Name of project: Virtual Exercise Groups in Adult Learning Disability Physiotherapy Service

Project lead: Omo Olaleye

Kent Community Health NHS Foundation Trust

What was our aim?

To provide virtual exercise classes to learning disability (LD) clients.

To save clinician time/resource by not traveling to a venue.

To make exercise classes more accessible, by giving client's a choice/options.

To achieve same attendance virtually, as face-to-face classes.

To ascertain the level of client engagement virtually compared with face-to-face class.

Why is it important to service users and carers?

Currently our LD physiotherapy service only provides exercises to clients face-to-face in a group setting, or on an individual basis at home.

Offering an alternative way of delivering exercises, using a virtual platform, will be more inclusive for those clients who cannot access a face-to-face group setting, or patients who need more intensive support from a physiotherapist.

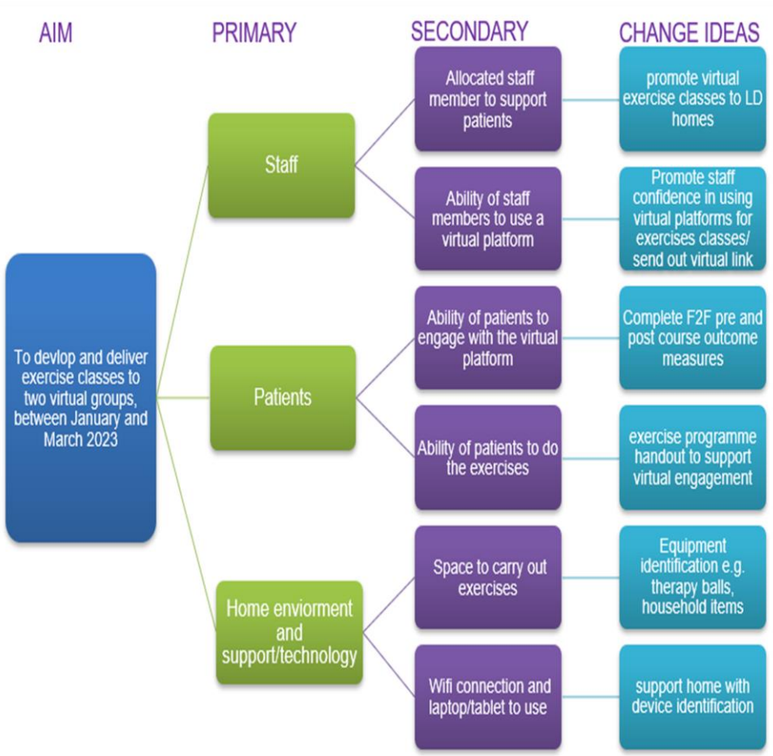
The physiotherapy team in the South Kent Coast (SKC) and Thanet locality is a very small team covering a very wide geographical area. Our venue for the face-to-face group setting is not always accessible for some people, due to issues such as the travelling distance or some carers not able to support clients to attend if they don't drive. There is also a requirement for the physiotherapy team to balance travelling to group venues with the need to see patients at home.

Ideas and tests of change

To develop and deliver two virtual exercise classes between January and March 2023, starting with five participants in the Wednesday group and four participants in the Thursday group. Weekly group sessions were carried out over eight weeks.

- To test whether LD clients can engage in virtual sessions as well as they do in face-to-face sessions.
- To identify the barriers with conducting exercises virtually and ascertain if virtual aids attendance.
- To ascertain client, staff and carers perceptions and feedback on undertaking virtual exercises compared with face-to-face.

The tools we used



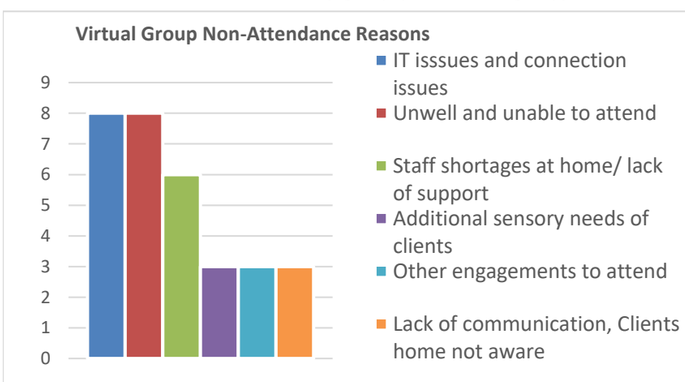
Results

Staff feedback: Savings in cost/ time, less fatigue as no requirement to travel and set up as with face-to-face in a venue. Level of engagement was good. Some distractions sometimes and limited space at the home.

Clinician time Savings: 1 hour traveling time + 0.5 hour set up/tidy up time x 8 weeks = 12 hours per staff member (per 8-week group). **Mileage saving**: £154 (275 miles)

Patient feedback included: enjoyed doing exercises, easy to do, well organised, prefer doing it face-to-face as like the social aspect, missed the equipment. **Carer feedback included:** No need to travel, could join and log off and continue with other activities, client does not have transport to access face-to-face, the session was well organised and well facilitated.

Virtual Attendance Rate: Wednesday group (Initial virtual group) had an attendance rate of 50%



Attendance rates virtual versus face-to-face

As part of the next plan, do, study, act (PDSA) , the team worked to resolve some of the IT issues highlighted in the first virtual group, held on a Wednesday. The learning and resolutions increased the attendance rate for second virtual group from 50 per cent to 72.5 per cent, which is similar to the attendance rate of 75 per cent for the face-to-face group.

What we learned and what's next

Engagement levels varied among clients. Some engaged really well while a few preferred in-person groups.

Clients with a sensory/memory impairment such as visual or early stages of dementia, struggled a bit more to engage and an individualised session was more appropriate.

Always have a test run session to check for any potential problems which can arise, such as logging onto MS teams, so solutions can be found before the class starts.

Always make sure there are a good number of staff confident to use the IT device and they all have access to the log in links.

To explore the option of a hybrid model for the group settings as this will give a bit more support and reassurance to colleagues supporting the clients.

The group suggested we make a video recording of the exercise classes which can give some clients more autonomy.

Explore ways to create LD friendly questionnaires/surveys and incorporate easy read formats to aid with feedback.

Using the Therapy Outcome Measure (TOM) compared to the Bergs outcome measure would have been a better tool to use to assess client outcomes. TOM is easier and quicker to complete and would have enriched the qualitative data with the activity, participation and wellbeing of the clients pre and post sessions.

we care