilities: Barriers and Facilitators of Intensive Collaboration' (Roundtable Discussion) at *Open Ground: Music Therapy in Collaboration and Exchange: British Association of Music Therapy Conference*, Online
10. Critchley, A., Power, N., Sandford, S., Odell-Miller, H., & Dokter, D. (2019) Starting from Scratch: Co-Production with Dramatherapy in a Recovery College in *Dramatherapy*. DOI: 10.1177/0263067219843442

11. Rothman, K. (2021) Expanding: a case study exploring online work and relationship in one-to-one sessions in an adult learning disability service in *Body, Movement and Dance in Psychotherapy*. DOI: 10.1080/17432979.2021.1880968

Improving the Quality of Orthotics Services in England

NHS England INFORMATION READER BOX

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Improving the Quality of Orthotic Services in England

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Prepared by: Neil Churchill, Director of Patient Experience, Cathy Regan, Associate Consultant, Primary Care Commissioning

Classification: (OFFICIAL)

Equality and Health Inequalities Statement:

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce inequalities.

Contents

1 Foreword

Orthotics services play an essential role in enabling quality of life for people with long term conditions, disabilities and limb loss. Being able to access the right orthotics equipment, quickly, and with appropriate support, is of paramount importance. Unfortunately, this doesn't always happen. People can find themselves waiting a long time for equipment and develop secondary health complications. Long waiting times mean that children in particular may have grown before their orthotics equipment finally arrives. These are avoidable and unfair inequalities.

A number of published reports over the last decade and more have discussed the potential benefits of improving orthotic services, including significant health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider economy if a comprehensive, integrated orthotics service is provided consistently throughout the patient pathway. Despite this, challenges with effective commissioning and provision of orthotics services still remain and patient feedback indicates variation in service provision. Quality can suffer for a number of reasons but the lack of quality measures and data have hindered effective commissioning. The failure to get things right first time for the patient is resulting in avoidable inequalities in access, worse outcomes, poor patient experience as well as poor value for public money and unnecessary costs to the NHS, meaning less is available for services for people.

In recent months a number of Clinical Commissioning Groups (CCGs) and NHS Trusts have been working to put that right. Some are now able to provide highly personalised care and next-day delivery for standard orthotics products. We have identified a number of effective models which achieve excellent outcomes and levels of patient satisfaction, some provided in-house in acute trusts or in the community, others outsourced to the private sector. The benefits of this improvement work mean better access through reductions in waiting times for assessment and fitting of orthoses, higher activity levels at reduced costs, more focus on achieving outcomes and a better overall experience of care for patients.

This report has been published following a formal escalation regarding the poor quality of some orthotics services from Healthwatch England in 2014. It incorporates findings from a review[1] undertaken by the NHS Quality Observatory of available data about the quality of orthotics services and commissioners' ability to assure the quality of these services. This review was considered at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England, where we also listened to patient experiences and shared case studies from CCGs and providers who have worked to improve the quality of services. This document sets out the key issues discussed and the learning from that event and we hope will help raise the profile of the need for effective commissioning of orthotic services both nationally and locally and provide some practical tips on how to do it. This will be the start of further discussions and work about how we can improve outcomes so that people with complex and changing

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[1] A. Chavda., K. Cheema (2014) Analysing orthotics: availability of data and information in orthotics services in England, NHS Quality Observatory, Horley.

needs can always get the right equipment in a timely way, with appropriate and continuing support.

Neil Churchill, Director for Patient Experience

Suzanne Rastrick, Chief Allied Health Professions Officer

2 Executive summary

This document sets out a case for action to tackle the rising demand and avoidable inequalities in access and quality of services experienced by children and adults requiring orthotic care in England. It explains why it is important to improve the commissioning of services in terms of patient care, clinical and cost benefits and discusses some of the key issues affecting services currently, along with the experiences that diverse patients and their families have had in using those services. Some case studies are presented from CCGs and providers who have worked to improve the quality of services and commissioning tips are provided for CCGs wishing to improve and redesign local services for the future.

Aligned with NHS England's Five Year Forward View, it supports a preventative approach through effective commissioning and provision of quality orthotic care to meet the growing challenge of an ageing population and increasing health needs associated with major clinical conditions including obesity, cardiovascular and peripheral vascular disease, diabetes and stroke. It also stresses the need to develop quality metrics to monitor orthotics services and encourages a move towards more outcome based commissioning and improving equity for patients.

The shared learning from the round table event and case studies highlight a number of common elements that commissioners and providers should consider in redesigning and improving orthotics services to secure efficiencies and quality improvements for patients, namely:

- Continuously engage and involve patients and their families;
- Include patient focused and outcome measures / KPIs in service specifications;
- Implement direct access referral for general practitioners, allied health professionals, registered nurses and consider self-re-referral for appropriate patients;
- Define criteria to accommodate the needs of children and patients requiring urgent treatment;
- Encourage adoption of multidisciplinary approaches and ways of working to maximise skills and efficiency;
- Consider introducing local tariffs for orthotics services.

These form the basis of a number of recommendations aimed at CCGs to help improve effective commissioning of orthotics services which are summarised in section 6.

A number of actions to help improve orthotics services in England were agreed as a result of the round table event and are outlined in section 8. Some of these have already been implemented, for example, the development of a model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

It is now imperative that the NHS finds the correct approaches to bring about national and local change that will support the drive to improved patient outcomes for those needing orthotics services alongside efficiency. NHS England is committed to working with CCGs and other key stakeholders to ensure these actions are implemented so that this review will have the impact that others have not for the direct benefit of those who use these services.

3 Introduction

3.1 Orthotics is a speciality involving application of external devices to the body to support and improve posture, function and mobility and manage pain and deformity. “Orthoses” is the term used to describe the external devices and includes insoles, braces, splints, callipers, footwear, spinal jackets and helmets. Compression hosiery can sometimes be provided as part of the orthotics service. Orthotists are generally the designated professionals responsible for the assessment, prescription, design, manufacture and fitting of orthoses to patients. The role of the orthotist is to consider and discuss with the patient the type of orthoses that will best meet his or her needs. Increasingly, this role is undertaken by other allied health professionals involved in a patient’s care such as podiatrists, physiotherapists and others.

3.2 Orthotics services provide treatment options for people with a wide range of conditions and orthotists work closely with a number of clinical specialties within the NHS including diabetes care, elderly medicine, neurology, orthopaedics, paediatrics, stroke and trauma teams. The correct supply and fitting of orthoses can help improve quality of life by reducing pain, keeping people mobile and independent and preventing more invasive and expensive interventions like surgery, amputation or the need for social care. As a result, the provision of orthotics plays a major role in many rehabilitation programmes. The NHS England Rehabilitation Programme defines rehabilitation as “the development, to the maximum degree possible, of an individual’s function and/or role, both mentally and physically, within their family and social networks and within education/training and the workplace where appropriate”. Good rehabilitation services deliver early intervention, restore or retain independence as much as is possible and enable people to live their lives. Orthotics services play a vital role in the rehabilitation pathway for many people and as such must offer effective, quality and timely interventions to ensure people reach their maximum potential.

3.3 Orthotics service provision in the NHS has been the subject of a number of reviews and reports spanning the last twenty years and more. The Disabled Living Foundation detailed longstanding problems in the provision of therapeutic footwear in its 1991 report[2]. In 1992, the Department of Health commissioned a critical review of the organisation of orthotics services in England and Wales.[3] The Audit Commission produced reports in 2000[4] and 2002[5] which highlighted serious problems with the quality of orthotics services and provided commissioning guidance for Primary Care Trusts in 2004[6] recommending increased levels of service provision, better access to services, and collaboration among multidisciplinary teams. The *“Orthotic Pathfinder”* report[7] identified several problems with the structure of orthotics services and the

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[2] Disabled Living Foundation. "Footwear: a quality issue: provision of prescribed footwear within the National Health Service." ;1991

[3] Bowker P, Rocca E, Arnell P, Powell E: A study of the organisation of orthotic services in England and Wales. Report to the Department of Health, UK; 1992.

[4] Fully Equipped – The provision of disability equipment services to older or disabled people by the NHS and social services in England and Wales. 2000, Audit Commission

[5] Assisting Independence - Fully Equipped 2002. Audit Commission.

[6] Guidance on the Commissioning of Orthotic Services, 2004, Audit Commission

[7] Orthotic Pathfinder – “A patient focussed strategy and proven implementation plan to improve and expand access to orthotic care services and transform the quality of care delivered” NHS Purchasing and Supply Agency; 2004.

significant benefits to be gained by the NHS, both in terms of improved quality and cost savings if these problems were resolved. In particular, it recommended condition specific direct GP Access to orthotics services and highlighted that for every £1 spent on improving orthotics services, the NHS could possibly save as much as £4. The potential impact of early orthotic intervention and improvements in service provision on health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider community were re-iterated in the York Health Economics Consortium report in 2009[8] and the Centre for Economics and Business Research report in 2011[9].

3.4 Most of these reviews and reports draw similar conclusions and support improved commissioning and provision of better resourced and more integrated orthotics services. They also highlight how orthotics services can help achieve some of the major policy objectives of the NHS. These include: reducing referral to treatment times; hospital admissions; the need for acute treatment; facilitating choice for people with long term conditions with better management and rehabilitation; and keeping people mobile and independent and therefore reducing the need for social care services, as well as getting people back into work or education. All of these contribute to reducing health inequalities. The York Health Economics Report[8] summed up the potential in the following statement:

"*Orthotic provision has the potential to achieve significant health, quality of life and economic benefits for the NHS if a comprehensive, integrated service can be provided, throughout the patient pathway. Service planning and contracting arrangements which emphasise the delivery of an integrated and comprehensive orthotic service are more likely to achieve the benefits to the NHS identified in the many reports."(p.10).*

3.5 Despite the consensus on the potential benefits of improving orthotics services, most agree it is still a "Cinderella service", poorly understood and generally not viewed as a priority for development[7] [8] [9] [10] [11]. In addition, the service is often "hidden" as part of other pathways of care contributing to the poor understanding, silo working and increasing confusion about access for patients. Concerns about the poor quality of services remain with patients, their families, clinicians and other stakeholder organisations raising issues about access, quality and variability of orthotics services more recently.

3.6 In July 2014, NHS England responded to a formal escalation by Healthwatch England about the quality of services nationally by commissioning a review, undertaken by the NHS Quality Observatory, of the data available on the quality of orthotics services and commissioners' ability to assure the quality of these services. The findings of the review[1] were shared at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England. The event also provided the opportunity to listen to the patient experience of those using orthotics services as well as share examples of

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[8] Hutton, J., and M. Hurry. "Orthotic Service in the NHS: Improving Service Provision" York Health Economics Consortium, Univ. of York;" 2009.

[9] Centre for Economics and Business Research Ltd . The economic impact of improved orthotic services provision - A review of some of the financial and economic benefits of a better functioning system for the provision of orthotic services; 2011.

[10] Scottish Orthotics Services Review, 2005, NHS Scotland

[11] British Association of Prosthetists and Orthotists, 2015: Improving the Quality of Orthotic Services in England.

effective commissioning and service delivery models, with the aim of sharing good practice and facilitating further action nationally and locally to improve commissioning and provision of orthotics services.

3.7 As mentioned previously, orthotics plays a major role in rehabilitation programmes for children and adults with a range of conditions and in many respects, the issues and challenges affecting orthotics services mirror those highlighted in recent NHS England initiatives targeted at improving rehabilitation and wheelchair services. The *Improving Rehabilitation Services Programme* aims to deliver rehabilitation at the right time, in the right place by the right person for all children, young people and adults in England so they are able to live long, happy and productive lives. NHS England is also working with a number of partner organisations to improve wheelchair services. Both areas have uncovered issues with access, quality and variation in service provision which NHS England is tackling in a number of ways. Improvement priorities for rehabilitation services include: exploring levers and incentives; establishing the economic benefits of rehabilitation and developing an economic model for service provision; and establishing the case of need for improvement in children and young people's rehabilitation services. Priorities for improving wheelchair services are: the development of a national data set; piloting of a tariff for wheelchair services; and the development of resources to support commissioners of wheelchair services.

3.8 The aim is for NHS England to prioritise the improvement of access for people and their experience and outcomes of orthotics services. The purpose of this document is to raise the profile of the need for effective commissioning of orthotic services both nationally and locally and re-invigorate the historic debate for change.

4 The Case for Action

4.1 *"Early orthotic intervention improves lives and saves money"* [8]*(p.1)* and yet the benefits to the NHS are still not fully realised by most commissioners and managers[9]. In this section, the clinical and cost benefits of orthotics services are discussed and the key challenges that need to be addressed are outlined, based on information and evidence from previous papers and reports and re-iterated further in discussions at the round table event.

Clinical Benefits

4.2 The provision of orthotics has a beneficial impact on a range of clinical conditions by relieving pain, increasing mobility, protecting tissues and promoting healing along with a whole host of other benefits including improved independence and self-image.[10] [12] The range of clinical conditions benefiting from orthotics includes chronic diseases and trauma as well as neurological, musculoskeletal and congenital conditions. A number of these remain as policy priorities for the Government and the NHS, examples of which are set out below:

- Diabetes – prevention and reduction of ulceration rates and amputation;

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[12] All-Party Associate Parliamentary Limb Loss Group, 2014: Patient Led Orthotic Services Patients Charter

- Stroke and other neurological conditions such as multiple sclerosis and cerebral ;palsy;
- Chronic Obesity – often leading to Type 2 diabetes and musculoskeletal problems;
- Cancer – managing the side effects of chemotherapy (peripheral neuropathy);
- Cardiovascular, including peripheral disease – effects of poor circulation;
- Degenerative conditions – rheumatoid arthritis and osteoarthritis;
- Congenital conditions - spina bifida;
- Spinal cord injury and scoliosis;
- Complications of viral infections such as polio;
- Common musculo-skeletal conditions and sports injuries - maintaining mobility and returning people to work sooner
- Treatment of the frail and elderly such as falls prevention.

4.3 Commissioners and managers should be aware of the positive impact that orthotics services can have on commissioning priorities such as the reduction of hospital admissions, accident and emergency (A&E) attendances and prevention of complications from diabetes, peripheral vascular disease and cancer. Appropriate orthotic management of patients with these conditions can delay and reduce the need for more expensive and complex treatment and the need for surgery. In addition, there are also benefits to wider health and social care priorities including promoting well-being and supporting independence in the community, for example by reducing the probability of falls in frail, older patients and keeping them mobile and independent reducing the need for social care. All of which contribute to reducing inequity.

Benefits for Children and Young People

4.4 It is particularly important that children and young people needing orthotic intervention get it quickly and that the orthoses are well fitted and of good quality. If they have to wait many months to obtain the correct orthoses, most will have outgrown them before they are fitted and endured unnecessary pain and immobility. This is unfair. It also undermines the work of the rehabilitation team and sometimes results in the need for further surgery and dependency on a wheelchair. This affects not only their physical health but also their psychological, emotional and social health. Children and young people will have changing needs as they develop and require responsive and flexible orthotics service provision. If not addressed these young people face avoidable inequalities.

Cost Benefits

4.5 The cost benefits to be gained by improving the commissioning and provision of orthotics services are well argued in previous reports[7] [8] [9]. In summary, savings are likely to be made by treating more people in primary care and reducing the need for consultant appointments and more expensive acute care procedures, in-patient stays, drugs and surgery. Most savings are expected to be made by keeping frail, older people mobile and independent for longer and reducing the need for expensive social and residential care services[9]. In quantitative terms, the *"Orthotic Pathfinder"* report estimated that the economic and social consequences of denying patients orthotic care are significant, costing an estimated £390 million per annum based on

2004 data. It suggested that for every £1 spent on improving orthotics service provision, the NHS could save £4[7].

4.6 The York Health Economics Consortium report quantified the potential cost savings of using orthotic interventions in primary, acute and long term conditions case studies compared to traditional secondary care treatment and surgery. Significant cost savings were demonstrated in the treatment of plantar fasciitis, ruptured achilles tendon and management of diabetic foot complications respectively[8]. Similarly, the Centre for Economics and Business Research report worked out potential financial savings to the NHS and social care through the better use of orthotic interventions in the treatment of plantar fasciitis, diabetic foot complications and stroke. In addition to the specific cost savings estimated for each condition, it was estimated that around £48 million could be saved by re-locating orthotics services from secondary to primary care[9].

4.7 In practice there are examples of delays in early orthotic intervention resulting in increased costs of care to the NHS as experienced by Rebecca and Des and their son David. David had a stroke in the womb so has a condition called hemiplegia which is a one sided form of cerebral palsy and has required orthotic care from when he first began to stand. In the early part of David's childhood, it was a struggle to get the speedy and responsive orthotic care he needed to keep up with his growth. It would usually take 18 weeks from identifying need to obtaining the support for his foot and ankle. At least four pairs of expensive orthopaedic boots had to go into clinical waste either at the point of provision or within a few weeks because they were too small.

4.8 By the age of nine, David's ankle and foot were getting more and more deformed. The family believe this was a direct consequence of his poor access to orthotic care. His orthopaedic surgeon recommended serial casting to set his foot straight with the associated increased costs to the NHS of:

- 5+ outpatient appointments with the orthopaedic surgeon and nursing team lasting over an hour each to cut off each plaster cast, wash his foot and reapply a new plaster cast;
- An attendance at A&E when one of the casts was applied too tightly.

4.9 David should have had an ankle foot orthosis (AFO) to wear immediately after serial casting to keep his foot and ankle straight. It took 17 weeks to get one and within days he had lost all his mobility and even the ability to weight-bear. The further costs of this to the NHS included:

- a wheelchair assessment;
- a wheelchair;
- months of intensive physiotherapy to try and recover the damage;
- a 10 week course of counselling for David due to the psychological and emotional stress caused by this situation;
- a six week parenting course the parents had to attend in order for him to be considered for counselling;
- complex foot surgery at a Children's Specialist Hospital out of area;
- outpatient follow ups at the Children's Hospital;

- more frequent reviews by his local paediatrician due to the impact on David's progress and development;
- occupational therapy advice to address his mobility in the home.

4.10 In addition to this increased financial cost to the NHS of delayed, poor care, the personal cost to David in terms of his development, education and emotional well-being were catastrophic. The impact on the whole family was immense both emotionally and financially. A real example of what is meant by avoidable and unfair health inequalities.

4.11 Clearly the potential cost savings associated with improved orthotics service provision warrants further consideration by CCGs and policy makers alike.

A Growing Challenge

4.12 It is a challenge to obtain accurate figures on the numbers of people in England treated by orthotics services currently, partly due to the complexity of pathways of care and as availability and accessibility of data in this area is poor, which was highlighted recently in the national review of orthotics data commissioned by NHS England[1]. The last known, referenced figure of 1.2 million[7] [8] was based on the 2007 report produced by The Foundation for Assistive Technology[13] which suggested using this number as a guide only as the total number of people benefiting from orthotics was unknown. An extrapolated figure based on a compound annual growth rate of up to 6% over 2010-2017, stated by *Global Pipeline Analysis, Competitive Landscape and Market Forecasts for Orthotics and Prosthetics*[14] would put current estimates at around 2 million.

4.13 This number will continue to grow, firstly due to expected increases in the ageing population. The majority of people requiring orthotic services are over 50 years of age[7] and the Office for National Statistics (ONS) forecasts that the English population aged 55 and over will have increased by 35 per cent from approximately 14.8 million in 2011 to 20 million in 2031[15]. At least 23 per cent of the total projected population of 60.4 million will be 65 and over[8]. This is likely to lead to an increase in demand for orthotics services.

4.14 The other factors affecting growth in demand are the rising prevalence of obesity, cardiovascular and peripheral vascular disease, diabetes and stroke[8] [15] [16]. Predicted rates of obesity are likely to affect around half the population by 2050 according to the UK Health Forum[17]. Obesity can contribute to musculoskeletal problems and is a major risk factor for developing diabetes and cardiovascular disease; in fact diabetes doubles the risk of developing cardiovascular disease[18].

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[13] Down K, Assistive Technology Workforce Development. The Foundation for Assistive Technology. June 2007.

[14] http://www.businesswire.com/news/home/20110419006508/en/Research-Markets-Orthotics-Prosthetics---Global-Pipeline#.VWcvw9JViko

[15] Centre for Workforce Intelligence, 2012: Workforce Risks and Opportunities. Prosthetists and Orthotists. Education Commissioning Risks Summary from 2012.

[16] National Allied Health Patients' Forum. 2011: Patient Concerns over the shortage of Prosthetists & Orthotists

[17] UK Health Forum, 2014: Obesity rates are rising but new predictions by National Obesity Forum may be an overestimate according to UK Health Forum. http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2014/Statement%20from%20UK%20Health%20Forum%20on%20NOF%20report.pdf

[18] NHS England, 2014: Action for Diabetes

Estimates suggest that the number of people with diabetes is likely to increase by 5% year on year from over 2.5 million people currently to more than 4 million by 2030[15]. Diabetes and cardiovascular /peripheral disease often result in foot complications, the worse-case scenario being amputation. Approximately 100 people a week have a lower limb amputated as a result of diabetes which could be avoided with the help of preventative foot care including appropriate orthotic provision[19].

4.15 Improvements in neonatal care mean that children are surviving with more complex disabilities and this together with the expansion of the ageing population and prevalence of major clinical conditions will impact significantly on the NHS and social care budget. They can all benefit from cost effective orthotic intervention.

4.16 The Five Year Forward View**Error! Bookmark not defined.** supports a preventative approach to the growing challenge of increasing health needs and encourages improvement in both the commissioning and integration of services and providing innovative models of care, ensuring that people of all ages are actively supported and empowered to lead the lives they want for themselves and their families in the best possible health. This would lead to reduced inequalities in access to services and the outcomes achieved. It will be important for CCGs to consider the Five Year Forward View and the factors affecting increased need for orthotics services in their commissioning decisions and to take account of this predicted growth in demand in the future commissioning and redesign of orthotics services.

The Data Challenge

4.17 The national review of orthotics data commissioned by NHS England and undertaken by the NHS Quality Observatory in 2014 concluded there was minimal routine, quantitative data accessible and available to review the quality of orthotics services and understand how they were delivered around the country[1]. The reasons behind this are predominantly due to coding issues, poor recording, block contracts with lack of tariff incentives, multi-speciality referrals “hiding” orthotics related information and commercial sensitivity around data held by private companies.

4.18 This significant lack of data poses a challenge for CCGs. The review expressed the need for a clear mandate to identify and collect process, outcome and patient experience measures from orthotics services that could be regularly monitored and reviewed to assess quality and identify areas of best practice. In particular, it recommended that a national data collection tool be developed in collaboration with commissioners of orthotics services and the British Association of Prosthetics and Orthotists (BAPO) to help inform an ongoing dataset to improve the information available on the quality of orthotics services.

4.19 The review also considered data obtained by Medway NHS Foundation Trust in response to its national orthotic service questionnaire which highlighted significant variation in a number of elements of orthotics service provision across the UK. These are discussed in more detail in the next section. Whilst this was not a formal audit commissioned by NHS England, the NHS Quality Observatory review acknowledged it had produced useful data to illustrate the lack of parity and equity of orthotics

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[19] Diabetes UK, 2013: Putting Feet First https://www.diabetes.org.uk/Documents/campaigning/Putting-feet-first-campaign.0213.pdf

service provision. It suggested a more formal audit process should be developed and implemented and this should be considered further by commissioners and policy makers.

The Quality Challenge

4.20 In addition to the lack of data available, there is also a lack of clear and measureable standards for orthotics services which results in the variation of access and quality around the country mentioned in various reports[1 7 12] and is the cause for concern for patients, their carers and organisations such as The Orthotics Campaign[20], the All-Party Associate Parliamentary Group on Limb Loss[12], Arthritis Research UK[21] and Healthwatch.

4.21 This may be due to the fact that historically orthotics services have been commissioned using a “commodity product” model based on volume and price rather than quality and outcomes[8 12]. It is also a result of the lack of specific policy guidelines for commissioners on what a “good” orthotics service looks like. Orthotics have been mentioned in National Institute for Health and Care Excellence (NICE) guidelines such as stroke rehabilitation, Type 2 diabetes foot problems and spasticity in children and young people with non-progressive brain disorders. These highlight the role of orthotics within a multidisciplinary team approach rather than provide specific measureable standards for orthotics services which commissioners can use to monitor and review quality.

4.22 The extent of variation in orthotics service provision was evident from the responses to a recent national orthotic service questionnaire conducted by Medway NHS Foundation Trust which was used to inform the data review commissioned by NHS England[1]. This looked at a number of areas including: staffing; clinical; waiting lists; budget and management; information technology; suppliers and procurement; geographical demographics; referral types; audits; patient experience and key performance indicators (KPIs). 55 organisations responded out of 188 surveyed in England, Wales and Scotland. The findings are indicative of significant variation and lack of consistency of provision of orthotics services supporting the continued notion of postcode lotteries[12]. For example, referral to treatment waiting times varied from 1 week to 58 weeks for both adults and children as illustrated in Figures 1 and 2 below.

4.23 The information analysed from the Medway questionnaire also found that not all services used KPIs and there is a lack of consistent KPIs monitored by those who do.

4.24 No doubt some of this variation is due to differences in the diversity of population demographics and case mix depending on whether a standard or more complex, specialised service is provided, as well as whether the service caters for children and adults only or both. However, what is clear is that variation and inequity do exist and the reasons why should be further explored.

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[20] http://www.orthoticscampaign.org.uk/what-pts-say.html

[21] Arthritis Research UK, 2012: A Call to Action: Providing better footwear and foot orthoses for people with rheumatoid arthritis.

Figure 1: Adult Waiting Times 2013/14

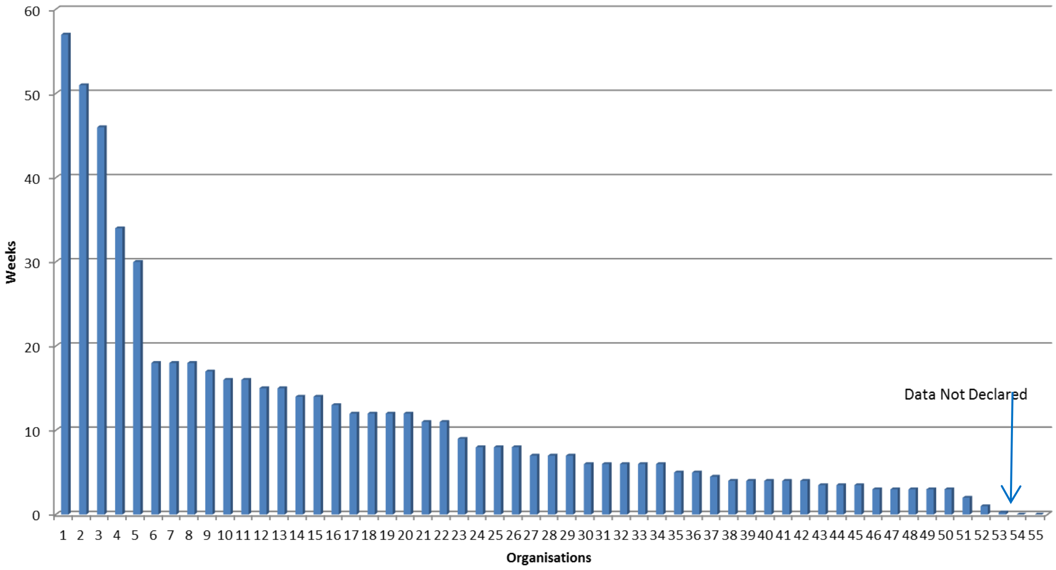
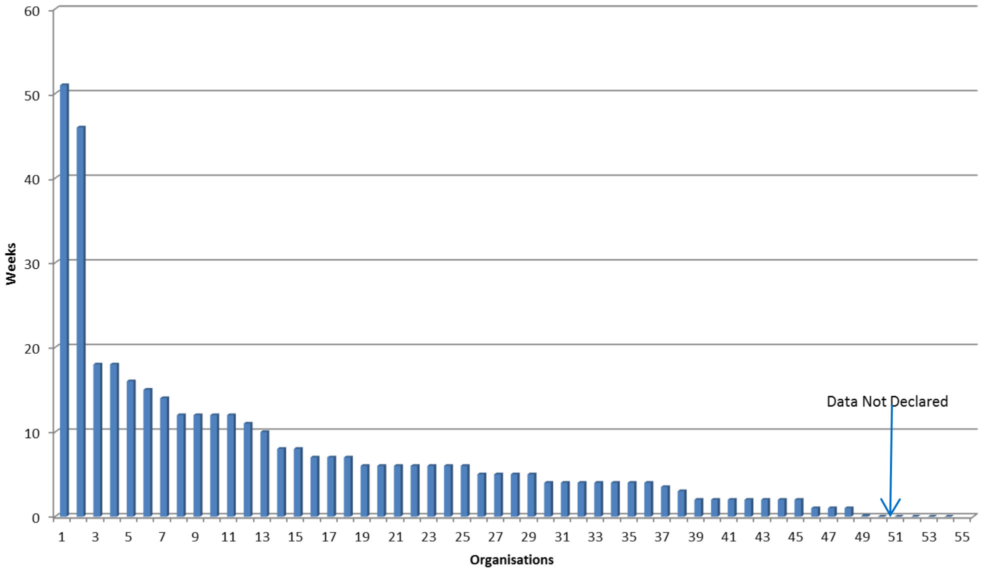


Figure 2: Paediatric Waiting Times 2013/14



The Workforce Challenge

4.25 The lack of data on orthotics service provision also relates to national workforce data, which is poor and incomplete. The number of orthotists working within the NHS is not accurately measured and reported[15]. Over 70% of orthotists are employed through sub-contracted companies in the private sector who deliver services on behalf of the NHS and do not have a unique occupation code for use in electronic staff records systems. However, the number of orthotists (and prosthetists) registered with the Health and Care Professions Council (HCPC) at the time of writing was 1012. Currently, fewer than 500 of these are estimated to be practicing as orthotists[11] [22]

4.26 As discussed previously, the demand for orthotists is likely to rise in line with increases in the ageing population and rising prevalence of obesity, diabetes and cardiovascular and peripheral vascular diseases. However, there are major concerns regarding the current severe shortage of orthotists within the NHS[16] [22] resulting from high attrition rates and a retiring workforce. The British Healthcare Trades Association (BHTA) view is that there will need to be a 30 to 50% increase in the number of orthotists to meet current and future demands of new models of care[22].

4.27 The lack of accurate workforce planning data needs to be addressed to identify current establishment and help plan for future supply. Recent initiatives providing guidance on career frameworks[23], education[24]and preceptorship[25] for prosthetics and orthotics should help to develop and sustain a flexible workforce and support commissioners in planning education and service development. They will also help support and promote skill mix and multi-professional working in integrated teams which is the approach needed to meet the increasing needs of patients and help tackle some of the current issues facing the orthotics profession, particularly within the context of scarce resources. In addition work is ongoing with the relevant professional and trade associations and educational establishments in Scotland to develop a national training programme for technicians involved in orthotic manufacture. This will be the first qualification of its type in the UK and will be launched in March 2016.

4.28 Some of the case studies presented in this document have adopted innovative approaches to reducing waiting times and improving orthotics services by developing a more multidisciplinary approach to the provision of orthotic care. This involves working with appropriately trained allied health professionals including podiatrists and physiotherapists, and registered nurses, as well as multidisciplinary clinics for specific conditions such as diabetes and others. This has had a positive impact and helped reduce waiting times for initial assessment as well as speed up in-patient treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

5 The Patient Experience

5.1 A key purpose of this document is to facilitate action in response to more recent concerns regarding the quality of orthotics services raised by patients and their families. They cover a range of issues such as unacceptable waiting times, lack of getting the orthotics fitted “right first time”, unrealistic clinic slot times, inconsistent product entitlements and generally poor quality services which have an impact on people’s daily lives affecting their level of pain, mobility and capacity to remain employed or attend school or higher education. The experiences of the few patients and their families presented here have been provided with kind permission by The

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[22] All Party Associate Parliamentary Group on Limb Loss, 2014: Campaign for More Orthotists.

[23] Health Education North West and University of Salford, 2014: Career Framework Guide Prosthetics and Orthotics

[24] Health Education North West and University of Salford, 2014: Education Framework Guide Prosthetics and Orthotics

[25] Health Education North West and University of Salford, 2014: Preceptorship Guide Prosthetics and Orthotics

Orthotics Campaign and help to understand the important issues from the patient perspective. They are a few examples of many, with well over a 130 patient/carer stories of poor quality NHS Orthotic care in England shared with The Orthotics Campaign to date. All show the reality of unavoidable health inequalities as result of poor services.

David's Story

5.2 As discussed previously, David, who is now 15 years old has received orthotic care since he was 18 months having been diagnosed with hemiplegia. The main focus of care in his early years was provided by a combination of orthopaedics, physiotherapy and orthotics to get him walking properly and prevent a foot deformity from developing. However, he and his family experienced long delays in getting appointments for the assessment and fitting of the orthotics he needed which sometimes led to waits of between 4 to 6 months. These delays were caused by a number of issues including staff shortages, poor administrative processes and outdated recording procedures. They generally resulted in the orthotics being the wrong size for David as naturally he would outgrow them during the long delays. The delays in care also meant that David only had sporadic access to a splint or pair of boots that he could actually tolerate or fitted properly without being in pain. This meant he did not get the full benefit of each orthotic intervention and then required further, more expensive intervention. In summary David went from needing Piedro boots to an ankle foot orthosis (AFO) and serial casting, only to wait 17 weeks for a properly fitted AFO. During this time he had to use a wheelchair and could not attend school as his classroom was upstairs. The personal cost to David of this poor care was a lot of pain, 17 weeks of lost education, lost mobility and the need for an unnecessary wheelchair. He also missed important family events and had difficulties managing and enjoying other family occasions such as holidays and a family wedding. He began to show his feelings and frustration about this and ended up needing counselling. Crucially he lost precious childhood experiences that he will never get back. As already mentioned, the wider impact of this on David's family was immense.

Simon's Story

5.3 Simon is a young adult with spina bifida. He usually has to wait for months or even years for new shoes to be authorised for him. He is only allowed 1 pair at a time. His shoes look really worn out and he feels embarrassed when he sees people looking at them.

Karen's Story

5.4 Karen has a young daughter who needs an AFO on her right ankle /leg and an orthotic insole for her left shoe to help her walk as her feet turn inward. She went for the casting of the heel cup for the left foot which took weeks to arrive and was too small. She was re-measured for a new one which was very hard and not well padded and caused blisters. The heel cup was returned for additional padding for extra comfort and as it had started to deteriorate. This incurred additional costs and delayed treatment for another 4 to 6 weeks .Karen's daughter also needed a hand support/splint for her right hand. It has been over a year since Karen requested this and she is still waiting. In the meantime, a lycra hand glove was made for her daughter which, on collection was too small. Again her hand and arm had not been measured properly and the glove had to be thrown away. Karen wonders why the orthotics cannot be made correctly the first time which would save money, unnecessary appointments and prevent the discomfort and long delays her daughter experiences.

Safeera's Story

5.5 Safeera is 16 and living with a degenerative muscular condition which leaves her with chronically weak muscles. From early childhood, she has needed a number of orthoses to help delay the onset of deformities, support her in a standing frame and maintain her everyday functioning. These have included the need for well-fitting foot splints (day and night); specialist footwear; a spinal brace (up to the age of 8); night-time wrist splints and a neck collar. Her mother describes the service provided in the early years as *"woeful*" having to experience ill-fitting splints that *"chewed"* Safeera's feet; spinal jackets that *"disappeared"* into her armpits leaving deep red tracks and hearing Safeera cry in her sleep due to the pain and discomfort caused. As well as this, Safeera often had to go to school in trainers, whilst the specialist footwear she needed sat on the shelf in the orthotics department because there was not an appointment to pick them up in time for the new term. The lack of responsiveness and flexibility of appointments often meant that Safeera's therapy and much needed orthotic intervention were delayed and hindered her progress. On top of this, there was one occasion when, after months of waiting for new splints they arrived and they were both for the left foot and the same vicious circle of waiting started again!

Diane's Story

5.6 Diane is 51 years old and has left sided hemiplegia. After a bout of suffering badly from pains in her legs and feet she conceded to needing help with footwear. She was referred to have a pair of shoes made. She felt embarrassed and ashamed that she needed help but still went along and had her feet measured and had imprints of her feet taken. She was shown the catalogue of shoes to choose from and was horrified. They were all unflattering and old fashioned. She waited months for the shoes to be made and although she did not like them, she was hoping for a comfortable pair of shoes to wear on a day to day basis. When the shoes arrived, they were far too big and slipped off with every step. After waiting weeks for an appointment to take them back, she saw a different orthotist who asked if she was sure she had been measured for the shoes. She is still putting up with her pain and now waiting for another fitting for her shoes. The whole experience has left her feeling angry and upset and she wishes she had not bothered. She believes that nothing can make her feel better about her disability and that she will never have a properly fitting pair of shoes. In Diane's view, the service offered for making footwear in the NHS needs a major overhaul.

5.7 These stories highlight examples of poor care; however some patients have a much more positive experience to share:

Keith's Story

5.8 Keith has cerebral palsy and needs specialist orthotic shoes to help him walk. Without them he wouldn't be able to go anywhere and would have no quality of life. He needs to visit his local orthotic service located in a large acute hospital trust every six weeks which is quite a long distance away from his home and costs at least £30 in travel costs each month. Keith is happy with the service he receives although couldn't help thinking it would be far more convenient having a service closer to home. He discussed this idea with the head of the service and in less than two months non-acute orthotic treatments were offered in two additional community settings in more convenient local areas for patients, enabling those patients to be treated and followed up closer to home and saving them time and money. Keith was delighted that someone actually listened to his idea and made it happen. In Keith's eyes this change will have a major positive impact on his life.

Factors affecting the Patient Experience

5.9 There are a number of factors affecting the patient experience of orthotics care in the NHS, some of which have been discussed previously. The Orthotics Campaign has categorised the main issues into nine key themes which are summarised below: (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-1.pdf).

- Commissioning (lack of guidance and data, historical bundling into procedural based and outpatient based tariffs, unintended consequences of block contracts and perverse incentives – income generation of surgery via payment by results versus cost of orthotic preventative care);
- Fragmented procurement ("commodity" approach rather clinical service with individual prescription tailored to needs; bureaucratic administrative processes adding to delays; focus on contract price, not timeliness and quality)
- Lack of quality standards and agreed KPIs;
- Service delivery (different provider models – lack of benchmarking, equity and consistency for patients)
- Substantial shortage of clinicians (impacts on waiting times and quality of service)
- Unrealistic clinical slot times not tailored according to the needs of the patient (clinics overbooked, waiting time delays and repeat appointments needed);
- Location of services - patients generally prefer a non-hospital setting with free parking close to the service;
- Access to bespoke footwear services when required according to need;
- Variation in patient entitlements;
- Education and specialist training (only one training centre in England, more courses required to facilitate multi-professional care)
- Stifled innovation (private companies have innovation ideas which may be too expensive for the NHS to implement)
- Skewed market forces.

What would a Quality Orthotic Service look like?

5.10 Much of the focus at the round table event was on what a good quality orthotics service would look like. Stakeholders at the event discussed key issues such as developing quality metrics to monitor orthotics services, what elements were important to consider in moving towards outcome based commissioning and the development of local tariff schemes for orthotics services, along with how the workforce would need to develop to support more outcome based commissioning.

5.11 From the patient perspective it was felt that the following key principles should underpin all services:

- Patients should have a voice in the decision making process throughout referral and service provision;
- The patient's quality of life should be better;
- Orthotics should cause no harm;
- It should not be a struggle to obtain them;
- The service should be timely and responsive;
- Care should be agreed and coordinated;
- Patients should expect consistency of care, for example seeing the same clinicians;
- The time and effort taken by the patient should be outweighed by the benefits to them;
- Quality is not measurable within one contact.

5.12 All stakeholders at the event expressed the need for national guidance to support more efficient commissioning and to be assured that orthotics services are of high quality and that outcomes are defined and reported. There were calls for the development of a model service specification for orthotics services which would cover agreed key elements and KPIs thought to be illustrative of a good quality service. Some of the key elements suggested and discussed included:

- Easy access via simple referral processes;
- Patient self-referral for follow up episodes once under care;
- Defined criteria to accommodate the needs of patients requiring urgent treatment and children who need a more responsive service and faster turnaround times to allow for growth;
- Agreed, acceptable maximum waiting times for first and follow up appointments;
- Agreed timescales from first appointment to supply of orthosis necessitating agreed timescales for manufacture by companies;
- Appropriately timed clinic slots for simple and complex cases;
- Named "orthotists" as case manager for a patient's care;
- Provision of patient information about their orthoses and care;
- Clear guidelines on patient entitlements;
- Agreed set of core KPIs to include patient outcome measures (e.g. comfort and goal achievement), feedback, complaints as well as other indicators such as waiting times, proportion of definitive treatments at first appointment, return rates of orthoses etc;

- Encouragement of multidisciplinary working and joint clinics with other specialisms where value can be demonstrated in terms of benefits to patients;
- Appropriately skilled and trained workforce to provide service.

5.13 There was consensus that developing local tariff schemes based on cost and volume rather than block contracts, although challenging, was beneficial in incentivising quality and helped improve data recording and capture to monitor quality improvement. Some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services.

5.14 The CCG and provider case studies described in Section 7 will set out examples of this as well as development of referral protocols, service specifications, KPIs, patient focused outcome measures and other useful information for those CCGs and providers wishing to improve and redesign orthotics services in their local area.

6 Top Tips for Commissioners and Providers

6.1 A number of common elements have been highlighted by the case studies and the stakeholder discussions at the round table event that may provide wider learning to commissioners and providers wishing to review and redesign orthotics services to secure efficiencies and quality improvements for patients.

Engage and Involve Patients and their Families

6.2 They have the best ideas on how the service can be improved and can be involved in a variety of different ways as well as the usual feeding back via patient surveys. By listening to individual service user stories you can truly understand the need for and benefits of orthotic care. For example consider involving them in: informing and shaping the service specification including KPIs and quality requirements; tender shortlisting and interview panels; and forming part of the performance steering groups with the providers of orthotics services.

Include Patient Focused and Outcome Measures / KPIs in Service Specifications

6.3 The case studies presented in this document have provided a number of examples of outcome based quality measures that can be incorporated into service specifications to review and monitor the performance of providers and to ensure the service meets the expectations and needs of patients. These may include the following amongst the many examples:

- Maximum referral to treatment times;
- Orthoses delivery times;
- Orthoses fitting times from initial assessment;
- % right first time;
- Patient outcome measures based on goal attainment scores, for example the proportion of users who report that they have achieved their goals and the percentage of users who report that they are comfortable in their orthoses,

- % of products failed;
- % of patients satisfied with the service;
- Number of patient complaints / compliments received;
- DNA rates

Implement Direct Access Referral for GPs, AHPs, Registered Nurses and consider Self-re-referral for Appropriate Patients

6.4 Direct access referral has been shown in the case studies to improve access for patients and considerably reduce waiting times for assessment and treatment as well as reduce length of stay for in-patients in hospital. Competency based educational packages and training programmes can be implemented to support direct access referral.

6.5 Self-referral can ease and simplify access for those patients who have longer term conditions and are in regular touch with orthotics services and can be supported by clear criteria.

Define Criteria to accommodate the needs of Children and Patients requiring Urgent Treatment

6.6 Urgent appointments and referrals for adults and children (who need a more responsive service and faster turnaround times to allow for growth) should be catered for in service specifications. Examples of urgent criteria may include the following:

- All in-patients;

- Outpatients with the following:

  - ulcerated foot
  - fracture clinic referral for acute injury
  - fracture of spine
  - post botox treatment
  - conditions triaged by clinician as needing ‘urgent’ treatment
  - patients with only one device that has broken and this cannot be repaired by technician
  - recently discharged patients with e.g. hip, spine brace – who are having problems with devices
  - patients requiring HALO vests.

Encourage Adoption of Multidisciplinary Approaches and Ways of Working to Maximise Skills and Efficiency

6.7 The development of a more multidisciplinary approach to the provision of orthotic care, involving appropriately trained AHPs including podiatrists and physiotherapists, registered nurses and multidisciplinary clinics for specific conditions such as diabetes and others has had a positive impact on care for patients. It has helped reduce waiting times for initial assessment as well as speed up in-patient treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

Consider Introducing Local Tariffs for Orthotics Services

6.8 As discussed previously, some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services which although challenging, has been successful in incentivising quality and helped improve data recording and capture to monitor quality improvement.

10 Steps towards Effective Commissioning of Orthotics Services

6.9 The following steps are a summary of the key recommendations to commissioners to help improve commissioning of orthotics services:

1. Understand what orthotics care is by talking to patients, carers, managers clinicians and the MDT
2. Examine all of the funding streams your CCG is using to fund orthotic care in your local health economy
3. Unbundle these funding streams to understand the total orthotic investment and consider using a tariff
4. Consider adopting the model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx) which includes patient satisfaction measures, KPIs and includes patient outcomes
5. Clarify the service delivery model you would like to use – for example, retain NHS employed staff (‘in house’) who may use multiple product manufacturers, versus privately employed clinicians who would largely provide their employers’ own products
6. Think about the location - patients generally prefer a non-hospital setting with free parking close to the service
7. Promote access and choice – can you offer near-to-home clinics from local health centres, community venues, day services or special schools?
8. Encourage multidisciplinary working by commissioning multi-disciplinary pathways for specific conditions such as diabetic foot clinics and orthopaedic clinics
9. Look at case studies to inform the most appropriate commissioning model for your area.
10. Involve service users in performance reviews of the service.

7 Clinical Commissioning Group and Provider Case Studies

7.1 Orthotics services are generally funded by CCGs, with some specialised commissioning occurring for patients with highly complex needs requiring specialised pathways of care, for example, spinal surgery, orthopaedics, paediatric neurology and specialised rehabilitation.

7.2 More than 70% of NHS funded services are provided by private companies[1] and a variety of service models exist. The in-house model uses NHS employed orthotists. These staff may have the freedom to use any product supplier or may have to procure the bulk of their product via a specified supplier who wins a product-supply contract. Other services are operated by privately employed orthotists who work for a particular company and who are expected to order products for their patients from that company.

7.3 There seems to be a general consensus that service models for orthotics should be focused on delivering individually prescribed solutions tailored to patient needs and should not rely on a “commodity product procurement” model[8]. In addition and in line with current Government policy**Error! Bookmark not defined.** [26] locally commissioned services should be based on outcomes and monitored on achievement of these rather than inputs[8]. The case studies presented here illustrate some examples of how this is being achieved to improve patient care and provide value to the NHS.

North Staffordshire CCG and Stoke on Trent CCG – Redesign of Orthotics Service

Overview

7.4 North Staffordshire CCG alongside Stoke on Trent CCG and in conjunction with The Orthotics Campaign (which was previously the North Staffs Orthotics Campaign (NSOC)), has completely redesigned the orthotics service locally which sees approximately 5000 adults and children a year. Historically, the orthotics service in Northern Staffordshire was provided by two separate organisations which was confusing for patients and carers. There were also long waiting times amongst other concerns and complaints. An external review in 2011 identified over 150 recommendations for improvement with the main one being that the service should be delivered by one provider. Since then there has been significant service user and carer involvement in the redesign of services and the re-tendering process and the newly commissioned service was contracted out earlier this year to one private provider which provides a hub and spoke model of care.

Developing a Service User and Outcome Based Service Specification

7.5 The overall aim of redesigning the orthotic service was to take account of the needs of patients as a priority and improve the service within existing budgets. The intention was for the redesigned service to deliver the following improvements:

- Better quality of life for patients and carers;
- Delivery of better information to patients and carers to help manage their own conditions;
- Better physical access to services;
- A service that offered equal access to anyone that needed it in the area;

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[26] Department of Health, 2014: The NHS Outcomes Framework 2015/16

- To invest in the prevention of deformity to avoid or delay, and where possible, surgical intervention.

Outcome and Quality Measures

7.6 The service specification includes a number of outcome and quality measures that were felt to be priorities for patients and carers. These include measures such as: time to first outpatient appointment; advanced booking of appointments for fitting whilst patients are in clinic; clear and standardised orthoses delivery times; bi annual patient satisfaction surveys; patient reported outcome measures taken from goal attainment scores (measuring before and after for improvement in function, improvement in ability to carry out day to day tasks, patient perception of the difference the orthotic device has made and improvement in gait); and the availability of clear information and advice in both written and verbal form. More detail on the key elements of the service specification that were felt to be crucial in the delivery of a quality orthotics service can be found at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-2.pdf).

7.7 The outcome and quality measures form the basis of a monthly core data set which is listed below and used to monitor the contract and performance of the provider:

- % of patients satisfied with the service,
- Number of patient complaints / compliments received,
- Service users/carers receive information about their orthoses including leaflets and information on how to care for their orthoses,
- The proportion of users who report that they have achieved their goals,
- Percentage of users who report that they are comfortable in their orthoses,
- Do Not Attend (DNA) rate,
- Numbers of clinics cancelled and reasons,
- Cancellation rate (by the provider).

Moving from a Block Contract to Local Tariff

7.8 There were significant challenges associated with the proposed move from block contract to cost and volume tariff resulting from the lack of a national tariff and accurate reference costs, as well as the absence of an accurate clinical information system and orthotics ordering system locally, which led to unreliable and infrequent data being presented. The CCGs decided that this approach would be beneficial as a lever to drive and incentivise the quality and performance requirements within the contract which can be at times restricted through the use of block funding arrangements. To overcome the issues faced, a cost and volume arrangement has been agreed with the provider based on one fixed price and inclusive of all costs, with a risk share arrangement in place to cover growth or any decrease in demand to give a level of protection to both commissioner and provider.

7.9 The CCGs have acknowledged that within the first year, this will be a risk for commissioners due to the lack of historic information to allow accurate understanding of the numbers of patients across Northern Staffordshire who will be utilising the service. However, they are confident this model of service delivery will improve outcomes for patients and in turn reduce the demand for high cost surgery for patients in whom orthoses should have prevented their condition from progressing to a level where surgical intervention is required.

7.10 Since the introduction of the redesigned service, early feedback from patients and monitoring of performance is encouraging with signs of improvement in access, patient outcomes and reducing costs. For example, performance is currently running at 60% over activity due to the clearance of a backlog and reduction in waiting times, whilst cost savings are projected to be approximately £300, 000 within this financial year against the historical block contract value across both CCGs. This continues to be monitored on a month by month basis alongside all quality and performance indicators.

Medway CCG and Medway NHS Foundation Trust – Improving Patient Pathways for Orthotic Services

Overview

7.11 The orthotics service provided by Medway NHS Foundation Trust consists of externally contracted orthotists. The service treats adults only from the age of 16 years onwards and treats between 14, 000 to over 18, 000 patients a year. The service has been recognised as a centre of excellence in the South East and was awarded this status in 2010 for its training and innovation and in the way it delivered timely treatments to patients.

7.12 Historically pre-2007, the service used to be provided as part of consultant led elective pathways only. This meant that patients had to be referred to a consultant to gain access to treatment whether the consultant added any clinical value or not to the patient pathway. This led to unacceptable waiting times for patients who generally had to wait at least 16 weeks to see a hospital consultant before reaching the assessment and definitive treatment stage within the orthotics service. It also wasted valuable consultant clinic time. In addition, there was no opportunity for primary or community care services to refer directly as part of the treatment package they could potentially offer to patients. This also led to issues with tariff payments in that the only tariff payable for orthotics were those tariffs attracted by the consultant input either through outpatients or any treatment pathway. A large proportion of patients prescribed an orthotic will require this to be renewed or replaced for the rest of their life and as the tariff only applied to consultant input there was no further payment for this orthotics activity, as often there was no further consultant input to the patient.

Developing Direct Access Pathways for Primary Care and Community Services

7.13 During 2012/13 Medway CCG, Medway NHS Foundation Trust and Medway Community Healthcare worked together to develop direct access pathways for primary care and relevant community services. This involved significant process mapping of existing and potential referral pathways to see where improvements could be made and analysis of referral and activity data which found that around £114K was being needlessly invested in outpatients appointments. A business case outlining the benefits to patients and the NHS organisations involved was approved and a service specification produced to describe the new referral and direct access pathways and the tariff arrangements depending upon the route of referral. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-3.pdf).

Locally Defined Outcomes

7.14 The outcomes defined in the service specification include the following:

- Improve timely and appropriate access to orthotics,
- Enable direct access to orthotics for primary and community services,
- Reduce unnecessary delay to patients caused by a tariff driven pathway rather than patient outcome pathway,
- Clearly defined and accounted for funding streams,
- Reduce the amount of unnecessary secondary care and community referrals,
- Reduce the amount of unnecessary consultant outpatient appointments,
- Deliver an easy to navigate pathway in line with national and NICE guidance.

The Direct Access and Referral Pathways

7.15 Five pathways are described in the service specification, which are the:

- Community Allied Health Professionals (AHP) Direct Access Pathway
- GP Direct Access Pathway
- Consultant Treatment Pathway
- Consultant Treatment or Diagnosis Pathway with concurrent orthotic input
- Consultant Assessment and Diagnosis Pathway

https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-4.pdf

Locally Agreed Tariffs for Direct Access

7.16 Local tariffs for direct access have been agreed and cover 53 orthotics descriptors categorised into 3 bands. More detail on these can be found at https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-5.pdf

7.17 The new direct access pathways have cut out around 20 stages in the referral process and resulted in marked improvement in waiting times, being reduced by 15 weeks. Currently, average referral to treatment times for orthotics are between 1 to 3 days.

Quality Initiatives and KPIs

7.18 In addition to improved access and referral pathways, the orthotics service at Medway NHS Foundation Trust has also worked on a number of other areas to improve the quality of the service and reduce costs. For example, it has a workshop on site and can offer some patients a one-stop-shop service. This means that an assessment, plan, implementation and evaluation system can be achieved within a single appointment. It has also specified expected average treatment times for assessment and fitting of various orthoses which help maximise clinic appointments and ward based work. These are listed at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-6.pdf).

7.19 Clinical evaluation of orthotics products takes place to ensure patients receive the most appropriate treatment to suit their clinical requirements. A scoring template is used by staff to rate different products in a number of areas along with reviewing outcomes such as product fails. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-7.pdf) These are categorised by patient discomfort, and referring clinicians re-referring patients to the orthotic service if they or the patient feel that the prescribed treatment has not worked by not having an improvement in their condition or their activities of daily living. This process has helped to reduce cost and still use high quality products without compromising patient care. Over an eight year period since 2007, the service has saved over £1million and the average cost per treatment provided has fallen from £63 to £32.

7.20 Finally, the service has adopted a rigorous system for continuously monitoring and improving quality and performance and uses a monthly scorecard consisting of numerous KPIs in categories covering quality, performance, workforce and finance. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-plstr-photo-scorecrd-2015-16.xlsx)

Nottingham University Hospitals NHS Trust – Modernising the Orthotics Service

Overview

7.21 The orthotics service at Nottingham University Hospitals NHS Trust is provided as an “in-house” NHS service with its own workshop on site. It treats both adults and children across two hospital sites and sees over 14,000 patients a year. Over the last seven years the service has been modernised to improve patient care by improving access and reducing waiting times and reducing costs whilst improving quality.

7.22 Prior to the service redesign, there were substantial staffing, operational and infrastructure issues which left the service struggling to meet the demands of the hospital and patients. This resulted in significant performance problems with long delays in treatment, multiple referral to treatment time breaches and a high level of complaints regarding the inability to access the service in a timely way. Less than 2% of referred patients were issued their orthotic treatment at their first appointment and there was no service specification or KPIs to monitor performance or improvement. Financially, the service was £500K overspent.

Redesigning the Service

7.23 The overall aims of redesigning the service were to:

- Put patient care at the centre of all decisions;
- Improve quality and efficiency;

- Document agreed pathways and policies;
- Develop a new financial structure and processes;
- Implement a new IT system

Improving Patient Access

7.24 A number of initiatives were put in place to improve access and reduce waiting times. This included implementing a triage system for referrals, so that all referrals are triaged by a senior orthotist to ensure urgent patients are seen as quickly as possible. Choose and book direct GP access and referral has been introduced across all sites. Clinic slots for new patient assessments have increased from 20 to 30 minutes as a minimum to allow sufficient time for accurate assessments. Patients with long term conditions that meet specified clinical criteria are able to self – refer back to the service after the initial GP referral. It is estimated this saved approximately 378 GP appointments and the associated costs in 2012/13.

Developing a Multidisciplinary Approach

7.25 Specific multidisciplinary or multi-clinician clinics are held for paediatric patients, diabetes patients, neurology patients, spinal patients and patients with knee and foot orthoses (KAFO). The joint clinics have reduced initial assessment waiting times and allow for patients to be seen at the most appropriate time; the multiple clinicians allow each patient to have a suitable amount of time for their appointment and facilitate learning amongst the clinicians.

7.26 The orthotics service has developed competency based educational packages and training programmes , so that trained physiotherapists and registered nurses can provide specific orthoses in their clinical areas which helps speed up in-patient treatment and reduce length of stay.

Moving from Block Contract to Local Tariff

7.27 A cost and volume tariff has been agreed with commissioners irrelevant of source of referral. Coding for orthotics has been simplified and includes 16 descriptors categorised into four tariff bands which are described in more detail at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-8.pdf).

Service KPIs, Patient Allowances and Patient Experience Measures

7.28 Key performance indicators are now clearly defined in the service specification and include the following:

- Patient treatment will be given within 18 week RTT pathway,
- All patients to have appointment generated within 5 days of receipt of referral,
- All routine patients to be appointed within 10 weeks of receipt of referral,
- All orthosis to be fitted within 6 weeks of initial assessment,
- All in-patient referrals to have treatment plan initiated within 24 hours of receipt of referral,
- Waiting time for a scheduled Orthotic appointment at the Trust will be kept to a maximum of 30 minutes.

7.29 Patient Allowances are also covered in the service specification and are outlined at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-9.pdf).

7.30 The orthotic service routinely monitors patient experience measures through patient satisfaction audits, the family and friends test and specific audits such as a foot wear audit and insole pain audit. Patient outcome measures are also used. These include 10m walking test, 3m up and go test and VAS pain scores.

7.31 Overall, these service redesign initiatives have led to substantial improvements in quality and patient experience, as well as reduce costs. For example, paediatric waiting times have reduced from 10 weeks to 2 weeks for an initial assessment and maximum waiting times for fittings have reduced from 8 weeks to 2 weeks. In-patient waiting times have reduced from up to 4 days to the treatment plan being initiated within 24 hours. Over 34% of patients now have their orthotic treatment issued at the first appointment and 98% of patients report a positive benefit from their orthotic treatment with an absence of complaints. Average costs per patients have also been reduced.

Leicester Specialist Mobility Centre – Redesign of Disablement Services Centre

Overview

7.32 Prior to the redesign, the Disablement Service Centre in Leicester was originally commissioned by East Midlands Specialised Services team and services were provided by the University Hospitals of Leicester NHS Trust across three separate hospital sites. The services provided included orthotics, prosthetics, wheelchairs and environmental controls. At the time, the orthotics service was subcontracted to a commercial provider to provide the clinician expertise with a separate contract for product provision, which led to extended waiting times for patients as clinician's prescriptions were administered by trust staff and orders issued to a variety of stock and bespoke product providers.

7.33 As a result of disinvestment decisions and organisational changes within the NHS, the contract transferred across to the CCGs in Leicester (Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG) in 2011, with Leicester City CCG acting as lead commissioner. During this transition, a service review determined that a single provider operating under a fully managed, directly commissioned service would offer all orthotic patients a better quality service. The new provider would employ staff, locate facilities, manage the service and report on patient outcomes. The tender for a directly commissioned service required an experienced provider to deliver an outcome based service under a block contract (equal monthly reimbursements) with the option to move to cost and volume over time. The current service is contracted out to a private provider and has an active caseload of approximately 10,000 orthotics patients.

Key Elements of Service Redesign

Outcome Based Quality Measures

7.34 The new service model is based on a number of outcome based quality measures which require the most efficient model of provision where clinical input and product provision (either produced in-house or procured) are managed together as part of the same process. There is rigorous reporting on the quality measures which are based on the NHS Quality Schedule and include a host of measures such as: infection prevention; patient experience; patient feedback; reporting of complaints and incidents and others (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-qual-sched-rep.xlsx). Specifically for orthotics, a 'right first time' quality measure has been introduced to reflect patient feedback about the historically lengthy process for delivery of orthoses. The % right first time indicator ensures the accuracy of the measurements taken by the orthotists and the manufacture and production enable for the first time right fit. The performance threshold is to ensure 95% or more of patients' orthoses are right first time. Other indicators, such as waiting times, sources of referral and orthotic spend are also monitored. (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-kpi.xlsx).

Flexibility of Location of Service Provision

7.35 The current service has relocated to a fit for purpose, community based facility and aims to meet the needs of patients by providing services in the most suitable setting for them, whether that is at home, school, clinic or in hospital.

7.36 Numerous satellite clinics in community hospitals and special schools cater for the rural community. There are 6 community hospitals and a host of special schools where the orthotists attend on a regular basis. Domiciliary visits are also catered for when the patient is unable to attend any of the clinics. Some of these services are contracted with the provider by a separate contract and paid in addition to the main block contract.

7.37 As the service is no longer located on the hospital sites, a timed ward service caters for the acute hospital's discharge policy. Ward referrals are sent electronically and orthotists will visit the hospital sites daily with the objective of fitting 75% of patients on the day to allow discharge.

Innovative Information Technology (IT)

7.38 There has been significant development in IT systems to enable easier booking of appointments and facilitate patient choice. Electronic patient records can now be accessed by other associated services such as prosthetics, physiotherapy and the wheelchair service and allows greater visibility and access to patient notes by clinicians as they attend satellite clinics.

7.39 The IT system facilitates reporting on all outcome measures and episode of care data and management information which helps to monitor improvements in quality and performance as well as identify accurate information On-going work with the provider is to develop a new process to review volumes of patients, types of patients, referral routes etc. which is important in terms of full validation of data and recognising patient quality and safety and assists the unbundling of funds from block contracts to move towards tariff based systems.

8 Actions agreed at the Round Table Event to Improve Orthotics Services in England

8.1 Commissioners do not currently have all of the tools they need to commission high-quality orthotics services. A number of actions were agreed at the national round table event which have been taken forward.

Agreeing and Developing the Key Elements of a Model Service Specification for Orthotics Services

8.2 North Staffordshire Clinical Commissioning Group has led a process of developing a model service specification for commissioning orthotics services, along with supporting material including key performance indicators. This has taken into account the learning achieved by a number of CCGs and providers. The model service specification is outcomes-based and addresses key issues identified by patient groups. It also addresses how improvement might be achieved step by step. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

Improving Data Quality for Orthotics Services

8.3 NHS England will develop a national minimum data set for orthotics services, which will take into account the KPIs from the model service specification. A workshop will be held in November 2015 in partnership with national professional bodies and patient groups to review orthotics data and develop a plan to take forward a national data set.

Workforce Development Issues

8.4 Health Education England (HEE) and NHS England will work together to assess workforce development needs for orthotics service provision, with oversight from HEE’s Allied Health Professional Advisory Group chaired by the Chief Allied Health Professions Officer.

Sharing Good Practice

8.5 NHS England, The Orthotics Campaign and Healthwatch Staffordshire will work together to raise awareness of the variability in quality and highlight the good practice which has been identified to improve the quality of services.

Rehabilitation Framework

8.6 NHS England recognised that the issues affecting the quality of orthotics services are also experienced in other areas of rehabilitation and will ensure that common factors are addressed in future developments.

9 Key Contacts for Case Studies

North Staffordshire Clinical Commissioning Group – Gemma Smith, Senior Commissioning Manager (Gemma.Smith@northstaffsccg.nhs.uk)

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The patient leaders who contributed to the project.

Occupational therapy leadership within the Fire Service to reduce fire risk and address health and wellbeing in vulnerable communities

Lauren Walker, Occupational Therapist, Royal College of Occupational Therapists (case study relates to a previous role with Healthy London Partnership)

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Description

An occupational therapist in a leadership role supported London Fire Brigade to implement health and fire-safety focused home visits in 5 diverse London boroughs. The project reached individuals at increased risk of fire and poor health outcomes and took a person-centred approach to identifying health and wellbeing needs, linking service recipients with a range of supportive local services. 90% of recipients reported feeling safer as a result of the service and onward intervention by partner organisations [1].

Context

Project aims and objectives

- Reduce fire risk and improve health and wellbeing for individuals known to be at increased risk – e.g. people aged over 60, those living alone, people with disabilities, people receiving social care services [2]
- Offer advice and person-centred interventions to address targeted health priorities and fire risk factors – falls prevention, cold homes, smoking cessation, social isolation
- Provide occupational therapy leadership for oversight of staff training and competencies; development of strategic relationships between the fire service, health, local authority and voluntary sector partners; and project evaluation
- Develop person-centred assessment, signposting and intervention skills with the fire service's community safety advisors

Baseline data and population demographics

- London Fire Brigade undertake over 80,000 home safety visits each year, providing an opportunity to support a wide range of people at increased risk of harm from fire and health inequalities [3].
- London Fire Brigade operate in all 33 London boroughs, serving an extremely diverse population of approximately 9 million people from a wide range of ethnic and social backgrounds.

- London has the widest health inequalities in England and is home to some of the most deprived communities in the country [4].

Project rationale

- There is a known correlation between people who are at the highest risk of dying as a result of a house fire, and people who have reduced health and experience poor health outcomes [5].
- By supporting people to address their health and wellbeing needs it is possible to also address their fire risk, and vice versa.

Method

Activities undertaken

- 5 London boroughs with diverse ethnic and social demographics were identified to pilot enhanced home fire safety visits, through joint engagement between London's 5 Sustainability and Transformation Partnerships and LFB. The boroughs selected were those where there was felt to be most correlation and prevalence in fire and health risks, and therefore the greatest opportunity for the project to have a beneficial impact.
- Relationships were developed with local health, social care and voluntary organisations to offer pathways supporting falls prevention, fuel poverty, smoking cessation and social isolation.
- Visits were delivered by dedicated London Fire Brigade staff for two years across the 5 boroughs.

Who was involved

- Leadership was provided by an occupational therapist employed by the NHS, working in a project team alongside fire service colleagues.
- The occupational therapist had responsibility for development and delivery of fire service staff training and competencies; development of strategic relationships between the fire service, health, local authority and voluntary sector partners; and project evaluation
- Community safety advisors were recruited specifically to deliver the enhanced home visits and received a range of fire safety and health related training, including Making Every Contact Count [6].
- Over 30 local health, social care, public health and voluntary organisations from the 5 participating boroughs were active members of local strategic working groups for the duration of the project.

Outcomes

Feedback was sought from recipients of the service and project partner organisations, to inform the project evaluation. See *Fire Safe and Well: project summary, learning and outcomes* for full details of methodology, evaluation and outcomes [7]

- 1,253 visits were completed with 1,384 individuals receiving direct advice and intervention
- 80% of visits were completed to households with at least one resident aged 60 or over
- 85% of visits were completed to households with a disabled resident
- 49% of visits were completed to single person households

- 805 referrals were made to partner services offering interventions for falls prevention, fuel poverty, smoking cessation and social isolation
- 99% of service recipients surveyed would recommend the service to friends and family members
- 95% of partner organisations felt participation in the project had been beneficial to their service users
- 90% of service recipients surveyed felt that their safety had increased as a result of the service

Comment from project partner organisation:

“We have had 104 high quality referrals from [community safety advisors] working on the project. These were all vulnerable older residents that our outreach methods had failed to contact. Making these referrals has certainly improved the lives of vulnerable people and, in at least two cases, has probably saved lives.”

Comment from service recipient:

“My daughter is disabled and my husband has memory loss, so I was very impressed with how the fire brigade staff spoke to them clearly and gave excellent advice.”

Key learning points

What worked well

- Occupational therapy leadership was effective in supporting fire service staff to receive training and develop skills that enabled them to apply person-centred approaches when working with at-risk people in their homes, and signposting them to supportive organisations
- Occupational therapy leadership was valuable in developing effective working relationships between the fire service, health, social care, public health and voluntary organisations
- The fire service are able to reach a wide range and large number of individuals who are at increased risk of fire and poor health outcomes.
- Fire service staff are trusted and were successful in linking people who were at risk, but not receiving assistance, with supportive organisations.

Challenges

- The complexity of the health landscape across London made it challenging to adopt a consistent and scalable approach to developing pathways and making onward referrals.

Future opportunities

- Occupational therapists are working in leadership and clinical roles within a number of fire services in England, Scotland and Wales, applying different approaches to embed person-centred assessment and intervention within their organisations’ community safety work.
- Although it was recognised that the demographic profiles of the project boroughs were diverse, closer evaluation of the demographics of home visit recipients would help to identify the impact of enhanced home fire safety visits upon health inequalities and disadvantaged groups. Future projects could be targeted more closely to deprived communities and those at greatest need.

References

[1] [7] Fire Safe and Well: project summary, learning and outcomes – Healthy London Partnership

[2] Health and Social Care Fire Safety Guidance – Greater Manchester Fire and Rescue Service & Manchester Mental Health and Social Care Trust

[3] Home Fire Safety Visits by London Borough – London Fire Brigade

[4] London Health Inequalities Strategy – Greater London Authority

[5] Consensus Statement on Improving Health and Wellbeing between NHS England, Public Health England, Local Government Association, Chief Fire Officers Association and Age UK

[6] Making Every Contact Count – Health Education England

Addressing occupational deprivation as a way to reduce health inequalities

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Description

This example will consider how staff at the University of Lincoln are encouraging occupational therapy students to explore health inequalities through their studies of occupational deprivation and the importance of engaging with hard-to-reach groups in practice.

Context

Aims and objectives:

- To increase student awareness of health inequalities.
- To enable students to apply an occupational lens to those issues.
- For students to ensure their practice in occupational therapy reached hard-to-reach groups.

Rationale for improvement

Graduates from the MSc Occupational Therapy will have the knowledge and understanding of the need to adapt their practice to ensure it includes addressing the needs of hard-to-reach groups in traditional practice, and they also are able to identify and build a case for roles in new areas of practice where OTs could be commissioned to address health inequalities.

Method

Second year students at the University of Lincoln participate in a number of learning opportunities that are interlinked and address health inequalities in different ways. It starts with a module on Applied Health Improvement which is an interprofessional module that explores the principles of public health principles, the priorities and practice and the social determinants of health, illness and health inequalities, which enables students to get a baseline understanding of health inequalities and they start to identify who the disadvantaged groups are. They then pick this up with an occupational lens in their Occupational Therapy module. In this module students explore their understanding of occupational deprivation and get a deeper understanding of who might be occupationally deprived and how they might identify and address the needs of those peoples.

As occupational therapists we see many people who are occupationally deprived and a wide range of reasons why. Working holistically and using a biopsychosocial approach the students use case scenarios of people who may be occupationally deprived as result of a range of factors such as disability, injury or illness, or as a result of their social circumstance or their individual diversity. We also explore the needs of people who have what may be described as “dark occupations” or occupations that may be less socially acceptable. The students focus is understanding what are the ‘push and pull’ factors for these occupations and how could they address the occupational needs of these people.

These activities are followed by a role emerging or extended scope placement where students get an opportunity to work with a charity or non- traditional organisation, many of which are trying to address the needs of hard-to-reach groups and who don’t have occupational therapists working there to explore how occupational based practice could help. Examples of the hard-to-reach groups students have supported are perpetrators of domestic violence, homeless and refugees. This gives students real insight into how they can address health inequalities of their population in practice.

Outcomes

Students have a real opportunity to demonstrate their understanding of health inequalities and how to address them and this is assessed in their summative assessments. As a result of role emerging placements there have been occupational therapy posts created or students have left a legacy to support existing staff to meet the occupational needs of their service users. One example was following a student working with a care farm. The student worked with children and adolescents with behaviours that challenge and many of whom are excluded from school and as a consequence occupationally deprived. The student was able to identify that an occupational therapy assessment identifying the needs of the child, addressing the barriers to occupations and offering interventions to support ways for the child to engage in meaningful occupations. This led to an OT post being created at the organisation and as a result most children are transitioned back into the school environment in a timely fashion and in a sustainable way with the right level of support to engage in their required occupations. The long-term effects of being in education reduce the likelihood of future heath inequalities.

Key learning point

All students graduating have a clear understanding of groups of people who may be occupationally deprived. The connections between the academic modules and the practical placement allow them to fully explore the realities of addressing occupational deprivation and are alert to the consequent impact on the health and wellbeing of the individual.

Supporting the Development of Placements for Allied Health Professionals in Public Health Settings

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Description

This example will outline a partnership between Public Health England, Health Education England, The University of Lincoln and The Royal Society for Public Health to increase opportunities for Allied Health Professions students to experience public health placements during pre-registration education.

Context

Aims and objectives:

- To explore the opportunities and barriers to increasing public health placement capacity from the perspective of students, higher education institutions, practice placement coordinators, clinical teams and potential providers of public health placements including providers in the voluntary sector
- To develop a toolkit to simplify and streamline the setting up of public health placements for AHP students
- To create a digital tool to support the matching of interested AHP students with potential placement settings

Starting point, baseline and useful data about population or demographics:

- AHP engagement in public health and prevention has increased over recent years and the UK AHP public health strategic framework sets out the commitment to do more. One of the priorities within the strategic framework is to ensure newly qualified AHPs are equipped with the skills, knowledge and attributes to embed public health and prevention into their practice and take actions to reduce health inequalities. The Council of Deans of Health Guidance: Public Health Content within the Pre-Registration Curricula for Allied Health Professions was published at the start of this journey and since then there have been efforts to increase availability and uptake of public health placements.

- The recent COVID-19 pandemic has necessitated a rapid re-imagining of practice-based learning including virtual placements. This, alongside the drive to increase overall placement capacity to meet the growing demand for Allied Health Professions, has created an opportunity to expand public-health placements.

Rationale for improvement

Expanding placement opportunities for pre-registration students in organisations such as public health teams and voluntary sector organisations will ensure the future workforce recognise and experience where they are able to contribute to improving health and reducing health inequalities.

Method

To explore the value of AHP students undertaking public health placements and the barriers currently preventing access, we conducted five focus groups for people from the following perspectives:

1. Students
2. Higher Education Institutions
3. Clinical Placement Co-Ordinators
4. Clinical Placement Teams
5. Local government, private and charitable organisations

In total 50 people took part in these focus groups, from a wide range of institutions in different parts of England and collectively representing nearly all of the fourteen AHP disciplines (music therapy and drama therapy were the two exceptions). We received four written responses to our questions by those who were unable to take part in the focus groups but wanted to inform our research. The focus group discussions were then transcribed and, together with the written responses, thematically analysed to identify commonalities in the experience of providing non-clinical placements to AHP students, as well as notable divergences.

The information from the focus groups and an advisory group for this work was used to identify key areas to be included within the toolkit. It was agreed by the advisory group that 3 toolkits would be preferable: one for potential public health placement providers, one for AHP students and one for education providers.

The focus groups were also useful to explore the requirements of the digital tool. Following this, a specification was devised to develop and pilot the digital tool.

Outcomes

The project is now at the piloting phase and will be piloted in one Health Education region with the support of the Royal Society for Public Health and one Health Education Region without the support of the Royal Society for Public Health.

There are plans for evaluation of the digital tool, evaluating the tool from the perspective of those who will be using the tool to look for a placement and those providing a placement and a number of questions applicable to both. This evaluation will inform future work on the digital tool.

We will also capture the number of increased placements provided as a result of this project and we are scoping a longitudinal study to identify the impact of public health placements from the perspective of students as they progress through their careers.

Key learning points

This project demonstrated the value of cross organisation working between Public Health England, The University of Lincoln, The Royal Society for Public Health and Health Education England. We also develop some broader key recommendations following the focus groups:

- The Health and Care Professions Council (HCPC) to review adding public health-related understandings and competencies into the standards of proficiency for the Allied Health Professions to encourage the further integration of public health into the curricula and placement offering of all AHP programmes.
- Higher Education Institutions (HEIs) to include public health-related learning outcomes in their assessment criteria for clinical placements, to enable students to view their clinical practice through a public health lens, irrespective of whether specific public health placements are available on their courses.
- HEIs to consider innovative ways of adding public health into the curricula of AHP courses where it does not yet exist, including online courses, elective accredited schemes, and public health-related activities in the community.
- HEIs should make the placement provider aware of the funding allocated in the DHSC Education and Training Tariff which contributes towards placements. The placement provider can then be contracted by HEE for this activity at the nationally mandated tariff price. Where HEIs receive this funding from HEE, they should ensure the funding to the placement provider is reflective of the national tariff price.
- HEIs to explore the possibility of virtual placements with potential providers, beyond Covid-19, to enable organisations who might otherwise struggle with some of the practical barriers to offering placements.
- Occupational Therapy Programme staff who have experience in training long-arm supervisors to share this learning with other AHP departments and professional bodies.
- Health Education England to commission further research and engagement with recruiting managers in the NHS to explore whether public health placements would present a true barrier to students finding employment in clinical settings and ways of communicating their value to employers within the NHS.
- AHP Professional bodies, Public Health England, Health Education England and HEIs to work together to raise the profile of AHPs working in public health and the contribution all AHPs make to the four domains of public health.

References

The UK Allied Health Professions Public Health Strategic Framework: http://www.ahpf.org.uk/files/UK%20AHP%20Public%20Health%20Strategic%20Framework%202019-2024.pdf

Council of Deans of Health Guidance: Public Health Content within the Pre-Registration Curricula for Allied Health Professions: https://councilofdeans.org.uk/wp-content/uploads/2017/09/Public-Health-Content-within-the-Pre-Registration-Curricula-for-Allied-Health-Professions.pdf

Royal Society of Public Health - **Expanding public health placements to AHP students: The barriers and solutions**: https://www.rsph.org.uk/static/0c06c3a5-8bc2-41f1-9e85438ade7c674f/Expanding-public-health-placements-to-AHP-students-report-1.pdf

Title An occupational therapy role emerging placement in public health and domestic abuse: Work within women's refuge.

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Description

The following case study details the journey of two pre-registration MSc occupational therapy students in their final year on a role-emerging leadership placement within Public Health at Nottinghamshire County Council, specifically working alongside the domestic violence team. It details the work they completed scoping the role for occupational therapy within women's refuges, where occupational therapists had no previous input. It continues to describe the two avenues this work took, one being environmental audits of the accessibility of the refuges and the other how occupational therapy led work could be offered to female survivors while they resided in refuge to improve their health and wellbeing outcomes.

Context

The Allied Health Professional strategy (NHS England, 2022) and UK AHP Public Health Strategic Framework 2019-2024 (ahpf, 2022) identified a role for occupational therapy within Public Health.

The idea for a role emerging placement was born from a needs assessment of refuge environments in Nottinghamshire commissioned by public health domestic violence team finding several accessibility issues for people with diverse disabilities.

The aim of this placement was to scope out the role for occupational therapy in public health domestic violence services with two objectives, to assess the physical environment of each refuge across Nottinghamshire by conducting environmental audits and to implement the occupational therapy process by working with survivors in groups and on a one-to-one basis.

The rationale is domestic abuse takes away people's occupational right "to do, be, belong and become what people have the potential to be in the absence of harm" (Wilcock & Hocking, 2015). This can cause occupational injustices including occupational deprivation and occupational imbalance, which can lead to occupational alienation. This can also impact on survivors' occupational identity, because if they cannot engage in meaningful occupations part of their identity is taken away from them.

The starting point for applying occupational therapy in domestic violence came from a project implemented in Wales by Clarke and Jones (2020) seed funded by Elizabeth Casson Trust. This project identified survivor`s occupational needs through the application of occupational therapy theoretical knowledge to practice, and evidenced powerful statistics, including disabled women are twice as likely to experience domestic abuse (Safe Lives, 2023) and an estimated 1.6 million women aged 16 to 74 experienced domestic abuse (Office for National Statistics, 2020).

Method

Environmental objective

The occupational therapy students undertook environmental audits of all six refuges, with support from their Practice Educators. This required adaptation of an Activity of Daily Living (ADL) assessment to suit the environment they were assessing and involved taking measurements of household facilities and taking pictures to truly represent each refuge. They identified any issues within each refuge that prevented accessibility for those with physical needs or impairments and recommended improvements, which were reasoned, and risk assessed.

Those involved in this objective included both students who undertook the audit, the occupational therapy practice educator, refuge managers who provided access to the refuges, and the student's mentor who was the public health commissioning manager who has reviewed and implemented the occupational therapy students' recommendations.

Occupational Therapy process

The occupational therapy students worked with survivors in one-to-one and group contexts. The one-to-one work involved an adapted assessment designed to assess physical, psychological, cognitive, sensory, and social needs of survivors. Two women were supported to apply for financial benefits (PIP application) and recommended to buy compensatory equipment to support their activities of daily living.

The therapeutic group work involved three different groups of women in separate refuges, stress management, arts and crafts, and a family peer support group. Both students, led the group work, and the refuge managers and staff helped with the organisation, planning and implementation of the groups. As a result of this work, the women have been given stress management techniques, more opportunities for meaningful creative occupations, and the opportunity to meet other survivors and to build peer support networks within their refuge.

Outcomes

Overall, feedback received from survivors, refuge staff and colleagues in the Nottinghamshire County Council was highly positive.

Feedback forms were used pre-and-post group sessions, with tailored likert scales to measure outcomes. The results from these showed small positive changes in the survivor's perceptions of their abilities to engage in occupations and manage stress over the three weeks of the groups.

Below are some quotes from survivor and refuge staff to give rich qualitative feedback:

"We want the sessions to keep going with you, they've been really useful." - Survivor feedback from stress group

"The women that attended have fed back that they have started to use the strategies highlighted to them and will keep thinking about it going forward." –Feedback from refuge manager.

"I have learned that it's good to take time out for yourself and I have enjoyed time with my eldest daughter doing something she loves." - Survivor 2 from arts and crafts group.

Public Health Strategic Commissioning outcomes.

- working through the occupational therapy students report to implement the environmental recommendations, to make their refuges accessible for a wider range of women.
- considering how the occupational therapy can add therapeutic value and impact in women's domestic violence refuges. The work the occupational therapy students have completed, along with the emerging national evidence base, will support the development of a business case for trauma informed occupational therapy practice in domestic violence refuge setting. In turn, and over time the aim is this would support new student placements in this setting.
- now committed to hosting AHP student placements. Each placement will be planned and designed to address the student's professional background, and the needs of public health. These placements are dependent on practice educator availability to give a profession specific long-arm supervision model.

As this was a university placement the financial cost was minimal, resources for all groups totalled no more than £50.

Key learning points

The key learning points are:

- the breadth of scope for occupational therapy in settings such as domestic violence and

- how the preventative interventions occupational therapists deliver, align with public health values.

Aspects of the placement that worked well were two students working together as a team, the group work, which was received positively, the relationship building with the women and staff in refuges, and the value and impact the environmental audits will have for Nottinghamshire. A challenge was adjusting to a different style of a leadership placement, and autonomy of hybrid working.

Going forward this occupational therapy role could focus on a range of preventative work packages either in the public health team or specifically placed in the refuges. Areas for further exploration include:

- working with individuals for housing and equipment needs assessments.
- recommending or assessing new properties put forward for refuge for access suitability.
- creating occupational therapy group programmes in all refuges to promote and increase engagement in meaningful activities.

References

Clarke, L. and Jones, K. (2020) *Domestic Abuse Occupational Therapy: A Project in Response to Covid-19.* Available at: Domestic Abuse Occupational Therapy: A Project in Response to COVID-19 - Bevan Commission

NHS England (2022) AHP deliver the Allied Health professionals strategy for England.https://www.england.nhs.uk/publication/the-allied-health-professions-ahps-strategy-for-england/

Office for National Statistics, (2020). Available from: The lasting impact of violence against women and girls - Office for National Statistics (ons.gov.uk)

Safe Lives (2023) *Spotlight #2: Disabled people and domestic abuse.* Available: Spotlight #2: Disabled people and domestic abuse | Safelives

Wilcock, A. A. and Hocking, C. (2015) *An occupational perspective of health. Third edition.* Thorofare: SLACK.

UK Allied Health Professions Public Health Strategic Framework 2019-2024. AHPR.org.uk.

UK AHP Public Health Strategic Framework 2019-2024.pdf (ahpf.org.uk)

‘Virtual Cuppa’

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Description

Image by Sue Ellis

‘Virtual Cuppa’ (VC) was a daily online peer led virtual support group for Art Psychotherapists during the Covid pandemic. Evolving as a safe virtual space for connectivity to meet the needs of therapists and clients alike, following radical changes to work practices in response to Public Health Guidelines at the onset of lockdown.

The UK Allied Health Professions Public Health Strategic Framework has 5 goals one of which is “Health and well-being of the workforce: The expertise of AHPs will be used to protect and improve the health and well-being of the health and care workforce” (Hindle and Charlesworth, 2019). This project demonstrates a response that meets this goal. ‘Virtual Cuppa’ evolved as a safe virtual space of connectivity, learning and emotional holding for Art Psychotherapists’ response to the COVID-19 pandemic.

Context

The pandemic created a unique dual experience affecting both the client and therapist alike, with isolation at an unprecedented level, directly impacting on their mental health, “Nearly a third of healthcare workers reported moderate to severe levels of anxiety and depression, and the number reporting very high symptoms was more than quadruple that pre-COVID-19” (Gulleen J, 2021).

The aim of VC was to support Art Therapists on two levels; first by creating a safe environment to support their mental health, secondly to create an environment for shared learning and professional development. Capturing the learning to create a new framework of online art therapy as a credible alternative to face-to-face interventions and enhance its capabilities by widening the scope of clients who find face-to-face models of therapy problematic.

By expanding our professional knowledge and skill base, Art Therapists are meeting the objective of the Royal Society of Public Health Strategic Plan 2022-2027 *“A skilled and well-trained workforce is essential for better Public Health”.*

Method

VC was available free of charge, accessed through an invite from Zoom video conferencing platform:

- Every weekday morning from 7.30-9.30 am
- Once a month evening sessions were offered
- Cyber Open Studio on Sundays, 4 hours of restorative creativity

VC delivered over 400 hours of support with an average of 3 people attending per session and a maximum of 12, and only a small quantity of sessions with no attendance. 12 evening session ran for 2 hours, average attendance 6 maximum 9. The Cyber Open Studio Sessions on Sundays delivered 100 hours with an average of 8 people in sessions and a maximum of 15.

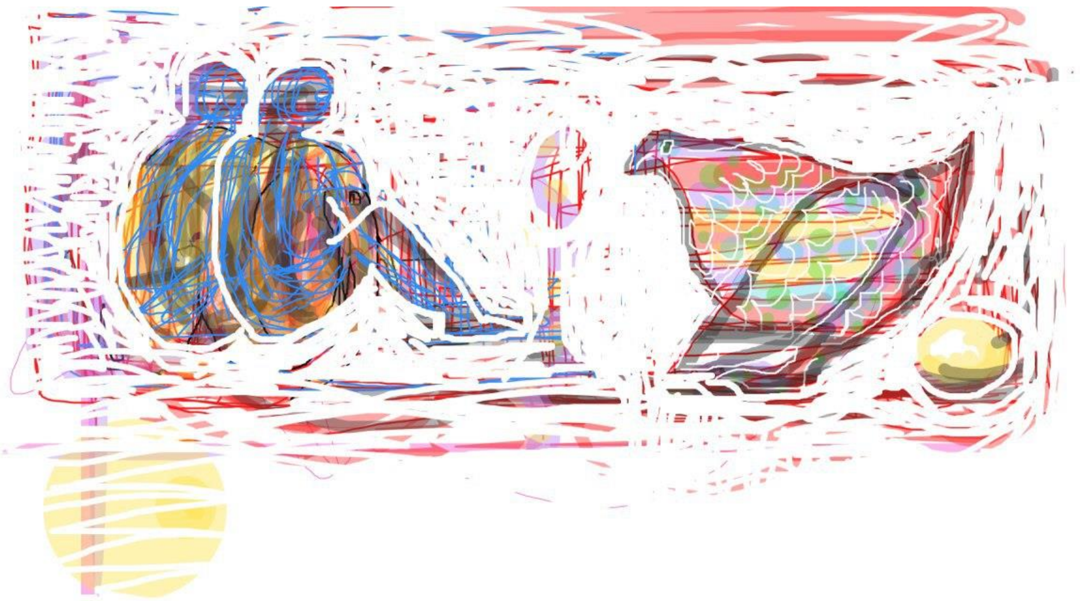

Image: by Sue Ellis in collaboration with another Art Therapist on the Zoom whiteboard

As time progressed, themes started to emerge and focused themed sessions were created to explore these further, inviting other professions/AHPs:

- Setting up our online studio space to look familiar to the art therapy space.
- Organising the technology, internet, camera, thinking about height to eye levels so the client did not feel you were looking down or up at them. Using one or two cameras, exploring lighting to create an authentic experience.
- Discussion around Arts for Health and art therapy online.
- Using Music, Drama, Movement and Poetry in therapy to support a less static and more sensory response to being in front of the screen.
- Using technology, photography, videography, VR, Minecraft and virtual games.
- Co-created Art in therapy – using the Whiteboard in Zoom creatively.
- Using a ‘transitional object’ to support connectivity with the client – sending letters and art projects out to clients with their name on the envelope, reinforcing their sense of self as a positive experience.
- Confidence – Imposter Syndrome.

- Going back to face-to-face working, taking forward our learning and experience of online working.

VC was Initially to support Art Therapists in the British Association of Art Therapists (BAAT) region 11 Yorkshire and Humber region. It expanded to include other BAAT regions and other Creative Therapists wanting to share their learning and experiences.

Although mainly attendees originated from Yorkshire, this grew over time to cover the length and breadth of the UK from Devon and Cornwall right up to the Orkney Islands and expanding across the globe with international colleagues from Europe, Canada, America, Australia, South Africa, South America and Israel.

Outcomes

VC showed we could successfully take art therapy online, following the early examples the USA Telehealth research, highlighted a credible option, ‘a plausible best method of therapy for some clients’ (Collie & Čubranić, 1999) cited in (Malchiodi, 2018). “A growing body of literature now suggests that use of telepsychiatry to provide mental health services has the potential to solve the workforce shortage problem that directly affects access to care, especially in remote and underserved areas.” (Antonacci DJ, 2008) (Rees & Haythornwaite, 2004). In their study Day and Schneider compared “psychotherapy: face-to-face, real-time video conference, and 2-way audio (analogous to telephone)” and suggested that “differences in process and outcome among the 3 treatments were small” (Day & Schneider, 2020).

To support the most commonly ask questions and pull together our learning we produced E-Booklets:

- Art therapist working online
- Clients introduction to online art therapy with safety plans
- Student Art Therapist E-Booklet

Feedback:

“I so wish that I had come across the ‘Virtual Cuppa’ sooner I have found it invaluable and am very grateful for the new connections I have made, practice discussions and shared learning resources. Through one of our discussions around appropriate adolescent referrals to therapy Sue kindly shared her ‘Venn Detective’, a creative assessment tool that can help practitioners identify areas of difficulty at home and school as well as hopes and aspirations. I have been able to use this already online. My interest in working creatively, ongoing personal learning and future development of my practice has been rekindled by meeting with so many like-minded, experienced, passionate and enthusiastic professionals. Thank you so much”. (Play Therapist and Creative Arts Counsellor for Children and Young People).

“How curious would Donald Winnicott be to see the use of his theory of the ‘potential space' introduced to the world in 1953 being used 67 years later within cyber based therapies in 2020”, (Art Therapist, 2020 in discussion in VC session).

“I’ve found the group to be the invaluable support I need as an early-career AT. Very inspiring conversations, with wise souls encouraging me to do my best out there! Hugely grateful” (message taken from VC Telegram page 2020).

“I like how Virtual Cuppa helps people, to work together and relate to one another using art and technology. Whilst at the same time supports learning and wider discussions, enabling people to know more about their process so partnerships can begin.” (Media Psychologist)

“Virtual Cuppa was my lifeline during the pandemic. In March 2020, I was naturally preparing to end work with several adolescents in alternative provisions. I had just been informed that my mother, who lived in a distant county, was terminally ill. Lock-down happened. Everything came to an abrupt stop. No proper endings. Wherever I was, Virtual Cuppa held me each morning before I started my day” (Art Therapist).

“I wasn't always able to make sessions but knowing you where there holding the space helped me feel held during my days especially when I have times of feeling overwhelmed” (Comment made in VC discussion).

Key learning points

The key learning points were the importance of holding the professionals and looking after their health and mental health in order that clients where safely held. The COVID-19 pandemic, fast forward the learning essential to place art therapy online in doing so, showed that distance need not be an exclusion for therapy.

We supported each other in dealing with the following:

- The extreme tiredness of online working
- Hitting the brick wall of Covid
- Emotional and practical complexities of online working with clients such as:
    - Regressive behaviors experienced by both client and therapist
    - Disinhibition effect on therapy and disclosures
    - When the clients turn off the screen - holding the empty space
    - Dealing with technical issues and backup plans
    - Determining the levels of appropriate space for talking and silence
    - Dissociation and emotional dysregulation

Members worked collaboratively to create a ‘heighten attuned response’ across this new dual therapeutic space, developing:

- Safety plans written with clients prior to the commencement of session.
- Maximising the creative potential of Zoom by using the Whiteboard for co-created artwork.
- Dyadic Art Therapy approaches designed to hold children safe with distance working.
- The change in power dynamics with parents, helping parents through psychoeducation to have the confidence to position themselves in their child’s healing, helping the parent be the hero.
- The powerful dynamic way of co-working with the clients and families became part of the new normal. That supported the transition from online working within their home back to their home as their lived environment.
- Learning to hold the chaos over distance.

Emerging themes over the course of lockdowns:

- Working in isolation, away from professional teams.

- The loss of professional voice and practiced narrative; the emerging domestic narrative taking precedence started to coincide with loss of professional confidence.
- VC reach has been wide and varied from embracing the challenges that this pandemic has brought on all levels of personal and professional identity. It has been integral in providing emotional support for therapists to sit with each other in times of darkness, despair, and sadness.
- VC became that safe space to be held, re-gather and regain perspective to gain strength and carry on. For some it was a lifeline.

The response for support needed to be swift at this most challenging of times, it is hard to see how this level of intense support would be needed as we regain our normal ways of working.

Doing things differently would be to take the essence of this learning into our new every day with a hope that it is not lost. Providing online art therapy as a credible option for our clients that was not thought possible pre-Covid.

This was a unique time in our history, the lessons we can take forward is art therapy can be done successfully online and can become part of the blended approaches to meet the needs of our clients in the future, distance is no longer an issue for clients to assess mental health support.

References

Antonacci DJ, B. R. (2008). Empirical Evidence on the Use and Effectiveness of Telepsychiatry via Videoconferencing: Implications for Forensic and Correctional Psychiatry. Behav Sci Law., 26(3), 253-269. doi:10.1002/bsl.812

Caldwell, L., & Taylor Robinson, H. (2016). The Collected Works of D. W. Winnicott: Volume 4, 1952-1955. oxford University Press.

Collie, K., & Čubranić, D. (1999). An Art Therapy Solution to a Telehealth Problem,. Art Therapy,, 16(4), 186-193. doi:10.1080/07421656.1999.10129481

Day, S. X., & Schneider, P. L. (2020). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. American Pschological Association.

Gilleen J, Santaolalla A, Aldearenas L, Salice C, Fusté M (2021). Impact of the COVID-19 pandemic on the mental health and well-being of UK healthcare workers. BJPsych Open.

Hindle, L. and Charlesworth, L. (2019). UK Allied Health Professions Public Health Strategic Framework 2019-2024. Public Heal Engl Allied Heal Prof Fed, pp.2019-2024.

Malchiodi, C. A. (2018). The handbook of Art Therapy and digital technology. London and Philadelphia: Jessica Kingsley.

Rees, C. S., & Haythornwaite, S. (2004, November). Telepsychology and videoconferencing: Issues, opportunities and guidelines for psychologists. Australian Psychologist, 39(3), 212 – 219.

Royal Society of Public Health (2022). Royal Society of Public Health Strategic Plan 2022-2027. Available online at: RSPH | Our Strategic Plan| The Royal Society for Public Health UK