

# Perspectives from Occupational Therapists on issues impacting the UK's ageing population



## Foreword

by **Shelley Hughes**,

*Sr Product Manager at Pearson and Occupational Therapist*

We understand there are considerably more older adults in the UK now than ever before. This is a great achievement overall that people are living longer, but it comes with its challenges when a large number of older people are living with a burden of ill health. As a trained occupational therapist, myself, I can view Occupational Therapy as a powerful tool that can help older adults overcome daily challenges caused by loss of mobility, cognitive decline, poor mental health such as anxiety and depression and other age-related difficulties.

In this document we compiled some great examples of the work my fellow occupational therapists do every day helping older members of our society to engage in everyday life through timely intervention, assessment and compassion. We hope you enjoy reading about the thoughts and experience of practitioners, working to improve life outcomes for older people.

*With warm wishes,*

*Shelley Hughes*

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## Case Study 1

# Assessing an older person with Depression



### Background

**Betty**, aged 84, was referred to the Community Rehabilitation Service following a hospital admission for a fall. The service combines short term (enablement) care alongside therapy input. It had been identified that Betty would benefit from community rehabilitation to regain independence in Activities of Daily Living (ADLs) and ultimately reduce her longer-term care needs.

### Initial assessment and observations

Within her initial occupational therapy assessment, a list of problems was compiled in conjunction with Betty. She suffered from severe osteoarthritis in her knees and hips and described how her mobility and balance had recently deteriorated. As a result, she had started to have trips and falls. She spoke of how both pain and her fear of falling were impacting upon her engagement in activities and how, in the months leading to her admission, she had become increasingly housebound. She was starting to struggle with functional tasks, particularly cooking, which was a task she used to enjoy. Betty expressed concerns that she was losing her functional independence and would soon start to become 'a burden'.

When reviewing her support network, it was established that Betty was a widow and her only son lived many miles away. He was supportive with regards to ordering her internet shopping,

but his busy job and distance meant he was only able to visit her sporadically.

On occasion it was observed that Betty found it hard to maintain her focus on the initial interview. She exhibited reduced topic maintenance and displayed disinterest in formulating goals to work on during her occupational therapy sessions. When discussing her memory Betty stated that she found it hard to concentrate on tasks and felt her brain was often 'foggy'. She equated this to fatigue and mentioned that since leaving hospital she had had trouble sleeping and her appetite was poor. She wondered if these symptoms were due to side effects of a new medication she was taking.

### Further cognitive assessment and therapy to combat depression

In her next session a rapport had been established with the occupational therapist and Betty was willing to engage in a standardised cognitive assessment. Betty managed to attend to the assessment and her score was within normative levels. However, in older adult's confusion or inattention caused by depression are often mistaken for symptoms of a cognitive impairment, such as dementia.

At this point in the assessment process there were indicators that Betty was potentially suffering from low mood. A depression scale was then undertaken with Betty and her score was indicative of depression. Using this tool had additional utility as it allowed Betty to open up further about her feelings. She described intense feelings of loneliness, which had started following the death of her husband three years previously but had further increased alongside her social isolation and reduced contact with her son. Betty went on to say that she often felt sad and believed that her life was empty.

Betty consented to an onward referral to the Increasing Access to Psychological Therapies (IAPT) programme to access appropriate talking therapies. She was also referred to a day centre with transport included, whereby she started to attend their luncheon club, chair-exercise sessions and computer sessions (so she could learn how to skype her son). Additionally, she was linked into a befriending service. These interventions reduced her loneliness and her mood improved. In turn she started to take pleasure in activities again and, with some adjustments, was able to resume cooking and baking. Her GP was also able to start to monitor her mood and offered further treatments if required, including pharmaceutical options.

### How is Betty feeling now?

It was important to recognise that Betty was suffering from low mood alongside her physical comorbidities. Evidence shows that within the health care system an older adult's physical health is often prioritised over mental health, by both the client and health professionals. Indeed, Betty herself had initially identified the disabling effects of her arthritis as her main problem. In therapy sessions Betty was given space to talk about and explore her feelings and was able to see that her experiences were normal. It is acknowledged that social

isolation, loneliness and functional decline are high risk factors for depression in older adults. Depression can also be associated with poorer recovery from physical illnesses. However, by treating her mental and physical health issues concordantly, Betty's therapy outcomes were vastly improved.

**About the author:** Nicola Pruss worked in the Criminal Justice sector for 10 years before retaining as an Occupational Therapist on London Southbank University's Masters Course. After graduating in 2009 she completed both community and acute rotations, gaining a wealth of experience in a variety of clinical areas. She now specialises in Elderly Care and has a special interest in older adult's mental health, particularly dementia care. Nicola also has a passion for using the arts in therapy and has worked on music and drama therapy projects with older adults. Nicola lives in South London with her family.

Depression is estimated to affect **22%** of men and **28%** of women aged 65 years and over in the UK (Royal College of Psychiatrists (2018) *'Suffering in Silence: age inequality in older people's mental health care'* – Access via: <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/cr221>).

## Case Study 2

# Older Adults and Anxiety



### Background

**Mary**, aged 74, was referred to occupational therapy following treatment for breast cancer, which was now in remission. Her illness and associated treatment had resulted in her becoming weak and deconditioned. Her GP therefore made a referral to community therapies for a Physiotherapy intervention to improve her muscle strength and exercise tolerance, alongside an occupational therapy assessment to review how she was managing her Activities of Daily Living (ADLs).

### Initial assessment and difficulties it flagged

Within her initial occupational therapy session Mary explained that she did not perceive managing daily tasks, such as washing and dressing herself, to be a significant problem. Since becoming unwell she had developed her own pacing and energy conservation strategies and had been provided with small aids and equipment following a previous occupational therapy intervention. She also had a supportive daughter who visited regularly and assisted her with shopping and heavier household chores.

When reviewing her pre-morbid function Mary described an active life whereby, she went out with her daughter at least twice a week for lunch or shopping trips, babysat her young grandchildren and attended the daily coffee mornings and other activities in her

sheltered accommodation scheme. When discussing her current routine Mary stated that she now only left her flat for medical appointments and, instead of meeting at cafes or the shops, her daughter currently came to visit her. Upon exploring how Mary could start to gradually resume meaningful activities she became upset and stated that she found it difficult to leave her flat. She described being nervous, tense and 'on edge' if she had to think about going outdoors and was particularly frightened of being in busy, crowded places. She extrapolated that ultimately, she only felt safe at home where she had control over her environment. Mary was able to articulate that she felt she had had no control over her illness or treatment and this in turn had diminished her feelings of control over her life. She explained how she was terrified of becoming ill again and this fear had manifested itself in obsessive compulsive hand washing and a phobia regarding germs. She was terrified about 'giving germs' to her grandchildren, meaning her contact with them had drastically reduced and this was also affecting her relationship with her daughter. Additionally, she was concerned about the extent to which her constant anxiety and worrying about her family was affecting her sleeping patterns, mood and overall quality of life.

*“ The NHS defines anxiety as something everyone experiences at times, and feeling anxious is a perfectly natural reaction to some situations. But sometimes feelings of anxiety can be constant, overwhelming or out of proportion to the situation and this can affect your daily life. ”*

## **Diagnosis of anxiety disorder and its origins**

Mary presented as someone with a generalised anxiety disorder with obsessive compulsive traits. She spoke about how she would fixate on bad things that might happen to herself and her family members if she did not undertake certain rituals such as frequently washing her hands and checking her doors and windows numerous times before going to bed. She recognised that her compulsions did not usually alleviate her anxious thoughts but still felt an intense need to continue with her rituals in order to keep herself and her family safe. Mary had insight into the fact that her heightened anxiety had developed after the trauma of her cancer diagnosis and she spoke of the feelings of guilt she had at this time regarding fears that she might die and leave her family behind.

Mary was keen to start challenging her irrational thoughts and break the patterns surrounding her compulsive behaviours. She reported that she had not been offered any counseling to date and was not sure how to access these services. She admitted that talking to the occupational therapy about these issues was a huge relief as she had recognised that she needed help but previously had not known where or how to ask for it.

## **Further steps to combat anxiety**

Mary was referred onto to the Increasing Access to Psychological Therapies (IAPT) programme and later completed a course of Cognitive Behavioral Therapy (CBT). Whilst waiting for this treatment the occupational therapy explored anxiety management strategies with Mary and taught her to use relaxation exercises, including deep breathing and visualisation, to help to manage her anxious thoughts. Graded exposure to stressful situations was also explored. Mary resumed having her grandchildren to visit twice a week, initially for a very short period but allowing the length of their visits to gradually increase. After the visits Mary was able to reflect upon the fact that the children had remained safe and well and her fears about them coming to harm when in contact with her were not realised. She was later able to start to visit cafes with her daughter by ensuring that their planned route avoided busy areas and being reassured that if she started to feel anxious and panicked, her daughter would accompany her straight home. The CBT sessions then helped significantly in reducing her compulsive behaviors.

*“ Researchers say it’s normal for older adults to worry more about things like deteriorating health and financial concerns as they age, but elderly with generalized anxiety disorder worry excessively about routine events and activities for six months or more. ”*

## **How is Mary coping now?**

Provision of the appropriate mental health support allowed Mary to start to manage her anxiety levels and reduce her compulsive behaviours.

This drastically improved her quality of life and restored her family relationships. As in Marys' case older person's interactions with healthcare services usually focus on their physical co-morbidities and their emotional health is habitually neglected. Anxiety is a common condition in older adults, especially those suffering from a long-term health condition. Pitman et al (2018) identified that anxiety affects approximately 10% of cancer patients and impacts upon quality of life, adherence to treatment and cancer survival.<sup>1</sup>

In 2010–11 a UK survey measuring wellbeing in adults identified that anxiety and depression in older adults was as high as 15% for 70-74 year olds, 17% for 75-79 year olds and 20% for those over 80.<sup>2</sup>

However, a 2016 report by the Mental Health Foundation discovered that only 6.6% of those accessing the IAPT programme were aged over 65, suggesting that many older persons are still not receiving the mental health support they need.<sup>3</sup>

**About the author:** Nicola Pruss worked in the Criminal Justice sector for 10 years before retaining as an Occupational Therapist at London Southbank University in 2007. After graduating she completed both community and acute rotations, gaining a wealth of experience in a variety of clinical areas. She now specialises in Elderly Care and has a special interest in older adult's mental health, particularly dementia care. Nicola also has a passion for using the arts in therapy and has worked on music, art and drama therapy projects with older adults. Nicola lives in South London with her family.

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## Case Study 3

# The complexity of frailty – Consequences of multiple falls interventions



*“ The Public Health Outcomes Framework (PHOF) reported that in 2017 to 2018 there were around 220,160 emergency hospital admissions related to falls among patients aged 65 and over, with around 146,665 (66.6%) of these patients aged 80 and over. ”*

Care of older people can be complex, particularly with regard to preventing or reducing the risk of falls. In a Frailty Rehabilitation unit occupational therapists are at the centre of this care and assessment. Enabling patients to live meaningful and independent lives is at the forefront of all decisions.

A case study of an older person admitted to hospital with multiple falls, highlights the breadth of the assessment and decision making associated with being an occupational therapist in frailty. Elements of the NICE Guidelines for Multifactorial Falls Risk Assessment (NICE 2013) are used to frame this case study.

## Background

**Peter** lives alone at the age of 85 and feels that he looks after himself quite well, albeit using ready meals for dinner since the loss of his wife 2 years ago. He finds it more and more difficult to go out so opts for staying at home with the TV and relies on occasional visits from family or neighbours to keep him ticking over. He walks with a stick and uses the furniture to steady himself where needed.

He presented in hospital for the fourth time in six months with yet another fall at home. Each time he is one of over 600 emergency admissions for older people with falls across the country each day. He reports his legs “just gave way” or he “lost his balance”. He has been sent home from the Emergency Department twice, assessed as “back at baseline” with mobility, patched up from skin tears to his right arm, the cut above the right eye stitched up, and looking a little worse for wear with bruises, but lucky to have not broken any bones.

Last time Peter had a fall, he couldn't get up and was found by a neighbour the next morning after almost 12 hours of laying on the floor. He made his way through the Emergency Department and the medical assessment wards having been treated for a pressure sore (from laying on the floor so long), an underlying infection and struggling to get himself about.

He ended up in the Frailty Rehabilitation Unit where he was assessed and treated by a frailty specialist occupational therapist.

## **Activity analysis through function – gait, balance and mobility**

Peter was assessed through functional activities including, but not limited to, the breakfast group and washing and dressing assessments. Through activity analysis these assessments showed strength, balance, range of movement, pain, sensation, and cognitive processing, as well as getting to know Peter and what is important to him. A treatment plan was made based on rehabilitation goals identified by Peter, to get him back to being independent with activities of daily living.

At the first breakfast group, and on the first washing and dressing assessment, Peter remained seated but showed good use of his upper body in managing basic functional tasks. With a combination of physiotherapy input and the Rehabilitation Assistants repeating practice of functional tasks, Peter grew stronger and more confident to push himself further and start doing normal activities of daily living while standing. He loved the groups and was always at the centre of conversations.

Still at risk of falling, Peter felt more confident using a wheeled walking frame to increase his base of support and enable him to push further in his rehabilitation. Getting Peter stronger was just one part of helping reduce falls and hospital admissions in the future.

## **Sensory impairments**

Part of the initial assessment for a person who has had falls is a basic vision assessment. This includes checking the condition of glasses, regularity of eye tests, episodes of blurred vision, and peripheral eye sight.

Increasingly avoiding leaving the house meant Peter had neglected his vision somewhat. His glasses were over 3 years old. His peripheral vision test showed he was missing items to the right-hand side. This was evident in his walking too, catching the frame on furniture and not noticing things on the floor. In addition to linking into charitable organisations such as Age UK to support access to eye checks, an assessment of the home environment was essential to contextualise the mobility, and sensory assessments with where the falls occurred.

## **Home hazards**

*“ Unaddressed fall hazards in the home are estimated to cost the NHS in England £435 million ”*

A comprehensive environmental assessment identified falls risks in the home and shaped recommendations for making the environment and daily activities safer and easier for Peter. A local handyman service, available to facilitate hospital discharges, were used to move furniture and fit grab rails to make walk ways clearer and safer for Peter. He wanted to be able to use his walking stick again. With a referral to the rehabilitation team at home, combined with minor adjustments to increase safety like the grab rails, Peter was able to get back to his normal level of function.

## **Anxiety and behaviour**

Another important contributing factor to multiple falls is the psychological elements of anxiety and behaviour. We identified the areas where anxiety was greatest so intervention could be focused.

Peter was particularly worried about bathroom as this is where two of his falls occurred. With

his gradually decreasing strength Peter was struggling to use the bathroom and agreed that alongside his ongoing rehabilitation minor equipment adaptations could help regain confidence with basic tasks, such as washing, dressing and using the toilet.

Peter also worried a lot about going out and about, having tripped up a curb when last attempting to walk outside. Peter was referred to the voluntary sector to support him access community services and attend social day centres. This helped to fulfil his social needs, as well as build confidence in leaving the house again. As a result, this had a positive impact on Peter's mental well-being.

## Where is Peter now?

Since the comprehensive assessment of Peter's physical, sensory, psychological and social needs Peter has not been readmitted to hospital. Cognitive assessment showed some mild cognitive impairment, but other assessments showed it was not at the extent of impacting function in daily living. Cognitive processing can also have an impact on frail older people which will be explored in the next blog and case study.

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## Case Study 4

# The complexity of frailty – Understanding cognitive assessment through functional activity



Every one of us uses complex cognitive processes even for the simplest of tasks, such as cleaning our teeth as an example. At first we recognise this is an activity that needs to be done. Social and sensory feedback, including taste, smell and texture in the mouth, may signal to the brain that the task is necessary. Then multiple cognitive processes take action: identifying the place to conduct this activity (in a bathroom/at a sink/with a bowl), what is needed to complete it (water, a toothbrush, toothpaste), knowing how to use these items, initiating the process, sequencing each element of the activity, maintaining memory, concentration and attention to continue the task, recognising the need to end it, and continuing to completion.

Brushing the teeth represents a simplistic and non-exhaustive sequence of cognitive processes and executive functions needed to complete a simple activity. This sequence and its processes are disrupted when a person has a cognitive impairment. In older adults' cognitive impairment is common and can have various causes. Two typical causes for this age group are:

- Dementia (an ongoing, gradual decline which cannot be reversed).
- Delirium (an acute onset of cognitive impairment which is reversible).

The root of delirium can often be identified using the PINCH ME acronym: Pain, Infection, Nutrition, Constipation, Hydration, Medication, Environment.

Delirium can be reversed by finding the root and adapting intervention to eradicate the cause. Dementia takes many forms, most commonly Alzheimer's Disease, Vascular Dementia or a mixture of the two. Cognitive impairment from a disease of the brain like Dementia is not reversible and will gradually worsen. It is also possible to have a delirium on top of a Dementia, which is not uncommon to older people in hospital.

Whatever the cause, cognitive impairment can significantly impact function – a huge element of an occupational therapy assessment. A case study is presented below, to demonstrate how cognitive impairment can be assessed, and interventions suggested, by occupational therapy in an inpatient rehabilitation ward for older, frail, adults.

## Background

**Pamela**, aged 80, was admitted to hospital with a Urinary Tract Infection (UTI), leading to a fall with a fracture of her pubic rami, and unusual levels of confusion. Her medical history included a diagnosis of Alzheimer's Dementia six years ago. Despite this, Pamela has been relatively independent in her daily life

at home – getting herself up in the mornings to have a shower (in standing but with grab rails to hold for security), making her own meals, and pottering around the house. She enjoys going out to her day centre once a week to socialise and has a very supportive daughter who arranges her food shopping and helps with heavy domestic tasks such as cleaning, laundry and taking out the bins.

When the Occupational Therapist on the frailty rehabilitation ward met Pamela, she had made her way through five different ward transitions, from Accident and Emergency through to the current ward. Pamela was needing assistance with her washing and dressing on the ward and managing a few steps with a wheeled walking frame.

## **Cognitive screening**

As part of her initial occupational therapy assessment a basic cognitive screen is done. Unsurprisingly on admission to the ward Pamela scored highly on the test showing cognitive impairment as an area of concern.

‘PINCH ME’ is applied:

Pain is a huge issue for Pamela. She continues to recover from her infection. She has had various environmental changes in quick succession all to unfamiliar, busy and over-stimulating hospital wards. She is introduced to more medication changes: pain relief and further antibiotic treatment.

## **Assessing cognition through function**

Pamela participated in two key activities for cognitive assessment through function: an observation of washing and dressing, and attendance of the breakfast group. The washing and dressing assessment is used to demonstrate cognitive, as well as physical, obstacles to independence.

In the “washing and dressing assessment” Pamela is observed to recognise all the items she needs to complete this familiar task. The items she chose are all laid out ready for use. A shower chair is used as Pamela struggles to stand and maintain standing balance due to pain and reduced mobility – a change from her usual routine and in an unfamiliar environment. Pamela independently initiated, sequenced, and completed washing of her upper body, recognising it was done and time to move on. She identified and appropriately used all the objects needed to wash her upper body.

Pamela then became distracted and confused, looking around her but not initiating the next part. She picked up various items such as hair brush, soap, flannel and towel, then put them down again. Apparently unsure what to do next the Occupational Therapist prompted her to move onto the lower half. The Occupational Therapist assisted Pamela to stand from the chair and advised her to hold the grab rails to maintain balance. Pamela was unable to identify the whereabouts of these white rails on a white wall until physically guided to them. Pamela needed assistance due to physical issues but had not demonstrated the cognitive ability to problem solve or complete the whole of the showering activity. She also showed clear visual-spatial deficits with white-on-white grab rails.

Likewise, when drying and dressing, moving on to the bottom half appeared to incur confusion. In addition, Pamela being sociable decided to chat to the Occupational Therapist while completing the activity. At various stages Pamela became so distracted by conversation she stopped the activity and then required prompting to continue when the conversation topic ended. She showed she was unable to maintain attention and concentration, not using her memory or recall to re-start the activity.

## Recommendations

The primary recommendation for anybody showing functional decline in hospital due to cognitive impairment is to seek a familiar environment, which is usually the home environment. It is therefore imperative to get people home as soon as possible. With the support of hospital discharge and the rehabilitation-at-home service, Pamela was able to have the reassurance of a daily visit (in addition to mealtime support), to continue developing her independence, and support her recovery in the familiarity of her own home, with important cues such as the scent of her own toiletries, and her own familiar routine.

Some minor changes were made to Pamela's bathroom: a shower chair to initially ensure safety while the pubic rami fracture continued to heal, and some new contrasting colour rails to enable Pamela to clearly distinguish and identify them.

Recommendations were also made to the rehabilitation-at-home team to ensure sensory stimulation (such as social conversation) during the specific task was kept to a minimum to enable Pamela to maintain concentration and attention to complete the task independently.

These were just a few of the cognitive processes identified and addressed through functional activity. The principles, however, could be applied across a variety of activities needed for daily living in any occupational therapy assessment and intervention for this patient group.

**About the author:** Dr Naomi Gallant is a Team Lead Occupational Therapist a Frailty Rehabilitation Unit, focusing on rehabilitation for frail older adults following admission to acute hospital. She completed her Doctorate in 2019 entitled, An Occupational View of Improving Meal Times for People with Dementia in Acute Hospitals: A Mixed Methods Study. Naomi is on the National Executive Committee for the Royal College of Occupational Therapists Specialist Section for Older People.

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## Case Study 5

# *No man is an island* – the importance of including carers within holistic occupational therapy interventions



*'No man is an island'*, as poet John Donne wisely stated almost 400 years ago, observing that the ill health of one individual is of consequence to all. As health practitioners we do well to remember this and must acknowledge that the illness and disability experienced by our patients and service users can also have a significant impact upon the health and wellbeing of the family members and loved ones around them. Likewise, a person's family and social circumstances can greatly help or hinder their management of, or recovery from, illness and disability.

Occupational therapists are experts at considering the physical and social environments that people occupy, and routinely consider these factors when working with patients and service users to achieve occupation-focused goals. 'Occupations', as described by the Royal College of Occupational Therapists are 'any practical and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day tasks such as self-care, work or leisure.'

Occupational therapists know that a holistic and person-centred approach is essential in supporting people to achieve outcomes that are meaningful to them. Including family members and carers in goal setting and

intervention planning can be vital in achieving successful results that not only benefit the disabled person, but also have a positive impact upon those around them.

Taking a pragmatic approach, there are estimated to be over 8 million unpaid carers in the UK currently, saving the health and social care system around £132 billion a year. NHS England have acknowledged within the Long Term Plan that the health system is reliant on the support that informal carers provide, and that they must be better recognised and supported. The most recent 'State of Caring' report, produced by Carers UK in 2019, shows that large numbers of unpaid carers experience poor physical and mental health, attributable to their caring roles, and many face financial challenges, for example due to giving up paid employment in order to care for a loved one. As health professionals we have a legal and moral duty to support unpaid carers, not just because it is the right thing to do in order to support the health and wellbeing of carers and those they care for, but also because the health and social care system could not cope without them.

## Background

I met **Winston** and his wife **Delrose** when Winston was referred to me for major home adaptations, following a loss of mobility

and independence due to a progressive neurological condition. The house that they had owned and lived in for over 20 years was no longer suitable for Winston's needs and he had become increasingly reliant upon Delrose for support with activities of daily living and moving around the house. In the space of just two years they had gone from being an active and sociable couple to feeling isolated and trapped in their own home. This was evidently taking a physical and psychological toll on both of them and they were at significant risk of illness and injury. Their daughter, son-in-law and two young grandchildren lived locally, but Winston and Delrose felt they did not have enough time or energy to do things with their family or to socialise with friends.

### **Holistic assessment and recommendations by an Occupational Therapist**

I recommended installation of a level-access shower and through-floor lift and creation of step-free access to the house and garden. While these adaptations were ostensibly provided to make it safer and easier for Winston to use the facilities in his home, and to reduce the physical demands upon Delrose as his main carer, the wider impacts were significant. As it was quicker and easier to support Winston with his morning routine, they started looking after their grandchildren two mornings a week, which enabled their daughter to start working part-time. As Winston was now able to leave the house without difficulty, I referred the couple to a local charity that ran groups and activities for older people and their carers. This enabled them to socialise and participate in activities that supported their wellbeing. Delrose also started volunteering in a charity shop.

### **Where are Winston and Delrose now?**

The financial value to the health and care system of enabling Winston to remain safely in his own home was significant, as was supporting Delrose to continue her caring role. There was also economic value in allowing their daughter to return to paid employment. However, the value of supporting the whole family to be happier and healthier was priceless.

**About the author:** Lauren Walker is a registered occupational therapist with a professional background in housing, social care, blue-light collaboration and public health. She has spent five years as a specialist housing occupational therapist within a London council, and two years working with London Fire Brigade to deliver person-centred, public health focussed home visits to vulnerable older people. Lauren has recently joined the Royal College of Occupational Therapists as a Professional Adviser.

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