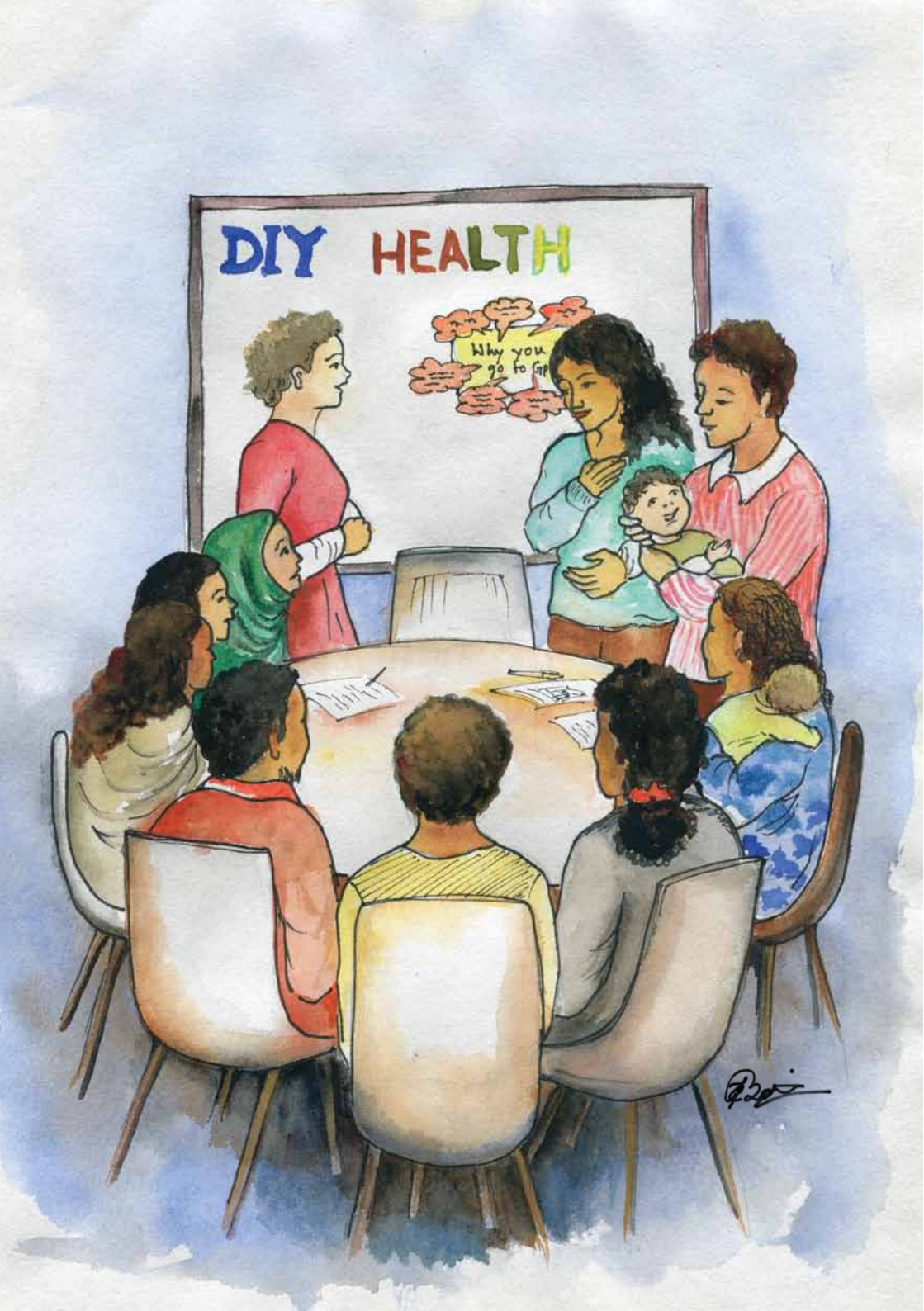
DIY HEALTH (0–5) *toolkit*

Co-producing solutions for managing minor ailments in children under 5 years old


DIY HEALTH
Why you
go to GP

Contents

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Project Partners

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Summary

This toolkit introduces a community-based learning model which aims to empower parents and carers with the knowledge, skills and confidence to manage minor ailments in children under the age of 5.

It emphasises the value of parents as participants in the design, delivery and evaluation of the service. Parent groups explore how best to manage common minor ailments and recognise when situations become more urgent. They also explore how to navigate the health system to access support in the right place and at the right time.

A total of 12 sessions are held on a weekly basis. They are facilitated by a multi-disciplinary team formed of a health professional, an adult learning specialist and supported by early years practitioners.

The groups cover topics such as cold and flu, diarrhoea and vomiting, fever, feeding, eczema and ear pain. The sessions aspire to support parental decision making processes, help participants navigate health services and contribute to a more resilient community of parents.

This toolkit had been written for commissioners, managers, health professionals (such as health visitors), community groups and parents.

Given the positive feedback from parents and professionals during a feasibility project in 2013, the **DIY HEALTH** model was developed and shared to reach more parents in Tower Hamlets.

It is our hope **DIY HEALTH** can continue to be applied within other cohorts and in other localities, and potentially for other condition types.

For this reason, we have created the toolkit containing the necessary guidance to plan and deliver your own **DIY HEALTH** project.

Introduction

When a child suffers from a minor ailment, parents and carers are required to make some difficult decisions. Knowing where to turn for help or how to manage the condition is informed by a complex combination of factors such as: recollections of previous experiences and interactions with health services, confidence in knowledge about the condition the child has, and levels of community support.

For some parents, their General Practitioner (GP) is usually the first person they turn to when they have a query about their child's health or wellbeing. This can mean they are accessing primary care for anything from feeding, sleeping and behavioural issues. Minor ailments are a common problem among the parent population, and they could be addressed by someone else or indeed managed at home with the provision of adequate information.

A **minor ailment** can be considered as any condition which has a suitable self-medication product available for purchase and self-care[1]. It is usually self-limiting and generally requires little or no medical intervention[2]. In a primary care setting the term can be validated after assessment by a GP.

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[1] *Tisman A. The Economic Burden of Minor Ailments. SelfCare 2010;1(3):105-116*

[2] *www.sandbachgps.nhs.uk/how-do-i/6077-find-out-more-about-the-local-pharmacy-minor-ailments-scheme*

Research on attendance rates for minor ailments in the under 5s[3]

Despite the prevalence of life-threatening acute childhood illness being at an all-time low, there has been a 42% increase in the last decade in children's emergency hospital admissions with acute illness[4], many of which are for minor ailments which could have been managed in the community.[5,6]

The **DIY HEALTH** model builds on previous research that suggests rather than having a top-down approach, it can be more effective to work alongside families to create a service to support parental decision making with regards to the management of minor ailments. This approach means the model is not static and will be tailored to meet the specific needs of local groups.

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[3] *Information based on ASK SNIFF (Acutely Sick Kid Safety Netting Interventions for Families) literature reviews and publications.*

[4] *Sands R, Shanmugavadivel D, Stephenson T, Wood D. Medical problems presenting to paediatric emergency departments: 10 years on. Emergency Medicine Journal. 2011 May 23, 2011;emj.2010.106229.*

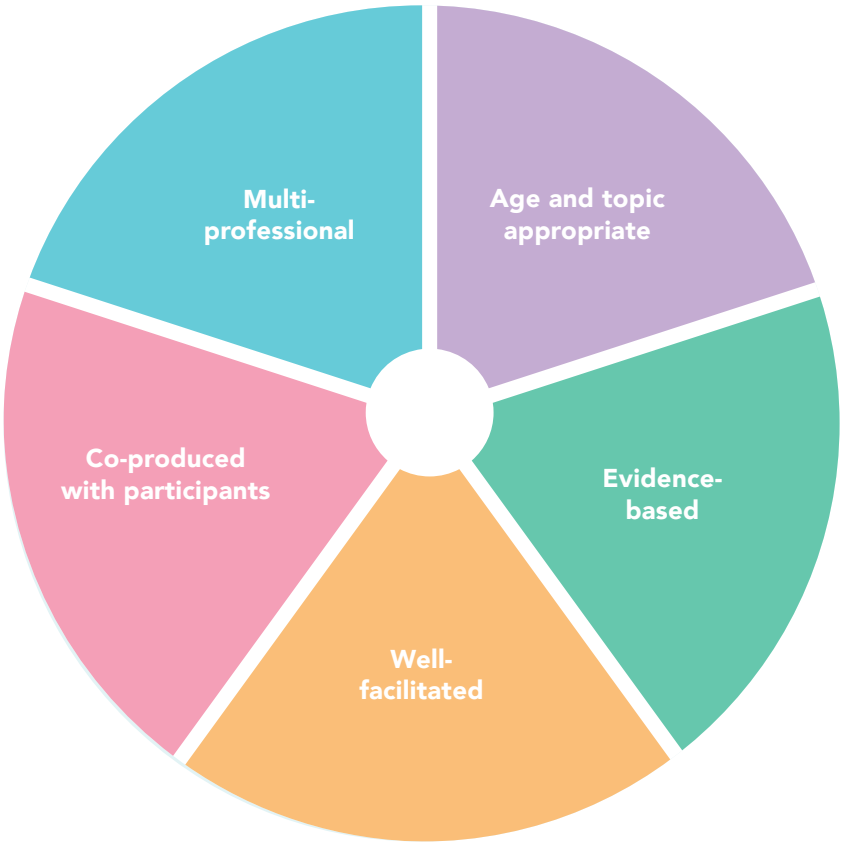
[5] *Gill PJ, Goldacre MJ, Mant D, et al. Increase in emergency admissions to hospital for children aged under 15 in England, 1999-2010: national database analysis. Arch Dis Child. 2013;98:328-34.*

[6] *Saxena S, Bottle A, Gilbert R, et al. Increasing Short-Stay Unplanned Hospital Admissions among Children in England; Time Trends Analysis' 97–'06. PLoS One. 2009;4:e7484.*

[7] *Jones, Caroline H D et al. "Information Needs of Parents for Acute Childhood Illness: Determining 'what, How, Where and When' of Safety Netting Using a Qualitative Exploration with Parents and Clinicians." BMJ Open 4.1 (2014): e003874. PMC. Web. 29 Mar. 2015.*

There are however some key ingredients that all **DIY HEALTH** interventions require to ensure the values of the **DIY HEALTH** model are met.

The model ingredients are



What is the DIY HEALTH toolkit?

DIY HEALTH is an intervention model and minor ailments have been used to demonstrate its application. With this toolkit we share the journey of the **DIY HEALTH (0–5)** initiative in Tower Hamlets and in doing so, provide a guide to support future delivery of similar projects.

The toolkit provides the ingredients to make such a model successful but modifications are encouraged to reflect locally available resources.

How is the toolkit organised?

Section 1 is called 'Managing **DIY HEALTH**' and acts as a guide for engaging with key stakeholders, setting up the project and overseeing delivery. This section is aimed at those who will be responsible for co-ordinating the project.

Section 2 is called 'Facilitating **DIY HEALTH**' and contains guidelines for consideration if you are involved with the delivery of **DIY HEALTH** project sessions. It provides the key requirements for those facilitating sessions and outlines some core principles needed to do so.

Section 3 is called 'Session Delivery' and is about the delivery of the sessions. It describes the approach needed for successful delivery and outlines the initial session and an exemplar session plan. It comprises of good facilitation tips, a range of activities for skills building and best practice examples of co-producing knowledge around the topic at hand.

What is the DIY HEALTH project in Tower Hamlets?

A feasibility project began in 2013 and was co-produced with parents to test the feasibility of the concept. During this period the structure of the intervention was planned.

Following the success of this programme at the St Andrews Health Centre (one of three surgeries run by the Bromley by Bow Health Partnership) it was refined and extended to a second surgery in partnership with UCLPartners.

The project was funded by Health Education England NCEL and an independent evaluation was undertaken by the Anna Freud Centre. Further information from the project evaluation will be made available from the Anna Freud Centre website.

The feasibility project worked with approximately 60 participants who were all parents of children under the age of 5.

12 weekly two hour sessions were facilitated by a multidisciplinary team of facilitators including health visitors and adult learning specialists, with each session supported by Children's Centre early years practitioners.

The core content was chosen based on GP attendance data and covered cold and flu, diarrhoea and vomiting, fever, feeding, eczema and ear pain. However, the content was constantly negotiated to incorporate parent-identified topics.

The skills, knowledge and abilities of participants were pooled in the sessions to create opportunities and solve problems.

What is co-production?

Co-production in this context can be understood as the pooling of knowledge, skills, capabilities and experiences to reach shared solutions; assuming equal partnerships between parents and professionals.

The approach recognises the differences 'users' can make to the quality of services provided when they themselves are directly involved in the design, delivery and evaluation of the service[8].

Although co-production methods are well established in business and social care settings, they have been less prevalent in healthcare until recently where there has been an interest in finding new models of care delivery within the NHS.

More information on co-production can be found here:

- *www.nesta.org.uk/sites/default/files/health_for_people_by_people_and_with_people.pdf*
- *www.nesta.org.uk/sites/default/files/the_power_of_co-design_and_co-delivery.pdf*
- *www.nef-consulting.co.uk/our-services/training-capacity-building/commissioning-outcomes-coproduction/*

[8] *www.institute.nhs.uk/share_and_network/pen/co-production.html*

Why is co-production important?

"It was a really engaging learning curve and the parents say how different this is, and they wish we did more of this. Some parents say they wish we had done this years ago, especially those with older children who have struggled all these years."

In the **DIY HEALTH** model, the curriculum is co-produced to ensure the agendas of both parents and health professionals are met. By giving parents a stake in their healthcare environment, they can take ownership over what they are learning, which is a hugely empowering experience.

Furthermore, a co-production approach leads to sessions that are tailored to meet the specific and localised needs of the group. Health professionals involved also develop strategies for sharing information with patients in an effective way.

Why work with groups of parents?

"When you hear an example from another person, in the same level as you, you take it in more."

By working with groups rather than on an individual basis, peer learning and support is encouraged. The group setting also gives parents the space and time to explore experiences and solve problems together.

"I'm not as anxious now. When my son is ill the world doesn't fall apart. We move on and get over it — I know he will get better."

The feasibility project found that not only did parents report feeling more confident in their own capabilities, but that they valued regular meetings with other parents in similar situations as a reliable source of support when managing minor ailments. Other examples of the benefits of social networking within the group included attending community events together, liaising with each other about their own specific health queries that they had in common and receiving additional support on wider issues such as advice on nursery and school applications.

Who is the toolkit for?

This toolkit has been written for commissioners, managers, health professionals (such as health visitors), community groups and parents.

It provides guidance for people who wish to establish a project using the DIY model for minor ailments or wish to apply the model to other clinical problems, as well as for those involved in the session delivery such as parents and facilitators.

Managing DIY HEALTH

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1 Managing DIY HEALTH

A co-produced approach with parent groups

The Tower Hamlets intervention was initially co-designed with parents in the local area to determine aspects of the feasibility and pilot projects.

Is this approach appropriate for your project?

Working with parent groups can be beneficial in communities where parents report knowledge and skills gaps in relation to managing minor ailments.

In the Tower Hamlets example, this gap was linked to re-attendances in general practice for minor ailments in children under the age of 5.

On what information should this decision be based?

Formative enquiries with target groups and health professionals should be used to judge the appropriateness of this approach. This process could include: community outreach and conversations, health professional consultations, parent forums, discovery interviews and patient groups.

Information should also be collected from health services regarding the key health issues in your area. This will help you consider community characteristics such as demographics, languages, locations and transient populations, to decide whether working with parent groups is suitable. It is also important to examine issues affecting marginalised, disadvantaged and isolated groups in your local community.

Establishing parent groups

Deciding who should participate

> The people most affected by a problem should be actively involved in assessing their situation, deciding what to do, taking action and measuring what difference their actions make.[9]

The process of defining a target group of participants should be informed by local needs and priorities.

Project aims should reflect parent and health professional goals, and should be flexible enough to be re-assessed throughout formative community investigations.

[9] *Good Practice Guide: Community Mobilisation through Women's Groups to improve the Health of Mothers and Babies* www.womenandchildrenfirst.org.uk/component/content/article/32-wcf-publications/wcf-publications/267-good-practice-guide

An important decision to make is whether the project has open or closed groups. A closed or targeted approach enables a more specific group of parents to be worked with, for which the host organisation has chosen the parameters.

This enables organisations to target parents who may benefit most from the service.

> In the Tower Hamlets example, parents with a high pattern of re-attendance were initially invited to take part.

Using more targetted recruitment strategies means you can focus on parents who may not otherwise access support services.

Potential barriers when working with closed groups include

- A strict eligibility criteria can mean raising awareness via word of mouth is restricted
- The number of parents able to attend is decreased and therefore flexibility allowing for dropout is reduced
- Partner organisations are less able to signpost parents into the project.

If your project design requires closed groups then the entry criteria should be specific enough to identify relevant participants, but broad enough to include sufficient people and allow for drop-outs.

If you are working with marginalised communities then a closed group design may require a tailored approach to further encourage the target group to engage.

Engagement may also be enhanced by adapting the content so that it addresses specific cultural and situational needs.

Datasets from health services can also be explored to help create your inclusion criteria. Example datasets include clinical systems that can be searched for particular characteristics (e.g. EMIS or RIO) or nationally available data such as local Joint Strategic Needs Assessments (JSNA).

Deciding how many groups you need and how big they should be

The number of parent groups needed depends on the size of the target population in the area you plan to work in. One way to decide on the number of groups is to consider the optimum number of parents per group given your overall target population.

> Our work with facilitated groups has found **the optimum group size to be between 10 and 12 participants** as it maximises the participation of everyone while creating a comfortable learning environment that is not overwhelming.

A decision on group sizes also needs to be based on safety factors such as ratios of children to those responsible for looking after the children.

This needs to be negotiated and decided on between the partner organisations. Bear in mind that if some families are bringing more than one child to a session where childcare is provided, this ratio might be distorted.

Although we did not invite additional members of the family to attend the sessions, this may be something to consider in your project because parents may not always be the sole carer for the child. Therefore the invite should extend to other carers such as extended family members.

Recruitment

During the design stages of your project you should carefully plan the recruitment procedure. It is important to allocate sufficient resources to raise awareness of the project, discuss the project and invite parents to join.

By making sure the recruitment process is straightforward and accessible you will avoid putting parents off enrolling. Remember to always aim to recruit more people than you require so you can compensate for those who are unable to attend or who drop out at later stages.

The Tower Hamlets example aimed to recruit 30 parents to each cohort, with the intention that 12 parents would consistently attend.

The target population of parents will inevitably have lots of competing priorities (e.g. child's routine, other children, work, study) and so it is important to make the group as accessible for parents as possible.

Factors to consider include:

- The time of the sessions (morning, afternoon, evening)
- Informing parents of weekly topics in advance so they can prepare and make arrangements to attend
- Forwarding leaflets, web-links and publicly available information to parents who are unable to attend

The following steps were taken during the **DIY HEALTH (0–5)** project recruitment process in the Tower Hamlets example:

1. Parents attending the GP **four or more times** in a 6-month period were identified through the EMIS clinical database.

2. **Phone calls** were made to invite parents to the initial session, making sure to explain the project clearly.

3. **Invitation letters** were sent before the initial session confirming the date, time and venue of the project. This is a good opportunity to introduce the 'brand' of the project, so you can include any logos that depict this where appropriate.

4. A **reminder message** (e-mail/text depending on preference) was sent to each parent before the first session and to encourage parents to feel supported.

Throughout the recruitment process it is good practice to begin to notice the preferences and priorities of parents as these will continue to inform how the project is delivered. It is important that such considerations are embedded into the recruitment process so it is useful to make a note of them as they arise.

You should decide on a minimum number of attendees you will aim to have in each session. If parents do not attend, you should try to find out why through follow up conversations and support them in overcoming any barriers they may encounter.

Parents who miss specific sessions might be invited to return to subsequent cohorts and you should be careful to consider these parents in your recruitment process.

The recruitment process may also need to be tailored for marginalised communities. For example if some are illiterate or do not have a phone then you may want to think of other methods of engagement such as attending existing community groups.

Considering who to work with

The **DIY HEALTH** model can be complementary to many other existing child health programmes, policies and initiatives. This should be discussed with relevant local communities in the initial stages of the project. Depending on the scope of the project you have in mind, it is good to consider how the model can support as well as benefit from existing structural priorities.

Aligning priorities

Formative community outreach investigation is a good place to start to identify project partners. Stakeholder analyses help map the priorities of those involved with the health of children under 5 (such as parents, GPs, nurses, Children's Centres, Health Visitors and pharmacists). The aims of the Tower Hamlets example aligned well with Department of Health high priority areas for Health Visiting, the deteriorating child and Public Health minor ailments management.[10]

Through this work you may also find there are already active parent groups or local health initiatives established in your community you can work with to implement the **DIY HEALTH** model.

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[10] *www.gov.uk/government/uploads/system/uploads/attachment_data file/413133/2902452_Early_Years_Impact_5_V0_1W.pdf*

Allocating resources

Identifying your partners' resource and time constraints can help establish a more realistic context to work within and will give you an idea of the resources and funds your project will have access to.

Allow enough time to approach the community, seek permission and support, and to learn about your partners' interests and stakes in the project.

You may like to consider the possibility of providing take-home materials for parents to keep after the sessions end. The provision of such materials should be negotiated between the partner organisations.

> For example each of the parents in the Tower Hamlets project left the project with a '**DIY HEALTH Toolkit**' containing over the counter medicines (e.g. digital thermometers, chest rubs and saline drops) to support the safe and effective management of minor ailments at home.

Selecting facilitators

One of the model's key strengths lies in its multidisciplinary team of facilitators. Ideally, groups will be supported by people the families feel comfortable with.

Ideally the facilitators should also have both clinical and educational skills. We chose to have groups facilitated by a health care professional, an adult learning specialist and supported by a child care professional.

> Although the configuration of this team may vary, it is important to replicate the skillset.

The **Adult Learning Specialist** would ideally specialise in family learning and is principally concerned with the way adults learn and acquire knowledge. They are responsible for creating an appropriate and stimulating learning environment.

The **Health Professional** is responsible for ensuring all information shared during the group meetings is evidence based and follows appropriate clinical guidelines. Safeguarding issues can also arise, so it is important the health professional safely and effectively manages these situations in line with safeguarding guidance.

The **Child Care Professional** is responsible for ensuring the environment is well suited for children who attend sessions with their parents. They can model behaviour for the parents and signpost them to local child care support activities and services. Age appropriate activities and snacks should be provided. They also allow parents to concentrate on the content of the session rather than on the children.

You will need to define the roles and responsibilities of facilitators. It is helpful to develop a brief role description and to discuss this with facilitators before you start training to make sure they are clear about what they will be expected to do. It may even be possible to involve the parents in the selection of facilitators to make sure they are acceptable.

You also need to be clear about what facilitators can expect to gain from the project and how involvement in your project is expected to fit in with their existing workload. This is to ensure their full support and engagement so the programme is sustainable. This requires full approvals from their employers.

Training facilitators

How you organise the training depends on your project requirements, your organisational capacity and the availability of the facilitators. Existing training that might be helpful includes Health Visiting training on minor ailments, such as resources found at *www.minorillness.co.uk*

During the **DIY HEALTH (0–5)** project, a preparatory multidisciplinary team away day was held prior to the project start date. This was attended by the facilitators as well as representation from organisations and parents involved. It provided the opportunity for the aims and principles of the project to be outlined so everybody was working to the same goals.

Workshops included:

- Co-production : Introducing the concept and using this approach to solve a problem
- Session Delivery : Introducing the format through a simulated exercise
- Evaluation : Deciding as a team how to measure what matters

Supporting the work of facilitators

Periodic multidisciplinary team meetings throughout the duration of the project can be used to raise awareness of the co-production model in partner organisations.

This can ensure it is embedded in a broader sense and can also build mechanisms through which learning can be taken back to organisations to inform best practice.

The meetings also function as a space for those involved to share their learning and reflect as a team as the process evolves.

Training and development opportunities should also be negotiated and incorporated.

Co-designing the curriculum

The **DIY HEALTH** curriculum aims to meet the agendas of both local parents and health professionals, and covers a range of topics that are agreed on by the group.

> To ascertain the agenda of the health professionals, an assessment of attendance patterns was undertaken.

The **DIY HEALTH** project analysed the records of eligible parents to identify six core topics that would form the basis of the curriculum; cold and flu, diarrhoea and vomiting, fever, feeding, eczema and ear pain.

The agendas of the parents are initially identified through the conversations carried out as part of the formative investigation process mentioned earlier in Section 1.

It is important to constantly check you have understood what the parents are highlighting as priorities, as you will then synthesise this information to inform part of the curriculum — this is explained in more detail in Section 3: The Opening Session.

The suggested length of the **DIY HEALTH** programme is 12 weeks. Given the iterative nature of the co-production approach, if a longer period of time is needed to explore both parent and health professional identified topics in adequate depth, participating organisations should be open to this. The length of the programme also allows parents and children time to naturally form new relationships and bonds.

Involving other community groups

Although this **DIY HEALTH** approach targets specific groups of parents, it is important to be flexible about including other community groups in the project so key messages can be shared throughout the wider community.

A simple way to do this is by organising one-off events for other community members and parents to attend. For example events can be arranged at central community locations such as children's centres, which are open for all local parents to attend.

It is important to work with parents to organise these events as it acts as an opportunity to build skills and give parents a stake in their local community.

Situations may also arise where participants invite their friends and family members who have children under the age of five, but might not necessarily be on your target list, or in your catchment area. It is important to be flexible about allowing these additional members to also join the group, taking into consideration the benefits of parents broadening their social network.

It is also important to draw on the expertise of other organisations in the local community who may be able to help with the management of minor ailments; for example pharmacies, local charities, online resources and other parent groups. Deciding as a group on the topics in advance will help you to engage with these other organisations, and invite them to participate in the sessions as appropriate.

> In the Tower Hamlets example, community organisations such as the Breast Feeding Buddies were invited to support the session and introduce parents to additional community support.

However, it is always important to ensure all information provided complies with national guidelines. This ensures consistent information is given to parents to avoid confusion. You will therefore need to be aware of the information that will be imparted by other community groups prior to the sessions.

Organising session delivery

Deciding when and where meetings take place

The meeting place should be somewhere everyone can get to easily, where parents feel comfortable and where they can talk freely.

The participating organisations should discuss this to provide the most appropriate options.

> The Tower Hamlets sessions were held at the GP Surgery because the participants were initially registered patients within a particular catchment area so were therefore able to reach the chosen venue easily.

Encouraging attendance

You should think of ways to encourage parents to attend sessions regularly.

> Initial findings from the Tower Hamlets groups suggest attendance was higher when group meetings were preceded by a longer lead of community sensitisation, which raised an awareness and understanding of the project.

During the process, you can take steps to try to support additional initiatives the groups may come up with after the project has finished. For example, you may wish to organise the provision of a safe space for participants to meet outside of formal sessions to support building a social network.

Evaluating DIY HEALTH

To demonstrate impact, you should consider evaluating the programme using carefully collected data. If you have the resources, you may choose to conduct a full evaluation in partnership with an independent evaluation organisation.

The Tower Hamlets example was evaluated by Anna Freud Centre, and the details are available on the UCLPartners and Anna Freud Centre websites.

Choosing evaluation inputs

A logic model can be used to facilitate the process of identifying different elements of the intervention and the process by which change occurs. It focuses on the context, mechanism and outcome.

Although what you choose to measure is up to you and should be based on the behaviours you are trying to change, the Tower Hamlets example aimed to evaluate:

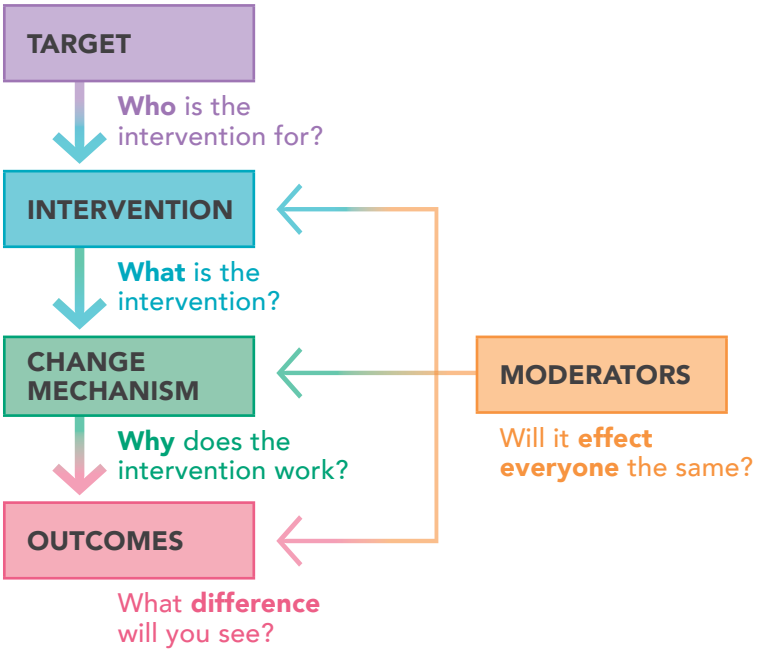
- If **DIY HEALTH** sessions led to a reduction in attendances to GP surgeries
- Changes in skills, knowledge and confidence to manage minor ailments in children under the age of 5
- The extent to which the sessions were 'co-produced'
- Barriers and facilitators to implementing **DIY HEALTH**

"I feel more confident in myself. Before I used to worry if my children fell ill. My son had the worst cold ever two weeks ago. I felt confident to take care of him rather than rushing to the doctor because I knew how to handle him. I was more confident in myself to deal with the situation."

Logic model for evaluation

An example of the logic model is outlined below, and will help you to think through the components of your evaluation.

The indicators mentioned in the diagram are based on the Tower Hamlets example, but they may be different when you carry out your own **DIY HEALTH** project.



[11] *Sharpe, H. Logic Model*

Data collection

You should carefully choose what information you will collect to evaluate your own **DIY HEALTH** Project. You might choose a mixture of methods and data but you should ensure each component is collected systematically. Some of the sources you might explore to collect data include routinely collected clinical data (e.g. EMIS, RIO), questionnaires and interviews.

Evaluation tools

To help the data collection process, you should consider the evaluation tools you will employ so that you ask the right questions and can gather the correct data. Some examples of evaluation tools can be found on the UCLPartners website.

Facilitator's Manual

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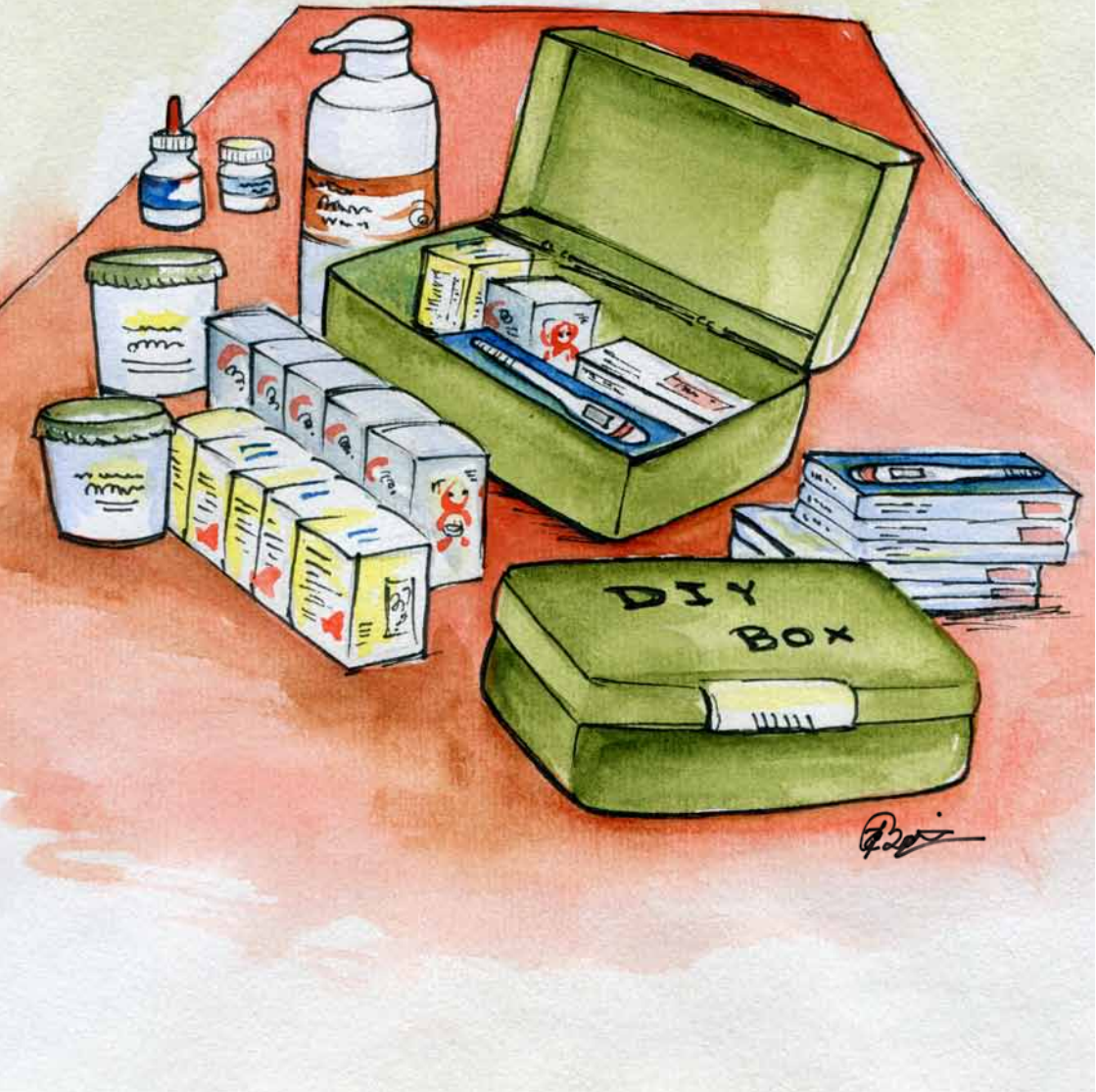
DIY
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2 Facilitator's Manual

The role of the facilitators is to accompany parents on a journey to become more confident, knowledgeable and skilled when it comes to appropriately managing minor ailments in children under 5.

Existing experience, skills and knowledge within the parent group form the basis of the **DIY HEALTH** model. As a facilitator, you must consciously draw this out in each session. Facilitators also develop the group's existing capacities through encouraging resourcefulness and leadership. In order to achieve all of this in a group setting, you will need to:

- foster group morale
- form equal partnerships with parents, giving value to everybody's existing experience, skills and knowledge
- create a safe and positive learning environment

Furthermore, throughout each co-produced session the facilitator should use methods and activities based on behavioural change techniques such as those presented in Theory of Planned Behaviour *(Azjen, 1975)*.

- Skill development will contribute to the level of control parents feel they have over being able to manage children's minor ailments. Topic specific skills should be introduced in each session.
- The facilitators share safe knowledge. They are also able to give best practice examples of how to manage each ailment discussed.
- The group setting of **DIY HEALTH** enables each parent to share their own experience and learn from those of others. This can provide reassurance that other parents also have similar experiences of managing children's health. These mechanisms encourage parents to reconsider how they think other people manage children's health, and subsequently what they think others want them to do to manage (e.g. family members, friends, GPs etc.).
- For each topic each parent should be encouraged to set and share a goal that the group has supported. This helps parents implement what they have learnt during the sessions at home.

"They always make the sessions interactive and make us feel involved. It's always about us and them, it's not about them telling us what to do, it's about us."

Co-producing solutions to problems

The first step in co-producing solutions to problems is to identify the health topics that are considered to be important by the group. Practical methods of doing this are outlined in Section 3.

You should embrace parents' existing knowledge on topics identified by the group. It is important you constantly integrate parent and professional knowledge throughout the sessions and support co-facilitation where appropriate.

> A demonstration of parent co-facilitation in the Tower Hamlets example occurred when one of the parents used her previous experience as a dental nurse to help successfully co-facilitate a session on children's oral health. This incorporated a trip to the local pharmacy to look at some of the over the counter products available to help look after children's teeth.

Facilitator roles

The Adult Learning Specialist is concerned with how adults learn and retain information, and is therefore principally responsible for ensuring the curriculum and associated course materials are accessible and support the learning process. As an educator, you should also be capable of ensuring each session meets the needs of parents with differing levels of health literacy and understanding.

The **Health Professional** is responsible for building on existing experience, knowledge and providing evidence based information for each topic of discussion and the materials developed. You are responsible for the overall governance of health information throughout the programme. Relevant guidelines should be adhered to in line with normal care requirements (e.g. NICE, BNF).

If you are a Health Visitor, the skills acquired throughout community development, group Facilitation and Positive Parenting aspects of Health visiting training form a foundation for this project to build upon.

Childcare Professionals are responsible for developing a programme of activities for the children that mirrors the parents' topics of discussion where possible. They deliver age appropriate activities for the children to support their physical, social and emotional development. Childcare professionals should use opportunities within the group to model and reinforce behaviours for example, hand hygiene and exploring healthy snacks.

Each session is planned in advance by the team of facilitators and the topic should be agreed by the group the preceding week. During this planning process the following points should be covered:

- The specific aims of the upcoming session
- Group and individual learning objectives
- Home and independent learning activities
- Specific target language/ definitions/ key terms
- Differentiation — how to consider different learning styles and abilities
- Health, safety and wellbeing concerns
- Equal opportunities

Drawing out leadership, expertise and experience

Facilitators also identify training and support needs in the group and come up with creative methods of nurturing the potential in the group members to develop their leadership skills. This can be achieved through the creation of parent representatives and parent facilitators, as well as through encouraging parents to share information about the group at community events.

It is important to draw out experiences because they highlight parents' reasons for health seeking behaviours, which are important to understand and build upon.

Evidence based practice

It is crucial to ensure that the information shared during the sessions is based on current evidence and does not promote harmful behaviour. In order to do this, sessions must be created in line with current guidelines to make sure parents get accurate, up to date and consistent information. Existing websites and apps can facilitate this process and are great resources:

- *www.nhs.uk*
- *www.nice.org.uk*

Sustaining action

Sustaining action during as well as after the project is vital to influencing enduring behaviour change. Facilitators play a key role in this by supporting parents to set individual goals, inspiring group morale, and feeding into group plans for continued action. It is also important to consider ways to support ongoing initiatives the group may come up with.

Here are some suggestions for other ways action can be sustained:

- Creating a scrapbook of information participants have learnt for future referral.
- Co-creating a plan of future meetings outside of the project to strengthen community networks.
- Supporting parents to develop facilitation skills to co-facilitate future cohorts, or specific sessions based on their own skills and knowledge.

Furthermore, you may think of ways to incorporate the knowledge gained from the groups to support child health outside of the sessions and this learning should be shared with other colleagues and team members.

Feeding back to critical bodies

Part of the empowerment process of the **DIY HEALTH** model is giving parents a stake in the health care environment.

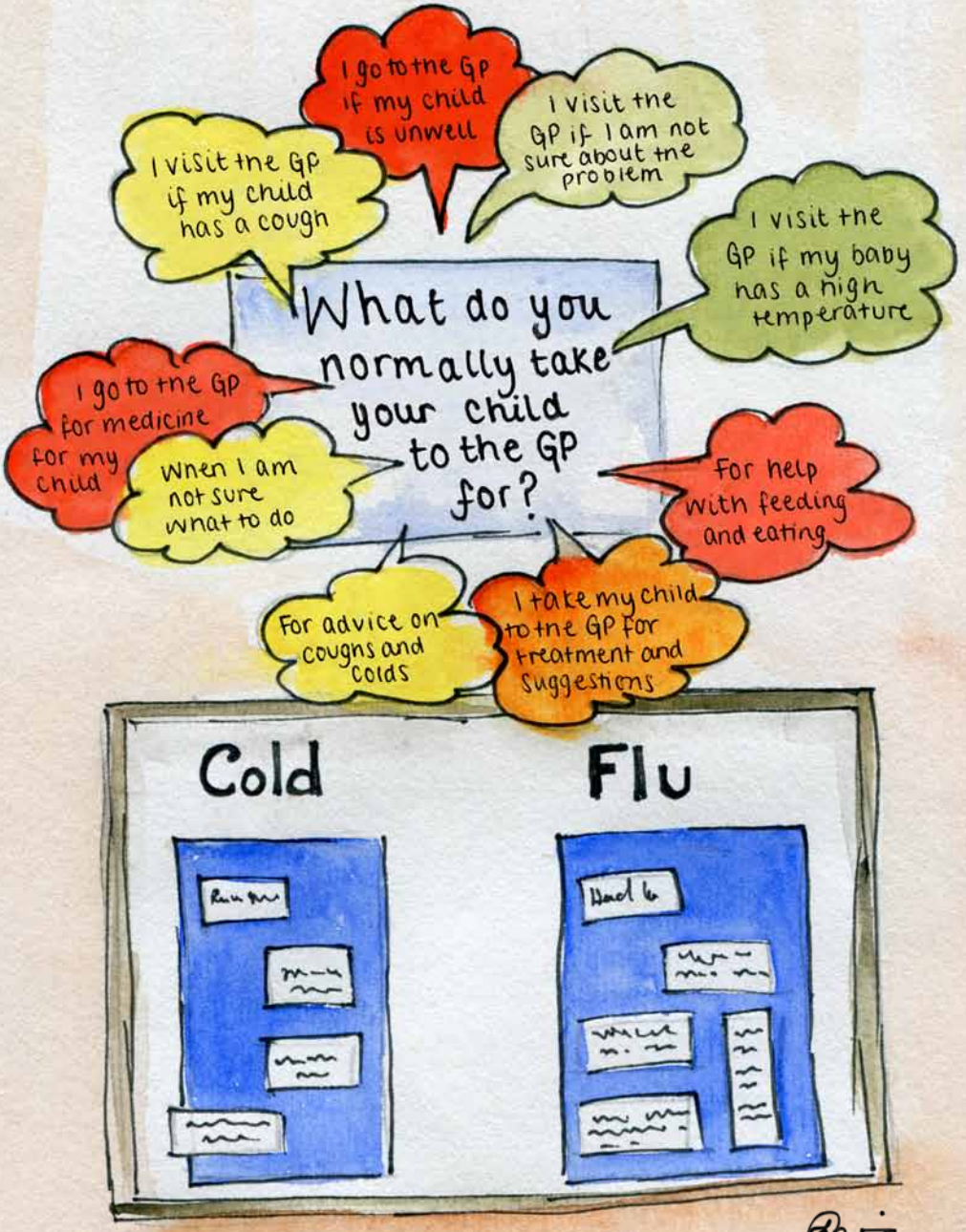
As part of the project set-up, it is important to consider ways in which you can feedback learning from the group to wider partner organisations and the community.

This can be achieved through

- Team meetings where you might choose to include a **DIY HEALTH** Parent representative
- Links with your local Clinical Commissioning Group
- Sharing the learning at broader meetings held by each of the partner organisations.

Session Delivery

3


I go to the GP if my child is unwell
I visit the GP if I am not sure about the problem
I visit the GP if my child has a cough
I visit the GP if my baby has a high temperature
What do you normally take your child to the GP for?
I go to the GP for medicine for my child
When I am not sure what to do
For help with feeding and eating
For advice on coughs and colds
I take my child to the GP for treatment and suggestions
Cold
Flu

Planning and Preparing

3.1

3.1
Helpful hints for Practitioners

Begin with your purpose in mind

As practitioners involved the session delivery for a **DIY HEALTH** project, you will have made to the decision to embrace co-production as a concept.

You will be interested in creating opportunities to use new methods and techniques. Acknowledging this is a critical part of the process and requires that you prepare to question conventional thinking and practices in order to reach shared solutions.

The **DIY HEALTH** model aims to empower parents, and therefore developments made during the sessions need to be transferred into everyday living. You should be ready to challenge the traditional status-quo when it comes to relationships between parents and professionals. This power imbalance is just as present in group settings and needs to be minimised in order to create a space that can enable true co-production and change.

Our purpose as **DIY HEALTH facilitators** is to encourage sustainable change within our spaces of practice that will contribute to improving lives outside of the learning environment.

The ideas in this section are drawn from our experiences and the examples demonstrate our attem pt at finding solutions that worked for our groups. We share these as a source of encouragement to find the methods that work for you. There is a wealth of material to read, watch or listen to, which will help your understanding and increase your own awareness of the processes involved in participatory practice. There is also a wealth of resources readily available, outlining specific methods and techniques you can use when working with groups. You should experiment with these but also try new strategies, adapt old ones and remember to keep an open mind.

The next stage is to put these principles into practice. Here we offer some practical suggestions of how to get started.

Put people first

People are your greatest resource. Even without any physical materials, it is entirely possible to have a great session in which everyone feels stimulated and active, interactions and processes meaningfully support the overall aims of the group, and learning comes to life.

> *"They always make the sessions interactive and make us feel involved. It's always about us and them, it's not about them telling us what to do, it's about us"*

Conversations with group participants will help you to understand who they are and what their needs in the session might be. This holds true whether they are parents, support workers or visiting specialists.

The first stage of applying the principle of valuing people is through your preparation. The details of whether the physical space is safe, accessible, appropriate in size, clean, comfortable and a pleasant space for everyone to be in and has been thoughtfully laid out demonstrate the importance placed on people.

Health and safety

We have a duty to ensure the health and safety of any group of people we bring together. This is applied in two levels.

Firstly, if you have a regular meeting room, your overall risk assessment will cover the physical conditions of the room, equipment, furniture and facilities such as toilets, lighting, water, ventilation, a clear and accessible fire exit and instructions on how to evacuate the premises.

It should also include arrangements for first aid, any named individuals and how to contact them.

A risk assessment is a working document, so adapt it to reflect the needs of your group. If your group consists of parents with very young children, consider additions such as appropriate sized furniture, covers for electrical sockets, baby changing and feeding arrangements, and where to store pushchairs.

The second level of risk assessment relates to the type of sessions and minimising the risks related to the specific activities involved.

A practical session involving food would need to pay additional attention to allergies in the group, choking hazards and the possibility of cuts and other injuries.

Outdoor activities and trips also need additional considerations such as the weather, travel and hazards in public spaces.

There are a wealth of materials to use and adapt from many sources. Learning and Skills council's Excellence Gateway[11] has a bank of good practice examples free to download and customise to suit your needs.

Depending on your physical space, you may find it helpful or even necessary to draw a simple room layout as a guide for setting up what is available to members of the group.

[11] *www.excellencegateway.org.uk*

Safeguarding

We have a duty of care and responsibility for the wellbeing of the whole group. Individuals need to feel safe, comfortable, and respected. This includes addressing bullying, ensuring inclusion and dealing with conflict.

The scope of our responsibility however, is not confined to what may take place within the sessions but extends to concerns that may arise from outside. You will need clear and transparent policy and procedure in place for handling concerns, dealing with complaints, disclosures or other concerns. Most organisations will have systems in already in place. It is important to know what these are, who the designated safeguarding contact is and what to do if issues arise. This should be shared with the whole group early on, such as during the period of establishing your values, activities and housekeeping arrangements.

Establishing the group's shared values

Both health and safety and safeguarding can be used to address issues of confidentiality, as well as equality and diversity policies and procedures. It's important to be explicit about expectations of conduct. Poster making activities are an effective way of navigating through the group's negotiable values and non-negotiable standards.

It also demonstrates our commitment to comply with statutory policies while setting the tone for an inclusive, supportive and safer environment.

Depending on your particular setting, it may be necessary to consider what learning agreements and permissions from members of the group might be needed. These could be for the use of photographs, audio, or text relating to individuals and their children. Think through the types of activities and consider how these might apply to them.

The look and feel

Aim for an informal but stimulating layout in the space with clearly designated areas for group work, a children's play area, refreshments and storage of coats, pushchairs etc.

Wall spaces can be used to display topics, objectives and previous work the group have done together. It adds to the atmosphere and focuses the group.

Large format, simplified and legible text with a variety of coloured backgrounds draws attention to important information.

Staging and time frame

While it is essential to have a structure to follow with distinct stages that separate one activity from the next, allowing for flexibility is just as crucial. It enables you to be responsive to changes and to the needs of the group.

When working with parents and very young children, we found that in a 2 hour session, our natural stages broadly were:

- Settling in *(approx. 10 minutes)*
- A focus activity based on the topic *(approx. 2 × 20 minutes)*
- Break and refreshment *(approx. 10 minutes)*
- Joint activity with the children *(approx. 10 minutes)*
- Reflection *(approx. 20 minutes)*

For most people, activities lasting more than 20 minutes are tiresome. DIY sessions were broken up into 10 minute interchangeable blocks. Where necessary, you can skip or group them, depending on who is present and what suits them best. For example, if there are no children, the group can decide to spend an extra 10 minute block on reflecting, re-capping, extending an activity or planning ahead for future sessions.

Opening Session

3.2

3.2
The Opening Session

The aims of the openings session are to

- Introduce the project and its approach
- Create a supportive and inclusive learning environment
- Elicit individual and group priorities
- Negotiate and agree on expectations, as well as the group's shared values

By the end of the session participants will have:

- A shared values poster
- A collection of priorities on display
- Decided on a topic or theme for the next session(s)

Activity
3.2.1

Getting to know each other

Welcome

The aim of this activity is to make everyone feel welcome, relaxed and safe. By the end of this activity participants will know a little bit more about each other.

Everyone in the room introduces themselves by name and tells the group a little bit about themselves (where you live, come from, how many children, something you really enjoy).

Allow up to 2 minutes per person

Facilitator's Notes

Each individual can choose how much they would like to share. Ensure everyone has an equal opportunity to speak. Use this to draw out strengths, skills and interests within the group.

A short story of how we got here

The aim of this activity is to ensure everybody has a clear understanding of the project. By the end of this activity, the group will understand how the project started and where they fit in.

The facilitator shares the journey of the project with the group. This might include an explanation of the problem in the local area, how the participating organisations have come together and what you hope to tackle as a group.

About 5 minutes. Allow extra time for questions and interjections as they naturally occur.

Facilitator's Notes

This is storytelling in narrative form. Before the session, it's important to practise the delivery so as to keep it simple, clear and concise. The content should be correct and facilitators should be careful not to mislead the group or overstate anything.

Use visual cues to illustrate the journey and keep it open-ended to allow for input from participants. Remember, parents who have already been involved can help to tell the story.

Our Shared Values

Making a poster

The aim of this activity is to enable the group to identify the positive values and behaviours they would most like their group to be characterised by. At the end of this activity participants will have a colourful poster formed of contributions from all participants.

The facilitator should start this conversation with an example of a value that could be shared by the group, and then explain why it is important. Examples include 'supportive', 'friendly' and 'educational'.

The facilitator encourages each participant to offer contributions either written on coloured card, post it notes or spoken. You can then add the words to a poster as they are shared. This will form the 'shared values poster' which should be displayed at the beginning of each subsequent session.

Allow about 10–15 minutes

Facilitator's Notes

This is the appropriate time to introduce inclusive policies such as equality and diversity, confidentiality and safeguarding.

Managing minor ailments: what is important to me?

Understanding Priorities, Needs and Goals

The aim of this activity is to better understand what drives parents to visit the doctors about their child's health. By the end of this activity participants will have identified topics or areas they would like to address during the project. These will be displayed as a colourful poster. Group priorities will also be elicited.

The facilitator should lay out cards with minor ailments written on them, and check the whole group's understanding of and familiarity with the terms. The recommended question '*what do you normally visit the GP with your child for?*' is asked at this point. Encourage participants to answer with as many reasons as they feel are important, then write these down using the materials provided. Choose an appropriate strategy for displaying the contributions and allow for participants to share and prioritise certain topics. **Body mapping** is an effective way of guiding this discussion, whereby outlines of children's bodies are provided for parents to label with ailments they need additional support in managing.

About 15 minutes

Activity
3.2.5

Free-flow interactions and break time

Building New Relationships

The aim of this activity is to encourage natural interactions between parents, facilitators and children and to provide time for participants to absorb and discuss the previous activities. This time also allows children and parents to enjoy playing, singing and having a snack together.

Everyone in the room shares a snack and song together led by the practitioners who are responsible for the children within the session.

Allow about 15–20 minutes

Facilitator's Notes

Song time supports the development of speech and language skills for young children, as well as the development of good listening, social and co-operative skills. Encourage parents to participate and follow the practitioner's lead so they can model behaviours for the children to copy. Also emphasise the importance of supporting language development and having fun together.

Reflection and acknowledgement

Closing the Session

The aim of this activity is to review the session and elicit participants' feelings about how it went. By the end of this activity the group will have also decided on what topic to cover the following week.

The posters created in earlier activities are used to guide the reflective discussion. Direct questions can be asked to prompt the participants such as:

'What did you think about…?'

'What did you gain?'

'What would you like more/less of?'

'What's our plan for next week?'

Achievements of the whole group are acknowledged.

About 15 minutes

Facilitators Notes

Finish with any general information. Some parents will want to ask further questions, others might want more information or raise concerns in a more private manner which facilitators should accommodate for.

Cold and Flu

3.3

3.3 Example session: Cold and flu

The aims of the session are to

- To discuss and raise awareness of the causes, signs and symptoms of the common cold and flu
- To identify remedies and actions to take at home
- To know when and where to seek medical help

By the end of the session participants will have:

- Awareness of the differences between viruses and bacteria
- Distinguished between a common cold and the flu
- Recalled at least 3 effective ways of managing cold and flu symptoms
- Stated at least 3 reasons to seek medical help
- Stated 3 options of where to get the right help and how

Settling in

Getting ready to start

The group is welcomed to the session and participants introduce themselves where necessary.

The main points from the previous sessions should be recalled to allow for a transition into the present topic. To keep a good pace, simple memory games such as quiz questions, matching and sorting exercises should be used.

Contributions from the group should be recognised, and the health professional should continuously check and build upon participants' existing knowledge.

To introduce the topic, remind the group of what was agreed in the previous session for example '*the topic that we agreed for today is…*'

Virus or Bacteria

Building Foundation Knowledge

The aim of this activity is to increase awareness and understanding of the main differences between viruses and bacteria. By the end of the session the group will be able to distinguish between the two.

A set of pre-prepared virus and bacteria fact cards may be mixed up and placed on the table, with large sheets of paper with the titles 'virus' and 'bacteria.' Each participant should place at least one in its correct group. Facilitators should encourage questions as the cards are sorted and provoke reactions to interesting facts that emerge from the discussion by asking open ended questions such as

'What do you think about…?'
'Did you know…?'

This type of activity generates questions from the group and is an opportunity for the health professional to clarify uncertainties and share factual information about the differences between viruses and bacteria.

When ending this activity, make a recording of the group's results and conclusions. For example, take a photograph or display the posters on the wall.

Activity
3.3.3

Cold and Flu Signs and Symptoms

Decision Making

The aim of this activity is to distinguish typical cold symptoms from typical flu symptoms. By the end of the session the group will understand the difference between cold and flu.

Another set of pre-prepared cards is introduced to the group, this time containing various cold and flu symptoms. All of the cards are placed in a mixed pile in the middle of the activity area.

Provide two large pieces of coloured paper labelled ‘cold’ and ‘flu,’ leaving a space in the middle for those the group are unsure of.

Participants take turns to pick a symptom and share it with the group. Each participant is encouraged to articulate their opinion before the rest of the group contribute to the discussion. The facilitator should guide the group towards a consensus and place the card accordingly under the heading.

As each participant takes their turn, use this time to elicit their own experiences of their children having those symptoms.

How to Manage Cold and Flu

Experience Sharing

The aim of this activity is to identify appropriate actions to manage cold and flu. By the end of the activity the group will know how to manage at home, and where and when to seek professional advice or medical help.

In this activity it is import to demonstrate the value and importance of the participants' own experiences in managing colds and flu.

The facilitator should encourage as many contributions as possible and record them all on a large surface — for example a whiteboard or large coloured paper. At this stage, the quantity of information on the board should be acknowledged and celebrated.

The health professional attached to the group confirms the details of how and when to use different management techniques, both medical and non-medical home remedies suitable for the under 5 age group.

Activity
3.3.5

Ending the session

The aim of this activity is to reflect on the session. By the end of this activity the group will have reached a decision about what the next session's topic will be.

Acknowledge the group's contributions and individual stories. Reflective questions help to consolidate the group's knowledge; for example:

'What is the difference between paracetamol and ibuprofen?'
'What kind of minor ailments can the pharmacist help with?'

Ask everyone how they feel about the topic and the session. This will encourage reflection and the development of ideas for future sessions.

End the session by deciding as a group what the topic for next week will be.

Summary

The **DIY HEALTH** approach aims to empower parents with the knowledge skills and confidence to manage children's health at home. Through our work with parents in Tower Hamlets, this model has demonstrated potential to support parents to manage minor ailments more appropriately.

We hope that you have found this toolkit useful and that it will be a helpful starting point when developing similar projects in your own area.

We urge you to adapt the model to meet the specific needs, preferences and priorities of your own local area.

The Tower Hamlets example outlines an approach and some fundamental components, but the application of the model to a range of health issues is flexible, and encouraged.

The toolkit is also available electronically on the UCLPartners website *www.uclpartners.com* and we look forward to hearing the ways in which you have adapted and implemented the model!

Notes

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For more information please contact diy.health@nhs.net