Scotland's Allied Health Professions Compendium 2023

NEW AND UPDATED FOR 2023

NHS Education for Scotland

ahpf scotland

Allied Health Professions in Scotland

AHPScot

Introduction

We hope this compendium helps Scotland's leaders and public better understand who allied health professionals are and what differences they make.

Scotland's NHS currently employs 13,145 whole time equivalent allied health professionals across the following 12 professions.

- Art Therapists
- Dietitians
- Dramatherapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Paramedics
- Physiotherapists
- Podiatrists
- Prosthetists and Orthotists
- Radiographers
- Speech and Language Therapists

In 2020, NHS Education Scotland commissioned the Allied Health Professions Federation Scotland to work in partnership with Allied Health Professions Directors Scotland Group to generate at least 50 positive AHP impact stories from across these professions.

In 2023, AHPFS added to the compendium with stories highlighting the lifelong impact of AHPs in mental health.

This compendium offers a selection of AHP positive impact stories. Read all the stories or use the index to choose a profession and/or care group and/or health and social care setting.

There are even more remarkable stories at www.ahpf.org.uk/Allied_Health_Professions_Federation_Scotland.htm

Twitter: **@AHPFScot**

Inspirational stories of AHP impacts also regularly feature on **@ahpscot**

To find out more about AHPs and the difference they make everyday, contact **admin.ahpfs@ahpf.org.uk**

Contents

New for 2023: The Lifelong Impact of AHPs in Mental Health

We thank the AHP Compendium contributors and the compilation team – Kim Hartley Kean, June Wylie, Debbie Provan, Fraser Ferguson, Elaine Hunter, Andrea Wilson, Helen McFarlane, Andrena Wilson and Nicole Kane

Compendium design: www.createpod.com

Forewords

I am delighted that this compendium has been updated to share more AHP examples with a focus on mental health – AHPs have a huge contribution to make in this area of work and the case studies included tell some of the stories of where AHPs help people to live their best lives. AHPs have an expert contribution to offer across the life journey and in all areas of health and social care.

On behalf of AHPFS I would like to thank everyone who has contributed to the development of the compendium so far and especially to Nicole Kane and her Short life Working Group who worked hard on behalf of AHPFS to bring all the stories together.

Alison Keir,
Chair of AHPFS

When I commenced my role in January 2020 as Chief Allied Health Professions Officer I, like every one of us, could not possibly have imagined the challenges we would have to face.

But we are AHPs, and rising to the challenge is what we do, we lead, we innovate, we adapt.

Through the breadth of our skill set and our reach across health and social care, housing, education, voluntary and independent sectors we assess, diagnose, treat and dis-charge people working collaboratively to enable those who need our services to live their lives to the full at home, in education and at work.

This compendium captures some of the inspirational work undertaken across our family of professions. What better way to celebrate the connections we share whether locally or nationally, within each profession or across teams, than by sharing our stories and celebrating our success.

I hope, like me, that you take the time to appreciate the incredible work that we do and the stories shared here and would encourage you to share this compendium as widely as possible.

Professor Carolyn McDonald,
Chief Allied Health Professions Officer,
Scottish Government
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Dietetic leadership improving treatment and prevention for diabetes

The National Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework was created as a result of work on the Scottish Diabetes Group's (SDG) Diabetes Improvement Plan. The plan emphasised prevention and early detection of diabetes.

A working group was established with dietitians, other specialists from adult, maternal and child health, public health, education and research, and Diabetes UK. Work began on guidance but this developed and expanded to become a national framework to sit alongside the Diet and Obesity Strategy for Scotland, under Population Health. The Scottish Government committed £42 million, over five years, to implement the Framework.

From development to implementation

Three early adopter Health Boards lead on implementation in 2018/2019. All other boards received seed funding for a scoping exercise that same year, with funding available for implementation of the framework in 2019/2020. There are four levels within the Framework (see chart). Boards set out plans aligned with specific levels of the framework:

Level 1 and 2 – Prevention, Awareness, Detection

- Risk stratification and awareness, included links with Public Health
- Promotion of self-assessment and targeted education
- Screening for moderate to high risk patients

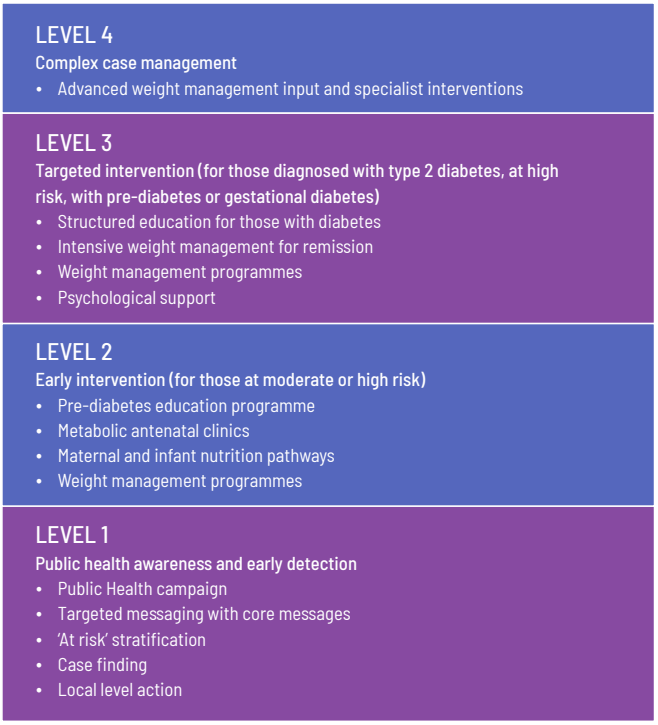
Level 2, 3 and 4 - Early, targeted and complex Interventions

- Timely access to structured education
- Equitable access to targeted interventions
- Access to weight management services
- Access to specialist input e.g. Intensive programmes for potential remission
- Complex case management
- Psychology

Progress so far

In Year 2

- All boards have implementation plans for 2019/2020
- All plans highlight the need for coproduction and targeting communities vulnerable to health inequalities
- There has been a big focus on early intervention for those newly diagnosed with Type 2 diabetes alongside prevention
- Key themes focus on GDM, Pre-Diabetes, Complex Pregnancy, Type 2 Diabetes Education, weight management and Type 2 Diabetes remission using digital resources to support self-management, motivation and engagement



Next steps

We have highlighted the need for enhanced physical activity and psychology input at all levels of the framework. Work is underway with psychology teams to produce recommendations for all aspects of behaviour change, professional education and clinical input. A crucial National Core dataset is being implemented.

We are also strongly linked with academia and research to capitalise on the new ways of working and enhanced services to demonstrate impact. This work has provided opportunities for dietitians to lead in pathway development and provide clinical expertise.

This work was included in the recent Scottish Government 'Programme for Government'.

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How to save a small fortune – ONS Prescribing Project

December 2016, Dietitians across Scotland were invited to participate in 'Once for Scotland' project; to reduce variation and improve efficiency of using oral nutritional supplements (ONS).

A multi-disciplinary group representing all 14 health boards tackled this with great energy and enthusiasm. A series of bi-monthly meetings hosted by the therapeutics branch stretched the I.T. abilities of the co-chairs; with 15 people present, six boards on VC and three by telephone. Representation from: Dietetics, Pharmacy, Prescribing, Nursing, care homes and Speech and Language Therapy.

Three work areas were identified;

- Data from boards recording the patients on ONS, amount and spend
- Formulary ensuring boards had an agreed list of ONS products linked to individual contracting processes
- Quality and consistency identifying and understanding the variation across Dietetic departments when applying the ACBS guidance for ONS

Two reports were produced and endorsed by both the Scottish Government and the British Dietetic Association:

- Best practice guidance for ONS formulating development
- Guidelines for appropriate ONS prescribing for adults (including 12 recommendations)

Previously, the data group indicated areas for improvement. Letters were sent to each board to encourage the discontinuation of:

- 1 kcal per ml ONS
- ONS desserts
- 'Long term' ONS prescribing (over 6 months). Bi monthly meetings included reports from individual boards on progress and projects examining the provisions, delivery and implementation of ONS

Including:

- Forth Valley's review system for patients receiving ONS
- Fife's Dietetic led non- prescription model
- Grampian's Dietetic led prescribing sent directly to community pharmacy
- Highland's revised ONS formulary and a 'Food First' approach for care homes
- Tayside's digital technology (Florence) and ONS using local delivery to care homes

The national group achieved this in 15 months, with a focus group sense checking and agreeing the recommendations. A new national Dietetic Prescribing Group commenced in April 2018 to continue implementing the standards.

How did the Scottish Dietitians achieve this?

- Seizing the opportunity to work with other professions
- Willingness to share experiences and results
- Tackling difficult issues of inappropriate use of ONS
- Establishing the correct use of ONS to support patients by improving nutritional status

Did we save a small fortune?

Yes. 2019 results showed spending had reduced to £11 million (£5 million saved) with a continued 4% drop in costs. This work has continued through COVID-19 and is important in reducing variation and in improving the efficiency of using oral nutritional supplements.

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Dramatherapy at Dundee Repertory Theatre

The Dundee Rep Dramatherapy Service has been running for 25 years and is the only therapy provision based in a UK theatre. It is an adult service, funded by the Health and Social Care Partnership and receives referrals from health, social care and third sector stakeholders.

The service was a response to increased numbers of local people experiencing mental health issues. It provides weekly dramatherapy to individuals and groups. Being part of a community arts hub has helped reduce stigma around mental health by increasing accessibility and encouraging clients to engage with the theatre which plays a key part of community life.

Dramatherapy is a psychological modality that supports individuals to address difficult feelings and thoughts, drawing on metaphor and symbolism using creative techniques such as objects, masks, movement, role-play, storytelling, story making, body sculpts and other arts and action-based approaches. It is one of a few services that offer long term provision in the area. Increasing demand means there is a waiting list.

A new animated film promotes the service and explain what dramatherapy is. See the film at https://dundeerep.co.uk/dramatherapy

Here is a small sample of a wealth of feedback. Clients have said -

"Dramatherapy has opened my eyes to the problems I have, rather than ignoring them. I've realised I'm not on my own, there are people who can help."

"I feel dramatherapy has really benefitted me, and has been a mentally cleansing experience. I highly recommend it to anyone."

Referrers have said -

"People I have referred to Adult Drama Therapy have all, without exception described a very positive experience and new and imaginative ways of making sense of the challenges they experience."
Paul Kinloch, Recovery Practitioner, Penumbra

"Dramatherapy at Dundee Rep is a unique and highly valued part of the mental health and wellbeing support network in Dundee. We are excited to be exploring a new collaboration with them using creative expression to share recovery stories."
Ruth Brown, Team Leader, Mental Health Engagement and Involvement (Dundee Voluntary Action)

During the COVID-19 pandemic, the need for people to have access to emotional support is as important as ever. Dramatherapy sessions have moved to remote contact via phone and video calls. We have found new creative ways of working ensuring there is still protected time for exploring existing challenges while processing the new and unknown.

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Dramatherapy service at the State Hospital

The State Hospital dramatherapy service sits within an arts therapies team (art and music therapy) alongside other members of the AHP team. It is the only permanent dramatherapy post in NHS Scotland and is a first in the hospital's history and in forensic settings in Scotland.

The service is recreational, rehabilitative and informed by psychodynamic principles. It provides interventions for adult male forensic patients in conditions of high security, offering creative opportunities for self-expression, increasing capacity to relate to others in healthy ways and promote well-being. Dramatherapy is established as a treatment option when considering patient pathways.

The service was established in 2012 following a 2010 pilot project. Group and individual work takes place in wards and therapeutic environments. Several groups involve both dramatherapy and music therapy. There is scope for further collaboration with art therapy and speech and language therapy, especially in learning disability wards where there is more need for support in communication, self expression and understanding feelings.

Dramatherapy is acknowledged as a psychological service. As a psychological practitioner the dramatherapist delivers reflective practice groups to multi-disciplinary staff teams. Programmes run across the hospital and plans are developing for open-access, drop-in interventions from 2020. Arts therapists attend regular clinical team and patient review meetings.

Awareness of dramatherapy and its benefits is widening across the hospital, improving access for hard to reach patients, the referral process and the way we identify patients for programmes. We are working on protocols for particular needs, improving access for patients with learning disabilities, seeking more cross-modality working and looking to embed dramatherapy as a highly utilised psychological therapy with the patient population.

Staff and patient feedback is the main source of information regarding the service and its effectiveness.

Patient's say -

"...you can put yourself in other people's shoes and it helps us learn empathy and sympathy."

"I used to think I didn't have a future. Now after Dramatherapy I know I'm on a path with something ahead."

Dramatherapy has been able to maintain meaningful engagement throughout the entire period of restrictions to a very isolated patient population. The pandemic has meant this kind of work has become even more important because it allows a place to be together playfully, creatively and thoughtfully, albeit in very small groups. This offers patients a chance to address, within therapeutic relationships, something of the fear and isolation that this population experiences anyway, but which has become amplified throughout this period.

Stephanie Turner,
Dramatherapist at the State Hospital

Here comes the sun - benefits of music therapy in a secure psychiatric unit

I work as a music therapist for NHS Lothian in medium secure psychiatric unit. Many of the referrals I receive are for individuals who find it hard to be with others. The wards can be busy environments and finding opportunities to be alongside the patients in our care can be difficult. When more funding for music therapy became available I wondered how I could use music to engage more people and reduce isolation.

We've all heard the news – singing is good for your physical and mental health. Choirs in forensic settings have been found to improve happiness and well-being, increase confidence and emotional connectedness, and improve relationships between patients and staff.

In collaboration with two colleagues from occupational therapy and nursing I set up an inclusive choir for staff and patients. We ran weekly group sessions made up of vocal warm ups, learning new skills and repertoire, singing requests and verbal reflection and reminiscence. Patients and staff from a variety of disciplines including domestics, allied health professions, administrative staff and psychiatry attended the choir over 12 months.

Participants said that they noticed improvements in the areas of confidence, mood, and developing relationships. They told us that being part of a community, developing skills and enjoyment of singing was what was most important to them in the choir.

Health and wellbeing outcome 4 is for services to be centred on helping to maintain or improve people's quality of life, and outcome 5 is that health and social care services contribute to reducing health inequalities. Patients in secure settings have limited access to community resources and can often experience exclusion as a result of their forensic history. We observed that an inclusive singing group could break down barriers between patients and staff and increase feelings of belonging and connectedness. One patient commented: ***"...It's feeling like you belong to something...that's the feeling you get... Just participating, the same as everybody else. It's not about me it's about the bigger group."***

Whilst opportunities for live singing in groups have reduced due to COVID-19, the opportunities for meaningful connections through music are even more important. Given the increased isolation experienced by many, including those already excluded from society in other ways, memories of participation in the choir have provided a grounding for digital therapeutic relationships. I am curious about the impact of maintaining musical or therapeutic relationships in other settings and welcome your stories.

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Music therapy in a child and family centre

As a music therapy student my final clinical placement was in a service for children with social, emotional and behavioural needs in a mainstream school. Through it I became fascinated the concept of 'inclusion' in schools.

I was struck by one child who had been permanently excluded from another school. He'd had countless experiences of exclusion from his peers, his class and ultimately his school. All of this occurred during primary 1 - he had just turned six.

The Scottish Government's Attainment Challenge aims to ensure that ***"every child has the same opportunity to succeed".*** It struck me that this little boy would have benefitted from support long before he arrived at primary school.

Fast forward two years; I am now a qualified music therapist working in a childcare centre supporting vulnerable pre-school children and their families. One day a week I work with six children individually, one mother and child and with a group of 8-13 children aged 3-5 years.

My child-centred approach means I take my lead from the child and how he or she presents naturally in the sessions. The work then evolves from the way the child and I relate to each other as we play music. I often draw from the nurture principles (Nurture UK, 2019).

Having music therapy within the centre is enormously beneficial as some families can struggle to access sources of additional input. It's also amazing for me to be part of an inclusive team. I am able to discuss specific children with staff, to consider all the relevant circumstances of the child's situation, and inform child planning and child hearings by sharing my experiences from sessions.

A recent funding increase has allowed us to extend and evaluate the service. Early results have shown that one child who received individual music therapy for six months was able to close the attainment gap in her most challenging area by 10 months, meaning she is now on track with the expected attainment for her age.

This falls in line with the government's call for teachers and practitioners ***"to raise attainment for all, close the attainment gap and, crucially, ensure that the focus on young people's wellbeing is given the importance it deserves".***

COVID-19 means this kind of work has become even more important because evidence has shown that lockdown widened that attainment gap further for many children in their early years.

Occupational therapy at a GP practice

Traditionally occupational therapists work in acute services, in community-based rehabilitation, secondary care services and in Social Work teams, supporting people when ill health or disability has had a significant, detrimental impact on day-to-day functioning. I am part of an occupational therapy team working in GP practices where we provide early intervention for patients and prevent health conditions or disability from stopping people getting on with their lives.

Our GP colleagues have been surprised at the range of ways that we can help their patients. By incorporating occupational therapy in primary care we have been able to:

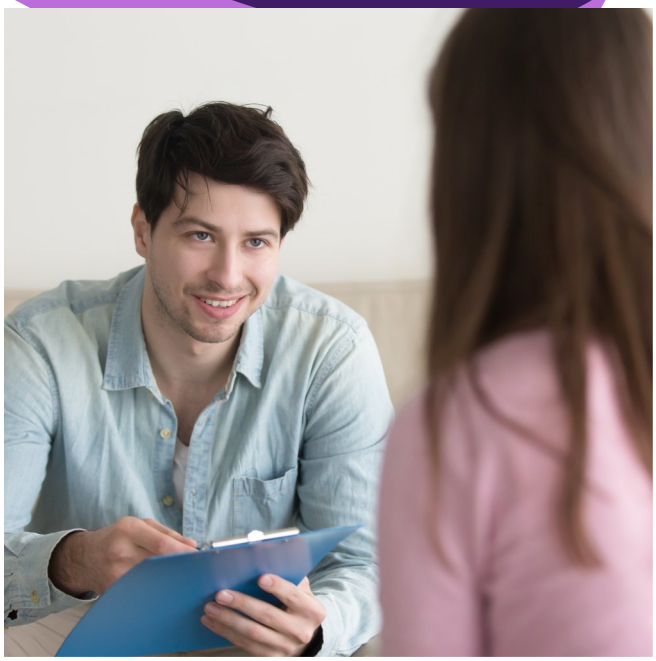
- Educate people with long-term conditions how to manage work and home tasks so they have energy to maintain a well-balanced life
- Support people who struggle to access their local community due to anxiety or poor mobility
- Recommend changes to a person's workplace or job role to help them remain at or return to work
- Provide equipment to make it easier for someone to carry out self-care tasks at home
- Connect people with health, social care and community services through signposting or referral

Our patients have been overwhelmingly positive about the difference that occupational therapy has made to their lives.

They tell us:

- They feel more independent in their homes
- They cope better with stress and anxiety
- They are engaging with activities in their local area
- They socialise with friends and family more often

We understand that when people do what is important to them they generally feel happier, require less health and social care support and are more likely to be at work. Evaluation of our service also suggests that it reduces referrals to secondary care and leads to reductions in spending on prescriptions, social care and welfare benefits.



Impact of COVID-19

There have been two distinct areas of need that we have been able to meet during the COVID-19 pandemic. These relate to the needs of people who have been advised to shield due to long-term conditions and the needs of people experiencing mental health and wellbeing issues as a result of COVID-19.

Despite the challenges of COVID-19, it has also provided us with opportunities to adapt our practice and try out a variety of new ways of working in order to meet the needs of our patients in a timely and person-centred way. We have embraced the use of digital health care and we have responded to these changes by developing clinical and patient resources that support us to communicate with patients remotely and maximise the benefit of our interventions as well as developing guidance and procedures to ensure that our patients and staff feel safe and supported.

More information about our work can be found at NHS Lanarkshire.

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Getting ready for practice in the digital world

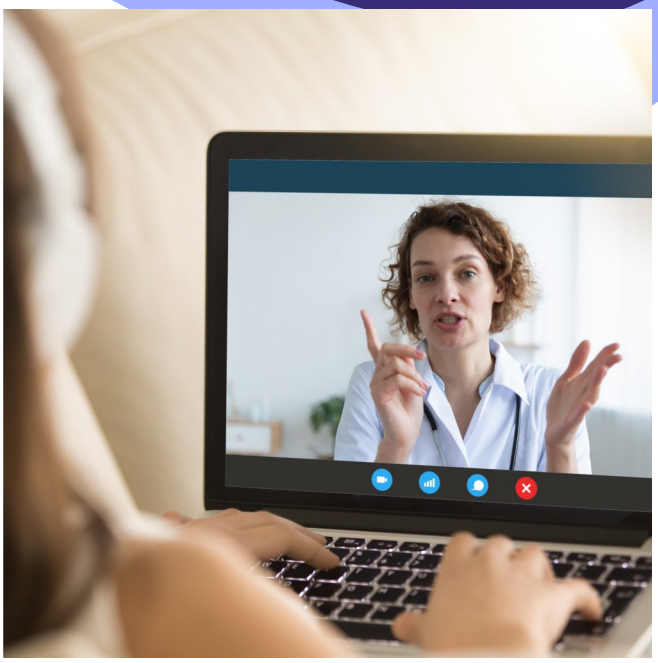
Digital technology is no longer a new and emerging phenomenon, it is a reality. It underpins how we as individuals, communities, and society, live our lives. Technology has and will continue to change how daily tasks are carried out but will also introduce a range of new tasks such as the charging, updating of devices, downloading software and undertaking more online activities. All of which require us to use physical, cognitive and sensory skills in a more intensified way than we ever had before.

Utilising an occupational therapy assessment and outcome measures we focus on what matters to that individual/family and identify and adapt the technology to match individual/family needs.

Digitalised working can be overwhelming for many of us, particularly when meeting our clients' needs and expectations and how as a profession we can ethically provide safe and sound digitalised interventions when there is no manual or formal guidance on how to do this.

One of the gaps that we identified is practitioners' low confidence on how to apply technology to practice, despite knowing what devices are readily available. Part of my work at the smart house pod has been to tailor specific training for occupational therapists and other health and social care practitioners on how to apply technology to practice. The training focuses on key challenges that staff face and how technology could be applied to assist. There is discussion around ethics, funding and ongoing support needs around adaptation of the equipment and environment. Our main mantra is to encourage a mixed economy of systems to meet an individual's needs.

We have developed a digital champion model that has been rolled out across Edinburgh. This is coupled with a catalogue resource which offers guiding principles to assessment and delivery of digital interventions available within the Partnership.



During COVID-19 we have had the opportunity to explore other ways digital devices could be used in practice: video conferencing our clients for assessment and delivery of on-line occupational therapy interventions, adult support and protection to keep people safe and well and how we can apply digital practices safely, within our scope of practice and professional guidelines.

There is still a long way to go to ensure that practitioners are digital ready for practice, but it has been a welcome opportunity to offer this resource to staff and we are now seeing an increase of practitioners considering digital solutions as a viable solution for their clients' health, safety and wellbeing.

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See4School with orthoptists

"I've always wondered how you can test a child's vision!" a lot of parents would say to us. Indeed it can be very difficult to tell if a child has a problem with their vision. That is why in Scotland we have preschool vision screening. This is conducted by an Orthoptist often in nurseries with the support of nursery staff and involves checking their eyesight and looking for a 'squint' or eye muscle imbalance.

The response from children when they are told they are going to get their eyes checked varies from the excited ***"When is it my turn?"*** to the horrified question of ***"Is it going to hurt?"*** or ***"Are you going to take my eyes out?"*** Of course, it doesn't hurt and is designed specifically for children.

Jasmine was tested at her nursery when she was four years old. However, it was difficult to check her vision as she struggled to name or match the pictures used for the test. As English was her second language, we wondered whether or not there was a slight communication barrier so we arranged for her to be retested at the Hospital with her parents present.

At the Hospital, with her Dad's help, the orthoptist was able to check her eyesight with the picture vision test using a matching method. She was found to have poor vision in both eyes. Her Dad had previously not noticed any problems with her vision at home.

The orthoptist put some eyedrops into Jasmine's eyes before testing by the optometrist to see if she needed glasses. She was found to be significantly short-sighted in both eyes and was given glasses to wear. Jasmine was also seen by an Ophthalmologist to check that her eyes were healthy and decide if further investigation was needed.

Luckily, the rest of the examination was satisfactory and on returning to the orthoptist after two months of wearing glasses her vision had improved significantly and she is now able to achieve a good level of vision, with the aid of her glasses.

It was very important for Jasmine's short-sightedness to be detected and corrected early on. It could have affected her learning when she started school as she would have struggled to see the board. Later in life, it could have prevented her from driving.

'See4School', please visit
www.nhsinform.scot/campaigns/see4school

Orthoptists improving vision post-stroke

It was a life changing incident for Mr Smith. He never thought it would happen to him, given his young age and good general health. Mr Smith was happily sharing stories with friends at dinner when suddenly his speech began to slur, and his smile suddenly dropped from one side of his face. The wine glass that he was holding slipped from the grip of his hand, spilling all over the table. Alarmed by what was happening, his friends immediately dialled 999 and he was admitted to the hospital where he was tended to by medical staff and had an MRI scan by the radiographer. After multiple examinations he was confirmed to have suffered from a stroke.

From that day onwards everything was different. Even the simplest tasks became difficult for Mr Smith. He could no longer work as he found it very difficult to focus on words on the page and suffered from double vision, needing to close one eye to stop this from happening. His limbs were feeling very weak and he was unable to stand or walk without being supported. As part of his rehabilitation, he was seen by an Occupational Therapist and Physiotherapist to improve his mobility and help him to complete daily tasks and referred to the eye team for his visual symptoms.

At the orthoptic assessment he was found to have an imbalance in his eye muscles causing double vision, so the Orthoptist fitted a prism to his glasses to help relieve these symptoms. The Medical Photographer took some photos of the backs of his eyes and the Visual Field technicians conducted a test to record his visual field. This was found to be smaller than expected in his left eye. The ophthalmologist also assessed the health of his eyes. Stroke can affect the brain's use of the eyes, but the eyes are often healthy.

After three months, things had progressed significantly, and Mr Smith was able to walk unaided with the help of the physiotherapy team and the prism on his glasses allowed depth perception. Six months later, his eye muscle imbalance and his visual field in his left eye began showing signs of improvement and he was able to control his double vision and was given a much weaker prism.

Mr Smith was very grateful for all the support that he had received from his health care team and was able to gradually get back to the work he loved and living an ordinary life again.

Teamwork makes the dreamwork

As an Advanced Paramedic Practitioner, I split my working time between the Scottish Ambulance Service and in primary care. That means if you call your doctors' surgery for an appointment you may be seen by me. The brilliant thing about Advanced Practitioners is that we could be from a variety of different Allied Health Professional backgrounds. That means there is a wealth of knowledge we can tap into to support each other and free up GPs to see the patients that need to see them.

On this day I had my list of home visits and was ready to go out and see them. One patient had called in stating they had a sore leg. The key for me is to become a kind of detective. Why is this leg sore? Is it a medical problem? Have they hurt it? Or is it something different altogether that they did not want to discuss on the phone? (I understand why people do that, but do not recommend it. Best to give all the information we need when booking their appointment).

This patient was recovering from a hip operation following a fall at home. It would have been all too easy to decide on pain management medication and get on my way to the next patient. However, that would be a complete injustice to the patient. The first thing to strike me was... almost the floor! I had nearly fallen victim to the multiple trip hazards in the home. Further investigation found that the patient was registered blind and had tripped over. Due to their fear of falling again, they had not been doing the exercises given from the hospital. I explained to the patient I would like to refer them to a falls team. This is a Multi-Disciplinary Team consisting of AHPs such as Physiotherapists and Occupational Therapists. They consented and once I made the phone call, the ball started rolling.

The Physiotherapist worked on rehabilitating the patient's mobility. The occupational therapist assessed the patient's needs and put in place a variety of aids; this empowered the patient to be able to live in their own home.

Following up, the patient has recovered well and has not had any further falls at home. They told me they are actually happier as they are not in constant fear that they are going to trip, fall and do some lasting damage meaning they would have to move out their house of 50 years into a care home.

@SASCraigYoung

Not ever again, not on my watch

Every city has recurrent problems. Young people joy riding stolen motorbikes is what gripped Edinburgh for a number of years. The worst emergency call you can imagine is a child dying. But that's exactly what happened. Heartbreak for the family. Heartbreak for their friends. Heartbreak for the emergency service that attended that day.

An initiative was started where different people went into the school where the young people were from and spent a day talking to the pupils. The police described what their role was in a road traffic collision. The Fire & Rescue service described their role too. And I went through my role as a paramedic. It was clear that the pupils that we were trying to get through to, were the ones not listening. I very quickly had to change tack. We could not allow another tragic loss of life.

"What's the worst thing you've ever seen" said one of them. I normally hate that question, you may as well ask *"can you retell me the thing that kept you awake at night for my entertainment"*. But the response expected is normally about broken bones etc. I quickly discussed with the teachers about how graphic we could be with the pupils. *"Anything, we need to get through to them."*

So, I started teaching them about needle decompression. When we insert a large cannula into a person's chest whose lung has collapsed. I showed the anatomy of the chest. How we do the procedure and what injuries can cause this

"Shut up, I'm trying to listen." One of the pupils who had admitted being involved in the stolen bikes had just silenced his classmate so he could listen. I was actually getting through. Then more questions came from the pupils. They wanted to know more.

After my time with them, that pupil came and thanked me for being the first person to be honest and actually speak to them. At this point I'm holding back the tears.

The event was so much of a success, it was repeated across many schools. The incidences of antisocial motorbike use began to fall. There is still a lot of work to do, but we're getting there. To prevent another tragedy like this we need education and prevention.

@SASCraigYoung

Paediatric Complex Respiratory Team

The Paediatric Complex Respiratory team from NHS Lanarkshire consciously changed their way of working with our neurorespiratory patients in early 2018. This was on the back of a run of regular hospital admissions of neurorespiratory patients. Additionally one of our physiotherapists completed his non-medical prescribing training. Between the nurses and physios of our team we decided to assess the respiratory risk factors of our neuro-respiratory caseload in order to manage our patients proactively at home to prevent hospital admissions. We did the assessment by using a screening tool developed at the Glasgow children's hospital which scored the respiratory risk factors which would contribute to recurrent hospital admissions.

After identifying ten of our most "at risk" patients we decided a nurse and a physiotherapist should proactively manage the patients by carrying out regular home visits, up to every two weeks. The approach was to assess the patient in their home environment in order to identify risk factors that clinic visits hadn't detected. We would assess from both a nursing and physiotherapy perspective. We also planned to try to conduct joint home visits if the child's parents expressed any concern over their child's condition. We aimed to optimise medication doses for respiratory risk factors like GOR, hypersalivation, optimise airway clearance, and provide antibiotics where required. We would also liase with MDT members e.g. SLT if aspiration was suspected, or dietetics for nutritional information. We would also provide microbiology sampling.

The decision was made to measure the outcomes of this change by comparing the following for one year before and after this practice change was made; hospital admissions, bed days, frequency of visits and antibiotic use. In addition we sought feedback from parents on their impressions of this service.

We set out with rather modest ambitions for this project, thinking if we could reduce admissions by 25% we would be very successful. We were pleasantly surprised when admissions and bed days of our ten patients dropped by 80% across the year. This was most striking over winter; one patient of our ten was admitted for one night across November to February. Their antibiotic use was unchanged which gives clear indication this was not the condition of these patients improving. Patient feedback was unanimously positive with parents discussing how much they appreciated the support and help of the team. They felt that multiple hospital admissions were prevented by this approach.

This way of working has continued and continues to benefit our neuro-respiratory cohort following the close of this project.

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Balmore Falls Project blog

Once upon a time in a dementia care ward, staff recognised that their patients were having a lot of falls – over 260 in ten months. Two physiotherapists, Angela and Gina, and a nurse, Maureen, put their heads together.

Angela gathered information from the incident reports, and by picking the teams brains, came up with some key areas. The Mental Health Network completed some conversations with carers to glean opinions.

Lap 1: Angela assessed each patient's walking and balance with the Tinetti Falls Assessment to produce a risk score of High, Medium or Low. This was displayed on a traffic light information sheet.

Lap 2: A guide was produced to help the team consider all the factors that could contribute to falls. This was utilised when writing care plans and in weekly team reviews, and falls communication boards were created for staff, patients and carers.

Lap 3: Staff recorded falls using sticky dots on a map of the ward – this showed that the main hotspots. Angela spotted problems with the furniture and colour contrast. Patients tried different seating and new furniture was bought which provided good height and colour contrast. Because of this the number of falls over three months related to seating went from 35 to five.

2016 annual falls: 266 | 2018 annual falls: 166

Lap 4: Pharmacy took a snapshot analysis of medication. This confirmed that some medications could be a contributory factor and the weekly team meetings ensured that medication was always discussed in relation to any recent falls.

Lap 5: Throughout the race one patient fall triggered a full review of the guidance. Information from six documents was condensed into a post falls flowchart. A kit called the Hoverjack was purchased allowing fallers to be lifted from the floor in a flat position.

Lap 6: Staff were keen to review the bed sensor alarms that were unreliable. A trial was completed and a fully integrated system was installed to include bed, door and chair sensors, call buttons and infrared sensors all linked to a pager call system.

Finally over the two year period falls were reduced from an annual 266 to 166 – a 38% reduction.

The success of the project was down to having a clinician on the ward leading the project. The result was in increase in falls awareness and how to reduce the risks throughout the entire staff group.

Glasgow Dementia Unit
Angela Watson
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Podiatry musculoskeletal pathways deliver savings and earlier access to appropriate treatments

Within NHS Shetland, innovative podiatry pathways are saving money and ensuring that people are seen by the most appropriate clinician in the right place, at the right time.

NHS Shetland does not have an orthopaedic service on the islands, meaning anyone requiring this service has to travel to the mainland, which is costly and time consuming for the Health Board and the patient.

As AHPs, Podiatrists assess, diagnose, treat and rehabilitate autonomously and independently of supervision. Podiatrists have fully utilised these skills to develop local musculoskeletal (MSK) pathways, which are leading to improved outcomes for patients.

All orthopaedic referrals from primary care in NHS Shetland are now triaged by MSK specialist Podiatrists. The podiatrist fully assesses the person before deciding which intervention would be most appropriate for their needs.

The lead MSK Podiatrist also heads up a foot and ankle video conferencing service with the consultant orthopaedic surgeon at the Golden Jubilee Hospital in Glasgow. Patients attend a clinic in Shetland with the Podiatrist and Physiotherapist and are linked directly with the surgeon in Glasgow. Should the patient be deemed inappropriate for surgical intervention, or would prefer not to have surgery, this allows the multi-disciplinary team to discuss treatment options and the podiatrist to offer alternative treatments.

Before these pathways were in place, numerous patients would have been unnecessarily referred onto the orthopaedic service or had to attend consultations on the mainland. Now, many are being given expert advice and access to appropriate treatments such as self-management programmes much earlier and closer to home, which is key to supporting the Scottish Government's 20:20 vision for healthcare. This pathway is also increasing the capacity of the orthopaedic service by reducing their waiting times. The cost savings associated from reduced travel are significant.

COVID-19 means this kind of triaging has become even more vital as opportunities to provide high quality care, without the patient having to travel significant distances to unnecessary appointments on the mainland, significantly reduces risk of infection and adds capacity within secondary care. Extended use of telephone and Near Me triage consultations, further reduces the need for local face to face contact.

This pathway has huge applicability in healthcare across rural Scotland. By fully utilising the skills of Podiatrists within teams to develop similar models, costs will be reduced across health and social care, capacity will be increased, and ultimately patient outcomes will improve due to improving access to treatments quickly and easily.

Podiatry training eliminates foot ulcer referrals from local care home

Foot ulcers can occur for many reasons. The most common type of foot ulcerations are diabetic foot ulcers and pressure ulcers, the vast majority of which are entirely preventable with appropriate intervention.

Foot ulceration can be extremely damaging, and in some cases fatal, to a person's health and wellbeing. Whilst in all cases of ulceration a person will suffer pain and discomfort, if a foot ulcer is left untreated for too long this may lead to lower limb amputation which is detrimental for the patient and extremely costly for the health and social care system.

NHS Fife's Podiatry Service identified that the number of referrals for foot ulcerations that were coming from one particular care home spiked in 2017 to eight per annum, and also that the majority of these ulcerations could have been prevented by care home staff.

In response to this, the Podiatry department delivered a series of 90-minute training sessions to care home staff. The training was based on CPR for Feet, which is an initiative which has been developed by the Scottish Diabetes Foot Action Group, a multidisciplinary network of clinicians who work in partnership to improve foot and lower limb health of diabetes patients.

The training covered how to check a person's feet to understand if action is required, how to protect a person's feet where necessary as well as how to quickly and easily refer to a Podiatry or multidisciplinary foot health team where necessary.

Thanks to the expert training from NHS Fife's local Podiatry team, which was received extremely positively from all care home staff, the number of foot ulcer referrals to Podiatry from that local care home reduced from eight a year in 2017, to two in 2018 to zero in 2019. This meant that patient outcomes improved, whilst at the same time, the capacity of the local Podiatry team and therefore ability to concentrate on more complex caseloads was increased.

COVID-19 means this kind of training has become even more vital as opportunities to provide high quality care, without the patient having to travel to podiatry appointments, significantly reduces risk of infection and adds capacity within primary and community care.

This example demonstrates the huge potential of podiatrists, AHPs, to improve patient outcomes through the sharing of knowledge and upskilling of other staff groups within Scotland's health and social care system. There is huge potential for this to be replicated throughout Scotland in order to multiply the gains which this successful model brings.

The backbone of orthotics

Natasha's MRI confirmed multiple level fractures along her spine. "That explains the pain then" she muttered worrying what this meant for her future.

"That's you!" snapped her husband, ***"No mountain biking ever again! No doubt you'll be stuck in that hospital bed for at least six weeks until you can walk again"***, he moaned.

Natasha didn't have to wait long to see an Orthotist and be advised that by application of a CTLSO - a spinal brace that stabilises the fractures from her neck to her lower back, she would actually be up and walking in a day or two.

Natasha smiled as she imagined herself flying back down that mountain (not that she told her husband!)

Our national Trauma Centres continue to be a priority despite the COVID-19 pandemic to ensure the best outcomes and it is more important than ever to ensure trauma victims receive responsive, evidence based care to ensure they can be discharged from hospital to start their recovery journey as quickly as possible and reduce the risks of them being affected by COVID-19 as they recover.

Over the years there has been a change in practice regarding the treatment of spinal fractures and rehabilitation of spinal injury patients from traditional bed rest to stabilising the spine via orthotic intervention and encouraging weight bearing and early discharge.

Why is this so significant?

"Prolonged immobility is harmful with rapid reductions in muscle mass, bone mineral density and impairment in other body systems evident within the first week of bed rest."

It has been documented that in a study featuring seven healthy males, that after six weeks of bed rest there was a loss in quadriceps strength by between 25% and 30%.

As well as being good for patients this approach saves the costs of a six week hospital stay (versus the cost of supplying CTLSO and facilitating discharge) plus the cost of providing physiotherapy to rehab the patient after a period of immobility.

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Orthotists instantly improve Jane's mental state and quality of life

Jane had Motor Neurone Disease and had been struggling to come to terms with her life limiting diagnosis.

The progression of the disease was fast, with onset of muscle weakness starting in her feet and quickly spreading across her body. The thing that hit Jane hardest was losing the power to hold her head up. To lose the ability to observe the world around her, to focus on her husband's kind and loving face whilst he tried to entertain her or to see her beloved football team scoring another winner was devastating and her mental health deteriorated quickly.

Jane was assessed by an Orthotist and provided a collar to stabilise her head, allowing her to make eye contact with the world once again, instantly improving her mental state and quality of life.

Orthotic intervention is more than just treating something physical, there should always be a consideration of the patient's mental health and wellbeing during treatment.

This links directly to point 3 of the Public Health Priorities (PHPs) for Scottish Government: **Point 3 – A Scotland where we have good mental wellbeing.**

The impact of a remarkable year...

It seems such a while back now, in December 2019 that a novel coronavirus was isolated from a cluster of patients in Wuhan, China. Knowledge grows but our scientists are still ignorant about so many aspects of COVID-19, as we now name this invisible predator engulfing all our lives. I am an allied health professional trained as a diagnostic radiographer and sonographer and during this unique, global crisis, I have witnessed healthcare change in ways never thought conceivably.

Sonographers undergo extensive academic and clinical post graduate study, to acquire the expertise to practice as skilled diagnosticians. Diagnostic ultrasound imaging is often a first test requested in a vast array of diseases and conditions from numerous diverse acute and elective specialities. Appointments are precious and we always have one eye on our waiting lists and a strong desire to see our patients promptly. What an astonishing and sadly strange, alien day it was therefore, in March 2020 when we were required to 'stop' all routine examinations.

Ultrasound services did continue during the lockdown that consumed the first half of 2020 but it was important to limit scans to only urgent patients whom the risk of not attending was greater than the risk of COVID-19. Everything took longer; patient distancing, personal protective equipment and cleaning. Everyone was efficient and professional however the responsibility of prioritising patients took its toll on us all. This and the additional numerous sources of personal anxiety inflict an inescapable shock to mental health.

We are now well into the monumental task of seeing our many long-suffering patients who have been waiting for our diagnostic expertise. With new referrals increasing it seems like a mountain to climb. We support each other and tentatively increase our ultrasound scanning activity as safely as possible but there are many challenges. Impossible to scan virtually we need to get up close and personal with patients for a good ten minutes or more.

I cannot understate the immense impact this pandemic has had on our practice, but we will continue to persevere, striving to impact positively on the health of our patients and do what we love to do; to diagnose.

Margaret Taylor MSc PGDMU DCR(R)
Lead Sonographer, Clinical Radiology, NHS Tayside

Please also see our related article *'An ultrasound service during COVID-19: A single tertiary centre's experience'*

"Nothing we can do" is never the answer - Speech and Language Therapy makes the difference

"It's Primary Progressive Aphasia", the neurologist said. "I'm afraid there's nothing we can do." This was the final outcome for a lady following months of tests. This came before lockdown 2020 when our services reconfigured to manage the pandemic.

"Nothing we can do." Really?

Firstly, what is Primary Progressive Aphasia? The family I was working with had never heard of it.

According to Alzheimer Scotland – ***"Progressive Non Fluent Aphasia is a condition that affects a person's ability to use language. Currently, there is no cure or specific treatment. There may be ways to treat some of the symptoms but these will depend on the individual's needs."***

There is a therapeutic army who could potentially help with the symptoms and work with individual's needs. This army comprises allied health professionals (AHPs) who are trained to deal with a wide array of difficulties.

You'll have heard of all of them - occupational therapists, physiotherapists, radiographers, podiatrists, art or music therapists, radiographers, dietitians, orthoptists, orthotists, paramedics and speech and language therapists. When dementia becomes *every* AHPs business and the workforce is skilled and knowledgeable in best dementia care, it can be transformative.

The lady with Primary Progressive Aphasia (PPA) went home with the leaflet she couldn't understand and wondered about her future. She wanted it all to end.

I visited her at home two days later. Using simplified language with visual cues and gesture, she was able to discuss her confusion and fear.

We set goals together. Each week, we added to a communication book about her life with key words and phrases she could turn to if she felt 'stuck'. We looked out old photographs and talked about happy memories. She wrote down three things she did each day so she could use the speech she had left to chat with her husband each evening.

She was losing weight so I referred her to the dietician and discussed best communication strategies with the dietician. She may require the skills of the occupational therapist to enable her activities of daily living. Perhaps the podiatrist can offer appropriate footcare.

We researched PPA together and she began to understand the condition. She told me she was feeling more positive and hopeful. She started to live well again with her diagnosis.

Nothing we can do? The AHP army is mobilised and ready for action.

Jenny Keir
Speech & Language Therapist, NHS Tayside

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Happy birthday George

Is your birthday soon? For many, it's a day to look forward to. There may be cards, presents and arguably most importantly a piece of cake.

On his 92nd birthday George woke up disorientated, could not get out of bed and his wife Maggie noticed that his face looked droopy and his speech was slurred.

George was rushed into hospital as his symptoms indicated that he could be having a stroke.

Stroke is medical emergency requiring urgent treatment. It is the third most common cause of death in Scotland and in 2017 over 9,000 people were admitted to hospital and diagnosed with stroke.

George's birthday began lying on a gurney in the accident and emergency department with his wife Maggie by his side.

As per care guidelines, George was seen quickly by the specialist stroke team. His brain was scanned by a radio-grapher.

George's symptoms indicated that he had possibly had a stroke in the left side of his brain, which could result in limb weakness and difficulties with his communication.

Over 50% of people have difficulty with swallowing immediately after a stroke. People admitted to hospital have a 'swallow screen' by a trained nurse within four hours of admission. George had some difficulty drinking water and was referred to the inpatient Speech and Language Therapists (SLTs) for assessment. SLTs work in a wide range of settings, including hospitals to assess and manage swallowing and communication problems in adults who are acutely unwell.

The SLT team prioritised George for assessment and headed to A&E where George's symptoms had started to resolve and his brain scan did not show evidence of a new stroke. George was now alert and reported feeling better but hungry and thinking about his birthday cake at home. The SLT carried out a case history with George and Maggie and a bedside swallow assessment which found that George was at his baseline for swallow function. He was able to enjoy a small amount of lemon drizzle cake in A&E before heading home for his own birthday cake and candles!

People with ongoing symptoms are admitted to the integrated stroke unit where the multi-disciplinary stroke team continue to assess and manage their symptoms.

For George, on his birthday, the collaboration of hospital staff and swift response from the inpatient SLT service contributed to George's timely discharge from A&E to get back home without the need for hospital admission.

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Embryonic and beyond – Radiography

Diagnostic radiographers contribute to the early diagnosis and detections of the brain abnormalities that can contribute to mental and physical disabilities using MRI, CT and ultrasound scanning.

Brain imaging, including the study of structural change has been the focus of both national and international studies for 40 years. As MRI imaging continues to improve with the use of more powerful scanners, it has enabled reporting radiographers and radiologists to identify minute changes in the brain structures. Queen Elizabeth University Hospital for example, has a diagnostic neuro-imaging department at the Institute of Neurological Sciences where research radiographers perform the examinations/procedures which are reported and help inform the neurologists and healthcare team.

Brain abnormalities can take place from embryonic stages and can be identified on an ultrasound scan. Radiographers also perform CT and MRI scans for many conditions of the brain that cause children's illnesses e.g. tumour growth which culminates in a mental and often physical disability and trauma. Dementia is another good example, and this can often be identified in not only old patients but sometimes relatively young.

Early detection of abnormalities that can impact physical and psychological function allows early intervention and planning to promote a positive quality of life!

Thanks to Dr Margot McBride for this contribution.

Children and Young People – Occupational Therapy

Occupational Therapists promote psychological wellbeing through engagement in meaningful activity.

Occupational Therapists within NHS Forth Valley's Children and Adolescent Mental Health Services have collaborated with local organisations to promote good mental health by facilitating football and forestry groups.

Football has allowed young people to improve their speed, agility, strength, cardiovascular endurance, and hand eye coordination. As well as the physical benefits the young people developed team working skills, routine, negotiation & communication, and sequencing. Skills that will support young people to succeed in other areas of their life.

Forestry has allowed the young people to develop fire safety skills, relaxation techniques, cooking skills, connecting with nature & others and the ability to increase their attention span.

Engaging in football and forestry has given young people the opportunity to socialise, engage in physical activity, learn life skills, and develop effective coping mechanisms that all contribute to psychological wellbeing.

The groups are ages at young people aged 8-17 years old and the groups have received positive feedback from the young people and their parents. Young people have reported that they have benefitted from safe spaces to engage in activity and socialise and that the groups have contributed to improved sleep, reduced stress, calmer behaviour and improved self esteem.

Thanks to Tracy Binnie, Occupational Therapy Advanced Practitioner, NHS Forth Valley, for this contribution.

Parent feedback board

Children and Young People – Speech and Language Therapists

Speech and language therapy promotes better social, emotional and mental health and wellbeing for all ages. It plays a crucial role in identifying communication and interaction needs and in contributing to differential diagnosis.

Case study

Emma is a 10-year-old looked after child presenting with a high level of anxiety in school and in social situations. At school she would present as very verbally and physically aggressive and was often extremely tearful and anxious at home, frequently saying how much she disliked school. Whilst appearing very talkative, Emma struggled to talk about her feelings, explain her own thinking and use language to problem solve. She often did not pick up on more subtle communications from others in social situations and found making and maintain friendships very difficult. This led to her becoming frequently disregulated and struggling to know how to manage her feelings.

Emma was referred to CAMHS. Her core worker queried a possible underlying neurodevelopment condition and wondered about her levels of understanding. Emma was subsequently referred to Speech and Language Therapy for an assessment of her language, social communication and interaction skills.

Following a block of appointments with a speech and language therapist, it was found that whilst Emma outwardly appeared chatty and able to hold a conversation, she found it very difficult to process and comprehend longer pieces of information, interpret key ideas, infer social information and predict. Her knowledge of vocabulary around emotions was also significantly reduced. She was therefore unable to verbalise her feeling as a way of regulating herself. Additionally, she struggled with language tasks that required her to effectively put her ideas into words. Therefore, when education staff would ask her to explain what had happened and give reasons for why she had done something, these were all language skills that Emma found extremely challenging.

In order to support Emma, she was provided with a block of input around developing her knowledge of emotion words along with practising strategies to help Emma identify that she had not understood and to let people know this. In addition to this, the SLT developed a communication passport for Emma, which detailed Emma's communication strengths and areas that she found more difficult, along with strategies to help those working with Emma to support her understanding and participation. A meeting was held with the SLT and education staff for the SLT to go through the passport with those working with Emma and emphasising the importance of others adapting and modifying their own communication to support her.

Staff working with Emma now report they feel much more able to communicate with her in an effective way. Emma's levels of anxiety and verbal/physical aggression have greatly reduced. She is more able to regulate her emotions, with key trans-actional supports from those around her and has learned phrases to use to indicate when she had not understood and ask for help. Her file has now been closed, very few difficulties have been reported since, and she has continued with mainstream education for three years.

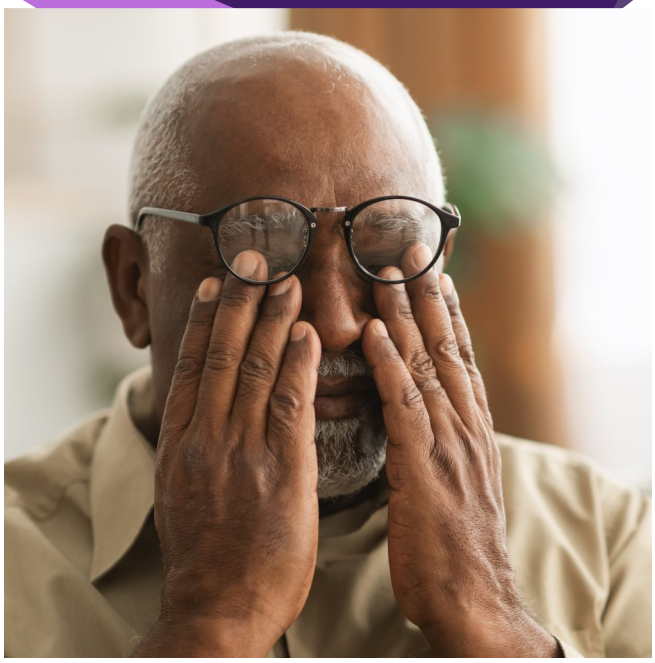
Thanks to Judy Whitefield, Highly Specialist Speech and Language Therapist, CAMHS, NHS Tayside, for this contribution.

Paediatrics to older adults – Orthoptists

Orthoptists as professionals have always diagnosed and managed their patient workload.

Historically the value of an Orthoptists skills and time was recognised when the Orthoptist was in a much more technical role and would catch up with the patient after the consultation was over with the Neurologist to ask if the patient would like to discuss things further. After training and support the role of the Orthoptist changed and rather than referring on the patient to have a difficult conversation about mental health and the impact of emotions presenting themselves as physical symptoms to the Neurologist this has become a key part the orthoptist role.

As part of the role now clinics no longer need the input from the consultant and is an Orthoptist led clinic for patients to assess the physical aspects of their condition and to support the patients in weight-loss and health strategies. Some of the tools used are motivational interviewing strategies and starting conversations around confidence and importance of weight-loss. There are a number of service users who would rather have a conversation with the orthoptist than the consultant as they may feel more comfortable and "don't want to waste the Dr's time".



In many cases conversations with the service users' orthoptists can discuss how to improve how they feel about their condition and how to adapt. Very often the service user will have their own ideas and it can be beneficial to discuss things in front of a loved one in a clinical space to be really heard. Sometimes this can be enough for the service user and their family to help and allow the service user to no longer require hospital attendance as issues and concerns have been discussed openly.

Thanks to Dawn Buchan, Advanced Orthoptic Practitioner, NHS GGC, for this contribution.

Physiotherapy – Young Adults

Rebound Therapy to manage symptoms of post-traumatic stress disorder and physical disabilities post-Epstein Barr virus diagnosis.

Case study

A 25-year-old nurse was referred to a Community Mental Health Physiotherapy Service with neurological complications following a lengthy hospital stay which left her wheelchair-bound, in severe pain and dealing with post-traumatic stress disorder and suicidal thoughts at home where she was completely dependent on her partner and family for support.

Physiotherapy initially focused on regaining mobility and independent function around the home. Later the focus shifted to community-based rehabilitation. Rebound Therapy in a local leisure centre offered an opportunity to work on both physical skills and mental engagement in a new setting. Post-Rebound Therapy, the patient continued to progress and was discharged from physiotherapy independently mobile with crutches, involved in volunteering for a mental health charity and able to work again within the NHS.

The patient created an Emotional Touchpoint to describe her which highlights the role of physiotherapy in bridging the gap between physical and mental health:

"When I first became ill I felt belittled as I was not able to do anything for myself. I felt that people were staring at me and they talked over me – making decisions for me. This made me feel ignored. People would ask others how I was. I also felt ignored by services. I was left on my own for long periods without any help to get better. I didn't fall into the 'right group' for rehabilitation and only felt like I got help when my occupational therapist and physiotherapist started to work with me.

I was frustrated and angry with life in general. I couldn't do anything and had no independence. I felt that I didn't have any input into my life and that I didn't have a role – I wasn't a daughter, a partner or a friend any more. I had lost my identity and this left me feeling unimportant.

I was embarrassed by myself and my situation. I would be embarrassed to go out or see people. I didn't like them to see me or how I was. I hated all the physical problems, the mental health issues and the effort that everything took.

I literally felt powerless – I wasn't able to do move or do anything myself. I had no control over my life or my body. I wanted everything to come back quickly but I didn't have enough control or power to do that.

After working with the physiotherapist I felt supported that I was being helped both physically and mentally. It did take a lot of time to find a therapy that actually helps as much as Rebound Therapy has. I am hopeful now that I have a future and have seen progression. I will be able to walk either unaided or with a walking stick. I am hopeful that I will get back to work and maybe my role as a nurse.

I have felt encouraged to believe in myself and to become more self-compassionate to an extent. I feel like I can push myself more now because I am mentally better. I feel encouraged to progress – every session I continue to do something that I haven't done before. I am good at pushing myself when I am in that frame of mind. I feel happy that I have managed to progress and feel a sense of pride and self-achievement."

Thanks to Kirsty Hughes, Advanced Physiotherapy Practitioner, NHS The State Hospital, for this contribution.

Foot Health in Mental Health – Young Adults, Podiatry

Podiatrists work as part of mental health teams to promote foot health that can contribute to both physical and psychological wellbeing.

Case study

This case study highlights the impact of podiatrists working in young adults' mental health rehabilitation wards.

Podiatrists identified that there was a much higher number of foot and ankle problems identified than was predicted. Of these was a 50/50 mix of MSK / general podiatry conditions (skin / nail conditions). 43% verbally reported no foot or ankle condition but 92% had a foot or ankle problem identified through screening. Furthermore 72% reported an impact from their foot and ankle problems. 10/11 patients achieved their goals follow podiatric intervention (incl. walking more, weight loss and to look after themselves better). Patients in an acute mental health setting are not actively reporting lower limb conditions and these exist unreported.

As a result of this work foot health champions were identified and trained. Staff from the wider multidisciplinary team said they had gained confidence, had a better understanding of podiatry, and knew what to look out for and how to support service users to self-manage their foot health.

Thanks to Sharon Weiner-Olgilvie, Podiatry Head of Service, NHS Fife, for this contribution.

Adults in the State Hospital – Dietetics

The 'Food and Mood' group was a new initiative wrote and delivered by dietetics in conjunction with an arts psychotherapist to support patients understand about their eating and drinking behaviours.

It ran weekly supported by an AHP support worker. Patients were facilitated in a variety of ways to look back over there childhood and adult eating and drinking patterns, intakes and associated behaviours to try and understand why for example, they had poor eating habits, weren't of a healthy weight, had adverse diabetic control and/or digestive problems that were food intake related. Supporting the patients to share their thoughts and feelings and relate patterns of lifestyle factors to physical outcomes was supportive in some instances of patients adapting and changing their intakes. For some adopting physical changes helped improve things too. Most of the patients had never had the opportunity or used these thought processes to link food and mood behaviours.

6 semi-structured sessions explored the following topics:

- Body image – perception versus reality
- Early experiences of food/ eating habits in early development
- Food and mood
- Being you – exploring how everyone has different relationships with food
- Keeping focused – what info do you need/ explore confusion
- Self care and responsibility

These were followed by suggested themes for art-making:

- My Body – self portrait/figure drawing/abstract
- Favourite & Disliked Foods – using favourite and disliked art materials
- My Eating Moods – what do they look/feel like?
- My Food Emotions – what do they look/feel like?
- Future Me – self portrait/figure drawing/abstract
- Living My Best Life – what does that look/feel like?

Several different outcomes were measured before, during and after the group. This included anthropometric measurements and blood results as well as more subjective data looking at patient feedback and emotional touch points/reflection.

Overall patients reported a positive experience from the group, based on feedback from their post group questionnaire and reflective interview. Some example of the feedback included: ***"[the group] made me stop and think about my emotions before getting my shopping"*** and ***"it was good that there was only a few patients so my focus wasn't disturbed"***. 80% of the patients reported that the length of the group was 'just right' and 100% rated the content of the group as either good or very good. Patients reported to particularly enjoy being able to explore their feelings using either their produced artwork or the picture cards- which can be used to help start constructing feedback.

Thank you to Fraser Breed, Specialist Dietitian, and Frances Waddell, Lead Dietitian, for this contribution – both at NHS The State Hospital.

Older Adults – Dramatherapy & Dementia Case Study

Referral

Enya (pseudonym) and her partner were referred for 1-to-1 Dramatherapy in an NHS Older Adults Day Unit by a community mental health nurse. This was to meet Enya's emotional needs during the middle stage of her dementia and to develop psycho-educational assistance for her partner, supporting his care for her. At this point Enya had little speech.

Assessment

Dramatherapy Questionnaires (Reference 3) were used to assess, and later evaluate, the extent of expressive meaning and dramatic involvement.

Both Enya and her carer separately were introduced to a diversity of stress-relieving objects (props). Both people loved the animal glove puppets and the picture of a Lifetree populated with human figures. Later, these aided non-verbal communication at home.

Therapy

Enya and her carer were each offered 14 weeks of weekly, 1-to-1 Dramatherapy. Projective play through pictures of different moods, miniature animal or human figures and reminiscence story books all helped Enya and her partner express their hopes and fears and process their experience of dementia. Added to this was embodiment play through movement and song.

Outcomes

Enya's quality of life increased by 75%. She found words easily to describe feeling like she was 'at the top of the tree', laughing. Her carer felt his quality of life had improved by 60%.

Both sets of Jones questionnaire evaluation results demonstrated substantial clinical improvement and were shared with staff continuing to support the patient and carer.

In clinical supervision, the dramatherapist reflected on qualitative improvements in Enya's mental health (Reference 2), evident in her:

- Reduced aggression and elevated mood
- Decreased confusion
- Easier access to memory for word finding and sentence flow
- Experience of being understood better through non-verbal and verbal communication
- Expanded emotional self-expression and self-regulation

Patient-Reported feedback

Enya squeezed her relaxation ball to de-stress, with a sigh of relief and said Dramatherapy, *"It helps... I like being here with you... I like this very much (pointing to the animal puppet). It is good to choose... good to touch soft things – relaxing."*

Carer-Reported Feedback on Patient and Self

"(Enya's) definitely happier in herself - her mood is more stable. She is hardly ever aggressive... Other people have noticed it too. She's trying to speak to people more often. The other day, for the first time in many years, she asked to go out. I was so delighted...I've been looking at things in a different light since I've been working with you. I now look at objects for communication from a different perspective and see more ways of using them."

Staff-Reported Feedback from the Day Unit

"I've never seen (the patient) so spontaneous."

"'As a result of this treatment for Enya, I'd be interested in more Dramatherapy Training for my own professional development. There is a definite need for Dramatherapy in the new assessment and treatment service for Older Adults. It gives patients a voice."

Conclusion

Dramatherapy outcomes illustrate substantive improvement for both patient and carer. Reduced stress and distress were obtained without medication which indicates cost-saving potential and clinically effective psychological therapy beyond talking therapy.

Dramatherapy enabled patient and carer to connect with and use their emotions. For a patient with dementia, this leads to an alleviation of negative symptoms like agitation, low mood and anxiety, and greater emotional health and social integration is gained.

Here, drama has been used as the primary means of communication and the means by which therapeutic rapport is formed. In the therapeutic relationship the patient can gain social-emotional reciprocity. The dramatherapist enables this by providing a safe dramatic structure for the patient to be spontaneous within and to take the lead in if motivated to do so. In this way dramatherapy has been an effective patient-led service in the assessment and treatment of dementia.

References

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