History to Health

Research into changing health agendas for the UK Medical Collections Group

Alison Bodley
June 2012
Achieving Great Art for Everyone  
Arts Council England, 2010  

“Why is this so important? Because art is intrinsically valuable? Because it is necessary for a successful economy, to our national prestige, to our mental health, to our social cohesion, to our sense of identity, to our happiness and to our well-being? All of the above – as we and others have constantly sought to demonstrate as scientifically as it is possible to do.”

Culture, knowledge and understanding: great museums and libraries for everyone  
A companion document to Achieving great art for everyone  
Arts Council Sept 2011  

Goal 2: More people experience and are inspired by museums and libraries  
We will embrace the lifelong learning work that museums and libraries have led the way on, building this into our broader work with the arts. We will champion the importance of creative experiences to people’s wellbeing and development and the role access to knowledge and information plays in supporting and inspiring these.
Executive Summary

The arts community has a strong connection with health and wellbeing, with Arts Council England having been active in this field for many years. Comparatively museums have less experience in this field, but despite this there is still some excellent work taking place, with museums engaging health professionals and providing services that health professionals value. However this work is not yet widespread.

The NHS itself is undergoing huge structural change and is undergoing a period of transition that will be complete by April 2013. Such a time of change makes the health service a challenging sector to work with, but also throws up many opportunities for the museum sector. The UK population is ageing and also becoming less healthy. Health threats are caused by obesity and sedentary lifestyles rather than by disease. Consequently the government is adopting the approach that “prevention is better than cure”. This means greater emphasis on public health, preventive approaches to medicine such as improved screening, and helping older people to live independently in the community for longer. The third sector is being invited to become more involved and help deliver these agendas and services; the NHS is embracing the Big Society.

In effect, a new sector is being opened up to museums. One of the reasons why museums do not have a strong track record for working in this sector is because they haven’t been perceived as being particularly relevant until now, whereas the NHS has been using art therapy in some form since the 1940s. Museums are now, however, very well placed to get involved; partly because the Arts Council has already done significant work positioning art as a contributor to wellbeing. It is a short step from here to justify the role of museums. Museums also have a unique selling point that is often taken for granted from within the sector and that is the role of collections, for example their use in reminiscence therapy. Few other sectors are so experienced and well placed to develop this activity.

Despite widespread public sector cuts there are also new funding streams available to enable third sector organisations to work with local authorities to help increase provision. Exciting as this is, it is also unfortunate as this funding has been available for a couple of years and some funding streams are now in their last phase. Museums are arriving late.

Potential initial growth areas for museums are reminiscence, ‘museums on prescription’ initiatives and also services for mental health. There are many others, but these are the ones where there is most expertise either within the arts or museum sectors. The UKMCG has a role in helping to facilitate some of this activity, enabling discussion, establishing key contacts at a national level, co-ordinating cross-organisational funding bids and raising the profile of museums to the health sector. All of this should be done while taking a robust approach to evaluation, to measure true impact, stimulate improvement and further demonstrate the role museums can have in healthcare.
1. Introduction

The UK Medical Collections Group (UKMCG) was established in 2005 and is open to any institution, organisation or individual with an interest in medical and healthcare related collections. Its aim is to demonstrate how medical collections can make a difference to the public, to historical researchers and to professionals. Through the network, support is provided for the development of medical and related collections.

In spring 2012 the UKMCG set up the History to Health project to build on previous work which showed how medical museums could successfully engage with diverse audiences and contribute to people’s health and wellbeing. A Consultant, Ali Bodley, was employed to:

- Review and report on changing health agendas
- Plan a conference to present the findings
- Begin work on an evaluation pilot.

The History to Health project has undertaken a major review of health agendas, met with health officers, identified new funding streams and run a successful conference. This report is a summary of findings with recommendations for the future work of the UKMCG network.

1.1 Summary of NHS changes 2012-13

The Coalition Government which came to power in May 2010 had aims to reform the NHS. Key factors identified were an ageing and unhealthy population placing an increasing burden on the state, and a shrinking working population able to support these costs.

One hundred years ago infectious disease was the most significant cause of ill health and death. Today’s illnesses are caused by or aggravated by lifestyle choices such as smoking or obesity. The policy line is that these lifestyle choices should be addressed in order to reduce the burden on the NHS, i.e. prevention is better than cure. The consequence of this is a shift in emphasis to public health and engaging with people in the community in order to greatly reduce lifestyle-linked diseases. To create choice and improve community engagement the government envisages a greater role for third sector organisations as part of the “Big Society” policy.

The emphasis is on patient-focused treatment, with power being devolved down to local level and GPs being involved in commissioning services. Instead of being target-led, the NHS will be led and judged by its ability to achieve outcomes and by the impact it has on individual lives.

The practical implication of this strategy is the complete restructuring of the NHS. Primary Care Trusts and Strategic Health Authorities are being abolished and replaced with a more local structure, with GPs taking a lead on what is needed in the local area. The third sector will have a bigger role in the new system. Local authorities will have a greater role in the domains of public health and social care. The NHS remains as the third healthcare domain.

The changes and health agendas are described in more detail in Appendix 1.

1.2 Arts and Health Agendas

For several hundred years the arts have been viewed as having a role in health. Occupational therapy, which often includes the arts in some form, has been used for over 200 years whilst from the late 1940s the NHS began to employ arts therapists. Over the last six years evidence has been building as to the important role that the arts can play. In 2004 the Arts Council began to pull
together evidence for the link between good health and the arts in *Arts in health: a review of the medical literature* and then in 2005 *Your Health and the Arts: a study of the association of art engagement and health.*

In 2007 the Department of Health published *Report of the Review of Arts and Health Working Group* which “received (responses) from over 300 colleagues in the Health Service, Local Government, the Arts Council, professional bodies and organisations, individual patients and users, artists, charities and the construction industry.” Many of these were examples of how the use of arts could speed recovery and reduce the length of hospital stays. The key findings were:

- Arts and health are, and should be firmly recognised as being, integral to health, healthcare provision and healthcare environments, including supporting staff
- Arts and health initiatives are delivering real and measurable benefits across a wide range of priority areas for health, and can enable the Department and NHS to contribute to key wider Government initiatives
- There is a wealth of good practice and a substantial evidence base
- The Department of Health has an important leadership role to play in creating an environment in which arts and health can prosper by promoting, developing and supporting arts and health
- The Department should make a clear statement on the value of arts and health, build partnerships and publish a Prospectus for arts in health in collaboration with other key contributors.  

This led to a prospectus published jointly in 2007 by the Department of Health and the Arts Council, giving more information on the type of arts projects being undertaken in a health context. In 2007 The Arts Council went on to produce an Arts and Health Framework which had two overarching aims:

- *To integrate the arts into mainstream health strategy and policy making, in order to make the case for a role for the arts in healthcare provision across the whole country and for a wider remit for the arts in terms of healthy living and wellbeing.*
- *To increase, and more effectively deploy, resources for arts and health initiatives, through funding, quality assurance of artists’ work and advocacy.*

The Arts Council describes itself as being “well placed to act as a broker between the arts and the health sectors.”

The Arts Council is funding a range of health related projects.

**National Alliance for Arts Health and Wellbeing**

Since 2010, organisations from across the country have been working together to develop a new national voice for arts and health. Supported by Arts Council England, this work has involved the development of a Charter for arts health and wellbeing, the building of a website and the establishment of a new organisation, the National Alliance for Arts Health and Wellbeing.

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6 *Ibid.*, p. 18
7 [http://www.cultureandwellbeing.org.uk](http://www.cultureandwellbeing.org.uk)
The National Alliance will launch in autumn 2012 and will aim to provide a clear and focused voice to articulate the role creativity can play in health and wellbeing. Over the past forty years, a huge range of arts and health work has developed in the UK, the National Alliance will seek to represent this work, to advocate on its behalf, to encourage the use of the arts by health and social care providers and to raise standards in this sector.

The following two organisations are part of the network of the Alliance and funded by the Arts Council.

**Arts and Health South West**

Arts and Health South West is an information, support and advocacy service that promotes the benefits of creativity in the arts for people’s wellbeing. Their aim is to encourage the development of both the arts and health sector across the south west, providing support through high quality resources, information and practical advice so that practitioners can deliver positive health outcomes through targeted arts and health interventions. Arts & Health South West encourages meaningful and productive partnerships between the health and arts sectors, supporting the development of arts and health professionals and providing a platform for arts and health practitioners to voice strategic concerns. The organisation is heavily involved in strengthening the regional arts and health infrastructure to bring sustainable development of arts and health practice.

**London Arts in Health Forum**

London Arts in Health Forum is a London-based network that develops links between the arts and health sectors. The forum shares expertise and ideas to promote knowledge, encourage the best ways of doing things and inspire innovation. It runs quarterly networking meetings, produces a newsletter, and provides advice and support for arts and health projects. Funding supports core costs. The network has recently been awarded a 2 year grant (09/10,10/11) to support the provision of networking, co-ordination and information services across England for the arts and health sector. In June 2012 the London Arts in Health Forum launched a new initiative, Creativity and Well Being Week, a focused week with organisations across London running related events. The Hunterian Museum and National Portrait Gallery are among the organisations taking part.

**Be Creative Be Well**

In July 2007 the Big Lottery Fund announced that it was giving just under £9.5 million to finance a new four-year health and mental wellbeing programme called Well London. The successful application had come from the Well London Alliance, a group of agencies from different sectors across the capital that shared a vision of ‘a world city of engaged local people and groups with the skills and confidence to improve their own physical health and mental wellbeing’.

The Well London programme included 14 projects. Some focused on support for community engagement and capacity building while others were based around five themes: culture and tradition, healthy eating, mental health and wellbeing, open spaces and physical activity. The culture and tradition theme was delivered through Be Creative Be Well, an ambitious programme developed by Arts Council England. However, creativity in the Well London programme was not confined to Be Creative Be Well – creative approaches were embedded throughout. In 2010, Arts Council England commissioned an independent team to carry out an evaluation of Be Creative Be Well.

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10 [http://www.creativityandwellbeing.org.uk/](http://www.creativityandwellbeing.org.uk/)
**Arts on Prescription**

The concept of arts on prescription was established in the mid 1990s with Stockport Metropolitan Borough Council introducing a scheme in 1995. Now it is a growing trend and programmes across the country offer a series of workshops to support clients suffering from anxiety and mental health problems. Dulwich Picture Gallery introduced such a scheme, “Prescription for Art”, following the success of the Good Times Project which focused on older people. Practice nurses with responsibility for older people identify those who are suffering bereavement and other issues and offer them a “Prescription for Art: the opportunity to attend creative workshops at the Gallery”. The programme has been highly successful and has expanded as a separate programme to the Good Times Project.

Many libraries are also engaged in this approach with GPs giving prescriptions to libraries for self-help books that will benefit patients. More is yet to come as the Arts Council is set to fund a national Books on Prescription Scheme along with several other health focused projects. Only a few museums are working in this area including Glasgow, where Mark O’Neill has proposed a “referral scheme”, Tyne and Wear Archives and Museums and Bolton Museum. The question is why aren’t museums doing more in this area? It offers huge potential to museums to connect with local health services and demonstrate impact. If GPs are going to be involved in the commissioning of services, then we should surely make them aware of what museums can offer.

**1.3 Museums and Health Agendas**

The MLA Council supported the museum profession for many years, but there appears to have been less specific focus on the role of museums in health settings than there was in the arts sector. This is, however, difficult to review following the integration of the MLA Council with the Arts Council. A recent report by the Arts Council, *A review of research and literature on museums and libraries*, does state that in the context of library evaluation “This is a gap that the MLA began to fill, publishing research on the range of health and wellbeing services, and digital participation activities, that libraries are engaged in”. It seems likely that this was a similar situation for museums and that with regard to health and wellbeing the evidence collecting process does not appear to have taken place for museums in the same way as in the arts sector.

**Public Health**

Public health is potentially a very easy way for museums to engage with health agendas, but few museums seem to be taking this approach, or if they do work in this area it is not necessarily being conducted under a public health banner. A good example of a successful project is *You Are What You Ate*, a project run by the University of Leeds with a consortium of partner agencies in West Yorkshire, funded by a Wellcome Trust Society Award. The website states:

*You Are What You Ate is an innovative new project run by historians, scientists, historical re-enactors and archaeologists. We want to bring up-to-date research on food science, nutrition, medical history and archaeology to a wider audience. Our aim is to encourage public debate and personal reflection on modern eating habits through exploration of the dietary choices of the past.*

*Over the next three years, look out for us at festivals and street markets, schools, museums and castles in the area of West Yorkshire. We are working in close association with Wakefield Council to*

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13 P 44/5
14 [http://www.leeds.ac.uk/yawya/](http://www.leeds.ac.uk/yawya/)
provide a wide range of activities such as schools and youth activities, exhibitions, talks, festival attendance, adult workshops and bone workshops.

The University of Leeds, University of Bradford and Wakefield Council are all involved, bringing together historical expertise whilst the Director of Public Health in Wakefield also supports the project, linking the project with modern health agendas. There is a schools programme and children are asked to walk to school in medieval costume, thereby getting some exercise, whilst there are also adult workshops and other events. During 2012 the consortium ran a *Dark Side of Eating* exhibition at the Pontefract Museum.

“*How horrible was history really? Find out more about the grim history of eating in Yorkshire from the Middle Ages to today. Compare medieval and modern ideas about famine, drink and obesity and see for yourself the effects of diet on the human skeleton.*”

The approach of this project does get people looking at the issues and perhaps in a more engaging way than *Change4Life*, but it can still link to this programme if required.

Another example is the interesting work currently taking place in Worcestershire at the Infirmary and George Marshall Medical Museum, working with young people to explore the history of sexually transmitted infections through medical collections and art. Work is still on-going on this project but it could produce some interesting results.

### 1.4 Museums and Social Care

#### Mental Health

Several museums are engaging in work around Mental Health. In 2008 the think tank Culture Unlimited published *Museums of the Mind* which looked at how museums could address issues in mental health.\(^\text{16}\)

**Open to All**

A major project which has taken place was the *Open to All* project, a mental health training programme for museum and gallery staff created by the National Social Inclusion Programme, MLA, Tate Modern, V&A, Wallace Collection and Nottingham University in 2008. The National Social Inclusion Programme was initially an arts organisation and widened its approach in order to work with the key partners. It appears that this work may have been prompted by the 2007 Department of Health report. Training can for museum staff can still be bought in from Open to All.\(^\text{17}\)

Some of the former Renaissance in the Regions partner museums have run their own health focused projects.

**Museum of the Mind**

Renaissance East Midlands funded the *Museum of the Mind* project, with 5 museums working in Mental Health. They used the *Open to All* training:

- Bassettlaw Museum worked with MIND interpreting objects and history
- Chesterfield Museum created loan boxes for people living with dementia
- Mansfield Museum worked with MIND to curate an exhibition

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\(^{15}\) [http://www.leeds.ac.uk/yawya/events/03-03-2012.html](http://www.leeds.ac.uk/yawya/events/03-03-2012.html)


\(^{17}\) [http://www.opentoalltraining.co.uk/index.html](http://www.opentoalltraining.co.uk/index.html)
• Wirksworth Heritage Centre worked with polarised groups of older people
• Nottingham City Museums and Galleries developed loan boxes with an Alzheimer ward

**Who Cares?**

In 2009-11 Renaissance North West developed the *Who Cares?* action research and evaluation project. Six Museums worked in partnership with the NHS or third sector organisations. Projects mainly focused on mental health, reminiscence and disability, but within this took diverse approaches using museum collections along with music, poetry, creative writing, arts and craft, and the use of creative practitioners. For the museum staff there were challenges around working with new partners and challenging audiences, whilst medical staff often had different approaches.

The following museums were involved in *Who Cares?:*

<table>
<thead>
<tr>
<th>Museum</th>
<th>Working with</th>
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<tbody>
<tr>
<td><strong>Tullie House Museum and Art Gallery, Carlisle</strong></td>
<td>Carers and care homes for older people – Bathing Beauty Reminiscence Project and related projects</td>
</tr>
<tr>
<td><strong>The Harris Museum and Art Gallery, Preston:</strong></td>
<td>The Observatory (Asian women with mental health issues); Foundations (formerly homeless adults); Disability Equality Group project (physically and/or mentally disabled adults). Mouthpiece and Foundations Projects, Disability North West</td>
</tr>
<tr>
<td><strong>Bolton Museum and Library Service</strong></td>
<td>Active Health – Bolton Council (adults with mild to moderate mental health issues including anxiety and depression) Therapeutic Arts Project</td>
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<tr>
<td><strong>Manchester Museum</strong></td>
<td>Local community and job centres (adults with physical and mental health issues) Start in Manchester (adults with severe and enduring mental health issues) museum objects and intimate attachments – Health Rocks, Creative Culture Course</td>
</tr>
<tr>
<td><strong>Whitworth Art Gallery</strong></td>
<td>Manchester Hospital Schools and Home Teaching Services, (children with physical and mental health issues e.g. eating disorders and self-harm) working with children from the Manchester Schools Hospital Service – creativity and the curriculum</td>
</tr>
<tr>
<td><strong>Manchester Art Gallery Start in Manchester</strong></td>
<td>NHS funded arts and mental health organisation (adults with severe and enduring mental health issues); Wigan CAHMS (young people with mental health issues); Christie Oncology Unit (acutely ill young people and their families). Working with Mental Health Partnerships</td>
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In 2011 this project won the Royal Society for Public Health Art and Health Award. Unfortunately, cuts in public sector funding have brought some of the work in this project to a halt.

The Museum of the Mind

Bethlem Royal Hospital Archives has been developing an HLF project to create a new museum, The Museum of the Mind, and has been undertaking work with key audiences. The consultation methodology depended on the needs of the group. Events included:

- An art class, painting and discussing feelings and anxieties
- A relaxation class leading into a discussion around anxiety and environment
- An object handling session with children in their ward day room, discussing what makes a visit fun and engaging
- A no-holds-barred ideas session with men in a medium secure unit
- Discussion around language use and eating disorders.

Some participants said that they would see the museum as somewhere they can take friends and relatives to explain what they are experiencing. The resulting report has strengthened the position for the Archives and Museum’s development and given increased direction and support to the funding application.

Reminiscence

Museums have engaged with reminiscence for many years and this is one of the main ways that museums engage with health agendas, albeit perhaps unknowingly. The “normality” of this activity means that the museum sector may fail to realise that this is a unique selling point and an easy way to engage with the emerging health care sector. A short search of the internet revealed 15 reminiscence services and there are probably many more.

A good example is the memory box service run by Kirklees Museums which has created a range of resource boxes, securing £10,000 of funding from the local Primary Care Trust. The Reminiscence Loan service has been running successfully for several years serving local residential and nursing homes and day care centres which borrow themed Memory Boxes and Local History Photo Packs for up to a month at a time. Each of the boxes contains about 20 multi-sensory artefacts alongside an information pack containing suggested trigger questions and activities. Such is the success of the project that the boxes are constantly fully booked and the museum service is now working with various partners to develop dementia friendly resources at its sites.

Sounding Out Your Heritage

The Group for Education in Museums (GEM) has also been engaged in this area and in 2010 developed the Sounding Out Your Heritage project. Part of the legacy of this project has been the creation of a Toolkit on the GEM website19 with case studies, guidance and resources such as on how to create a memory box. The project was funded during 2009-10 through the Department for Business, Innovation and Skills’ Transformation Fund.

House of Memories

The House of Memories is an innovative project developed by National Museums Liverpool that not only works with older people but also trains health care workers to use museum objects20. The training:

- Introduces basic knowledge about the various forms of dementia
- Represents the challenge families face for people with early stage and progressive dementia
- Introduces memory activity resources linked to the museum experience, which can also be used within care settings.

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19 http://www.gem.org.uk/soyh/soyh_menu.php
20 http://www.liverpoolmuseums.org.uk/learning/community/house-of-memories/
To extend the learning beyond the initial training experience, participants are also equipped with resources to take back into their settings. These include:

- A Memory Box - facilitated museum outreach programme to settings
- A Suitcase of Memories – access to the museum’s object loan programme
- A Memory Toolkit – a ‘how to’ guide for developing memory activities in residential settings.

Over 1000 care workers have now been trained. This project shows an intelligent approach to engaging with the healthcare community and ensuring that healthcare professionals are aware of what museums can offer. It has potential for further development.

1.5 Museums and the NHS

Heritage in Hospitals

Heritage in Hospitals is run by University College London’s Museums & Public Engagement department and is one of the few museum projects to go directly into a hospital setting. It is a unique project funded by the Arts and Humanities Research Council and explores the potential of museum object handling as an enrichment activity for patients. Six objects were taken into acute, chronic and psychiatric wards, neurological rehabilitation units and residential care homes in facilitated one-to-one or group discussions lasting 30-40 minutes. The project was carefully evaluated and showed that, on average, participants’ mood improved by about 20%. A control group used pictures of objects instead of objects and this did not have the same effect. There is the potential for wider use of this type of work in museums.

1.6 Other approaches to health and wellbeing

The Happy Museum

The Happy Museum project was launched in 2010 and the paper *The Happy Museum – a Tale of How it Turned Out Alright* was published in 2011. The Happy Museum is relevant to health agendas in museums as it was inspired by *The Five Ways to Wellbeing* developed by the New Economics Foundation. NEF was asked to collaborate on the Happy Museum paper, which is “intended as a provocation to museums to think about how they might become high-wellbeing organisations.” Sustainability is also a driving component of the work, in common with the approach offered by NEF.

Instead of *The Five Ways of Wellbeing* a “manifesto for wellbeing” is offered:

1. Make People Happy – including using *The Five Ways to Wellbeing*
2. Pursue Mutual Relationships
3. Value the Environment, the past, the present and the future
4. Measure What Matters
5. Lead on innovation towards Transition
6. Think Global and be Networked
7. Support Learning for Resilience
8. Find Your Niche

The project is funded by the Paul Hamlyn Foundation’s Breakthrough Fund and seeks to create a community of practice in UK museums committed to supporting transition to a high well-being, sustainable society. So far it has commissioned 12 related projects in museums around the country.

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22 For explanation of *The Five Ways of Wellbeing* see p 48 of this report
23 [http://www.happymuseumproject.org/about-us](http://www.happymuseumproject.org/about-us)
All projects link with the community in some way and specific areas include mental health, play, community curators, developing a community hub, and sustainability.

On the project website Tony Butler, Director of The Museum of East Anglian Life and Director of the Happy Museum says:

“We now have the ingredients for putting the Happy Museum into practice. We recognise many museums already appreciate their position in their community and many combine this with scholarship, stewardship, learning and a desire for greater participation. What the Happy Museum Project is trying to do is to show that the context is now different. Environmental change, pressures on the planet’s finite resources and awareness that a good, happy society need not set economic growth as it most meaningful measure offers a chance to re-imagine the purpose of the museums. Museums should realise their role as connector, viewing people not as audiences but as collaborators, not as beneficiaries but citizens and stewards who nurture and pass on knowledge to their friends and neighbours.”

The Happy Museum Project offers a new mind-set and is taking a brave step to re-invent the museum. Becoming a social enterprise may be the way forward for some museums but critics may argue that what Butler is proposing encompasses much of what the museum community is already doing and it’s just that museums have so far not presented this in such a holistic way. Many services and museums are being re-shaped anyway by the need to engage with the concept of the “Big Society” or to embrace the emphasis from the Arts Council and this Government on “resilience”. Perhaps it is the difference between trying to lead and being led, but it is left to museums to decide if they need to re-brand themselves under the notion of the Happy Museum or develop their own approach according to their own circumstances. The Happy Museum project may have invented a new future for museum culture or as political contexts change, it may just be seen as a product of its time. Whichever, it does provide a context to talk about the role of museums in a positive way, and claim a valued role in society, which is perhaps something a sector reeling from financial cuts is in need of.

1.7 Museums and health agendas – summary

All museums can potentially be seen as a tool for wellbeing and perhaps the Happy Museum commissioned projects help to make that point: not all the projects are specifically health based but they all contribute to wellbeing. Because museums do this so well, they are integral to the concept of wellbeing and a project which has no intentional connections to medicine or health care may still be contributing to people’s “wellbeing” as sought after by the medical profession. Consequently it makes it hard to categorise this kind of project as addressing “health agendas”, when in fact they are.

Museums can be wonderful versatile organisations and in recent years museums have been chasing a range of policies such as social cohesion, delivering the curriculum, working with specific audiences, youth engagement, tackling racism and so many more issues. Museum professionals pursue these agendas as they have a deep enthusiasm for what museums can do. At last it is acceptable to say that “museums are just good for you”. It’s an opportunity the sector should grab with both hands.

24 http://www.happymuseumproject.org/commissioned-projects/commissions
2. Opportunities for Museums

In terms of policy there is huge potential for museums to get involved in agendas relating to health care, public health and well-being. The Government is actively encouraging more engagement between healthcare and the third sector, whilst work done through the Arts Council has already demonstrated that the arts have a role in healthcare. Health professionals met during this project have also shown much enthusiasm for the role that museums can play; this has not always been the case for museums when trying to engage with new sectors. So it could be said that museums are knocking at an open door. The problem is that while some museum professionals are aware of this the majority are not. In terms of relating museums to policy, some areas are easier to engage with than others and museums will have to decide what works for them.

2.1 Making Policy Practical

These are suggestions but innovative and creative museum professionals will probably develop many more. As one of the roles of museums is to inform, virtually any topic/domain indicator from the new government could be used as a focus for an event or exhibition.

More ideas can be found in the suggestions from delegates at the Becoming a Healthy Museum Conference in Appendix 1.

Public Health

In general museums need to link more to public health issues. Often museums are already working in this area and a slight “tweak” could create direct links to health agendas.

- Sign up with the Public Health Responsibility Deal\textsuperscript{25} - it’s not particularly aimed at museums, being a vehicle for large supermarkets to improve food etc., but there is no reason why museums can’t get involved.
- Be aware of how the Change4Life programme and other public health issues could link to collections and activities. The programme is blatantly about living a healthy life but museums could generate debate and discussion by taking a more subtle approach:
  - Museums could develop a trail between museum buildings/ across a village or key locations to fit in with Walk4Life in autumn 2012.
  - Build activity into programmes and make events active, rather than allowing them to be sedentary
  - Incentives for people arriving by foot rather than car
  - Ensure that café/restaurant food is healthy
  - Provide pedometers so people can count their steps around the museum
  - Work with groups with mobility issues where exercise and stimulation around a museum could help recovery
  - Make more use of land/park/gardens around the museum building
  - Be aware of the role of museum as a potential safe space with vulnerable groups
  - Create a community around museums and use venues to host slimming clubs, sports clubs, clubs for older people, blood pressure testing, giving blood etc
  - Exploring dance through time could not only provide exercise but engage older or isolated people. It may attract younger audiences.
  - Costume collections can be used to compare the average size of people in history to people now – explore the reasons why discussing nutrition

\textsuperscript{25} http://responsibilitydeal.dh.gov.uk/
Explore changes in diet over time – archaeological collections, social history domestic objects, recipe books and cookery demonstrations etc.

Explore how occupations have changed over time and become more sedentary. This could link in to programmes to get the workforce healthy

Explore play and games past and present

Transport collections can explore the impact different forms of transport have had on health.

- Review existing programmes in the light of wellbeing agendas. Can some of what museums are already doing such as working with volunteers, engaging and collaborating with the local community be refocused as wellbeing or do they have to create a new programme?

- Be aware of the other NHS public health campaigns and how museums might be able to link to them

- Use the history of food to tackle work around dental health e.g. what impact did the introduction of sugar have, oral health without modern day dentists etc.

- In 1974 Public Health was removed from the control of the Local Authority and it is now being returned. Look at how things have changed since then – suggestion from a Director of Public Health.

**Social Care**

- Museums are in a unique position to deliver projects around reminiscence and there is existing expertise in the sector to make this happen. This could be loan boxes, sessions in the museum, or outreach into homes. Contact your local Memory Clinic.

- Provide activities that older people will enjoy – museums may have to develop specialised marketing with healthcare professionals to reach and encourage isolated people

- Get involved in *Time to Change* and devise exhibitions and events that tackle the stigma around mental health

- Work with health professionals to devise activities to help people with mental health issues

- Link dementia and community memory

- Explore new areas such as palliative care where oral history could provide a therapeutic Process,

**NHS**

- Follow UCL’s best practice and take objects into hospitals and other healthcare settings for therapeutic purposes.

- Develop projects around recovery or specific disease

- Military museums have potential to work with people injured working for the armed Services.

**2.2 Creating Sustainability and Resilience**

A key ingredient for museums to create resilience and sustainability is to develop partnerships and long term relationships with the healthcare professionals in their area. In this way projects:

- Fit with local need

- May be able to attract local seed funding as demonstrated by Kirklees Museums

- Have an improved chance of being able to become a commissioned service.

Making contact may be challenging especially as health care services are in a huge state of flux. This report may give the impression that everything fits neatly in to the three headings of Public Health, Social Care and the NHS. This maybe a convenient way for the Government to describe policy, but...
delivery on the ground is more complex and likely to become more so with the government emphasis on localism and devising services that best support the users. A particular type of service, say for mental health, may well be delivered through a local authority in one area but through a hospital in another, so it is difficult to develop guidance on how to contact people.

During this research, advice was sought from Dr Andrew Furber, Director of Public Health at Wakefield Council. He suggested that museums should directly contact the Director of Public Health in their area. Eventually all directors will be located in their local authority and this should make an easy access route for local authority museums. Some are still located in the NHS and until 2013 they can be contacted through the local Primary Care Trust. Some NHS Trusts have posts that are particularly based around partnerships and making links with the communities and these are the type of posts to try and locate. In time, working with your local Health and Wellbeing Board may well become an important way of engaging with the local health community. These, however, are still being set up and meetings aren’t open to the public as yet.

It is also important to build contacts with local third sector organisations such as Help the Aged, the Alzheimer’s Society, or any specifically health-related charity. As well as being sources of specialist knowledge and contacts, these organisations are already answering the Government’s call to get more involved in offering health services. They may already be linked in or looking for partners to take a more integrated or innovative approach.

Commissioning is a route which is often cited as an opportunity for museums. There is potential but it is a challenging area for museums to undertake and more support would be required as noted by the Arts Council in A Review Of Research And Literature On Museums And Libraries:

\[\text{It has also been suggested that museums and libraries could build stronger local partnerships by acting as commissioned service providers for local authorities and other local services such as health services, which would require strengthening skills in responding to commissioning systems.}\]

Although the political climate is one of cuts, the Government has developed funding programmes, some through the Department of Health, to encourage the development of the third sector in delivering health agendas. It appears that museums will be late arrivals to these programmes.

\[\text{Excellence and Strategic Development Fund (IESD) Scheme – Strategies in voluntary sector to improve health care.}\]

The final funding round will take place in 2012. Organisations must be voluntary/charities and apply under one of three strands:

- Innovation
- Excellence
- Strategic Development

And under one of the following themes:

- Personalisation and Choice of Care and Support
- Delivering Better Health and Care Outcomes
- Improving Public Health
- Improving Long-Term Care and Support


\[\text{26 P 33}\]

\[\text{27}\]
Previous awards have been between £14,000 -£170,000.

**Health & Social Care Volunteering Fund**

The Health & Social Care Volunteering Fund (HSCVF) has two distinct grant schemes:

- Local grant scheme – for locally constituted Voluntary Sector organisations supporting volunteering. Priority is given to projects focused on local health, public health and social care needs
- National grant scheme – for national organisations / partnerships with national reach.

Successful projects will deliver strategic or developmental volunteering projects in the health, public health and social care sector.

The Local Grant Scheme programme is driven by clear strategic priorities that support the Big Society agenda in the health and adult social care field, as well as key health service priorities. Local volunteering charities, community organizations or social enterprises, co-operatives, mutuals and other not-for profit organizations with social aims will be able to make an application and will be asked to apply under one of the following themes:

- Theme 1: Individual Choice and Control: Care and Support
- Theme 2: Delivering Better Health and Care Outcomes
- Theme 3: Improving Public Health
- Theme 4: Improving Health and Social Care
- Theme 5: Building Capable Communities

**Time for Change**

The *Time to Change* grant fund supports projects that change public attitudes by bringing people with and without mental health problems together to drive attitude and behaviour change in their communities.

Grants are being awarded to projects that are led by people with first-hand experience of mental health problems, or those that have a high level of leadership from people with personal experience throughout all aspects of the project. They are looking for projects that engage local communities in meaningful conversations about mental health in diverse, creative and effective ways.

25% of the fund is for projects run by and for people from Black and Minority Ethnic communities, and 20% is for projects that work with young people. In Round 1 of funding grants will be awarded to children and young people’s projects that are based in the West Midlands region only.

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29 [http://www.time-to-change.org.uk/grants](http://www.time-to-change.org.uk/grants)
Round two will open in autumn 2012 and there will be two further rounds in 2013. There are four grant rounds up to 2015 and the fund aims to support 75 organisations with a total of £2.7 million (average of £36k per org).

If museums receive regular funding from these types of funds, it would raise the profile of the sector within health care generally.

**Funding Central**[^30]

This is a government website that draws together funding opportunities for voluntary groups and charities. Healthcare is being pushed into the “Big Society”, so it is worth exploring new “non- traditional museum” funding that enables engagement with the local community.

3. Evaluating Health Projects

The question is what exactly are we trying to evaluate? Impact on patients? Value for money? The role of objects? Or just an all-round indication of success? The Government report *A Vision for Adult Social Care: Capable Communities and Active Citizens* actually encourages voluntary organisations, mutual and social enterprises to get involved and says that these need to be nurtured by local government. But is does state that in order to do this, local government “...will need robust evidence about what local markets offer and how they operate.”

So how can we provide this evidence? At the moment museums are taking several different approaches. In the context of reminiscence GEM suggests using the *Inspiring Learning for All* framework which focuses on learning outcomes. Each project in the *Who Cares?* project developed a self-evaluation process for their project which was co-ordinated by an external evaluator to ensure that there was consistency in the data recovered.

“In data thus came in a wide variety of forms from the relatively superficial recording of perceptions as in self-evaluation questionnaires, to film, semi-structured and narrative style interviews and in-depth observation of group process by a trained observer. Creative outputs including visual displays and poetry were understood to “contain” the experience of their production, and were thus also regarded as a source of understanding.”

*Inspiring Learning for All,* developed by MLA, has been the accepted evaluation model for museum learning and work continued on this approach to develop Generic Social Outcomes (GSOs). This includes a section on Health and Wellbeing and so in theory is perfect for museums working in this area. The problem is that GSOs are linked heavily to the previous Government’s Local Authority Area Indicators, which have been abolished. In theory perhaps the GSOs could be mapped across to new government initiatives, but there seems little point when it is simpler to refer directly to current policy. Museum professionals, however, may still find some of the resources useful. ILFA offers a non-politically linked approach. There are some limitations within the context of assessing health projects, however, as this is a framework for learning and not for measuring healing, although it could be argued that well-being could be focused on if required.

The Arts Council has been critical of the quality of evaluation that has taken place in recent years in the report *A Review Of Research And Literature On Museums And Libraries* which was published in September 2011. One of the issues appears to be that museums have carried out evaluation in order to justify themselves to funders and the priorities of local government rather than wider values.

*It has been argued that the sectors are not in a position to make best use of any of these approaches, due to a lack of robust data based on common indicators. It is recommended that therefore the first step must be for central government funders to provide guidance on standard terminology and data collection methods. In addition, it is recommended that funders work to build understanding among stakeholders of the contingent valuation and social return on investment methods (Jura Consultants, 2008).*

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31 P 8
34 P 43
The report goes on to recommend areas for further work:

- Develop a small set of key indicators to support the museums sector to consistently report on its activities
- Create more detailed segmentations of museum and library visitors and non-visitor
- Consolidate the developing body of knowledge on community engagement and consider how it can be further grown
- Continue to track new approaches to building sustainability, both in terms of business models and finances and in environmental activities
- Build on the MLA work on measuring the impact and value of the sectors, including by developing shared terminology and data collection methods.\(^{35}\)

The Museums Association, however, is also critical of how museums evaluate and in June 2012 announced a new project, Evaluating Evaluation, funded by Heritage Lottery Fund and the Wellcome Trust. It is unclear if this project is being launched as a response to A Review Of Research And Literature On Museums And Libraries or has some other inspiration.

The Happy Museum tells us to move away from the numbers based approach which was encouraged by the previous Government.

“Counting visitors tells us nothing about the quality of their experience or the contribution to their well-being. Listen to the debate about measuring happiness: watch the Office of National Statistics and their research into a happiness index; hear what think tanks and academics have to say about the subject; ask your audience how your work affects them emotionally; don’t wait for someone else to design the perfect metrics – talk to people, understand what makes them feel happier, measure that.”\(^{36}\)

The announcement of measuring “happiness” received a mixed reception when announced by the Prime Minister in 2011. To get this information, four new questions have been inserted into the ONS Survey, the Social Survey produced by the National Office of Statistics.

- Overall, how satisfied are you with your life nowadays? (Evaluative approach)
- Overall, to what extent do you feel the things you do in your life are worthwhile? (Eudemonic approach)
- Overall, how happy did you feel yesterday? (Experience approach)
- Overall, how anxious did you feel yesterday? (Experience approach)
- Respondents are asked to provide an answer from 0 (‘not at all’) to 10 (‘completely’).\(^{37}\)

This idea is taking root on an international basis. For instance the Organisation for Economic Co-operation and Development (OECD) Better Life Index\(^{38}\) shows that people are happier in the UK than people in France, but not as happy as people living in Australia. Part of the problem with happiness is that it hasn’t really been focused on like this in politics before. It is based on qualitative research and how people feel. This makes it difficult to link to quantitative financial outcomes, which most people feel are concrete and understandable. Consequently it can come across as a “fuzzy” concept. That doesn’t mean it’s not a valid approach, just that evaluation and description of results need careful handling in order to get the credence it deserves. A recent Arts Council Report, Measuring The Economic Benefits Of Arts And Culture, looks at how to evaluate arts on an economic basis. One of the techniques it advocates is the established technique of Social Return on Investment (SROI). It

35 P 47
38 http://www.oecdbetterlifeindex.org/#/1111111111
gives the example of Tyne and Wear Museums evaluating *Culture Track* which aimed to work with volunteers to develop employable skills and move on to find work. The evaluation which used SROI explored the following areas:

- reduction in welfare payments because of employment
- increase in tax receipts from employment
- reduction in welfare payments because of increased qualifications
- increase in tax receipts from increased qualifications

It demonstrated how the programme saved the government money in the long run. This really is the crux of all the government policies around health agendas. Prevention is better than cure; if we can keep people healthy then money can be saved. If museums can demonstrate that they contribute to this then that can only be good.

In terms of general evaluation of policies the Treasury has produced the Magenta and Green books which give policy makers on how to evaluate. These publications have been produced to help to assess the impact of national policies and so could be considered an excessive approach to take in smaller museum projects. The general approach however, needs to be understood, but it would be more meaningful to take a lead from the Arts Council.

The Arts Council has been successful in getting the role of arts acknowledged as relevant to improving health, so it is important to look at how they achieved this. In the Department of Health’s *Report of the Review of Arts and Health Working Group* responses were received “from over 300 colleagues in the Health Service, Local Government, the Arts Council, professional bodies and organisations, individual patients and users, artists, charities and the construction industry.” These publications have been produced to help to assess the impact of national policies and so could be considered an excessive approach to take in smaller museum projects. The general approach however, needs to be understood, but it would be more meaningful to take a lead from the Arts Council.

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A different approach should be expected when working with a new sector. Understanding these differences and what it entails is a huge opportunity for museums. It should also be asked if museums can make an evaluation assessment alone when attempting to address health issues; museum professionals are simply not trained to recognise if a patient has had a healing or therapeutic experience. So in order to truly evaluate and validate the work of museums in health care there must be some kind of collaboration with health professionals. The opportunity to do this is complicated by the fact that the health care sector is in a period of transition which will not be complete till March 2013 whilst the full range of indicators in the government’s own frameworks are still not complete. The coalition government also takes the approach that they are creating a framework, but within that individuals have and organisations have choice as to how the outcomes are achieved.

The cross-governmental mental health outcomes strategy *No Health Without Mental Health* has a section headed “Other potential indicators”.

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39 P 27
40 [http://www.hm-treasury.gov.uk/data_magentabook_index.htm](http://www.hm-treasury.gov.uk/data_magentabook_index.htm)
41 P 1
“There are a number of indicators that can be used to measure progress against local strategic needs assessments. One well-evidenced example for measuring adult mental wellbeing is the Warwick-Edinburgh Mental Wellbeing scale. Psychological therapies services already regularly measure outcomes of interventions and access to services by different groups. In addition, the implementation of Payment by Results will ensure that services use health of the nation outcome scales (honos) regularly to measure outcomes in secondary adult mental health services. Other key national indicators of relevance to the mental health objectives include the following:

- The office for national statistics is consulting on national measures of wellbeing.
- Disaggregation of the data to local area detail will be useful for local planning.
- The adult and child Psychiatric Morbidity surveys can be used to estimate the rates of mental health problems such as anxiety and depression and conduct disorder, and also to monitor changes over time.
- The 12-item General health questionnaire (Ghq-12) is also collected by the health survey of England.
- The labour force survey collects the sickness absence that is attributable to mental ill health.
- The new life opportunities survey may potentially provide information on a range of outcomes, including: barriers to employment, accessing health services, and participation in leisure and social activities”.

Showing the impact of your project in the figures of the Office for National Statistics is a challenge, as with the labour force survey. But other approaches may be more manageable and also be met with understanding from the medical community. Indeed the Warwick-Edinburgh Mental Wellbeing (WEMB) scale was used by the Who Cares? project. This scale asks participants to rate how they have been feeling in the last two weeks to set statements such as “I have been dealing with problems well”, “I have been feeling good about myself” and so on. UCL used generic Quality of Life scales, asking patients to rate how satisfied they are with their life and also to assess their health status along with Positive Affect Negative Affect Scale (PANAS), which uses words to assess mood. Both of WEMB and PANAS are recognised tools for assessing mood and wellbeing. The approach which the government is taking in its assessment of “happiness” is not so far from these scales.

The next stage on from acceptance with individual health professionals or service is getting acknowledgement on a national basis. This may sound ambitious, but there is a simple way of doing this, as pointed out by Dr Andrew Furber, Director of Public Health in Wakefield. The National Institute for Health and Clinical Excellence has an on-going programme of consultations following which it creates guidance for the health sector. The consultations are displayed on their website and it may be possible to for museums to register as a stakeholder and submit evidence on the roles museums can play. For instance at the time of writing there is a consultation open on Social and emotional wellbeing - early years. Many museums do excellent work in this area and would consider it to be something they could provide evidence on. Obviously projects which have been done in partnership with health professionals are likely to have more credence in this context. So evaluating the impact of health projects is rather more complicated than may have first been assumed. For many museums this represents a new area and sector to work with, the NHS is in a stage of transition, whilst the Museums Association is reviewing how museums evaluate projects in general. Problems around the GSOs shows the problem of linking too closely to government agendas, whilst the Arts Council wants to encourage improved standardisation of terms and data collection techniques, including the use of SROI. Wellbeing projects such as the Happy Museum

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45 [http://www.nice.org.uk/getinvolved/currentniceconsultations/current_nice_consultations.jsp](http://www.nice.org.uk/getinvolved/currentniceconsultations/current_nice_consultations.jsp)
Project are looking to the Government measurement of happiness. Any organisation receiving funding will also be under pressure to provide evaluation for funders. There is a lot happening, and any work done by the UKMCG will potentially be highly significant, due to the lack of previous work in this area at a national level. In terms of creating a robust evaluation framework that is relevant and useful for museums working on health care projects the following will have to be taken into account:

- The Arts Council approach to museum evaluation and how this will develop especially in the context of the development of ILFA, standardisation of terms and other recognised techniques such as SROI
- Work undertaken by the Museums Association
- Measures of healing and wellbeing as used in a medical context by healthcare professionals.

Such a framework will have to be robust and consistent with the rest of the arts sector, while also including the type of assessment that is meaningful to healthcare specialists. It should also be politically resilient, able to produce meaningful information despite changing political agendas and use elements of pre and post evaluation. The UKMCG should liaise with these organisations to establish the best approach. It would be important to pilot future UKMCG work within this context and indeed such projects in the long term may be of use also to more general museum project evaluation. A starting point would be to undertake discussions with the Arts Council and explore further the potential role of existing frameworks and techniques such as ILFA, SROI, WEMB or PANAS. Evaluation pilots could be devised which focus on one or a combination of these techniques, depending what is appropriate, taking into account the changing evaluation context.
4. Conclusions

The NHS is undergoing a huge period of change as it moves towards a preventative approach and working in the Big Society. This provides much opportunity for museums and finally it is enough to claim that “museums are good for you”.

Museums are creating good practice, but there is much more potential for this to happen. For many museums working with healthcare will mean working with a new sector, but there does appear to be funding available to help make this happen. There is also potential towards a cultural shift within the sector to develop resilience and sustainability by being regularly commissioned to provide services by the health care sector. To achieve this, the museum sector will need support from the Arts Council to develop the skills required for this process.

Other challenges include the confusion thrown up by the NHS being in a period of transition which hinders the opportunity to make key contacts or select new organisations to try and work with. This will become clear as the new structure takes effect from March 2013, but it is likely that museums will still need some guidance to navigate the new system.

Key issues are developing robust evaluation models demonstrating the role that museums can play, getting the message out to the health community and providing simple access routes in to the museum sector. The potential is huge and the UK Medical Collections Group can help to make it happen.
5. Recommendations

5.1 General recommendation for all museums

Museums should embrace the concept that “Museums are good for you” and re-assess existing work within the context of “wellbeing”.

5.2 Recommendations for the UK Medical Collections Group

UKMCG has the opportunity to lead on developing excellence and innovation in collaborative work between museums and the health sector. The UKMCG can inspire other museums, develop leadership, develop the workforce and forge new routes to sustainability, resilience and innovation.

1. UKMCG should write a strategy on the network’s role in developing excellence in this area, building on the opportunities created for the network by changing health agendas and the existing and potential role for museums.

2. Through Arts Council England, UKMCG should establish connections with the existing healthcare work taking place in the arts sector and establish the role for museums alongside this. Consultation should take place with the National Alliance for Arts Health and Wellbeing and it should be considered whether museums can have a role within this structure, or if the UKMCG should initiate a similar approach with museums.

3. UKMCG should disseminate information to museums on healthcare policies, how to work with healthcare professionals and examples of good practice. It should support and encourage museums that are breaking new ground. This could be through an annual conference and other specific training events and reports etc. If development is successful then further consideration should be given to the UKMCG’s role as an “information hub” and the development of a website that guides museums and also guides health professionals on how to work with museums. Consideration should also be given as to the potential role of the Collections Trust in this.

4. Through a co-ordinated approach, UKMCG should optimise the use of existing knowledge and expertise by acting as a facilitator to bring together museums developing expertise in specific areas. The most developed subject areas appear to be reminiscence therapy and, to a lesser extent, mental health. There is much experience and expertise in reminiscence therapy within museums, but organisations seem to work alone. The UKMCG should enable these organisations to come together, discuss best practice, how the museum workforce can be developed and how this can then be promoted to the health profession. The perception of reminiscence within the museum profession needs to change so that it is no longer taken for granted as a low profile museum function, but is instead seen as a valued service for health professionals and of public benefit.

5. Stimulate new practice and pilot robust evaluation models with a series of projects leading on a range of specific areas across Public Health, Social Care and the NHS. Contact should be made with both the Arts Council and the Museums Association to ensure that models comply with current evaluation thinking. The pilots should also consult with health professionals working in the relevant subject specialisms. Consideration should be given as to how museum work can be submitted to NICE consultations.

6. Learn from other sectors. Both the arts sector and libraries are working extensively on Arts/Books on prescription. UKMCG museums should learn from this and those already doing...
this in the museum sector and encourage and promote a model for use in the museum context, presenting it effectively to the health community.

7. Develop working relationships with key health professionals and organisations:
   - Build on the work of the ‘History to Health’ conference and invite the healthcare speakers to meet with representatives of the UKMCG to talk about the potential for museums working in healthcare in general. Consideration should be given to developing an advisory board of key health professionals to help guide future work or developing some kind of on-going interaction with UKMCG Steering Group.
   - Consider establishing links at a national level with Public Health England and Healthwatch England. This will only be possible once structures are in place and relevance of such links can be properly assessed.

8. Help museums move towards resilience and sustainability:
   - Develop models that are cost effective to deliver and easy to embed within on-going programmes.
   - The network should also work with the Arts Council to deliver training on the commissioning process so that museums can move towards delivering health services for local authorities.
   - Submit joint funding applications to the Arts Council and the Excellence and Strategic Development Fund (IESD) Scheme.
   - Investigate the potential fit with new funding strategies for the history of medicine with the Wellcome Trust and any other appropriate funding pots for collaborative work.

Alison Bodley
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Jo Bartholomew from the Thackray Museum who managed this project.
7. Sources

In general terms for health care:

- All research, policy, and development plans can be found on the Department for Health website: [http://www.dh.gov.uk](http://www.dh.gov.uk)
- Delivery of policy through public programmes can be found at the NHS Choices Website: [http://www.nhs.uk/Pages/HomePage.aspx](http://www.nhs.uk/Pages/HomePage.aspx)

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7.2 Public health information websites

Health and Wellbeing boards http://healthandcare.dh.gov.uk/hwb-guide/

Change 4 Life http://www.nhs.uk/Change4Life/Pages/change-for-life.aspx

Healthy Schools Programme
http://education.gov.uk/schools/pupilsupport/pastoralcare/a0075278/healthy-schools

Public Health Campaigns
• Smoke-free http://smokefree.nhs.uk/resources/ aimed at smoking cessation
• ACT FAST stroke campaign http://campaigns.dh.gov.uk/category/act-fast/
• Be Clear on Cancer – focusing on symptoms of bowel cancer
  http://campaigns.dh.gov.uk/category/beclearoncancer/. This campaign is likely to move on to other cancer areas
• Dementia – to help people recognise the first signs of Dementia
  http://campaigns.dh.gov.uk/category/dementia/
• Talk to Frank – drugs advice http://www.talktofrank.com/

NHS 111 – for services when problems are urgent but not life threatening – currently being trialled:

Public Health Fact Sheets Dec 2011 Department of Health
http://healthandcare.dh.gov.uk/public-health-system/

Young people’s marketing Strategy http://campaigns.dh.gov.uk/2012/02/13/youthstrategy/ A set of criteria for developing a young people friendly health service has already been published:
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UK Journal of Public Mental Health, vol 9 issue 4


Culture Unlimited

### 7.8 Evaluation


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Appendix 1: Background to NHS changes

1.1 Overview

The Coalition Government came into power in May 2010 with aims to reform the NHS. Faced with an ageing and unhealthy population, there is increasing burden being placed on state, and a shrinking working population with which to support it. Key areas of concern are:

- Rise in obesity leading to other diseases such as heart disease, diabetes and other complications. Two out of three adults are overweight or obese and a worrying number of children are also obese.
- The population is aging. By 2033 almost a quarter of people will be over 65 and by 2024 half the population will be over 50. Currently on average men live to 78 and women to 82 but by 2020 it will be 81 for men and 85 for women.
- 1 in 5 adults smoke, costing the NHS £2.7 billion a year.
- Alcohol intake is too high
  - 1 in 3 young adults drink to point of drunkenness. Alcohol related accidents are the biggest cause of death among 16-24 year olds.
  - Liver disease is rising and is the fifth biggest cause of death.
  - Drunkenness is linked to half of assaults and quarter of domestic incidents.
- Mental health costs £77.4 billion in 2003. People with mental health problems are more likely to drink to excess and smoke.
- Leading causes of death are circulatory, cancer, respiratory diseases.

Background and poverty has a big impact on life expectancy and health. A man living in Kensington and Chelsea can expect to live to 88 compared to 71 in Tottenham Green, a difference of 17 years and on average people in poorer areas live 7 years less than more privileged areas. They can also expect 17 more years of ill health. Low income and deprivation are associated with obesity, low birth weight, mental illness and harm from drugs and alcohol misuse. Inequalities based on race, disability, age, religion, gender, sexual orientation can also impact on health outcomes.

Over time the health requirements of the population have changed. A hundred years ago a common cause of death and ill health was infectious disease but this now accounts for only 1 in 50 deaths. Today most illnesses are caused by or aggravated by self-inflicted lifestyle choices such as smoking or obesity. The Coalition Government’s view is that if these lifestyle choices can be addressed then the burden on the NHS can be reduced as prevention is better than cure. Consequently there is a big shift in policy focus towards public health and engaging with people in the community to greatly reduce lifestyle linked diseases. In order to create choice and improve community engagement, there is a greater role for third sector organisations as the NHS enters the “Big Society”.

46 Healthy Lives Healthy People p 19
47 Our Health and Wellbeing p 32
48 HLHP p 21
49 HLHP p 19
50 HLHP p 19
51 HLHP p 20
52 HLHP p 20
53 HLHP p 20
54 HLHP p 13
55 HLHP p 4
56 HLHP p 5
In July 2010 the Government published *Equity and excellence: Liberating the NHS* in order to begin the process of transforming the NHS. The Government aims are:

1. The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.

2. We will increase health spending in real terms in each year of this Parliament.

3. Our goal is an NHS which achieves results that are amongst the best in the world

4. We will put patients at the heart of the NHS, through an information revolution and greater choice and control

5. To achieve our ambition for world-class healthcare outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government’s objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all.

6. The Government’s reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level.

7. The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change.

8. We will maintain constancy of purpose. *This White Paper is the long-term plan for the NHS in this Parliamentary term and beyond. We will give the NHS a coherent, stable, enduring framework for quality and service improvement. The debate on health should no longer be about structures and processes, but about priorities and progress in health improvement for all.*

9. *This is a challenging and far-reaching set of reforms, which will drive cultural changes in the NHS. We are setting out plans for managing change, including the transitional roles of strategic health authorities and primary care trusts. Implementation will happen bottom-up.*

Treatment will be more patient-focused following the idea that shared decision-making with the patient will become the norm: “no decision about me without me”. Patients will have a voice and more say in their own care. Patients will have individual budgets and a system of payment by results will be introduced. Power will be devolved down to local level and GPs will be involved in the commissioning of services. Efficiency savings of £20 billion will be found whilst management costs will be cut by 45%. Rather than be target led, such as the number of people treated in a specific way, the new NHS will be led and judged by achieving outcomes, and the impact it has on individuals’ lives.

The practical implication of this strategy is a complete physical restructuring of the NHS. The old style NHS was structured around Primary Care Trusts and strategic Health Authorities.

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57 P 3-6
Primary Care Trusts are made up of the people who deal with initial health problems such as doctors, dentists, opticians and pharmacists. They control 80% of the budget and liaise with the Local Authority and other agencies to ensure that local services are provided including hospitals. There are currently 10 Strategic Health Authorities which develop plans for improving healthcare, monitor quality, increase capacity and ensure national programmes are carried view into their areas. They manage the NHS locally and provide a link between the NHS and the Department of Health.

The new structure will see the abolition of both the Primary Care Trusts and the Strategic Health Authorities creating a structure that will focus more on the local level, with doctors taking a greater lead on what is needed in a local area. It is hoped that the new system will save money and be more responsive to the needs of patients, give more choice and give them a stronger voice. The third sector will also have a bigger role in the new system. The introductions of these proposals have been very controversial. The new roles and organisations are as follows.

At a local level:

- Local authorities are to take greater role particularly in the areas of public health and social care.
- Each top tier and unitary authority will have its own Health and Wellbeing Board. The boards will bring together local commissioners of health and social care elected representatives and representatives of Healthwatch to agree an integrated way of improving local health and well-being. They have strategic influence over commissioning decisions across health, public health and social care.
- Local clinical commissioning groups give GPs and other clinicians responsibility for using resources to secure high-quality services. A representative sits on the local Health and Wellbeing Board.
- Local Healthwatch, launching in April 2013, will take on the work of the Local Involvement Networks (LINKs) and will also:
  - Represent the views of people who use services, carers and the public on the Health and Wellbeing Boards set up by local authorities.
  - Provide a complaints advocacy service from 2013 to support people who make a complaint about services.
  - Report concerns about the quality of health care to Healthwatch England, which can then recommend that the Care Quality Commission (CQC) take action.

Local activity is supported at a national level:

- Public Health England will harness its experience, intelligence and evidence base to promote transparency and improvement in performance across the public health system, and to provide impartial and expert advice to policy makers across Government on the best operational means to achieve public health goals. It provides expert intelligence.
  - Delivering services to national and local government, the NHS and the public
  - Leading for public health
  - Supporting the development of the specialist and wider public health workforce.
- Healthwatch England is a new national consumer champion that enables the collective views of the people who use health and social care services to influence national policy, advice and guidance. Working at both a national and local level it will advise NHS Commissioning Board, English local authorities, Monitor and the Secretary of State. It also has the power to recommend that action is taken by the CQC when there are concerns about health and social care services.
  - NHS Commissioning Board supports and holds to account local commissioning groups.
In order to manage and deliver the outcomes it requires, the Government has developed frameworks for 3 key areas. Each area was preceded by research and white papers:

<table>
<thead>
<tr>
<th>Public Health</th>
<th>Development document/ White paper</th>
<th>Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care</td>
<td>A Vision for Adult Social Care: Capable Communities and Active Citizens Social Care Policy, DH 16 Nov 2010</td>
<td>2011/12 Adult Social Care Outcomes Framework</td>
</tr>
<tr>
<td>NHS</td>
<td>Liberating the NHS</td>
<td>The Operating Framework for the NHS in England 2012/13</td>
</tr>
</tbody>
</table>

These documents contain many proposals which are leading to the restructuring of the NHS in order to deliver the outcomes. These changes went through Parliament in the Health and Social Care Bill in March 2012 and now are law. The year March 2012 – 2013 is seen as a year of transition and the new structure and frameworks will be in place from April 2013.

The Frameworks

With the abolition of Public Service Agreements and Local Area Agreements used by the previous government, no way remained to measure the achievements of the NHS on a national basis and the frameworks will introduce a new way of doing this by looking at outcomes. Each framework has overarching aims, key domain areas and indicators. Many of the indicators are based on existing work that is currently being delivered. Some indicators will not be published until April 2013 and these tend to be areas where much of the change is taking place.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Public Health</th>
<th>Adult Social Care</th>
<th>NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Improving the wider determinants of health</td>
<td>Enhancing quality of life for people with care and support needs</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>2</td>
<td>Health improvement</td>
<td>Delaying and reducing the need for care and support</td>
<td>Enhancing quality of life for people with long term conditions</td>
</tr>
<tr>
<td>3</td>
<td>Health protection</td>
<td>Ensuring that people have a positive experience of care and support</td>
<td>Helping people to recover from episodes of ill health or following injury</td>
</tr>
<tr>
<td>4</td>
<td>Healthcare public health (and preventing premature mortality)</td>
<td>Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm</td>
<td>Ensuring that people have a positive experience of care</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>
The frameworks will be aligned where appropriate, but already a complicated picture is emerging. The NHS framework has 60 indicators, alone whilst detailed plans for delivering mental health are linked to outcomes across Public Health, Adult Social Care and the NHS.

Across the domains issues can also be looked at in the context of life stages:
The five key stages of the life course:

- Starting Well
- Developing Well
- Living Well
- Working Well
- Aging Well.

1.2 The Public Health Framework

The key document focusing on public health is the white paper, Healthy Lives, Healthy People: our strategy for public health in England published in November 2010. This supported by Our Health and Wellbeing, November 2010 which gives and overview of public health in 2010.

A holistic approach is taken to the health of the nation, embracing the notion of the Big Society and looking at health through people’s whole lives. Prevention is better than cure, so leading a healthier lifestyle will cut down on health intervention and so save money.

The white paper summarises this:

8. The opportunity – and the challenge – is stark, for example:
   a. By improving maternal health, we could give our children a better start in life, reduce infant mortality and the numbers of low birth-weight babies.
   b. Taking better care of our children’s health and development could improve educational attainment and reduce the risks of mental illness, unhealthy lifestyles, road deaths and hospital admissions due to tooth decay.
   c. Being in work leads to better physical and mental health, and we could save the UK up to £100 billion a year by reducing working-age ill health.  
   d. Changing adults’ behaviour could reduce premature death, illness and costs to society, avoiding a substantial proportion of cancers, vascular dementias and over 30% of circulatory diseases; saving the NHS the £2.7 billion cost of alcohol abuse; and saving society the £13.9 billion a year spent on tackling drug-fuelled crime.
   e. We could prevent many of the yearly excess winter deaths – 35,000 in 2008/09 – through warmer housing, and prevent further deaths through full take-up of seasonal flu vaccinations.  

The Government feels that previous administrations put too much emphasis on treating the results of bad health, rather than trying to eliminate the root causes. They believe that this cycle needs to be broken and for this reason, public health takes on a greater role with this government, including the provision of ring fenced funding. They want to take a radical new approach that will focus on outcomes, empower local communities and give individuals freedom and is fair. The process will attempt to keep intervention at a low level, prompting people into positive action rather than making them do things. The approach will be:

- responsive – owned by communities and shaped by their needs;
- resourced – with ring-fenced funding and incentives to improve;

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58 HLHP p 5
• **rigorous** – professionally-led, focused on evidence, efficient and effective; and
• **resilient** – strengthening protection against current and future threats to health.

The overarching outcomes of the Public Health Framework are:

Outcome 1 - Increased healthy life-expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2 - Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

The Framework is based around the three pillars of public care which normally include:

......**health improvement** (including people’s lifestyles as well as inequalities in health and the wider social influences of health), **health protection** (including infectious diseases, environmental hazards and emergency preparedness) and **health services** (including service planning, efficiency, audit and evaluation).

The Government has included an additional “pillar”, **Improving the wider detriments of health**, which provides a wider context and links up with other non-specifically health focused Government policies.

**The Domain Indicators**

These are set out in Improving Outcomes and Supporting Transparency Parts 1 and 2: January 2012, Department of Health. The following are taken from Part 1. A placeholder is an indicator which is yet to be published.

<table>
<thead>
<tr>
<th>Domain 1 improving the wider determinants of health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td>• Children in poverty</td>
</tr>
<tr>
<td>• <em>School readiness</em> (placeholder)</td>
</tr>
<tr>
<td>• Pupil absence</td>
</tr>
<tr>
<td>• First-time entrants to youth justice system</td>
</tr>
<tr>
<td>• 16-18 year olds not in education, employment or training</td>
</tr>
<tr>
<td>• People with mental illness or disability in settled accommodation</td>
</tr>
<tr>
<td>• <em>People in prison who have a mental illness or significant mental illness</em> (placeholder)</td>
</tr>
<tr>
<td>• Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness</td>
</tr>
<tr>
<td>• Sickness absence rate</td>
</tr>
<tr>
<td>• Killed or seriously injured casualties on England’s roads</td>
</tr>
<tr>
<td>• <em>Domestic abuse</em> (placeholder)</td>
</tr>
<tr>
<td>• <em>Violent crime</em> (including sexual violence) (Placeholder)</td>
</tr>
<tr>
<td>• Re-offending</td>
</tr>
<tr>
<td>• <em>The percentage of population affected by noise</em> (Placeholder)</td>
</tr>
<tr>
<td>• Statutory homelessness</td>
</tr>
<tr>
<td>• Utilisation of green space for exercise/ health reasons</td>
</tr>
<tr>
<td>• Fuel poverty</td>
</tr>
<tr>
<td>• <em>Social contentedness</em> (Placeholder)</td>
</tr>
<tr>
<td>• <em>Older people’s perception of community safety</em> (placeholder)</td>
</tr>
</tbody>
</table>

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### Domain 2 Health Improvement

**Objective**
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

**Indicators**
- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- Smoking prevalence – 15 year olds
- Hospital admissions as a result of self-harm
- *Diet (placeholder)*
- Excess weight in adults
- Proportion of physical active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependent issues who are previously not known to community treatment.
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

### Domain 3 Health protection

**Objective**
The population’s health is protected from major incidents and other threats, while reducing health inequalities

**Indicators**
- Air Pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plan
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*
Domain 4 Healthcare public health and preventing premature mortality

Objective
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Indicators
- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases (placeholder)
- Excess under 75 mortality in adults with serious mental illness (placeholder)
- Suicide
- Preventable sight loss
- Health-related quality of life for older people (placeholder)
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts (placeholder)

1.3 Specific policy areas

Development of policy is still a work in progress and detailed policies to support this work are being published on an on-going basis.

Smoking cessation
Healthy Lives, Healthy People: A Tobacco Control Plan for England was published in March 2011 by the Department for Health. The NHS spends around £2.7 billion treating smoking related illnesses. It is committed to three main aims:

- Reduce smoking prevalence among adults in England: To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, meaning around 210,000 fewer smokers a year.
- Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.
- Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

Delivered through six internationally recognised strands:
- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to second hand smoke
- effective communications for tobacco control
**Alcohol**

*The Government’s Alcohol Strategy* has been published through the Home Office rather than the Department of Health.

2.1 Over the last decade, we have witnessed a dramatic change in people’s attitude to, and the harms caused by, alcohol consumption. We estimate that in a community of 100,000 people, each year:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.  

And the Government aims to:

1.6 Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess. The outcomes we want to see are:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines;
- A reduction in the number of people “binge drinking”;
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.  

The strategy focuses on the regulation of price and marketing of alcohol and giving communities the power to deal with these. Alcohol reduction also features in the *Change4Life* programme.

Information on trends in alcohol use and harm and effective practice is available at the Alcohol Learning Centre.  

1.4 Key programmes delivering policy

**Public Health Responsibility Deal**

The *Public Health Responsibility Deal* was launched in March 2011 and the Government has taken the approach that public health is not just down to the Government but to all parts of society. For instance it is up to food producers to bring down the amount of salt in food and to make it clear through labelling the level of fat etc. in the food they are selling. As the Government wants to bring in legislation as a last resort, companies are being invited to sign up to the *Responsibility Deal* and help to tackle public health issues. Key pledges are:

- Alcohol

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60 P 6
61 P 5
62 [http://www.alcohollearningcentre.org.uk](http://www.alcohollearningcentre.org.uk)
• Food
• Health at work
• Physical activity
• Calorie reduction

Under each area there is a list of pledges from 3 to 8, depending on the subject area. Partners write a delivery plan for each pledge followed and on an annual basis in April are asked to report back on progress. For some pledges this will be against pre-defined quantitative measures.

Pledges of organisations can be found at: http://responsibilitydeal.dh.gov.uk/individual-pledges/

1.5 Department of Health Campaigns

Change4Life
The largest current public health campaign, this programme was brought in under the previous administration and is major delivery vehicle for changing individual’s attitudes to public health. The current government has retained it and broadened it range, developing a marketing programme, The Change4Life Three Year Social Marketing Strategy. Involvement is cited as a way that organisations can deliver some pledges in the Public Health Responsibility Deal. There are six sub brands:

- Bike4Life
- Breakfast4Life
- Let’s dance with Change4Life
- Play4Life
- Swim4Life
- Walk4Life

The website is packed full of resources to make people more active and lead healthier lives. Organisations are encouraged to become partners, use the branding and help to encourage public engagement. The Department of Health Campaign website it is also being used to head up work around:

- Games4Life
- Stop the drink sneaking up on you
- Change4Life Super meals

The marketing strategy aims to move away from TV advertising and use a wider range of social media. The role of local partners is valued and will keep the role of national initiatives low, in order to allow local issues to be followed. The plans for 2012 are:

- January – Great Swapathon where families swap their normal food for more healthy options
- Summer - Really Big Summer Adventure
- Autumn - Walk4Life
- Go on, try it! – to help people find easy way to try new things,
- Reduction of alcohol consumption,
- Collaboration with the children’s T.V. programme Lazy Town
- Olympics and Paralympics – introduction of Change4Life sports club focusing on Olympic sports – already popular with secondary schools, due to be rolled out in Primary schools from Jan 2012
- Start4Life – re-invigorating this programme to improve maternal health
The programme has produced key behaviours around which there is consensus of efficacy from health professionals:

The eight recommended behaviours for families were:

- 5 A DAY – eating at least five portions of fruit and vegetables every day
- Sugar swaps – reducing consumption of added sugars
- Cut back on fat – reducing fat consumption
- Snack check – reducing unhealthy snacking
- Me-size meals – serving age-appropriate portions
- Meal time – eating three regular meals per day
- 60 active minutes – doing at least an hour of moderate intensity physical activity per day
- Up and about – avoiding sedentary behaviour.

7.13 The six recommended behaviours for adults were:

- Portion swap
- Snack swap
- 5 A DAY
- Fibre swap
- 150 active minutes
- Drink swap

7.14 The Start4Life recommended behaviours for the under-twos were:

- Mum’s milk – initiating breastfeeding
- Every day counts – encouraging continued breastfeeding
- No rush to mush – delaying weaning
- Taste for life – encouraging a wide range of age-appropriate foods
- Sweet as they are – avoiding added sugar
- Baby moves – physical activity.

The Change4Life Local Supporters Guide gives more information on these areas

The marketing strategy says:

*Change4Life works in partnership with a wide range of organisations: civic, commercial and charity. Partnership marketing seeks to attract additional non-government activity to the programme; however, it is not free and as the number and contribution of partners increase, there will be resource implications for the partnership team.*

This approach offers an opportunity for museums to engage with the programme.

**Other on-going campaigns**

- **Smoke-free** – smoking cessation
- **ACT FAST** – awareness of the symptoms relating to strokes - resurrecting a campaign from the previous administration
- **Be Clear on Cancer** – focusing on symptoms of bowel cancer and also lung cancer. This campaign is likely to move on to other cancer areas
- **Dementia** – to help people recognise the first signs of Dementia
- **Frank** – drugs also carried through from previous Government
- **NHS 111** – for services when problems are urgent but not life threatening – currently being trailed

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64 P 34
The Government is also working on a new young people’s marketing strategy to try and develop a young people friendly health service. An appeal is currently out for organisations that would like to be involved.

1.6 Healthy Schools Programme

The Healthy Schools Programme was active under the previous government, but currently is now just a website resource. In future this programme will be funded by Public Health England and it remains to be seen if this will re-invigorate the programme. The Personal Social Health and Economic Education Association is the subject specialist association for teachers and although they link to the Healthy Schools Programme they take a more curriculum based approached and don’t for instance particularly link with the Change4 Life programme. At the moment there doesn’t seem to be a strong relationship with PSHE in schools and public health professionals, but this may change with the government’s increased emphasis on public health.

1.7 Social Care Framework

The Government’s vision for social care takes a similar approach to that of public health i.e. that prevention is better than cure. Policies aim to keep people as independent as possible and out of hospitals.

The vision is summarised in following commitments:

- *Break down barriers between health and social care funding to incentivise preventative action;*
- *Extend the greater rollout of personal budgets to give people and their carers more control and purchasing power; and*
- *Use direct payments to carers and better community-based provision to improve access to respite care.*

*A Vision for Adult Social Care: Capable Communities and Active Citizens* 65

Power will be devolved down from Government, care will become more personalised and there will be more emphasis on supporting carers.

The Key Principles are:

**Prevention:** empowered people and strong communities will work together to maintain independence. Where the state is needed, it supports communities and helps people to retain and regain independence.

**Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.

**Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.

**Plurality:** the variety of people’s needs is matched by diverse service provision, with a broad market of high quality service providers.

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65 P 6
Protection: there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people’s freedom.

Productivity: greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.

People: we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.  

Pilots have taken place to see how giving people personal health budgets and direct payments are more appropriate and efficient, and this is now being run out more widely. Some groups may need more support with direct payments:

- Older people
- People with learning difficulties
- People with mental health conditions
- People in residential care

The Government aims to improve information provision of what support and services are available both in the public sector and wider community.

The introduction of the idea of plurality within the market is a real opportunity for museums and galleries and the Vision for Social Care actually states in paragraph 5.1:

People will demand the services they want to meet their needs, creating truly person-centred services. These will be delivered by organisations, including social enterprises and mutuals, that can respond to the demands of their communities. This can include niche and specialist providers. It can also include more mainstream and universal service providers – for instance, those offering transport or leisure options, or employment and education support – which are able to cater for people’s needs without operating exclusively in the social care sector.

The report goes on to say in paragraph 5.2

Social care already involves a diverse range of providers, including the voluntary and private sectors. But more can be done to make a reality of our vision of a thriving social market in which innovation flourishes. Councils have a role in stimulating, managing and shaping this market, supporting communities, voluntary organisations, social enterprises and mutuals to flourish and develop innovative and creative ways of addressing care needs. Local government has already made great strides towards developing local services with their local communities and voluntary organisations. To build on this they will need robust evidence about what local markets offer and how they operate.

Also commissioning should move away from the traditional idea of block contracts. This throws open a wealth of opportunity to museums and galleries that wish to engage with social care agendas. Engaging in the commissioning process has been a difficult process for smaller organisations and few museums have achieved this. The Government says that it wishes to make the process easier, create a fairer playing field and
Commissioners of services should work with suppliers in the independent and voluntary sectors to better understand market capacity and capability, and decide how innovation and best value can be incentivised effectively. 67

Partnership working and joined up thinking is to be encouraged. The government is keen to see people living independently as long as possible and people who have been in hospital to be “re-abled” as quickly as possible.

1.8 Social Care Framework

<table>
<thead>
<tr>
<th>Domain 1 Enhancing quality of life for people with care and support needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overarching Measure</td>
</tr>
<tr>
<td>1A Social care-related quality of life</td>
</tr>
<tr>
<td>Outcome measures</td>
</tr>
<tr>
<td>• People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs</td>
</tr>
<tr>
<td>• Carers can balance their caring roles and maintain their desired quality of life</td>
</tr>
<tr>
<td>• People are able to find employment when they want, maintain a family and social life, and avoid loneliness or isolation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2 Delaying and reducing the need for care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overarching Measures</td>
</tr>
<tr>
<td>2A Permanent admissions to residential and nursing care homes, per 1000</td>
</tr>
<tr>
<td>XX Effectiveness of prevention/preventative services</td>
</tr>
<tr>
<td>Outcome measures</td>
</tr>
<tr>
<td>• Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their health care needs</td>
</tr>
<tr>
<td>• Earlier diagnosis, intervention and re-ablement means that people and their careers are less dependent on intensive services.</td>
</tr>
<tr>
<td>• When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3 Ensuring that people have a positive experience of care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overarching Measure</td>
</tr>
<tr>
<td>People who use social care and their carers are satisfied with their experience of care and support services</td>
</tr>
<tr>
<td>• Carers feel that they are respected as equal partners throughout the care process</td>
</tr>
<tr>
<td>• People know what choices are available to them locally, what they are entitled to and who to contact when they need help.</td>
</tr>
<tr>
<td>• People, including those involved in making decisions on social care, respect the dignity of the individual and ensure that support is sensitive to the circumstances of each individual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 4 Ensuring that people have a positive experience of care and support</th>
</tr>
</thead>
</table>

67 Paragraph 5.4 p 22
Full Table can be found in *Transparency in outcomes: a framework for quality in adult social care The 2011/12 Adult Social Care Outcomes Framework*. Some domain content/ indicators are incomplete and still being written.

### 1.9 Specific Area Policies

**Mental Health**

The key policy document is *No Health without Mental Health* published in February 2011. The Government has set out six key aims for mental health services:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

The importance of good mental health is described in paragraph 1.7:

*Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.*

Mental health problems are not uncommon and one in six adults is affected at any one time whilst 60% of people living in hostels have a personality disorder, and 90% of prisoners have mental health problems. The most deprived communities have the worst levels of mental health and well-being. Mental health accounts for 23% of ill health in the UK and is the largest cause of ill health. Strategies are outcome-led moving away from the top down approach. They aim to ensure that mental health is high on the Government’s agenda and a key priority for Public Health England, and that a new national measure of wellbeing is agreed. Early intervention is a priority across all ages and health inequalities will be tackled. Money will be invested in psychological therapies and people in contact with the criminal justice system will have improved access to mental health services. The best treatment possible will be provided for Service and ex-Service personnel and experts will look at improving body confidence. The Royal College of General Practitioners and the Royal College of Psychiatrists will agree advice and support for GP consortia to commission effective mental health services that are accessible to all, including the most disadvantaged and excluded and a new cross-government suicide prevention strategy will be published.
Much emphasis is being put on *Time for Change*, a programme funded by the Department of Health and Comic Relief but run by the charities Mind and Rethink Mental Illness. Organisations are invited to get involved and a grant round opens later in 2012.69

Mental Health Strategy links to all the 21 outcome indicators in the first domain of the Public Health framework. It also links to indicators in the Social Care and NHS frameworks, as delivery of mental health takes place both in the community and hospital settings. Consequently a complicated picture of evaluating outcomes is emerging, as different conditions operate across the entire framework structure, of which mental health is probably just one. While this may make perfect sense to health professionals, it creates a challenging system for organisations working alongside health care.

In 2008 the Labour government department for Business Innovation and Skills, through the *Foresight Programme*, commissioned the New Economics Foundation to undertake a piece of work around Mental Capital and Well Being. NEF is an independent think-and-do tank that inspires and demonstrates real economic well-being. They developed the *Five Ways to Well Being* which is regarded as the mental health equivalent of the Five a Day. They are:

**Connect**...
*With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.*

**Be active**...
*Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.*

**Take notice**...
*Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.*

**Keep learning**...
*Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.*

**Give**...
*Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.*70

Although not featuring strongly in the current Government’s approach towards health care, the use of the 5 Ways appears to be common practice within the National Health Service.

69 [http://www.time-to-change.org.uk/home](http://www.time-to-change.org.uk/home)

**Dementia**

In 2009 the Labour government published a strategy on dementia, *Living Well with Dementia – A National Dementia Strategy*, and it was one of the first strategies of its type in the world.

Progress was made with:

- 94% of primary care trusts (PCTs) creating a dedicated memory service for dementia
- The NHS and Social Care, working together with wider partners, have taken forward initiatives to reduce the prescribing of antipsychotic drugs for people with dementia to improve quality of life
- More than 90 leading organisations have joined the Dementia Action Alliance (DAA) since October 2010
- A Dementia Commissioning Pack was launched in July 2011

In March 2012, the current government built on this work by publishing *Prime Minister’s challenge on dementia - Delivering major improvements in dementia care and research by 2015*.

It aims to make the UK a world leader in dementia research and care.

*The PM’s Challenge on Dementia is a challenge to the whole of society as well as government. It will focus on three key areas:*

- *Driving improvements in health and care*
- *Creating dementia friendly communities that understand how to help*
- *Better research.*

**Key commitments are:**

**Driving Improvements in health and care**

1. Increased diagnosis rates through regular checks for over-65s
2. Financial rewards for hospitals offering quality dementia care
3. An Innovation Challenge Prize of £1m for hospital staff who come up with new ideas in dementia care
4. A Dementia Care and Support Compact signed by leading care home and home care providers
5. Promoting local information on dementia services – website pioneered by NHS South West

**Creating dementia friendly communities that understand how to help**

6. Dementia-friendly communities across the country
7. Support from leading businesses for the PM’s Challenge on Dementia
9. A major event over the summer, bringing together UK leaders from industry, academia and the public sector, to take forward the PM’s Challenge on Dementia.

**Better research**

10. More than doubling overall funding for dementia research to over £66m by 2015
12. £13m funding for social science research on dementia (NIHR/ESRC).
13. £36m funding over 5 years for a new NIHR dementia translational research collaboration to pull discoveries into real benefits for patients. Four new NIHR biomedical research units in dementia and biomedical research centres which include dementia-themed research will share their considerable resources and world-leading expertise to improve treatment and care.
14. Participation in high-quality research offering people the opportunity to participate in research will be one of the conditions for accreditation of memory services.

In essence there is a bigger focus on dementia care than ever before, an area which some people think was previously largely ignored.

Support for Dementia is being developed through Dementia Action Alliance which is the coming together of organisations from across the charity, public and private sector to radically improve the lives of people with dementia. Members sign up to a declaration of seven outcomes for people with dementia:

1. I have personal choice and control or influence over decisions about me
2. I know that services are designed around me and my needs
3. I have support that helps me live my life
4. I have the knowledge and know-how to get what I need
5. I live in an enabling and supportive environment where I feel valued and understood
6. I have a sense of belonging and of being a valued part of family, community and civic life
7. I know there is research going on which delivers a better life for me now and hope for the future

As with the Public Health Deal, organisations then go to write an activity plan which shows how they are going to deliver against these outcomes.

**Palliative Care**

Systems of palliative care vary across the country and the Government is currently reviewing this with the aim of setting up a new funding system by 2015. Eight pilots (7 adult, 1 consortium for children) have been set up to research the possibilities.

**NHS**

Many of the changes to the NHS have already been covered when describing the structural changes to health care in general. The NHS will be in a period of transition during 2012/13. In The Operating Framework for the NHS in England 2012/13 NHS leaders are responding to four inter-related challenges:

- The need to maintain continued strong performance on finance and service quality;
- The need to address the difficult changes to service provision required to meet the Quality Innovation Productivity Prevention challenge in the medium term;
- The need to complete the transition to the new delivery system set out in Liberating the NHS;
- And the urgent need to ensure that elderly and vulnerable patients receive dignified and compassionate care in every part of the NHS.

The NHS Framework is based around outcomes about preventing premature death, enhancing quality of life in long term conditions, helping recovery, improving the experience of care and keeping people safe.

Provision is being adjusted with the opening of 22 trauma specialist centres are to open to treat seriously ill emergencies and save up to 600 lives every year. Emphasis is also being put on keeping patients safe within the care system with the opening of 2 patient safety research centres.

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72 P 2
Domain 1 Preventing people from dying prematurely

**Overarching indicators**

1a Potential years of life lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

**Improvement Areas**

- Reducing mortality from the major causes of death
  - Cardiovascular
  - Respiratory
  - Liver disease
  - Cancer – colorectal, breast, lung
- Reducing premature death in people with serious mental illness
- Reducing deaths in babies and young children
- Reducing death in babies and young children

Domain 2 Enhancing quality of life for people with long-term conditions

**Health-related quality of life for people with long-term conditions**

**Overarching Indicator**

- Ensuring people feel supported to manage their condition
- Improving functional ability in people with long-term conditions
- Reducing time spent in hospital by people with long-term conditions
- Enhancing quality of life for carers
- Enhancing quality of life for people with mental illness
- Enhancing quality of life for people with dementia

Domain 3 Helping people to recover from episodes of ill health or following injury

**Overarching indicators**

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

**Improvement areas**

- Improving outcomes from planned procedures – Hip replacement, knee replacement, groin hernia, varicose veins
- Preventing lower respiratory infections (LRTI) in children from becoming serious
- Improving recovery from injuries and trauma
- Improving recovery from stroke
- Improving recovery from fragility fractures
- Helping older people to recover their independence after illness or injury

Domain 4 Ensuring that people have a positive experience of care

**Overarching Indicators**

4a Patient experience of primary care
4b Patient experience of hospital care

**Improvement areas**

- Improving people’s experience of outpatient care
- Improving hospital’s responsiveness to personal needs

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73 [http://mediacentre.dh.gov.uk/2012/04/02/new-major-trauma-centres-to-save-up-to-600-lives-every-year/](http://mediacentre.dh.gov.uk/2012/04/02/new-major-trauma-centres-to-save-up-to-600-lives-every-year/)
- Improving people’s experience of accident and emergency services
- Improving access to primary care services
- Improving women and their families’ experience of maternity services
- Improving the experience of care for people at the end of their lives
- Improving experience of healthcare for people with mental illness

### Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm

#### Overarching Indicators
- 5a Patient safety incidents reported
- 5b Safety incidents involving severe harm or death

#### Improvement areas
- Reducing the incidence of avoidable harm
  - Hospital related venous thromboembolism
  - Healthcare associated infection HCAI, MRSA, difficile
  - Pressure ulcers
  - Medication errors
- Improving safety of maternity services
- Delivering safe care to children in acute settings

Full list in *The NHS Outcomes Framework 2012/13 at a glance*
Appendix 2: Becoming a Healthy Museum conference report

Becoming a Healthy Museum
UKMCG
The UK Medical Collections Group

Thackray Medical Museum
29th May 2012

Evaluation Report

Summary
Approximately 80 people attended the conference of which 36 people returned evaluation forms. The conference was very successful with well over 90% of people being satisfied or very satisfied with the organization on the day, venue, lunch and programme content. Prior information and booking scored slightly lower, and this was probably due to the tight timescale in which the conference was organized and the number of speakers involved; with over a dozen speakers final confirmation of the programme could not take place as early as had been hoped. Taking this into an account, the evaluation response isn’t really a cause for concern.

Almost 90% of people enjoyed the day and the level of the information seemed about right for the audience. The balance of information could have been improved, and there was criticism that hand outs weren’t clear and sufficient. There were not many hand outs and several people asked for the presentations to be made available, as reflected in the comments part of the evaluation form. These weren’t available on the day as not all speakers forwarded hand outs/presentations in advance, and some of those who did changed them on the day. Organizing hand outs would have added to the cost of the conference in terms of staff time and photocopying costs. The presentations will be made available on the Thackray Medical Museum website.

72% of respondents left the conference with the intention of planning a health care project, which shows the significant impact of this conference: only about 30% were already delivering health care projects.

Most people had heard of the conference through the UKMCG network or the GEM list, and many people had had information forwarded on to them by a colleague or line manager.

The forms revealed 12 projects which the UKMCG network and their researcher were unaware of and this will help bring expertise into the network.

53
80% of organisations are interested in future partnership work/projects. The area of most interest for future projects is social care followed by public health and then the NHS, but all areas have potential for further work and conference has provided a useful pool of people to approach.

Most comments praise the conference or ask for copies of the presentation.

The last session of the day was discussion. Delegates had three questions to discuss and wrote on table cloths. Every ten minutes they changed tables and moved on to the next question. Analysis of the table cloths reveals many ideas for engaging with health agendas. They also show that people don’t fully understand the agendas or how the NHS is changing. It is a complicated subject and the NHS is currently in a period of transition so it is impossible to address all the issues in a single event. The research which supports this project will help to address this and will be published in July. There will still, however, be a large degree of regional variation in how health care systems operate in particular areas.

Overall it was a very successful event, creating many opportunities for future development.

**Figures in bold = percentage**

1. | Area                      | Very dissatisfied | Very satisfied | Total satisfied |
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<tr>
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<td>Organisation on the day</td>
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<td>94.5</td>
<td></td>
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<tr>
<td>Venue</td>
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<td></td>
</tr>
<tr>
<td>Lunch and refreshments</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Programme content</td>
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<td>94.5</td>
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2. | Statement                                           | Strongly Disagree | Strongly Agree |
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<tbody>
<tr>
<td></td>
<td>Circle the relevant number below</td>
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<tr>
<td>I enjoyed the day</td>
<td>0 0 3 8.5 15 42 17 47</td>
<td>89</td>
</tr>
<tr>
<td>Information given was clear and easy to access</td>
<td>0 0 3 8.5 15 42 18 50</td>
<td>92</td>
</tr>
<tr>
<td>There was about the right amount of information in the day</td>
<td>0 0 5 5 15 42 14 39</td>
<td>81</td>
</tr>
<tr>
<td>Handouts are clear and sufficient</td>
<td>1 2.77 1 2.77 12 33 17 47 7 19</td>
<td>66</td>
</tr>
<tr>
<td>I will be planning projects around health agendas</td>
<td>0 0 6 7 9 25 17 47</td>
<td>72</td>
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3. How did you hear about this conference?

<table>
<thead>
<tr>
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<td>Email</td>
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<td>Website</td>
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<tr>
<td>GEM List</td>
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<tr>
<td>UKMCG</td>
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<td>22</td>
</tr>
<tr>
<td>Thackray Museum</td>
<td>1</td>
<td>2.77</td>
</tr>
</tbody>
</table>

4.a Had you heard of the UK Medical Collections Group before this event?
Yes 16 44  No 19 53

5.b If yes are you/ the organization you work for already members?
Yes 9 25  No 10 28

If you aren’t a member and would like to become one then or find out more then please email: UKMCG@thackraymuseum.org. Membership is free and includes an email list and regular newsletters.

Are you already running healthcare projects in a museum setting?
Yes 12 33  No 17 47

I you are then please tell us about it (speakers and workshop leaders excepted).

Leics. County Council Learning Team
Run many sessions using accessioned and handling resources. Collections teams and sites run many relevant exhibitions and events and developed engaging collections travelling cases for use in mental health and social care audience work.

Care Homes, adults with learning difficulties, adults with physical disabilities, siblings of a disabled child, autism after school club, clubs for children in care, intergenerational work, mental health projects and others e.g. support for other local museums

Tyne and Wear Archives and Museums
Developing activities for social prescribing lists to deliver a range of outcomes e.g. increase confidence, reduce isolation, increase skills/abilities, enhanced interest which GP’s can prescribe

Ordsall Hall Salford
Young Carers – Home as Starting point for archive digital work and interpretation for provision – part of on-going working relationship producing activities during breaks in caring

Heritage Services – Bath and North East Somerset Council – Roman Baths, Fashion Museum, Victoria Art Gallery, Bath Record Office
Carer’s Projects – breaks for Carers. Initial contact with a member of NHS Mental Health – planning a menu of activities and talking about evaluation

Ripon Museum Trust
Reminiscence Loan Box

Calderdale MBC
Currently running “Museum Minded” pilot courses for service users exploring the impact of museums and objects on wellbeing. Planning to create wellbeing welcome packs and a series of referral days.

The Wordsworth Trust
Intervention for people with mild cognitive disorders – working with Mind, Age UK, The Reader organization, local authority residential homes looking into using manuscript collection for outreach activities.

Tullie House
We’re doing and will do when new post start – some reminiscence work

University of Worcester
Sexual Health

JAM?
Access for people with disabilities. In the past there was an outreach and mental health worker who took redundancy. I will be working in this area from the autumn (e.g. outreach, craft skills sessions)

Public Health Manager NHS Leeds
Really interested in developing something around health protection or jointly develop loan boxes to link to workforce development

Papworth Hospital
Work as Heritage Project Officer at Papworth Hospital – so more a museum project in a healthcare setting (!) which can be challenging

Imperial NHS
Work with local social service groups nursing and medical educators, health information

If in future the UK Medical Collections Group develops partnership/ joint projects based around health care would your organization be interested in taking part? Yes 29 80 No 1 2.77

What areas are you most interested?

Public Health 21 58
e.g. preventative care – healthy eating, exercise, awareness of health issues

Social Care 27 75
e.g. mental health, care of elderly, special needs

NHS 11 30.5
e.g. clinical care in hospital

Any other comments
Fantastic Day – Many Thanks- extremely informative and inspiring. Please can some PDFs of power points be made available online and email to a link to be circulated

Today was very interesting and helpful – Thank you
Very Interesting day
Interesting and helpful day. Understandably workshops were very focused on use of objects. I would have found it beneficial to also look at how museums and heritage sites are using their exhibitions/grounds/buildings as inspiration for creative projects – similar to those briefly mentioned by V. Betton and Dr Chivers. Top tips for how to build initial relationships with health care/well-being orgs e.g. The way in is....
Can we have hand outs of the presentations?
UKMGC could continue to raise the health agenda to wider museums community e.g. Director Level, Heads of Service. Session at MA Conference
A good very full day with lots of useful information and advice
Brilliant day thank you! Can we have another one/ a development session please.
Thank you for today ☺ Please will we be sent the power-point. A little too much talking and could have been more active learning
As an archivist also charged with managing museum collection of RCOG and Royal College of Midwives, would value notification of collaborative projects, especially in the development of online resources.

Discussion Question
How can museums help deliver health agendas in:

- Public Health
- Social Care
- NHS

Discussion Points – taken from table clothes
Public Health
Table 1 Venue – visible communities
   Heart of Community
   Exercises spaces in gardens and galleries
   Trails – fun
   Healthy eating events and exhibitions – tours
   Healthy cafes
   Volunteering
   Health Checking – know your numbers
   Use outdoor spaces – where does food come from
   Historic food – life styles
   Cross curricular opportunities
   Archival collection – letters describing post-natal depression
   Schools outreach – sure start centres
   “Wellbeing Welcome pack”
   Training Across organization
   Medical collections to raise awareness
   Train care workers to access the museum
   Healthy Eating Workshops, Keep active workshops. In house and outreach (relevant galleries)
   Exercise incentives with a reward scheme certificates – gold, silver, bronze
Table 2 Organisations – Who, Universities, teaching hospitals, medical colleges, Red Cross, NGO’s Charities, Patient Groups
Active Lifestyle
Smoking
Alcohol
Contacts – local, allotments, healthy schools, RHS, Parks/Gardens, local council
PSHE
Need to research health agendas
Need – boundaries, risk assessment, crb, - children and healthy food, a safe outdoor space for learning, outdoors learning
Agendas – mental health, well-being, smoking, vaccinations, disease control
Taster sessions of sport, growing things
Exhibitions in sport and chair exercise
Collaboration
Children help themselves and their communities
The right opportunities – sensitivity – not preaching – suitable language
You need an audience
Identify agendas

Table 3 Sustainable projects with partners – NHS, schools, youth groups
Exhibition with activity to test health – workshops, festivals, family workshops, learning through play
Exhibition in building space with health context
Historic – what’s safe to drink, drink dependence, modern context, social stigma
5 ways to well-being – 5 a day style thinking
Environment – pollution
Using volunteering as a way to get into the community
Obesity
Linking with goals and objectives
Diseases past and present – public health through time – anonymous testing
Get students involved – teach others – come to workshops, university medical schools
Occupational Life and home life
Historic point of view – industry, pollution, environment

Social Care
Table 1
Consultation with families and other social groups about what their needs are
Community Heritage – people having a sense of who they are
Provide Positive images of disability, the elderly
Finding accessible connections – crossing boundaries
Embedding attitudes in organisations – both sides
Specially dedicated programmes to make museums accessible and inclusive for special needs families (one to one help, social stories, specific clubs
Promotion of museums to healthcare professionals
Invite health experts for a fresh look at museum collections
Don’t be afraid of staring at the basics
Memory and resource boxes
Safe places for groups to meet “Dementia Cafes”
Volunteer opportunities
Staff disability forums
Nail bar etc.
Health Tours
Do not touch → please touch
Use objects to increase observation skills of health professionals

Table 2 Looked after children – access to cultural activities – enhance opportunities for learning
Group Collecting and co-produce – exhibitions, scripts
Domestic violence – family activities – new environment – safe normal space
Families agenda – history of the family and culture – contemporary relevance
Mind, down Syndrome Assoc, Age UK, Bigger Museums with more resources, local volunteering centre
Language – families living together – Big Society
By providing volunteering opportunities
Share experiences and be listened to
Reminiscence – focus with value, emotional subjects in a non-confrontational way
Fun days out
Intergenerational activities – understand each other’s world, “Museums are not for Me”
Talking objects – giving young people help with skills for future jobs – helping with issues of isolation

Table 3 Volunteering
Local priorities – partners to collaborate – libraries, museums, networks
Image and context to emphasis “like You”
Special needs schools
Eps surgeries
Young Minds school
Older people mental health care – peer support dementia
“Message” under social change e.g. de-stigmatising
Social cohesion
Oral histories – filming – digistories
Co-creation activities – learning/disabilities – “specialist tsars”, language consideration,
different cultural groups, physical access, access audits
Dressing up, role play, interactive workshops
Activities – after school, reminiscence, intergenerational, object handling, healthy food,
memory clinics – cafes – grandparents similar support memoirs, family activities,
neighbourhood, tots town for mum and babies
Inclusive for carers and child minders

Table 4 Consultation of user groups
Access barriers
Finding out about agendas
Making contacts – key workers – keeping them engaged
Identify – public unit, social services, housing association
Shift happens
Give individuals a voice
Evidence
What’s our starting point?

NHS

Table 1 Need further understanding of weird NHS Structure
- More opportunity with community health trusts?
  client, practitioner, collection
- Dissemination of knowledge – importance of taking medication, avoid hospital acquired
  infection
- Humane Hospital environment
- Expert advice
- Occupational health – craft skills, breaking out from trapped self

Table 2 Relaxation
- De-accession of objects offered to NHS Trusts for display on site and loans of displays
- Holistic – multisensory- contacts
- How do you find the right way in?
- Objects/ activity to induce contemplation, observation skills, listening
- Partners – NHS – Culture provider
- Collaboration
- Creative Arts – Music appreciation, Creative writing, drama, storytelling, digital
- Taking objects into hospitals
- Integration – public space
- Contacts???

Table 3 Fitting into groups that are established e.g. friends orgs in hospitals, speech groups –
- one week cooking, one week art
- National Health Agendas – idea of outcomes that need to be delivered – has to link to
  museum collections
- Consultations in Museums – financial opps for museums and NHS
- Care in the community – becoming part of the care pathway
- PSHE
- 2 way partnership and sharing ideologies of Both NHS and Museums learning from each
  other and breaking down barriers with joint working
- Meeting people at right level – area mismatch – ensure peers meet peers – make sure
  the info and ideas go to right people
- Longevity – making and keeping relationships – resilience
- Continued long term delivery and evaluation – also short term projects
Becoming a Healthy Museum
UKMCG
The UK Medical Collections Group
Thackray Medical Museum
29th May 2012

10.00 Coffee
10.15 Welcome on behalf of the Thackray Medical Museum/ UK Medical Collections Group
10.20 Changing landscape of health agendas – overview of UKMCG research Ali Bodley/ Jo Bartholomew

NHS Speakers
Dr Andrew Furber, Director of Public Health, Wakefield District Council
Public Health
Dr Victoria Betton, Associate Director of Partnerships, Leeds and York Partnership NHS Foundation Trust
Social Care and Mental Health
Dr Mandy Chivers, Assistant Chief Executive, Mersey Care NHS Trust
NHS and Clinical Care

11.20 Coffee
11.40 How the heritage sector is engaging with health agendas

Michelle Douek Dulwich Picture Gallery
Good Times Art for Older People

Myna Trustram - Independent cultural consultant
Who Cares? Museums, Health and Wellbeing
Laura Butland  The Infirmary/George Marshall Medical Museum
Sensitive Issues: Working with Young People to Explore the History of Sexually Transmitted Infections through Art and Medical Collections

Janine Marriott, Learning Coordinator Arnos Vale Cemetery
A Matter of Life and Death: The History of Medicine in Bristol, past and present

Joanne Catlow, Education & Outreach Manager, Kirklees Museum and Galleries
Reminiscence Loan Scheme

1.00 Lunch

1.45 Practical Workshops:

1. Who Cares? Museums, Health and Wellbeing programme
   Leisa Gray, Community Development Manager, Manchester City Galleries

2. The PSHE education curriculum and working with schools
   Lucy Marcovitch
   Education consultant and writer

3. Heritage in Hospitals: Best Practice
   Linda Thomson, UCL Museums & Public Engagement, University College London

   Sarah Clarke
   Independent Consultant
   Victoria Northwood Head of the Archives and Museum Service South London and Maudsley NHS Foundation
   Annabel Elliott Museums and Galleries Consultant

5. Museum and Galleries
   Reminiscence Loan Scheme Joanne Catlow Education & Outreach Manager, Kirklees

3.00 Coffee

3.15 Discussion – How can we work together to deliver against healthcare agendas

4.00 Close
Appendix 3
Case Studies of current work – Presented at UKMCG Conference

Dr Linda Thomson, UCL
Heritage in Hospitals: Best Practice
Researchers and curators from University College London (UCL) and University College London Hospitals Arts established a unique programme investigating the therapeutic role of museum object handling on the health and wellbeing of hospital patients. This three-year project, ‘Heritage in Hospitals: Exploring the potential of museum object handling as an enrichment activity for patients’, was funded by the Arts and Humanities Research Council (AH/G000506/1). Selections of six objects comprising archaeological artefacts, artworks, geological and zoological specimens from UCL Museums & Collections (e.g. Grant Museum of Zoology, Petrie Museum of Archaeology, UCL Art Museum) were taken into healthcare settings to create a multisensory experience where participants were encouraged to explore the visual, tactile and kinaesthetic properties of these objects. Sessions lasting around 30-40 minutes were conducted in acute, chronic and psychiatric wards, neurological rehabilitation units and residential care homes in facilitated one-to-one or group discussions. Conversation focused on the tactile and emotional properties of each object in turn (e.g. What does it feel like? How does it make you feel? Does it remind you of anything?). Prior to the sessions, participants were asked to read an information leaflet and sign a consent form agreeing to take part in the research and for auditory recording. The research used mixed evaluation methods including self-report rating scales, interviews and observational techniques. Quantitative measures, consisting of PANAS (Positive Affect Negative Affect Schedule) mood assessment scales for psychological wellbeing (Watson, Clark and Tellegen, 1988) and VAS (Visual Analogue Scales) for subjective wellbeing and happiness (EuroQol Group, 1990), were taken immediately before and after the sessions to compare baseline measures with effects of the intervention. Publications resulting from the research include a best practice manual, Heritage in Health: A guide to using museum collections in hospitals and other healthcare settings’ available from: www.ucl.ac.uk/museums/research/touch/heritageinhospitals/publications

Results
As predicted, museum object handling brought about significant increases in positive mood, wellbeing and happiness and decreases in negative mood when measures from before and after the sessions were compared statistically. All participants appeared to benefit by the same amount across measures (18-20%) compared with their baselines consequently there were no significant differences between patient groups except for care home residents who showed no improvement in happiness. In order to determine whether it was the museum objects or simply the conversation about them that led to wellbeing improvements, a control group was used where participants discussed photographs of objects rather handling them. The control group showed little improvement so it is likely that the addition of the tactile component helped to enhance wellbeing.
Thematic analysis of recorded discourse revealed that museum object handling generated increased engagement and enjoyment, enhanced participants’ sense of identity and self-esteem, and provided a positive distraction from clinical surroundings. Participants demonstrated improved social interaction with hospital staff and visitors, and reported experiencing their hospital stay more positively. Findings add weight to the need for provision of heritage- and arts-focused activities by museums and galleries for older audiences and those excluded by virtue of their healthcare status.

Lessons learned
• What went well
• What went less well
The museum object handling sessions proved to be a successful, non-pharmacological intervention applicable across a range of healthcare settings. Findings suggest that ‘museum object therapy’ programmes could be rolled out more widely across the UK using a virtually free resource of museum objects not on public display or part of main collections, given sufficient training for facilitators. New funding has recently been made available via a HLF ‘Your Heritage’ grant for researchers at UCL to train museum and hospital volunteers to carry out museum object handling sessions using the ‘Heritage in Hospitals’ protocol and best practices developed through the research.

It was surprising that despite few alternatives in terms of activities in hospitals and care homes, many patients refused to participate in the sessions, expressing beliefs that museum objects should not be handled or taken into hospitals and should be kept behind glass, preserved for posterity. Of potential participants approached (i.e. those awake, sitting up in bed), approximately one in eight consented to take part in the research consequently considerable time was taken up explaining the project to people who subsequently declined. It would be advantageous in the future to elicit more support from carers and staff in encouraging participation.

For further information
- Contact details for key person/organisation
- Weblinks to publication, project content etc

Email: Dr Helen Chatterjee (Principle Investigator) h.chatterjee@ucl.ac.uk
or Dr Linda Thomson (Lead Researcher) linda.thomson@ucl.ac.uk
For further information visit: www.ucl.ac.uk/museums/research/touch
and www.ucl.ac.uk/museums/research/touch/heritageinhospitals

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A Matter of Life and Death: The History of Medicine in Bristol, past and present
Janine Marriott, Arnos Vale Cemetery

I will be outlining our new project which is designed to stimulate interest and engage a wide range of audiences with the important contribution that biomedical knowledge and practice has made to our understanding of public health and disease.

The project will build on existing research of the medical history at Arnos Vale Cemetery, set against a backdrop of a time period of the past c.200 years, and will be set within the context of cultural practice surrounding death and remembrance in Arnos Vale Cemetery within the context of medical science during that time.

The project is based on an exciting multi-disciplinary collaborative partnership between Arnos Vale Cemetery Trust, University of Bristol and Ashton Park Secondary School, with the involvement of medical practitioners, medical historians, science and history teachers, as well as undergraduate medical students and secondary school pupils.

Arnos Vale cemetery is a great 'depository' of Bristol’s social history, with strong links to the histories of public health, sanitation, disease and medical treatment in the city. Using Arnos Vale as a primary resource (its landscape, graves and epitaphs, private burial records, archives and historic development) the project will explore and present three main themes:
- a) disease & mortality;
- b) public health & sanitation;
- c) medical pioneers past and present.
The intention of the project is to draw parallels and contrasts between historic and contemporary biomedicine, and to be relevant to a broad range of different audiences.

Results
*Unknown*

**Lessons learned**
- N/A project at start

**For further information**
- Contact details for key person/organisation
  Janine Marriott – Learning Coordinator. learning@arnosvale.org.uk

**Working with young people to explore the history of sexually transmitted infections through medical collections and art**

Laura Butland, The Infirmary/George Marshall Medical Museum

The project was designed to run via 2.5 hour sessions over 16 weeks, based in the former Infirmary Chapel. The general structure was designed to begin sessions with casual conversation over lunch, then an ice breaker game or provocation from our artist, and the rest of the time used creatively by the group. This worked very well as a way of making the group feel comfortable and getting to know each other.

The project was funded in part by HLF (as part of a wider exhibition and engagement project – The Infirmary) and in part by 5x5x5: Creativity Worcestershire. A key part of working with 5x5x5 on this project was the use of a co-enquiry approach with participants. Over the 6 month period of the project, the input from participants will shape the end product, depending on the ideas and resources they respond to the strongest. This has been difficult to manage at times due to specific criteria to meet for HLF funding. The participants have also indicated that they want to know where the project is heading, and what the end goal is.

In general the multi-layered funding of this project has also thrown up some interesting disparities; the co-enquiry based approach of 5x5x5 and the clear working framework of the HLF project have proved to be rather contrasting approaches to project management.

Working with participants in or at risk of NEET status has not proven to be as challenging as first thought, though this is largely due to the excellent support they receive at the Youth Development Centre in Worcester. A youth worker was brought in at the start of the project, which has worked very well in keeping the participants feeling supported.

The participants’ feeling of ownership over the former Infirmary building has been particularly strong, and was unexpected. This has highlighted the need for flexibility in future projects and challenges in trying to predict a group’s interests and level of engagement with the chosen topic.

**Results**

This project is still on-going, and as such no final results can be reported. At the time of the conference, the project will be around two thirds of the way through. At this time the only data that can be confidently shared are the attendance figures. Due to the difficulties involved in encouraging young people at NEET status to commit to projects such as these, attendance figures are an important indicator of how well the project has been able engage with the participants. Out of a
pool of participants who showed interest at the start of the project, attendance has been measured as a percentage of how many of those actually attended. Over the first 8 weeks, attendance figures have been above 50% for all but one session, which ran immediately after the half-term break. The majority of the sessions have had at least 75% of the potential pool of participants, with the eighth session achieving 100% attendance rates.

Lessons learned
What went well
- The engagement of young people from the Youth Development Centre worked very well, especially in the city centre University location.
- Forming relationships with the participants was personally rewarding for all involved.
- Making connections with the local NHS sexual health education team proved to be very valuable, both in terms of resources and expertise.
- Working on a subject that wasn’t well covered within any existing exhibitions was a brilliant way of using more of the collection.

What went less well
- Navigating through the project via a process of co-enquiry could be difficult at times, and lead to confusion in the group

For further information
Contact details for key person/organisation
- Laura Butland, Graduate Trainee: l.butland@worc.ac.uk

Weblinks to publication, project content etc
- GMMM website: www.medicalmuseum.org.uk
- GMMM Facebook: www.facebook.com/TheMedicalMuseum
- Infirmary Facebook: https://www.facebook.com/TheInfirmaryWorcester
- Project blog: artintheinfirmary.wordpress.com/
- Artist’s website: http://collectiveunconscious.co.uk