Renfrewshire Community Health Partnership Committee

Date: 21st November 2014
Author: Katrina Philips, Head of Mental Health & Addictions

Agenda Item Description: Mental Health and Addiction Services Update

1. Purpose

1.1 The purpose of this paper is to update the Committee on progress and current position with regard to the developments in the Renfrewshire Community Mental Health Teams and Inpatient Services both Adult Services and Older Adults Services.

2. Operational Policy and Standing Operating Procedures (SOP’s)

2.1 The Community Mental Health Team (CMHT) forms part of an integrated whole system approach to mental health services for the adult population of Renfrewshire. The integrated service is delivered in conjunction with: Doing Well; the Intensive Home Treatment Team (IHTT); Out of Hours (OOH) Services; Inpatient Services and Network Employability Service and includes access to Intensive Psychiatric Care (IPCU) beds in Inverclyde. The service will systematically interface with Addictions Services, Older People’s and Child and Adolescent Mental Health Services (CAMHs).

The service model aims to meet the commitments and targets described in key strategic drivers for modernising mental health and Social Care services in Scotland as outlined in:

- Delivering for Mental Health, Scottish Executive (2006)
- Admission to Adult Mental Health Inpatient Services, Best Practice Statement, NHS Quality Improvement Scotland (2009)
- Mental Health Service Development Framework (2012)
- NHS Greater Glasgow and Clyde Mental Health Services: Case for Change & Framework for Mental Health Services (2012) (work in progress)
- Mental Health Strategy Scotland (2012)
- 2020 Vision for Health and Social Care
- 21st Century Social Work Review
- Public Bodies (Joint Working) Bill
- West of Scotland Adult Support and Protection (ASP) Guidance and Procedures

This operational policy and SOP’s were implemented on the 1st September 2014 and set out to describe the pathway of care through the CMHT, covering all aspects of service delivery from the principles, ethos and values base for practice, through to quality assurance and care governance processes. It describes the day to day work of CMHT providing where appropriate standards and SOPs.

This operational policy has been subject to Equalities Impact Assessment (EQIA) to ensure that issues with regard to gender, race, disability, sexual orientation, age and religion have been fully considered and described within this document.
2.2 Principles & Values Underpinning Care Delivery

The ethos of the service and the practice of all of the multi disciplinary and multi-agency team(s) is underpinned by the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003; the Equality Act 2010; and the 10 Essential Shared Capabilities (ESCs) and in line with the quality ambitions outlined in the NHS Quality Strategy 2010, Efficient and Effective Community Mental Health Services.

Confirming person centred care as the basis of all our service activity/responses, the multi disciplinary team places particular importance on collaboration, efficiency and effectiveness, in order that what we do and how we practice provides treatment for service users which is accessible, timely, safe, equitable, consistent, and that care is delivered at a level to match assessed need.

Underpinning the practice of the Mental Health Service will be the following values identified within the ‘Ten Essential Shared Capabilities’ (2005):

- Working in partnership
- Respecting diversity
- Practicing ethically
- Challenging inequality
- Promoting recovery
- Identifying people’s needs and strengths
- Providing service user centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

The Mental Health Service will work with service users to achieve the following outcomes:

- Improved health and well-being
- Improved quality of life
- Choice and control
- Freedom from discrimination
- Personal dignity

In delivering the above a variety of interventions will be available and provision of advice/education around concordance with treatment within a framework of care co-ordination.

Routine recording of service user clinical outcomes and satisfaction will be achieved through the use of CORE, HONOS and in agreed service user’s satisfaction surveys.

2.3 Person Centred Care – Standards for Care

Within integrated mental health services it is our aim to engage with and listen to our service users, carers and other stakeholders, including independent third sector providers, in order to be able to determine and deliver responsive, high quality, cost effective and efficient, user focussed services.
3. The Community Mental Health Team Duty Hub

3.1 This proposal provides background information regarding the Duty Services of the Paisley and Renfrewshire Community Mental Health Teams [CMHTs] and outlines the proposed changes to the services offered with the development of a Pan-Renfrewshire Duty Team. This Duty Team will be located within the Charleston Centre, Neilston Road, Paisley and will be operated by staff from both the Joint Community Mental Health Teams. The Duty Hub will be operational from the 1st September 2014.

3.2 The Duty Hub will:-

- Promote consistency and equality in services being offered to all Renfrewshire residents.
- Foster continued team working between both CMHTs, in-patient services, Intensive Home Treatment Team, Addiction Services, Locality Teams and Third Sector Services.
- Assist to improve communication and interface between other service providers within NHS GGC & Renfrewshire Local Authority Services.

4. ESTEEM

4.1 The ESTEEM service operates across NHSGGC to provide a dedicated service for people aged 16 to 35 years old who are experiencing a first episode of psychosis. The team offers advice, support, treatment and various interventions. The team is Multi-disciplinary, comprising consultant psychiatrists, psychologists, occupational therapists, nurses, support workers and administration staff. Referrals are accepted from a variety of sources including: GPs, CMHTs, PCMHTs, and voluntary organisations.

- As of 1st September 2014 this service will be launched in Renfrewshire & Inverclyde. Contact with ESTEEM is via telephone referral for all services as base is at Leverndale Hospital, Crookston.

5. Access to Psychology Therapies HEAT Target

5.1 The Psychological Therapies Heat target is aimed at improving access to mental health services and requires that by December 2014 no-one will wait longer than 18 weeks from referral to the start of a psychological therapy treatment.

5.2 The target is a measure of all psychological therapies being delivered by health services across the Board area and include the following care groups in both inpatients and community settings: Adult Mental Health, Older Peoples Mental Health, CAMS (beyond March 2013), Forensics Services and where there is an associated mental health problem in Learning Disability, Addiction and Acute Physical Health Services.

5.3 At present Mental Health Services in Renfrewshire continue to work towards the target December 2014 target.

6. Gender Based Violence Action Plan

6.1 The NHS GG&C Gender Based Violence (GBV) Action Plan was developed following the CEL-41 and highlighted mental health services as a priority area. With the implementation of Sensitive Routine Enquiry, all new adult female and male service users should routinely be considered at the point of assessment about sexual assault and childhood sexual abuse.
In addition to this all new adult female service users should be routinely asked about domestic abuse at initial assessment. Females and Males may be asked about further experiences of abuse if deemed appropriate.

6.2 In Renfrewshire 6 one day workshops have been arranged to facilitate the training of a total of 120 staff across Mental Health Community, In-patients and addiction services.

7. Young People Moving from Child and Adolescent Mental Health Services [CAMHS] To Adult Community Mental Health Teams [CMHTs] Within Renfrewshire

7.1 At present there is going work in developing a protocol to ensure that the transition of young people with a mental health problem from the Child & Adolescent Mental Health Service [CAMHS] to the Community Mental Health Teams [CMHTs] within Renfrewshire is planned and implemented consistently and safely and should occur with as little disruption as possible to a young person’s journey of care.

7.2 A key component across all levels of service provision is the adoption of person-centred, matched-care, enabling the ability to deliver the appropriate level of care that best meets a young person’s needs.

7.3 In order to facilitate the development of a smooth transition process with appropriate joint working arrangements between Children’s and Adults Mental Health Services, a pathway is in the process of being developed.

8. Planned Mental Welfare Commission Planned Visit

8.1 The Mental Welfare will be carrying out, as part of its monitoring visit programme, visits to individuals who are subject to Community Compulsory Treatment Orders (CCTO's) for a period of 24 months or longer. These visits will be conducted between November 2014 and March 2015.

9. Adult Inpatient Mental Health Services

9.1 There are 37 beds based in Dykebar Hospital for Acute Admissions in North & East Ward and there are 20 beds in Arran and Bute ward for Rehabilitation and Recovery. All referrals to the service are assessed by the Intensive Home Treatment Team (IHTT) and decisions around admitting patients as an alternative to community care are taken at time of assessment or, if required, during period of care and intervention by the IHTT. This is a 24 hour service shared with the IHTT and the NHS GGC Out of Hours Service. We also provide a same day assessment service to colleagues in wards at RAH via our Liaison Psychiatry Service. The IHTT Operational Policy outlines arrangements for referral, assessment, decisions to admit and support for discharge from inpatient services. Specific reasons for admission are agreed and documented at time of admission. There will be a consultant led full MDT review meeting weekly for all patients which is planned in advance with patients and carers. Discharge planning is initiated at the point of admission, with the patient and where appropriate, carer, named person and external agencies are informed of expected date of discharge. For patients who have more complex care needs we have multi-disciplinary reviews and plans for discharge to other appropriate care facilities or to our Rehab & Recovery Beds. We are currently reviewing 10 of these patients who are almost for discharge with our Renfrewshire Council Social Work colleagues to facilitate more effective working arrangements and to allow these patients to be discharged to appropriate accommodation in the community.
10. Older Adult Mental Health Services

10.1 There are 40 acute beds at the RAH Wards 37 & 39 for older peoples services, 20 for functional illness assessment and 20 for organic illness assessment. There are 46 beds for NHS Continuing Care which are currently temporarily based at the Mansionhouse Unit in Glasgow. There are proposals being considered at present to return these patients and staff to accommodation in the Renfrewshire area.

10.2 All patients are admitted for assessment to the acute beds to identify care needs. Older adult CPN input is available from the RES Service for patients in the wards. The four wards all have their own dedicated lead consultants who will provide expert input into key matters of service delivery, and overall service co-ordination. Specific sessions are set aside in the consultant’s job plan to ensure sufficient time is available for their consistent and regular input to the wards and related forums. There are also dedicated AHP Services including Occupational Therapy, Physiotherapy and Activity Nurses on all wards.

The wards have an agreed minimum staffing level across all shifts which are met. There are systems in place that ensure that all factors that affect staffing numbers and skill mix are taken into consideration, and staffing levels are reviewed on a daily basis. These factors are:

- Levels of observation
- sickness and absence;
- training;
- supervision;
- escorts;
- the need to promote patients’ independence;
- therapeutic engagement;
- acuity levels;
- Clinical meetings.

The wards all have access to the following referral services:

- Dental assessment and dental hygiene services;
- Visual reviews;
- Hearing reviews;
- Podiatry;
- Wound care services;
- Phlebotomy services;
- Specialist infection control services;
- Tissue viability nurse;
- Specialist continence services.

10.3 Staff who undertake assessment and care planning in the acute units have received training in dementia awareness. The Scottish Governments Dementia Strategy Framework is used to describe the patient pathway from the initial concern regarding memory problems, through diagnosis, to post diagnosis support. Other initiatives that contribute to raising awareness for staff include training; Dementia Champions; and the GGC Workforce Planning Sub-Group of the Dementia Strategy Group, which produce local recommendations. All of this activity is supportive of Anticipatory Care Planning – encouraging pro-active management and avoidance of crisis by alerting people to the services and supports available. People may present with memory difficulties in a number of settings and it is important that those with whom they come in contact have the ability to point them in the direction of the appropriate service. The decision to admit to the service will usually be made by a Consultant Psychiatrist. Whilst in the service the patient will receive a multidisciplinary assessment of
the problems with which they are presenting and a management plan will be instituted. From this the patient may be discharged back home or to a care home. The GP will be informed of the outcome of their assessment and the plans for follow up. Initial follow up will usually be by Secondary Care Services with care passing to Primary Care when the patient no longer needs input from Secondary Care, although there may be some patients who can be discharged directly to Primary Care for follow up. Some patients will be transferred to our NHS Continuing Care Beds in Mansionhouse Unit for further assessment and treatment. Their treatment will continue in this unit for as long as their needs dictate and will be assessed every six months to see if care needs could be better met elsewhere.

10.4 In the functional acute unit there is no age discrimination to access for this service. The Service provided outlines arrangements for referral, assessment, decisions to admit and support for discharge from the inpatient service. Specific reasons for admission are agreed and documented at time of admission. There will be a consultant led full MDT review meeting weekly for all patients which is planned in advance with patients and carers. Discharge planning is initiated at the point of admission, with the patient and where appropriate, carer, named person and external agencies are informed of expected date of discharge.

10.5 There is currently ongoing work to improve the patient pathway and experience of all older people’s services in Renfrewshire being led by myself as Head of Service and the Inpatient Services Manager.

11. Recommendations

11.1 The Committee is asked to note the progress across Renfrewshire’s Mental Health Services.
1. **Purpose**

The purpose of this paper is to provide an update to the CHP committee on progress and current position of Drug and Alcohol services in Renfrewshire.

2. **Drug and Alcohol Services**

2.1 There are 3 tier 3 specialist addiction service in the Renfrewshire area:

- Integrated Alcohol Team (IAT) which is an integrated health and social work team which is jointly managed by a Senior Social worker and Nurse team Leader and includes Nurses, Social Workers and Support Workers. The team also hosts an Occupational Therapist and Psychologist who have a remit across drug and alcohol services. They provide a range of interventions from reducing harm associated with alcohol dependence and motivational work to abstinence and recovery. They will provide assertive outreach to high risk individuals and have a key role in relation to adult support and protection.

- Renfrewshire Drug Service (RDS) is a joint health and social work team and is managed jointly by the Nurse Team Lead and Project Leader. The team comprises of Nurses, Medical Staff, Drug Workers, Groupworker and Family Support Workers. They provide a range of interventions including extensive harm reduction provision and rapid access for injecting drug users. There is a 3-stage approach to care and treatment involving assessment and engagement, active treatment, including psychosocial interventions and stabilisation on opiate replacement therapy as appropriate, and recovery and abstinence support.

- Alcohol Problems Clinic (APC) day service provides an evidence based programme for individuals with alcohol dependence. A range of psychosocial and pharmacological interventions are provided. The programme is approx 8-12 weeks depending on individual need and provides detoxification, evidence based and recovery focussed, education and relapse prevention group work programme, and abstinence support including protective medications. The day service also manages access to inpatient beds as required. The tier 4 in-patient provision is delivered from the Kershaw Unit at Gartnavel Hospital, Glasgow. The day service provides pre-admission support with an expectation that individuals admitted electively for detoxification will then participate in the day service programme on discharge.

2.2 In addition there is the Acute Addiction Liaison team and the provision of GP enhanced services across Renfrewshire which is supported by drug team staff.
3. **Progress**

3.1 Renfrewshire CHP Development Plan and the Alcohol and Drug Partnership (ADP) Delivery Plan describe a range of performance areas to be achieved by drug and alcohol services. A few of the key performance indicators are highlighted below.

**Improve access to services**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>90% of clients will wait no longer than 3 weeks from referral to drug or alcohol treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 Target</td>
<td>91.5%</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>All drug and alcohol services continue to exceed target.</td>
</tr>
</tbody>
</table>

**Reduce harm and deaths by drug overdose**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Number trained in overdose awareness raising. Naloxone units issued.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 Target</td>
<td>Based on previous prevalence data, Renfrewshire ADP has an estimated 2,100 problem drug users. ADP’s were provided with targets of a minimum of 25% coverage of people at risk of opiate overdose.</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>In Renfrewshire reporting on the first quarter indicated coverage of 20.48% indicating a shortfall of 95 kits by July 2014. However, a targeted overdose awareness day in August resulted in a further 36 individuals trained and kits issued by the service leaving 59 kits to be issued over the next 6 months to achieve target.</td>
</tr>
</tbody>
</table>

**Roll out the use of the STAR outcome tool to demonstrate recovery improvements.**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Establish baseline, and then demonstrate % improvement in each dimension.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 Target</td>
<td>No specific target</td>
</tr>
<tr>
<td>Actual Performance</td>
<td>Positive change has been achieved across the majority of the key dimensions. Further awareness raising is planned with RDS staff to ensure appropriate completion of the tool which should improve overall performance around drug use. The main areas of change across teams are in relation to: Drug use, Alcohol use, Emotional health and use of time Alcohol services also report high impact around physical health and relationships.</td>
</tr>
</tbody>
</table>
3.4 Service User Network (SUN) Development

The SUN has focused on the opening and running of the Sunshine Recovery Café, which opened in April 2014. The SUN act as steering group for the Café and govern the project. SUN will also be responsible for arranging a memorial service and are participating in the Renfrewshire Mental Health and the Arts Film Festival.

A variety of individuals attend the SUN and include representatives from family support, the addiction worker training project and drug and alcohol services.

In the last year we have completed the SRI2 for service which includes service user and carer feedback.

All teams are currently completing annual service user feedback surveys. The results from the Alcohol Problems Clinic day service have recently been analysed.

3.5 Workforce Development

Workforce development strategy and training plan implemented.

Core Behavioral and CBT skills for relapse prevention and recovery management has been promoted among all drug and alcohol service staff with an expectation that all specialist staff will attend this. To date 16 of the current staff group have completed and a local training event is planned for November with places for approx 16 staff.

3.6 Circles of Care

Circles of Care is a theory being piloted by Scottish Training on Drugs and Alcohol (STRADA) and a number of organisations throughout Scotland.

A response to recommendations in ‘Melting the Iceberg of Scotland’s drug and alcohol problem: Report of the Independent Enquiry’, the Circles of Care concept aims to support recovery by developing robust networks, or ‘Circles’, of people (friends, family, communities, those in recovery) to support a person as they recover from addiction.

Renfrewshire has agreed to be test site for Circles of Care. This will involve participation in a small pilot, with staff from Renfrewshire Drug Service, Alcohol Problems Clinic and Integrated Alcohol Team using a Circles of Care approach with a small cohort of Service Users.

4. Key Challenges

4.1 There are a number of key challenges for drug and alcohol services to continue to build on and improve the way we do things, and to meet our performance targets as outlined in both CHP Development Plan and the ADP Delivery Plan.

4.2 We need to consider locally how we deliver on any recommendations coming from the NHS GGC drug and alcohol Clinical services review as the work streams associated with this start to develop models of care and recommendations to deliver a high standard of care alongside the challenges of the financial landscape.

4.3 To build on existing recovery oriented systems of care through the continued development of recovery communities to support moving on from specialist services.

4.4 The profile of our service users is changing. We are seeing younger people with significant health problems associated with alcohol and serious liver disease and older drug users with complex physical and mental health needs.
4.5 We need to consider how to respond to the emerging picture around novel psychoactive drugs and the use of illicit benzodiazepines and associated behaviours.

4.6 We need to ensure information infrastructure is fit for purpose to enable robust reporting in relation to drug and alcohol service activity and outcomes.

5. **Recommendations**

5.1 The Committee is asked to:

- Note the progress in the update across Alcohol and Drug Services.