

SERVICE REDESIGN

INTEGRATED DRUG TREATMENT AND REHABILITATION SERVICE

INTRODUCTION

The NHS Grampian Substance Misuse Service (SMS) is proposing to undertake a major re-organisation of the way it delivers services in order to meet national targets and best practice. This proposal represents a restructuring in line with continuous service improvement and lean management principles ensuring cost effective and efficient service delivery within an integrated service pathway from stabilisation through to recovery.

The Steering Group and associated Sub Groups have fully involved Service User representation, Primary Care representation, Staff, Staff representatives, Nurse, Medical and Support Service Management.

All should be assured that clinical safety and minimum disruption for staff and clients will, as always, remain paramount in the design and implementation of any changes or developments.

We have also reviewed opportunities for implementing ideas generated by staff in relation to quality assurance, at for example, the recent workshop events *"How the support, supervision and quality assurance process can be improved – what do you need and when?"*

BACKGROUND

Eighteen months ago Aberdeen City had a waiting list of 799 people, 90% of whom were waiting to access the specialist SMS service of NHS Grampian. Through a range of phased actions we have managed to reduce this significantly: Phase 1 was essentially about additional capacity to address the unacceptably long waits for many and to buy some time and flexibility, to allow longer term, sustainable redesign to take place in Phase 2.

There are currently 1700+ people in NHS treatment services for addiction. Strategically we want to increase the number of people moving through treatment onto rehabilitation and ensure that they have holistic, needs led care and opportunities for sustainable recovery within their community, in the long term contributing to the regeneration of these areas.

The broad strategy for treating and rehabilitating drug users is to stabilise people on a substitute prescription and provide them with rehabilitative support with the ultimate aim, in the long term, of people becoming drug free in their community with improved occupational, health and wellbeing opportunities.

This is captured in three broad care objectives of:

- **Stabilisation:** Aim: to medically and socially stabilise client and drug use
- **Moving On:** Aim: to assist client develop coping skills to avoid relapse
- **Moving Out:** Aim: to assist client move out of treatment towards employment and sustainable community based recovery

To facilitate this we are redesigning services around these objectives. The Integrated Drug Careplanning & Stabilisation Service development is designed to be a "hub" from which client care is planned, coordinated and monitored.

PROPOSAL

The SMS are re-organising into five teams; one team that will be the "front-door" service, three cluster teams that correspond with the Primary Care Clusters within the Community Health Partnership (CHP) and a fifth team based at Fulton Clinic that will specialise in very complex dual diagnosis.

The teams will be organised along an integrated, managed, multidisciplinary pathway for treatment rehabilitation and recovery.

The redesign covers three core elements of the service:

- Physical as we move towards the opening of the new Timmer Market building in Feb 2011
- Structural in how we want to reorganise the way we want to deliver services with our partners
- Staffing in terms of the make up and profile of the specialist NHS Service

Structural Change

We have 27 out of 32 GP practices providing 'Shared Care'. Sessions delivered in Primary care have evolved over a number of years and are based on the historical availability of accommodation and resources rather than need. Therefore we have the challenge of managing a large staff team who can be timetabled across the city. Aberdeen has always had good "buy-in" from Primary Care in relation to 'Shared Care'.

As well as Primary Care there are a number of other providers offering support and overall clients didn't always get a holistic package of care as it is complex and time consuming to manage.

Individual practices will still receive the same level of SMS input and our plan is that this input will be further enhanced with Community Rehabilitation Staff, Social Work, Housing Services and Family Support. Aberdeen City Council are in the process of investing an additional £500k recurring into capacity building within this new structure.

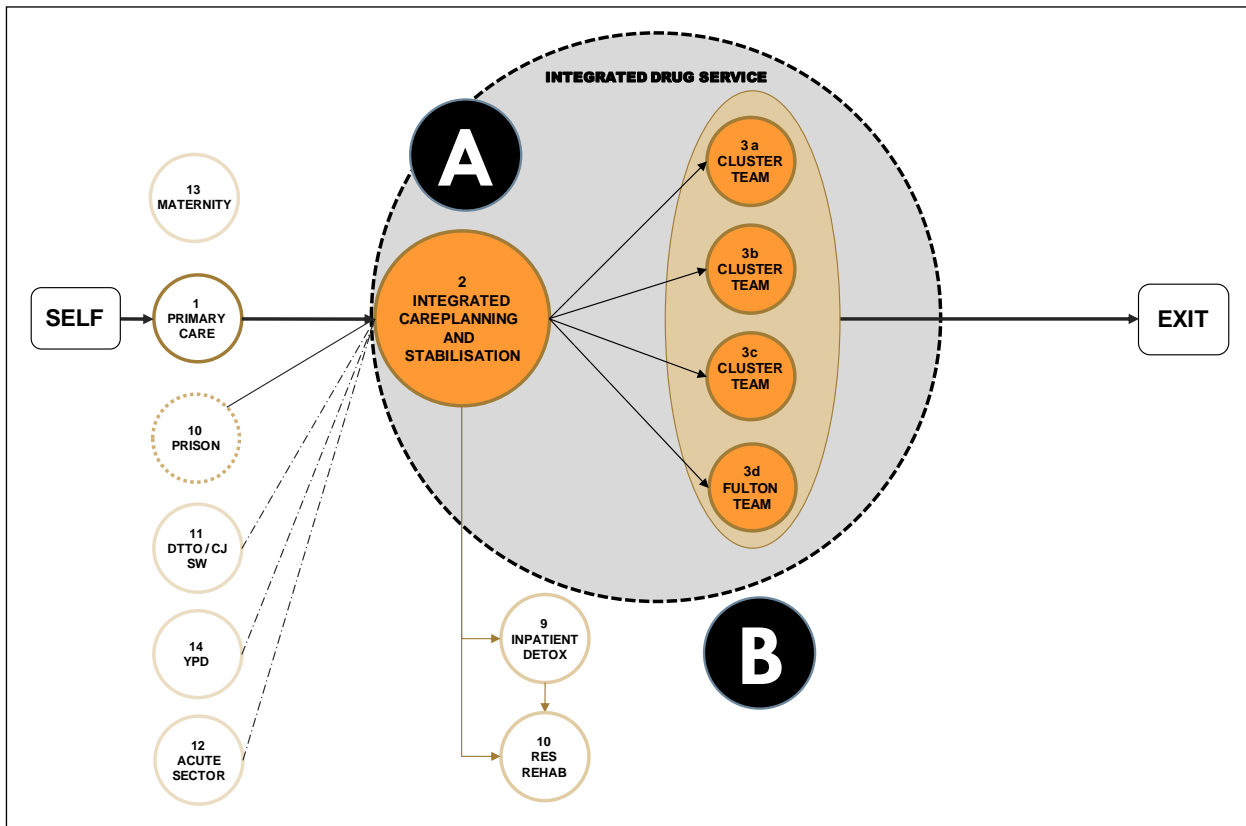
In the long term all new referrals, rather than go to the SMS Practice Nurse will go through a “front-door” service called the Integrated Drug Service Careplanning and Stabilisation Service. Ten practices are already working through this model whereby the multi-disciplinary team provide a 12 to 16 weeks intensive stabilisation programme before the patient returns to primary care. This will eventually be the service delivered from the Timmer Market development.

The planned changes should improve the way services are delivered and the process should result in minimal disruption to Primary Care, other services and most importantly Service Users.

The proposals and benefits of the redesign of particular interest are as follows:

- A central “one-stop-shop” service for assessment and intensive stabilisation with patients returning to their practice with a comprehensive treatment plan
- Each cluster team will have a team leader who will co-ordinate the overall care of drug users across the professions, provide operational management, report outcomes and ensure there is a recovery focus to care
- The cluster team will lead and co-ordinate with GPs 6 monthly reviews of care so that each patient will have a careplan towards recovery
- There will be a specialist doctor aligned to each cluster who will work with complex cases
- There will be better linkage with other services and Community Rehab Staff, Social Workers, Housing and Family Support workers aligned to each practice and each cluster
- There will be better and more efficient use of specialist staff and partner agencies
- We are appointing a Consultant Nurse who will lead on service quality and clinical governance within the nursing team
- Job Centre Plus are aligning Advisors to each cluster to assist people towards work and education opportunities
- There will be a clear set of service outcomes and the teams will be performance managed by results and outcomes

- There will be opportunities for late night clinics and cluster based Protected Learning Time / Training / Engagement etc.



REMIT / SERVICE SPECIFICATIONS / OBJECTIVES

The client pathway is structured around the 3 stages in a client's journey aimed towards the client successfully leaving treatment. Detailed Integrated Carepathways are illustrated at **Appendix 1**.

A) INTEGRATED CAREPLANNING AND STABILISATION SERVICE

Multidisciplinary team made up of Medical, Nursing, Social Work and Rehab Staff with the primary remit of engaging, assessing and stabilising clients over a 12 – 16 week programme.

OBJECTIVES

- Stabilisation Aim: to medically and socially stabilise client and drug use
- Provide a 12 – 16 week stabilisation programme for referrals which will seek to stabilise drug use and other related chaotic situations
- Assess, reduce and manage risk
- Ensure there is a long term careplan
- Reassessing and restabilising if required

OUTCOMES

- Number / % of clients reporting satisfaction with the service

- 90% of clients assessed within 28 days of referral
- 90% of clients started treatment within 28 days of assessment completed
- Number / % of clients completing 12 – 16 week programme and returning to Cluster Team

B) CLUSTER TEAMS x 3 + Fulton Clinic Team

Cluster Teams: multi-disciplinary team made up of Medical, Nursing, Primary Care, Community Pharmacy, Social Work, Family Support, Rehab Staff, and Job Centre Plus staff with the primary remit of providing client led care towards long term recovery.

Fulton Clinic Team: Consultant led team providing care for highly complex cases involving violent patients, complex prescribing and dual diagnosis cases. Team will also include acute sector liaison (Infection Unity and Vascular Ward) and maternity service.

The team will provide appropriate treatment and advice for patients with dual diagnosis of drug addiction and mental illness and develop care pathways with Adult Mental Health services. The development will be in line with Commitment 13 as contained within the Mental Health Delivery Plan and aim to improve the awareness of co-occurring mental health and substance misuse problems; to improve support and service provision for people who have both mental health and substance misuse problems (and their carers); to reduce stigma and influence positively attitudes towards this care group; and provide a direct link for care of those whose complex mental health needs are severe and enduring and whose needs are best met within specialist mental health care.

OBJECTIVES

- Assess, reduce and manage risk
- Ensure there is a long term careplan towards recovery
- Reducing illicit drug use by supporting individuals stabilising on a substitute medication or detoxifying (where appropriate); by providing psychosocial interventions aimed at reducing the range of different substances being used by the individual; by reducing the frequency of drug use and minimise the risk of future relapse. The ultimate goal is to help the individual to stabilise or to become drug free.
- Reduce the risk of the spread of blood-borne viruses, in particular HIV, Hepatitis B and C, and other blood-borne infections from injecting and sharing injecting equipment. This may be achieved through a reduction or cessation of sharing injecting equipment and appropriate injecting paraphernalia, a reduction or cessation of injecting and by the reduction or cessation of risky sexual practices in addition to providing advice,

information, counselling, support towards BBV testing, immunisation and use of needle exchange.

- Improving all aspects of health by assisting the individual to reach and maintain a state of good physical and psychological health. This will be partly achieved by the goals above, but drug users may also have a number of other physical health problems to address. The service will target interventions to address mental health problems such as depression, low self esteem and anxiety.
- Reduce involvement in criminal activity, in particular to reduce the need for criminal activity to support or finance drug use, including prostitution, theft and offences regarding the supply of drugs.
- Improve personal, social and family functioning by assisting the individuals to maximise their ability to make clear and rational decisions and enable them to develop a level of social and family interaction with which they feel comfortable. This may include an improvement in family relationships and the development of new social networks.
- Improved education and employment prospects by assisting the individual to access existing opportunities to increase their employability and providing support to them while they are undertaking education or training, or beginning voluntary or paid employment.
- Improved stability of housing / accommodation by assisting the individual to access opportunities for housing, or improvements in housing and to provide support while they are undertaking any change in housing.
- Provide clients with rehabilitative support to move out of services and sustain themselves within their families and communities. It is recognised that whilst reaching the stages of 'Moving on' and 'Moving out' needs, aspirations and circumstances can change and at times further stabilisation and redirection of goals will take place. This is accommodated by a person centred approach assisted by evidence based practice to care planning and recovery.

***OUTCOMES**

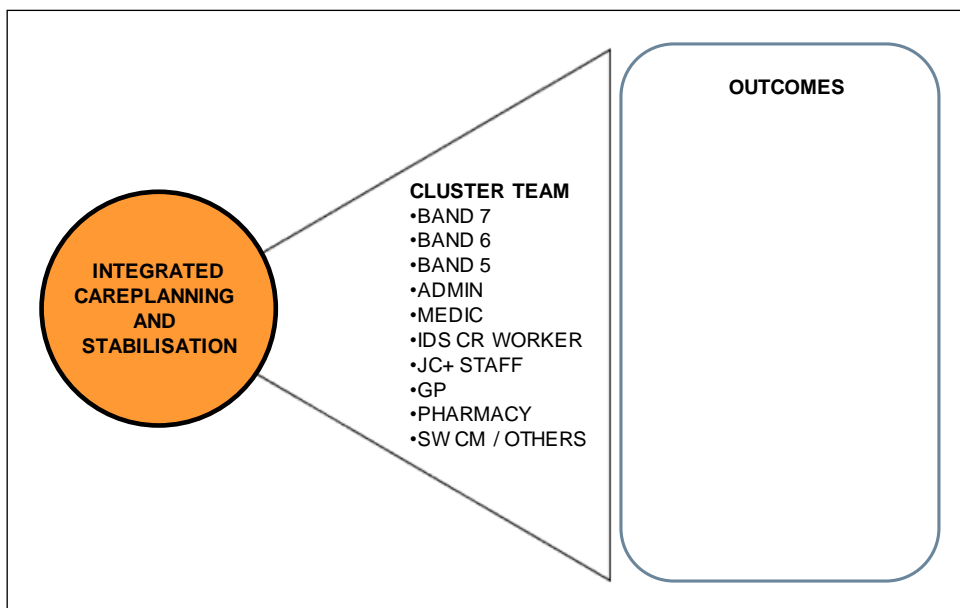
- Number / % of clients reporting satisfaction with the service
- Number / % of clients maintained within the community
- Number / % of clients successfully leaving treatment
- Number / % of clients supported into work JC+ Outcomes

- Number / % of people not illegal drug free per year
- Number / % illegal drug free for 3 months per year
- Number / % illegal drug free for 6 months per year
- Number / % illegal drug free for 1 year per year
- Number / % Methadone and illegal drug free 6 months per year
- Number / % Methadone and illegal drug free 1 year per year

*Outcomes are draft and subject to change pending publication of national core outcomes

CLUSTER TEAMS

Clusters will be multidisciplinary and will have a common set of outcomes. Teams will be performance managed and will report quarterly on progress.



COMPETENCY FRAMEWORK

A competency framework is detailed at **Appendix 2**. This sets out the following areas of competency:

- **Mandatory:** elements that all professional staff have to have
- **Management:** areas of competency for management responsibilities
- **Core:** What all staff working in the structure are required to have in relation to addictions
- **Specialisms:** Areas that are unique to the various professions

Within in this Competency Frame work different staff have various roles and Responsibilities which are broadly set out below:

ROLES AND RESPONSIBILITIES

Medic Role

- Clinical lead for the cluster
- Provide clinical support and prescribing

- Chair clinical / case conferences
- Liaison with Primary Care

Consultant Nurse

- Audit and Research
- Clinical Governance
- Practice Development
- Best Practice and Clinical Supervision

Band 7 Team Leader of Cluster / Fulton

- Lead nursing with cluster / client group eg Maternity etc
- Carry specialist caseload
- Overview of entire cluster caseload
- Responsible for stats, service user feedback, performance
- Day-to-day operational co-ordination / annual leave / sick leave

Band 7 Clinical Specialist

- Lead nursing with client group eg Maternity etc
- Carry specialist / complex caseload
- Case management and supervision role

Band 6

- Provide and maintain shared care treatment
- Admission and discharge of caseload
- Specialist Mental Health Assessment
- Provide specialist treatments eg advise prescribing, talking therapies
- Provide psychological therapy
- Manage Band 5 Nursing Team

Band 5

- Provide shared care treatment
- Provide specialist mental health assessments
- Careplanning
- Mental Health interventions
- Manage physical health
- Working in conjunction with community rehab staff on recovery plan

Admin

- Realignment to clusters
- Administration of clusters

- Centre point for communication
- Management of letters / appointments

Social Work

- Provide a social work service

Community Rehab Worker

- Provide a range of psycho-social rehabilitative supports to assist clients to move on and out of treatment

QUALITY ASSURANCE

One of the primary aims of the redesign is to improve and develop the quality assurance and clinical governance of the service. Ideas have been generated by staff in a number of workshops entitled *"How the support, supervision and quality assurance process can be improved – what do you need and when?"*

The structure for Clinical Governance and Quality Assurance (Fig 1) and the Continuous Improvement Cycle (Fig 2) is illustrated below:

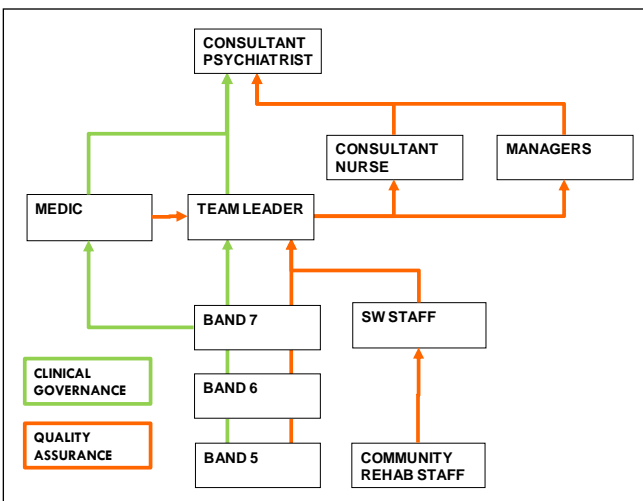


Figure 1: Clinical Governance / Quality Assurance Structure

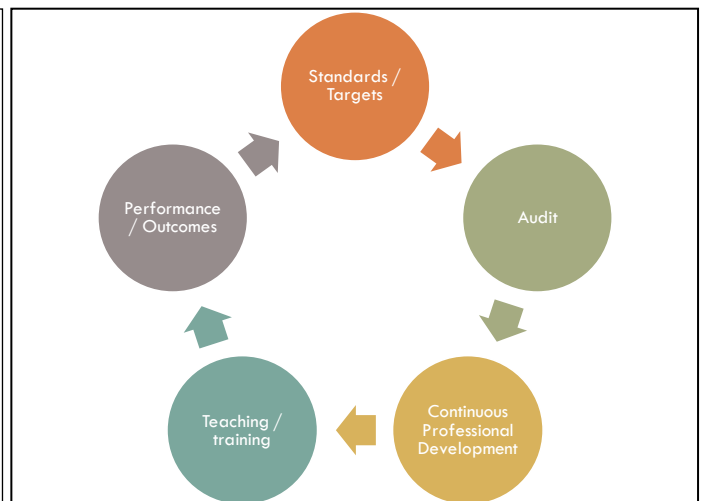


Figure 2: Continuous Improvement Cycle

Specific activity relating to quality assurance will be built into the mainstream operating of the service:

a) Clinical Governance Structure

Overall responsibility for the clinical work of the service lies with the Consultant Psychiatrist. Below the Consultant each cluster will have a doctor. On a day-to-day basis the Team Leader will have operational responsibility for the service and the delivery of clinical services in line with policy and practice.

b) Team Leader / Nursing Clinical Lead / Case Management

The Team Leader will have day-to-day operational responsibility for service delivery within the cluster team. They will be tasked with delivery a quality service and ensuring that standards are maintained – this will include:

- Managing annual leave
- Managing sickness/absence
- Induction
- Training
- Appraisal in conjunction with professional lead
- Capability
- Performance reporting
- Case management
- Clinical support

The role will be supported in the areas of Case Management and Clinical Support by the Band 7 nurses within the team.

Each client in the cluster will have a recovery based care plan that will be reviewed 6 monthly.

c) Clinical Meetings

Each team would have a weekly clinical meeting with their Specialist Doctor ie three clinical meetings per week. Consultant will provide cover and leadership.

d) Communication Meeting

Traditionally SMS has run a weekly communication meeting for all staff. The proposal is that this meeting becomes a Quarterly Meeting freeing up time for Clinical Meetings, and Teaching and Training Sessions. All meetings, teaching and training will be open to all disciplines in the cluster teams.

e) Teaching / Training Programme

The Consultant Psychiatrist and Consultant Nurse will lead a teaching programme based on the strategic priorities of the service and the needs of staff. Significant elements to be delivered by medical and nursing staff and cover the underpinning theories and practice in relation to working with addictions, motivational work and harm reduction.

f) Caseload Supervision

Each cluster will have a peer support structure and the Team Leader and Band 7 nurse will undertake one-to-one case supervision for the nursing staff. Caseload Supervision will include:

- Discussing individual cases
- Observed practice
- Skills and personal development

g) Policies, Protocols, Guidance and Toolkits

There will be development of joint materials that cover policies, protocols, guidance materials and toolkits for working with people to ensure consistency of practice. The Consultant Nurse will lead on these developments

h) Performance Reporting

Team Leaders will attend a quarterly performance meeting to be chaired by the Service Manager. These meetings will be used to look at performance against targets and any operational barriers to delivering to service specification.

i) Child Protection Case Conferences

Team leader will on behalf of a cluster team collate and organise for representation from the team at Child Protection case conferences. Currently nurses across the service attend, often necessarily at short notice which can upset clinical capacity.

j) Risk Management

All staff within the cluster will have a professional accountability for managing risk relating to Child Protection and Vulnerable Adults. Social Work staff within the teams will add to the professional response of the team by taking a lead role specifically in managing risk and will undertake home visits.

k) Service User Feedback

A key indicator of quality will be feedback from Service Users indicating their satisfaction with the service as well as any other issues or barriers they face to making progress in relation to their problems.

SMS Nursing Structure

The current nursing structure within the SMS in Primary Care / Fulton Clinic Aberdeen City is weighted towards Band 7 and Band 6 Nurses. This has an impact in relation to recruitment for RMNs across the hospital and long term workforce planning. This structure is no longer necessary now that the service has reached a position of consolidation.

Therefore the proposal is as per the table below:

	B7 TL	B7	B6	B5	
IDS	1	2	2.8	0	5.8
SOUTH CLUSTER	1	1	1	3	6
CENTRAL CLUSTER	1	1	1	2	5
NORTH CLUSTER	1	1	1	2	5
FULTON TEAM	1	1	2	0	4
CJ	0	1	0	0	1
RB	0	0.8	0	0	0.8
DTTO	0	2	0	0	2
TOTAL	5	9.8	7.8	7	29.6
TOTAL CLINICAL SESSIONS	25	68.6	54.6	49	197.2
PRIMARY CARE / FULTON TOTAL	4	4	5	7	20
CLINICAL SESSIONS	20	28	35	49	132

The nursing team will be further enhanced by £500k of recurring investment from Aberdeen City Council SW Department to improve:

- child protection,
- care management, and
- expand the Community Rehabilitation Service to be city-wide.

CHANGE PROCESS AND TIMESCALES

Detailed Staff Organisational Change Plan for SMS Redesign

- Question and Answer Sheet to be available to all SMS Staff **w/c 24 January 2010**.
- Consultation with stakeholders to finish by **24 February 2010**.
- Write to ring fence (all permanent band 7 staff) advising of complete list of posts and draft job descriptions - **w/c 1 March 2010**.
- Ring-fence staff to state order of preference for posts complete preference form and return to Melanie Noble, Assistant HR Manager **by Friday 12 March**.
- Short interviews to be held **17/18/19 March 2010**. Panel SP, MB, MN. Each applicant will be scored.
- Panel to meet and arrange for preferences and interview scores **23 March 2010**.
- Staff to be advised of outcome and offered posts in writing **24 March 2010**.
- 1-1 meetings with staff to feedback and look at individual circumstances and to take action where appropriate **24/25 March 2010**.

- Slotting in unsuccessful Band 7's to Band 6's posts. A slotting in of current Band 6'.
- Confirmed list **01 April 2010**
- Transition to commence from 01 May 2010

WHO HAS BEEN INVOLVED

The Steering Group Membership is:

- Karen Gunn, Service Manager
- Service User Representation
- Bill Harrison, Clinical Director / General Manager Mental Health
- Bruce Davidson, Lead Consultant – City
- Simon Rayner, Development Manager, Integrated Services
- Susan Harold, City CHP Representative
- Claire Wilkie, City Senior SW Manager
- Shirley Porter, Clinical Nurse Manager
- Moira Bowie, Team Leader
- Iain Cowie, CPN/Staff Representative
- Suzanne Bright, CPN/Staff Representative
- Martin MacKay, Staff Side Representative
- Alison Penman, Support Services Manager
- Melanie Noble, Deputy HR Manager
- Scott Baxter, IDS Community Rehab Co-ordinator
- Lynn Sutherland, Public Health

COMMENTS AND QUERIES

If you have any comments or queries please feel free to pass them on by no later than 24th Feb 2010 to:

Karen Gunn Service Manager, Specialisms Directorate Fulton Clinic Royal Cornhill Hospital Aberdeen AB25 2ZH Tel 01224 557298 Email: Karen.Gunn2@nhs.net	Simon Rayner Development Manager, Integrated Services Fulton Clinic Royal Cornhill Hospital Aberdeen AB25 2ZH Tel 01224 557871 Simon.Rayner@nhs.net
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APPENDIX 1:

INTEGRATED PATHWAYS

A) Pathway 1 – 2: Primary Care to Integrated Careplanning and Stabilisation Service

Currently 10 out of 27 practices refer to the Integrated Drug Service. Our aim is to increase this to the full 27 practices.

B) Pathway 2 – 3: Integrated Careplanning and Stabilisation Service to Cluster Teams + Fulton

Referrals will go the cluster team for long term support and treatment. Highly complex cases requiring Consultant level support will go to Fulton Clinic. Clients who do not have a GP able / willing to prescribe long term will go to Rosebank.

C) Pathway 2 – 9: Integrated Careplanning and Stabilisation Service to Inpatient Detox

Clients requiring Inpatient Detox will have their care plan agreed and auctioned from the IDS Team.

D) Pathway 2 – 10: Integrated Careplanning and Stabilisation Service to Inpatient Rehab

Clients requiring Inpatient Detox will have their care plan agreed and auctioned from the IDS Team.

E) Pathway 11 – 2: Prison to Integrated Careplanning and Stabilisation Service

This pathway is a pilot development to take 20 prisoners into community treatment on release. Longer term it is envisaged that all referrals from prison will come through this route

F) Pathway 12 – 2: DTTO / Criminal Justice to

To be discussed with Criminal Justice SW.

G) Pathway 13 – 2: Acute to Integrated Careplanning and Stabilisation Service

Clients not already in treatment will be referred via this pathway. Clients already in treatment for their addiction will link with the Fulton Clinic for liaison.

H) Pathway 14 – 2: Maternity Service to Integrated Careplanning and Stabilisation Service

The maternity service is a direct route into treatment and will continue to be so. The task of returning clients to their cluster etc will be negotiated between the teams

I) Pathway 15 – 2: Young Peoples Department to

Referrals will be made via this pathway

APPENDIX 2

		MANDATORY					MANAGEMENT							CORE						SPECIALIST												
		PROFESSIONAL STANDARDS / CODES OF CONDUCT / REGISTRATION	CONTINUOUS PROFESSIONAL DEVELOPMENT	EMPLOYER POLICIES: HEALTH AND SAFETY ETC	CHILD PROTECTION / VULNERABLE ADULTS	RISK MANAGEMENT	TEAM MANAGEMENT	PEOPLE MANAGEMENT	OPERATIONAL MANAGEMENT	PROFESSIONAL / CASELOAD SUPERVISION	CLINICAL GOVERNANCE	QUALITY ASSURANCE	PERFORMANCE MANAGEMENT	SCREENING / ALLOCATING CASES	CASELOAD MANAGEMENT SKILLS / ASSESSMENT	ADDICTIONS WORKING: RELAPSE MANAGEMENT etc	TALKING THERAPIES EG MOTIVATIONAL INTERVIEWING	KNOWLEDGE OF CLINICAL TREATMENTS / SUBSTITUTE PRESCRIBING	RECOVERY FOCUS	HEALTH PROMOTION / HARM REDUCTION	SERVICE USER ENGAGEMENT	CLINICAL DIAGNOSIS / ASSESSMENT / STABILISATION	EXPERT KNOWLEDGE AND SKILLS FOR COMPLEX CASES	SPECIALIST PSYCHOLOGICAL THERAPIES	MENTAL STATE ASSESSMENT / MANAGEMENT	MANAGING PHYSICAL ILLNESS	ADULT SUPPORT AND PROTECTION	SPECIALIST PRESCRIBING	HOME VISITS	INCAPACITY / HOUSING	REHABILITATION	
	BAND 7 (TL)	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●							
	BAND 7	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●							
	BAND 6	●	●	●	●	●					●	●	●	●	●	●	●	●	●	●		●	●	●	●							
	BAND 5	●	●	●	●	●								●	●	●	●	●	●	●				●	●							
	CONSULTANT	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●			
	STAFF GRADE	●	●	●	●	●				●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				●			
	SENIOR SW	●	●	●	●	●		●		●	●	●	●	●	●	●	●	●	●	●		●						●		●	●	●
	SOCIAL WORKER	●	●	●	●	●							●	●	●	●	●	●	●	●		●						●		●	●	●
	CO-ORDINATOR	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●									●	●	●	●
	REHAB WORKER	●	●	●	●	●								●	●	●	●	●	●	●								●	●	●	●	●
	ADMIN	●	●	●	●	●																										

