SW London **System**

Small Grant Projects 2013

South West London
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The Small Grant programme is a well-established and essential part of the SW London System's activities. Since its creation in 2010 – to complement the System's larger strategic projects – 26 diverse projects have been supported. Health and social care professionals in every south west London borough have worked together, often with university-based researchers, and successfully applied for a small amount of money that has frequently enabled bigger changes.

The Small Grants programme exemplifies collaboration across academic, health and social care boundaries, reflecting a fundamental principle of the SW London System. Anyone from our member organisations can apply for a grant, whether or not they have had any previous experience of research. A Small Grant can encourage health and social care professionals to get involved and develop evidence that can help shape better services for south west London and possibly beyond. Our grants can aid in the development of new and effective ways of working – whether between agencies or across the whole of south west London.

Our aim is to emphasise **learning** - through innovation, collaboration, from the actual experience of doing a project and **dissemination** – so that lessons learnt, good practice and successful outcomes can be shared across the SW London System and wider.

This booklet contains information on each of our 2013 Small Grant projects, along with posters produced for our annual conference that year. They cover a wide range of health and social care areas, and typify the SW London System's approach to innovation and collaboration. We have recently selected the new Small Grants for 2014, details of which are on our website.

For more information, visit our website at www.swlondonsystem.org.uk

To Identify the Effectiveness of Speech and Language Therapy Input to the Croydon Youth Offending Service for Young People on Intensive Supervision and Surveillance Orders

Ann Harvey, Service Manager, and Clare Andrew, Highly Specialist Speech and Language Therapist, Paediatric Speech and Language Therapy Service, Croydon Health Services NHS Trust

The aim of the project is assess the efficacy of speech and language therapy with young people, who are on an intensive surveillance and supervision order (ISS) in Croydon Youth Offending Service (YOS).

Following training, YOS staff will identify and refer clients on a ISS Court Order for a language screening assessment with the Speech and Language Therapist.

On completion of the language screen a report would be compiled explaining the specific communication difficulties the young person is experiencing, the impact of these and the effect these may be having on their ability to comply with the work programme. The therapist will also give staff specific advice and strategies to implement when working with the young person.

Information gathered as part of language screening or the more detailed assessment of communication skill will be used as a means of identifying the level of need for on-going speech and language therapy intervention for this group of young people.

The key aims of the project are to:

- ensure YOS staff are confident in their ability to identify communication difficulties
- identify the level of need for speech and language therapy intervention with Young People on ISS orders in Croydon YOS
- provide support to staff on how to adapt their communication when working with young people with communication difficulties
- provide and support implementation of general and person specific strategies to promote effective communication for individuals in the client group
- trial the implementation of specific speech and language therapy intervention programmes

One barrier can lead to another…

Speech & Language Therapy in Youth Offending Service

Background

Increasing body of evidence highlights the link between youth offending and communication needs.
Professor Karen Bryan (Head of School of Health and Social Care, University of Surrey) reports:
"Children with SLCN (Speech, Language & Communication Needs) face a compounding risk;
their communication difficulties put them at risk of literacy difficulties and this in turn puts them at risk of further educational problems;
…as they come to adolescence they have problems coping with peers, with school and with family relationships and their communication difficulties become labelled as behavioural problems."[1]

The Project

To assess the effectiveness of Speech and Language Therapy (SLT) to the Croydon Youth Offending Service (YOS) for young people on Intensive Supervision and Surveillance disorders (ISS)

Why this Project?

- A reported 60% of young offenders have speech, language and communication problems;
- Four out of five young people are not in education, employment or training and a large proportion of young people excluded from school have speech, language and communication problems.
- Contrast the cost of providing effective speech and language therapy to help young offenders to improve their language skills with the much larger cost of keeping a young person in the criminal justice system.

WHERE were you on the night of …? WHO was accompanying you? WHAT happened next?

I was… I know this one… He went… Then it happened…

What do you mean, 'Stop scowling'? I'm not – I'm confused!

You have not complied with your order…… I am sentencing you to…

Aims of the Project

- To ensure YOS staff are confident in their ability to identify communication difficulties;
- To identify the level of communication needs amongst young people on ISS orders in Croydon YOS;
- To provide support to staff on how to adapt their communication when working with young people with communication difficulties;
- To identify level of need for on-going speech and language therapy support;
- To trial the implementation of speech and language therapy intervention programmes;
- To provide an evidence base on which to frame future service models and commissioning intentions.

Benefits to the Young Person

- Identifying previously undiagnosed communication difficulties;
- Providing strategies to help more effective communication;
- Identifying need for more in-depth assessment and specialist intervention;
- Understanding the terminology of the criminal justice system;
- Accessing the interventions provided within YOS, many of which rely on verbal communication;
- Identifying any mental health concerns and referring on to Child and Adolescent Mental Health Services (CAMHS) as necessary;
- Referral on to other services as required;
- Better understanding of their communication needs;
- Strategies to reduce negative impact of communication difficulties;
- Empowerment to manage communication breakdown in an acceptable and effective way.

Benefits to YOS Staff

- Better understanding of communication needs of young people in their care
- Identifying communication needs of young people;
- Adapting their verbal communication ;
- Adapting written information given to young people.

1. (All Party Parliamentary Group on Speech and Language Difficulties *The links between speech, language and communication needs and social disadvantage*)

Clare Andrew. Croydon YOS. clare.andrew@croydon.gov.uk

Changing Environment and Work Practices to Improve Physical Activity, Physical and Psychological Wellbeing, Quality of Life and Dignity in Care Homes

Mike Hurley, Professor of Rehabilitation Sciences, and Magda Dudziec, Researcher, Faculty of Health, Social Care and Education (a partnership between Kingston University and St George's, University of London)

Currently, there are nearly 750,000 residents in UK care homes, mainly elderly people with physical and mental frailty and ill-health. This number is rising rapidly as more people live longer, putting enormous pressure on health and social care budgets.

Good physical function is vital for maximising their activities of daily living, independence and delay age-related deterioration. Increasing physical function requires improving a person's physical condition and providing opportunities for stimulating, meaningful activities and social contact. This is best achieved by care homes taking a holistic approach to the services they provide, and establishing a supportive and encouraging ethos, attitudes, working practices, culture and environment.

An innovative programme facilitating meaningful physical, mental and social activity has been implemented at three centres in South West London. Preliminary evaluation suggests the programme is popular with staff and residents. Wide implementation of the programme could potentially benefit many people. With support from the South West London Academic, Health & Social Care System the programme will be formally evaluated and documented and will examine the benefits, barriers and facilitators required to implement it. It is hoped that this will then be shared and replicated across South West London.

The key aims of the project are to:

- understand whether, how and why the intervention is (in)effective
- interview care home residents, staff and therapists before, during and after implementation of the programme to capture their worries, expectations, beliefs, opinions and experiences
- facilitate wide implementation
- document the programme's rationale, ethos, content and operationalisation
- document the requirements needed to implement the programme - essential personnel, activities, potential barriers, facilitators and challenges, with ways to overcome these
- disseminate this information to interested health and social welfare and third sector agencies

Increasing physical activity, wellbeing, quality of life and dignity of care home residents

M. Dudziec[1], F. Jones[1], B. Kennedy[2], L. Anderson[2], I. Jackson[3], M. Hurley[1]

[1]School of Rehabilitation Sciences, St George's University of London and Kingston University,
[2]Integrated Falls & Bone Health Service, St George's Healthcare NHS Trust,
[3]Wandsworth Council Adult Social Services.

Background

Nearly 750,000 people with physical and mental frailty live in care homes.
Staff and families want to maintain residents' health and wellbeing to ensure they live full and rewarding lives.

"*Access To Well Being*" is a programme that looks at the residents, their individual needs, the environment in which they live and staff work practices to maximise independence, activity and participation.

The programme has been implemented in a day centre and will now be piloted in a residential home for people with dementia.

Interviews with staff, management and residents will be carried out and analysed using thematic analysis in order to document Access to Well Being's ethos, rationale and requirements to enable others to replicate it.

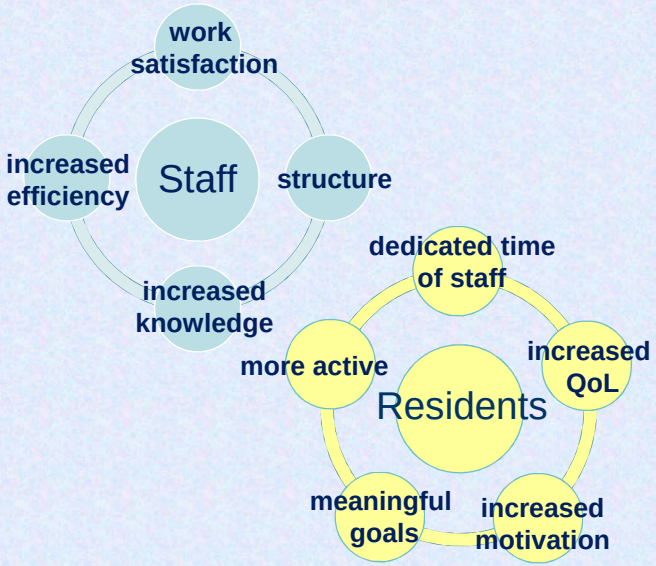
Aims

- **Encourage activity & healthy lifestyles**
- **Increase physical activity & independence**
- **Tailor activities to individual needs**
- **Create an environment that physically & psychologically enhances individual experience**
- **Train staff to support & empower residents**
- **Reduce incidence of falls**
- **Improve quality of life & dignity of residents**

Whole Systems Approach

Organisation	Work Practice	Service Users	Environment
•Culture & ethos change	•Managerial involvement	•Individual assessments	•Floor-plan to encourage mobility
•Encouraging independence	•Staff training on goal setting & dementia	•Dementia specific activities	•Improved signage
•Staff assist residents in goals	•Tools to enable support	•Focus on quality of life	•Activity Boards
•Staff help facilitate meaningful activity	•New documentation system -*an aid not a chore*	•Increase physical activity	•Dementia friendly environment
			•Safe, stimulating & personalised

Benefits



Further information available from: M.Dudziec@sgul.kingston.ac.uk
M.Hurley@sgul.kingston.ac.uk

Feasibility Pilot Study of Collaborative Work To Provide Patient Centred, Low Level and Low Cost Supported Exercise Programmes in the Community to Patients with Chronic Pain

Amanda Clifford, Clinical Specialist Physiotherapist, Kingston Hospital NHS Foundation Trust, and Shirley Piotrowski, Physical Activity Lead, Royal Borough of Kingston upon Thames Public Health

A meeting between the Pain Clinic at Kingston Hospital and Kingston Public Health's Physical Activity Team identified there was a severe lack of suitable exercise provision in the borough for clients seen in the pain clinic, who have very limited physical activity capabilities; many of these clients have multiple issues due to pain or a mixture of pain and other health conditions which limit exercise. This feasibility pilot study will see if collaborative work between the Pain Clinic and the Public Health Physical Activity Team can provide patient centred, low level and low cost supported exercise programmes in the community for patients with chronic pain conditions.

The project aims to establish a three-pronged approach to support those with extremely low exercise tolerance by providing options for outdoor exercise through healthy walks and indoor exercise sessions to allow for maximum uptake and patient choice. These will include supervised, low level free walks, an Aquacise class for patients to exercise in water and a low-intensity free exercise class for those patients that are unable to partake in the walk programme or Aquacise.

The key aims of the project are to:

- increase the number of Pain Clinic patients participating in regular physical activity.
- measure of patient self-efficacy with pre- and post-baseline questionnaires, and at three months
- walk test with pre- and post-exercises measures for walk group
- measure health and physical activity through the SF8 health survey scoring sheet and/or Physical Activity Questionnaire
- reduce medical appointments at hospital or GP by reviewing the number of doctor appointments over six to 12 months during the pilot
- reduce medication use by client, as reported by client
- improve patient mood
- measure and maintain adherence rates of class attendance

Moving away from pain

A collaborative physical activity pilot study between Kingston Hospital Physiotherapy service and the Royal Borough of Kingston Upon Thames Public Health team to provide bespoke exercise opportunities for patients with chronic long term pain conditions who find existing community physical activity programmes beyond their physical capability.

Shirley Piotrowski, Physical Activity Lead, Royal Borough of Kingston Upon Thames and Amanda Clifford, Clinical Specialist Physiotherapist, Kingston Hospital

Background

Chronic pain has a major physical impact on people's lives, but it also has many negative emotional, social and psychological effects. People in chronic pain often feel depressed, frustrated, worried or helpless because of the pain that they are experiencing, tending to shy away from physical activity with fear of doing more harm than good. In fact, the right kind of exercise can greatly assist in making pain more manageable and improving overall quality of life. As a result of meetings between the local authority's Get Active exercise referral team and Kingston Hospital Pain Clinic, it was recognised that there was a lack of suitable and sustainable exercise provision in the borough for pain clinic clients. A patient consultation exercise revealed the type of activity that patients preferred for this pilot study supported by clinical expertise on the appropriate level of intensity.

The Walking Group

Physical Activity Pilots

12 weeks of free multi-activity physical activity programmes:

***Aquacise *Group Health Walks**

***Core & Stretch *Dance**

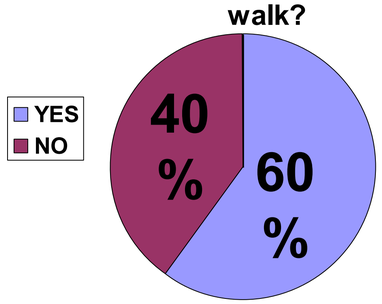
Pilot Aims

- Establish collaborative partnership working between NHS secondary care and local authority health improvement services
- Address the gap in provision of suitable low level exercise for those with chronic pain and limited physical activity capabilities
- Provide patient choice and access to physical activity in the community
- Improve physical functioning, emotional wellbeing and reduce social isolation through increased participation in physical activity

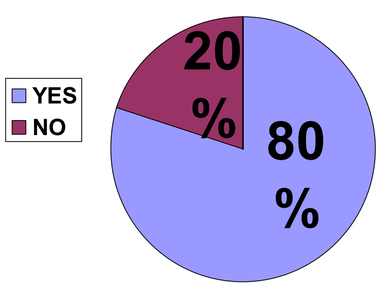
Planned outcomes

- Increase in physical activity participation
- Reduced frequency of hospital appointments
- Reduced medication use by patient
- Improved patient mood and wellbeing
- Sustainability of activity programmes post pilot
- Patient satisfaction

Do you feel your pain has improved having attended the walk?



Has your confidence/mental wellbeing improved post the walk?



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Developing Community Leisure

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Pathways for PCOS: Mapping Treatment and Referral Routes for Women Diagnosed with Polycystic Ovary Syndrome

Dr Yvonne Jeanes, Senior Lecturer, and Dr Sue Reeves, Principal Lecturer, University of Roehampton

Polycystic Ovary Syndrome (PCOS) is the most common endocrine disorder in women, affecting 1 in 10 women. Symptoms of PCOS include menstrual irregularity and infertility, acne, excess male pattern hair, male pattern alopecia and obesity. Many of the symptoms associated with PCOS have been shown to lead to a reduction in health-related quality of life and consequently depression and anxiety are commonly reported in women with PCOS. PCOS is also an independent risk factor for type 2 diabetes and there is an increased prevalence of cardiovascular disease (CVD) risk factors; many women with PCOS have impaired glucose tolerance and insulin resistance. Healthy lifestyle advice for weight management is recommended for all women with PCOS.

There are suggestions of variable care and presently there is a lack of data charting the referral routes for women with Polycystic Ovary Syndrome (PCOS); women with PCOS may be seen and treated by GP's, fertility specialists, endocrinologists, dermatologists or dietitians. Therefore the project will investigate and map the treatment and referral routes for women with PCOS living in South West London in order to help develop recommendations for the future.

The key aims of the project are to:

- investigate and map current treatment and referral routes for women with PCOS living in South West London
- identify differences in care for women with PCOS provided between clinical commissioning groups
- investigate if women with PCOS are getting appropriate advice for long term health
- increase GP's awareness of current recommendations and help develop recommendations for the future

Pathways for polycystic ovary syndrome (PCOS): Mapping treatment and referral routes for women diagnosed with PCOS

Y.M. Jeanes[1], H. Mason[2], S. Reeves[1]

[1]Health Sciences Research Centre, Department of Life Sciences, University of Roehampton, London.
[2]Biomedical Sciences, St Georges University of London.

INTRODUCTION

- Polycystic Ovary Syndrome (PCOS) is the most common endocrine disorder in women, affecting 1 in 10 women (March *et al.,* 2010).
- Symptoms of PCOS include menstrual irregularity and infertility, acne, excess male pattern hair (hirsutism), male pattern alopecia and obesity (Teede et al., 2010).
- Many of the symptoms associated with PCOS have been shown to lead to a reduction in health-related quality of life and consequently depression and anxiety are commonly reported.
- PCOS is also an independent risk factor for type 2 diabetes and increased prevalence of cardiovascular disease (CVD) risk factors; many women with PCOS have impaired glucose tolerance and insulin resistance.
- Prevalence of obesity is high in PCOS and is known to exacerbate the metabolic and reproductive complications of the syndrome (Teede *et al.,* 2010).
- **However, there is a lack of data charting the referral routes for women with PCOS, since they may be seen and treated by GP's, fertility specialists, endocrinologists, dermatologists or dietitians. Therefore we would like to investigate and map the treatment and referral routes for women with PCOS living in South West London in order to help develop recommendations for the future.**

STUDY AIM

- To investigate and map current treatment and referral routes for women with PCOS living in South West London.
- Identify differences in care for women with PCOS provided between clinical commissioning groups.
- Investigate if women with PCOS are getting appropriate advice for long term health.
- Increase GP's awareness of current recommendations and help develop recommendations for the future.

STUDY DESIGN

- Quantitative data will be collected using an online questionnaire package known as the Bristol Online Survey.

BOS Bristol Online Surveys

- GP's working in the South West London network (Croydon, Wandsworth, Richmond, Kingston, Sutton and Merton) will be invited to participate.

- At the end of the data collection period (3 months after the initial invitation email). The data will be anonymously collated and analysed using Excel and SPSS.
- Service planners & commissioning groups will also be contacted regarding funding pathways for women with PCOS to find out what treatments for PCOS are currently funded by the NHS.
- Feedback to the GP's will also provide information relevant to their education and training in relation to PCOS awareness.
- Findings will be published in a primary care journal aimed at GP's and presented at the British Dietetic Association annual conference. PCOS UK and Verity will also be used to disseminate the findings.

REFERENCES:

March, W., Moore, VM., Willson, KJ., Phillips, DI., Norman, RJ., Davies, MJ.. (2010) Hum Reprod. 25, 544-551

Teede H, Deeks A and Moran L (2010) BMC Medicine 8, 41

ACKNOWLEDGEMENTS

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South West London Academic, Health and Social Care System

Lithium (Level Monitoring and Physical Health Monitoring) App

Carl Holvey, Principal Clinical and Deputy Chief Pharmacist, South West London and St Georges Mental Health NHS Trust

Lithium is a medicine used to treat mood disorders, with a small margin between blood levels that have a good effect on symptoms and adverse effects. It is an effective medicine to prevent relapse in bipolar disorder and may be used, as with other medicines, to treat depression. Close monitoring of levels and physical health ensures it is used safely. South West London & St George's Mental Health NHS Trust is to develop an app that works across many platforms (software and devices) to replace the lithium monitoring hand held paper record and provide individuals with the opportunity to record how they mood and sleep in the app. We have found that 88% of mental health service uses access the internet regularly, and that 33% of our service users access the internet daily from their smart phone; the app thus has the potential to be used by a large proportion of patients. The app will help to ensure the medicine is reviewed, prescribed and supplied safely and effectively.

The key aims of the project are to:

- stop using the hand held paper record
- involve patients in their medicine management and safety issues
- ensure patients across South West London are using the app, not just patients in the Mental Health Trust
- obtain 1,200 users, which would mean every patient in the geographical area served by the Trust would be using the app, which would be the ultimate goal
- achieve advancements in use of technology in health

South West London Academic, Health and Social Care System

South West London and St George's NHS Mental Health NHS Trust

Lithium Monitoring App.

'THE MEDICINES MONITORING PASSPORT'

Dr Stuart Adams, *BSc. MBBS, PgDip CBT, MRCPsych*, Consultant Psychiatrist
Dr Helen Miller, *MBChB, MD, FRCPsych*, Consultant Psychiatrist
Carl Holvey, *MPharm, DipClinPharm, IPresc, MCMHP,* Lead Clinical & Deputy Chief Pharmacist
Springfield Hospital

AIMS

To develop an app to:

- improve the use of lithium patient held records.
- monitor mood and sleep, as an aide to monitor the progress of illness.
- give Community Pharmacists greater access to blood test results, required to safely dispense lithium.

THE MEDICINES MONITORING PASSPORT

Why have a patient held record?

- Lithium is a medication used to treat bipolar disorder and severe depression.
- Too much lithium can cause toxic effects which may be life threatening.
- The difference between the level of lithium in the blood that treats a patient and the level that is toxic is very small.
- Drs and pharmacists both need to check the lithium levels. Patient held records are the most reliable way of communicating the levels to community pharmacists.
- The hand held patient record ensures the patient has the required results of important physical monitoring needed for Drs to review them and Pharmacist to dispense the medicines safely.

Who are the target group?

- All patients taking lithium who have access to a smartphone.
- There are approximately 1200 patients taking lithium in South West London; the majority are seen by GPs alone. 330 patients are under shared-care mental health services, wherby the GP will monitor the blood tests, and the mental health team will advise on treatment.

What will the app do?

The app will:

- be available from multiple platforms.
- hold details of physical monitoring.
- allow users to record details of their mood and sleep patten and review their progress.
- allow important safety notifications to be 'pushed' to patients.
- allow patients to send records to clinicians.
- be able to give reminders for physical health checks.

Collaborators

App developer:

incentivated building mobile

Charity:

bipolar UK SUPPORTING PEOPLE AFFECTED BY BIPOLAR

Future Opportunities

Many medicines require physical monitoring or drug level monitoring the app could be expanded to include other medicines or receive electronic results reporting from other systems.

carl.holvey@nhs.net 020 3513 4566

Empowering and Supporting Carers Management Skills for People with a Diagnosis of Dementia

Miles Rinaldi, Head of Recovery and Social Inclusion, South West London and St George's Mental Health NHS Trust

Working in partnership with the Alzheimer's Society, London Borough of Merton and the Royal College of Nursing, a pilot project will be set up to co-produce guidance with families and carers on what to do and how to respond to their relative's behaviour symptoms and changes with the onset of dementia. This includes 'Zoning: Focused Support' which co-ordinates support and facilitates knowledge-sharing and ranks need levels through a Red, Amber, Green system. The protocol can be used by families seeking to fast-track their concerns to health professionals.

The key purpose of this project is to develop and pilot a protocol that determines the content of an educational and skills based educational programme to empower carers of people with a diagnosis of dementia. It is anticipated this protocol will reduce demand on emergency health services as it will help carers to understand and manage the behavioural symptoms of dementia, formally appraise their concerns when symptoms exacerbate so they can access appropriate services and promote ways to look after their own health and wellbeing.

The key aims of the project are to:

- coproduce and pilot a vulnerability and needs protocol that ranks need levels and identifies how and when carers should access statutory and non-statutory services
- coproduce and pilot an educational and skills based programme to support the protocol implementation
- enhance carers' resilience and care managing experiences

Empowering and supporting carers management skills for people with a diagnosis of dementia

Aim

To coproduce and pilot a vulnerability and needs protocol that then determines the content of a skills based educational programme to empower carers of people with dementia. This project will work across organisational boundaries between health, local authority and the voluntary sector with carers of people who have a diagnosis of dementia at its core. It is anticipated this protocol will reduce demand on emergency health services as it will help carers to: understand and manage the behavioural symptoms of dementia, formally appraise their concerns when symptoms exacerbate so they can access appropriate services, promote ways to look after their own health and wellbeing and, enhance carers resilience and care managing experiences.

Introduction

The journey into mental health services can be particularly problematic for families, sometimes coping for several years with their relative experiencing increased symptoms before they finally gain access to specialist dementia services. Local health and social care commissioners are looking at strategies to improve the current service model. Despite planned service improvements, it is probable that even with fully operational services many carers will remain traumatised by the experience of supporting someone with dementia, especially at times of crisis. Their relative is likely to be a risk to themselves or others and this can be an extremely frightening for untrained informal carers.

Families often want guidance on what to do when and how to respond to their relative's behaviour symptoms and changes. The team involved in this project have extensive experience of developing successful protocols to promote 'chains of care' creating a common language and shared understanding between carers, health and social care professionals and other agencies.

Methodology

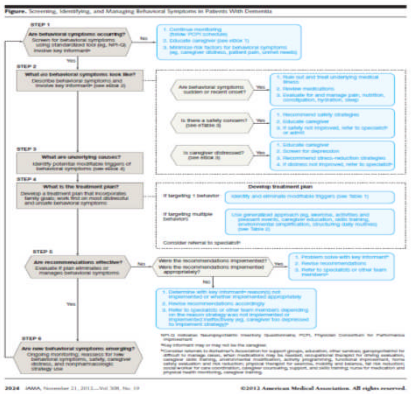
There are two interrelated work packages to this project:

The first work package will coproduce and pilot a vulnerability and needs protocol that ranks need levels and identifies how and when carers should access statutory and non-statutory services. The development of this protocol will add to the dementia road maps being developed in Merton.

To guide the initial development of the protocol the research literature on non-pharmacologic management of behavioural symptoms in dementia has been used. In particular, a recent review of the literature published in the Journal of the American Medical Association provides a framework for screening, identifying and managing behavioural symptoms – see Figure 1. To ensure the protocol is personalised to local need it will be coproduced with carers of people with a diagnosis of dementia, the Alzheimer's Society and health and social care professionals. The Dementia Lead from the Royal College of Nursing will provide a subject expert consultancy role. The protocol will aim to create a common language and shared understanding between carers and health and social care professionals.

The draft protocol will be piloted with n=10 carers for three months at which point the draft protocol will be reviewed for face validity and changes made based on the experiences of the carers, Alzheimer's Society feedback and, the health and social care professionals involved. Based on the changes made further piloting will take place with carers in the 'Dementia Hub'.

Figure 1: framework for screening, identifying and managing behavioural symptoms



The second work package will coproduce and pilot an educational and skills based programme to support the protocol implementation. The programme will run in parallel with the piloting of the protocol developed in work package one. The aim of the pilot educational and skills programme is to enhance carers' resilience, care managing experience and facilitate the implementation of the protocol from work package one. Whilst the negative effects of behavior and psychological symptoms on carers are well documented, there has been little appreciation of carers ability to influence the occurrence and severity of these symptoms. A recent meta-analysis of non-pharmacological interventions for symptoms of dementia published in the American Journal of Psychiatry showed that carer interventions can significantly reduce behavioral and psychological symptoms in the person with dementia as well as the carer's negative reactions to these symptoms. The meta-analysis showed that if education and skills based courses are provided to carers such as problem-solving skills combined with other carer support strategies they can effectively reduced behavioral symptoms and carer distress. In addition, educating carers in strategies such as distracting the person with a diagnosis of dementia, backing away and leaving the room (if the person is safe) have been found to be helpful at effectively managing aggression.

The Trust has a track record of coproducing educational and skills based courses for adults with enduring mental health conditions, their carers and families through the Recovery College. The Recovery College use an educational paradigm to complement traditional treatment approaches through providing information, resources and self-management education. All courses are co-facilitated by a mental health practitioner and a peer trainer. Evaluations of the Recovery College have demonstrated that people who complete 70% of more of courses have significant reductions in health service usage.

The Recovery College runs a successful and positively evaluated skills based programme for carers and families for people diagnosed with a psychosis as well as a course on 'understanding a diagnosis of dementia'. Work package two would build on this knowledge and expertise and extend the work of the Recovery College into the 'Dementia Hub' by coproducing with carers, the Alzheimer's Society, health and social care professionals and the Dementia Lead at the Royal College of Nursing a programme of educational and skills based courses.

The recent meta-analysis of non-pharmacological interventions for symptoms of dementia published in the American Journal of Psychiatry provides a helpful outline of potential themes for courses under the headings of:

- Coping skills training for carers
- Education for carers
- Activity planning and environmental redesign
- Enhancing support for carers
- Self-care techniques for carers
- Collaborative working with health and social care professionals.

All courses developed in this project will follow the Recovery College model with all courses co-facilitated by a mental health practitioner and a peer (carer) trainer. The scope of this project is to coproduce and pilot a small number of courses and evaluate their acceptability. It is expected that initially n=4 courses will be developed and piloted. If successful a full programme of courses could then be developed. The coproduction process will determine which courses are developed and piloted. However, a self-care techniques course for carers will be suggested based on the recent call by the Royal College of GPs that carers should be routinely screened for signs of depression to ensure their health needs are not neglected.

Evaluation

The first work package will be evaluated by:

1. Feedback on the experience, usefulness and relevance of the protocol. Changes will be made based on the experiences of the carers, the Alzheimer's Society and the health and social care professionals involved (face validity).
2. Carers assessment of managing index of the caregiving experience will be completed at the beginning of the piloting and then repeated at 3 & 6 months.

The second work package will be evaluated by:

1. Post training evaluation of the courses, student experience and the family and friends test.
2. As part of the skills based courses carers will be asked to set themselves health and wellbeing goals. Four weeks post course carers will be asked to rate themselves in terms of whether they have been able to achieve their goals. Goal attainment scaling will be used.
3. Carers assessment of managing index of the caregiving experience will be completed at the beginning and end of the courses.

For further information please contact:

Miles Rinaldi
Head of Recovery & Social Inclusion. Miles.Rinaldi@swlstg-tr.nhs.uk

Cath Gamble
Consultant Nurse. Catherine.Gamble@swlstg-tr.nhs.uk

References

Brodaty, H. & Arasarantnam, C. (2012) Meta-Analysis of nonpharmacological interventions for Neuropsychiatric Symptoms of Dementia. *American Journal of Psychiatry* 00, 0, 1-8.

Gitlin, L.N. et al (2012) Nonpharmacologic management of behavioural symptoms in dementia. *JAMA* 308, 19, 2020-2029.

Alcohol and the 136 Suite: Pilot of a Brief Alcohol Intervention

Dr Aileen O'Brien, Honorary Consultant, South West London and St George's Mental Health NHS Trust and Senior Lecturer in Psychiatry, St George's, University of London

Section 136 of the Mental Health Act 1983 (amended 2007) empowers police to remove a person who they believe to be suffering from a mental illness, from a public place if they deem them to be a risk to themselves or others. They are taken by the police to a Place of Safety for assessment which for the boroughs of Wandsworth, Merton, Sutton, Richmond and Kingston is Ward One at Springfield Hospital.

A recent audit of assessments demonstrated that over a six month period 245 individuals were detained and 108 (44%) were intoxicated; this lead to longer assessment times and a decreased likelihood of being admitted to hospital. There is substantial evidence that brief interventions in harmful drinkers can be effective.

The key aims of the project are to:

- deliver a brief intervention to service users admitted to the 136 suite where alcohol plays a large part in their admission, prior to discharge
- improve the physical health monitoring of this at risk group
- improve the liaison with primary care regarding the outcome of the 136 assessment in this group
- improve liaison with other local services in the five boroughs regarding alcohol misuse
- embed brief alcohol intervention into routine practice

South West London
Academic, Health and Social Care
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South West London and St George's NHS
Mental Health NHS Trust

ALCOHOL INTERVENTION IN A SECTION 136 SUITE

INTRODUCTION

Section 136 of the Mental Health Act 1983 (amended 2007) empowers police to remove a person, whom they believe to be suffering from a mental illness, from a public place if they believe them to be a risk to themselves or to others. South West London and St George's Mental Health NHS Trust has one section 136 Assessment suite serving a population of approximately a million people. A recent audit of consecutive admissions for six months demonstrated that of 245 individuals admitted 108 (44%) were intoxicated, leading to longer assessment times; these patients were less likely to be admitted to hospital.

This project aims to establish and embed alcohol identification and brief advice interventions into routine practice supported by a physical health check and make referral appointments to partner integrated drug and alcohol service providers. The project will commence September 2013 and will last for 6 months. In order to do this we will employ a nurse to provide alcohol brief interventions, training for others and support physical health checks.

Currently once assessed the patients are discharged from the 136 suite, if they do not require admission to hospital for the management of a mental health disorder. They are usually discharged to the care of the GP, with no intervention addressing their alcohol use and no physical investigations.

However there is a substantial body of evidence suggesting that brief interventions in harmful drinkers are effective, with the evidence focusing on primary care and general hospital settings (1,2).

PROPOSAL

The proposal is therefore that a Band 6 nurse is employed for 12.38 hours per week

Their role will be :

- To train the Band 5 nursing staff in the 136 suite in brief alcohol interventions
- To train the nursing staff in phlebotomy
- Develop joint training for police undertaking arrests under Section 136
- To introduce a system whereby the outcome of the 136 assessment and results of blood tests is fed back to colleagues in primary care
- Provide information to individuals about services available to help with alcohol dependency and signpost individual to services (Integrated Drug and Alcohol Service [IDAS] and KCA drug service)
- To arrange appointments for patients with local services for follow-up assessments and access to support for problems related to alcohol use, where possible
- To evaluate the impact of these interventions

ALCOHOL BRIEF INTERVENTION

An alcohol brief intervention (ABI) is described as a short, evidence- based, structured conversation about alcohol consumption with a service user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm. There is a substantial evidence base for the effectiveness of alcohol brief interventions and there is strong support for the effectiveness of screening and ABIs in A and E.

AIMS

- To deliver a brief intervention to service users admitted to the 136 suite where alcohol plays a large part in their admission, prior to discharge
- To improve the physical health monitoring of this at risk group
- To assist in early identification of alcohol related risk through alcohol screening in mainstream health settings such as mental health services
- To improve the liaison with primary care regarding the outcome of the 136 assessment in this group and alert GP's to potential need for intervention in relation to developing alcohol problem
- To improve liaison with other local services in the five boroughs regarding alcohol misuse
- To embed brief alcohol intervention into routine practice
- To make client appointments with partner agencies such as KCA to support engagement with needs appropriate services

PROGRESS

Band 6 nurse appointed
Satisfaction in assessment suite being assessed
Phlebotomy training underway
Brief alcohol intervention training underway
Liaison with IDAS

REFERENCES

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AUTHORS

Aileen O'Brien, Cheryl Hunter, Louise Clark,
Alex Onyenaobiya, Christine Byasi
South West London & St George's Mental Health Trust

Innovative Home Monitoring for Hypertension in Pregnancy

Elaine Sheehan, Research Midwife and Day Assessment Unit Midwife, St George's Healthcare NHS Trust

Hypertensive disorders complicate 6-12% of pregnancies. 25% of women who present with Pregnancy Induced Hypertension (PIH) will develop Pre-eclampsia (PE), a severe hypertensive disorder in pregnancy. Women who develop PIH are advised to attend the hospital twice weekly for monitoring of blood pressure and testing urine for significant proteinuria. This frequent monitoring can present a source of anxiety to these women and their families and has significant cost implications for limited healthcare resources.

With 'Innovative Home Monitoring for Hypertensive Disorders in Pregnancy', we will involve women in their care and reduce the frequency of these appointments by making it accessible to have their blood pressure monitored and urine tested at home. We will supply these women with automated blood pressure monitors and urine dipsticks, which are currently used at the Day Assessment Unit. This would enable them to perform the majority of their monitoring at home without unnecessary hospital attendance. Women would be advised to monitor their blood pressure and urine daily and will be given a contact number if the blood pressure exceeds a cut off measurement or if the urinary protein is elevated on dipstick. This policy is likely to improve the patient experience and their anxiety level, with less time off work and less concern regarding childcare. It would also lead to significant cost saving, especially medical and midwifery staff time.

'Innovative Home Monitoring for Hypertension in Pregnancy' is an innovative project that will contribute to improving patient experiences by reducing expenses, improve patient wellbeing and empower patients to become involved in their own care. Professional advice will only be a phone call away for any abnormal measurements that are found.

The key aims of the project are to:

- implement a new model of care to address novel care pathways
- empower patients to become involved in their own care
- enhance patient experience and satisfaction
- eliminate long waiting times for patients whilst simultaneously reducing busy workloads and time consuming tasks for NHS staff
- perform a cost saving mechanism for patients and the NHS
- reduce the wait of unnecessary medical intervention and adverse pregnancy outcomes

Home Monitoring of Hypertension in Pregnancy

Home monitoring of hypertension in pregnancy is an **innovative** project that will contribute to improving patient experiences by **reducing expenses**, **improving patient wellbeing** and **empowering patients** to become involved in their own care. Patients will have the ease of monitoring their own health at home or even in their workplace. Professional advice will only be a phone call away or patients can use an **interactive** text messaging service to send their blood pressure measurement to a midwife who will inform them if further action is needed.

6-12% of pregnancies are affected by hypertensive disorders, and hypertension causes 8-10% of preterm births. Up to £260 million could be saved a year if the delivery of all premature babies could be delayed by one week (Mangham et al, 2009).

Summary of New Care Pathway:

The target group will be pregnant women diagnosed with mild gestational hypertension

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These women will be supplied with an automated blood pressure machine and urine dipsticks to take home.

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Women will monitor their blood pressure 3 times a day and test their urine once every three days at home or at work.

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If there is an abnormal result, women can ring or text the assigned phone number for professional advice.

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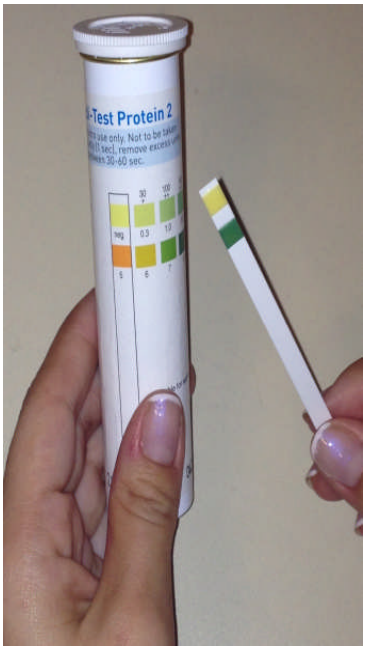
Women with an abnormal result will be reviewed by a doctor or midwife with the appropriate action taken. If normal review, women can continue home monitoring with 2 weekly appointments at hospital.

AIMS AND OBJECTIVES:

- **Implement a new model of care** to address novel patient care pathways
- **Empower women** to become involved in their care
- **Enhance patient experience** and satisfaction
- **Eliminate long waiting times** for hospital appointments
- **Cost saving mechanism** for patients by eliminating transport and childcare costs
- **Reduce busy workload** and time consuming tasks for NHS staff
- **Reduce the rate of unnecessary medical intervention** and adverse pregnancy outcomes



South West London Academic, Health and Social Care System

Elaine Sheehan
Basky Thilaganathan
Amar Bhide
Sandra Linton
Asma Khalil
Day Assessment/Fetal Medicine Unit

St George's Healthcare NHS Trust

Published by the South West London Academic, Health and Social Care System
St George's, University of London
Cranmer Terrace
London SW17 0RE
www.swlondonsystem.org