Edinburgh Integration Joint Board

REFERRAL REPORT

Mental Health Services (including Substance Misuse): Quality Assurance – referral from the Clinical and Care Governance Committee

Edinburgh Integration Joint Board

28 April 2020

Executive Summary	The purpose of this report is to refer the attached report on Mental Health Services (including Substance Misuse): Quality Assurance from the Clinical and Care Governance Committee to the Edinburgh Integration Joint Board for approval/consideration with the Committee's recommendations detailed below.

Recommendations	The Clinical and Care Governance Committee recommends that the Edinburgh Integration Joint Board**:** 1. Supports the proposal that the Edinburgh Health and Social Care Partnership join the Royal College of Psychiatrists (RCoP) Accreditation Scheme for adult in-patient and community mental health teams.

Terms of Referral

1. The Clinical and Care Governance Committee on 17 February 2020 considered a report on Mental Health Services Quality Assurance, which provided an overview of mental health and substance misuse services and the scrutiny that sought to provide assurance of quality of care and clinical practice.

2. During consideration of the report, the Committee discussed the following:

- The complexity of mental health and substance misuse service structures, including lines of responsibility across different services and the number of partners involved in delivering services;
- The tools, networking and learning that could be gained from the RCoP Accreditation Scheme would help staff to consider ways to improve the quality and efficiency of their work and the care that they provided;
- Recognition that not all of the targets required to achieve accreditation from the RCoP Accreditation Scheme would be appropriate for Edinburgh, but that despite this there were a number of benefits to adopting these, in particular the learning to be gained from self-assessment and peer review exercises;
- The benefits of other Lothian IJBs also joining the RCoP Accreditation Scheme;
- The importance of ensuring members understood clearly which services were within the remit of the HSCP and the IJB and where responsibility lay for each; and
- The development of the new quality hub to bring together improvement teams to share best practice, provide support and deliver on initiatives.

The Committee also noted the financial implications for the IJB as there was a cost of £2,250 per year per team to join the Accreditation Scheme. The annual cost would be £9,000 to cover the four community mental health teams.

3. The Committee agreed:

3.1 To note the national quality indicators for mental health and their alignment to wider system outcomes.

3.2 To recognise the progress made in relation to the whole system approach in response to NHS Lothian escalation.

3.3 To acknowledge the significant change agenda for mental health and substance misuse services.

3.4 To support the proposal that the Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme for adult in-patient and community mental health teams.

3.5 To support the proposal that mental health and substance misuse services were part of the Quality Hub which would ensure a consistent and constant focus on quality assurance.

3.6 To take significant assurance that monitoring and evaluation frameworks were in place to measure the impact of Action 15 and Seek, Keep, Treat funding allocations.

3.7 To request a report within 6 months' time providing information on mental health services, where responsibility was held for each area, the assurance monitoring processes in place, risk identification and mitigation processes, and how targets and outcomes were set and measured in order that the Committee could take assurance that processes were in place in these areas.

4. The Integration Joint Board is asked to consider the recommendations of the Clinical and Care Governance Committee, particularly in relation to 3.4 above, to support the proposal that the Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme for adult in-patient and community mental health teams.

Report Author

Richard Williams

Chair, Clinical and Care Governance Committee

Contact for further information:

Name: Rachel Gentleman, Committee Services

Email: rachel.gentleman@edinburgh.gov.uk Telephone: 0131 529 4107

Appendices

Appendix 1	Mental Health Services (including Substance Misuse): Quality Assurance – report by Head of Operations, Edinburgh Health and Social Care Partnership

Edinburgh Integration Joint Board

REPORT

Mental Health Services (including Substance Misuse): Quality Assurance

Clinical and Care Governance Committee

17 February 2020

Executive Summary	The purpose of this report is to provide the Clinical and Care Governance with an overview of Mental Health and Substance Misuse Services and the scrutiny that seeks to provide assurance of quality of care and clinical practice. The report also recommends that the Committee support the Health and Social Care Partnership's aspiration to join the Royal College of Psychiatrists Centre for Quality Improvement accreditation programme which would contribute to our local assurance system. The report also recommends that Mental Health Quality Assurance is a key component of the recently established Health and Social Care Partnership Quality Hub.

Recommendations	It is recommended that the Clinical Governance and Care Committee: 1. Note the national quality indicators for mental health and their alignment to wider system outcomes. 2. Recognise the progress made in progress whole system approach in response to NHS Lothian escalation 3. Acknowledge the significant change agenda for mental health and substance misuse services. 4. Are assured that monitoring and evaluation frameworks are in place to measure the impact of Action 15 and Seek, Keep Treat funding allocations. 5. Support the proposal that the Health and Social Care Partnership join the Royal College of Psychiatrists Accreditation Scheme commencing with community mental health teams.

	6.	Support the proposal that of mental health and substance misuse services are part of the Quality Hub which will ensure a consistent and constant focus on quality assurance.

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		✓
	CCGC may consider the need to recommend a direction to EIJB for consideration/implementation	

Report Circulation

1. Members of the Clinical and Care Governance Committee.
2. Members of the Edinburgh Health and Social Care Partnership Executive Management Team
3. Members of the Royal Edinburgh Hospital and Associated Service Executive Management Team

Main Report

4. Action 38 of the Mental Health Strategy 2017-20271 committed to and published a Quality Indicator (QI) profile in mental health (September 2018) which includes measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely.

5. It also committed to measuring progress towards parity by introducing a measurement framework similar to those used in physical health, which will draw on a range of information to understand the differences that are being made to, for example, premature mortality, what money is being spent, how long people wait to access services, rates of employment, and poverty levels. The quality profile did not set new targets but was built predominantly build on data that is already available.

6. The delivery of the QI profile requires actions by:

Scottish Government – national analysis of aggregated reports will allow consideration of improvement action. The Annual Report to Parliament on progress in relation to the Mental Health Strategy will use selected data to illustrate progress.

Information Services Division, NHS NSS – collection, analysing and reporting data.

Healthcare Improvement Scotland (HIS) – whilst working with Boards through the Mental Health Access Improvement Support Team (MHAIST), HIS will encourage Boards to generate data required by ISD for collection, analysis and reporting of data.

Health Boards – aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

Integration Authorities - aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

7. The detailed list of QIs provides secondary definitions for each QI, and maps them against:

- the six Quality Outcomes (Timely, Safe, Person Centred, Effective, Efficient and Equitable)
- the nine Health and Wellbeing Outcomes
- relevant actions set out in the Mental Health Strategy.

Appendix 1 sets out the national QIs and the publication schedule.

8. NHS Lothian was escalated to level 3 of NHS Scotland's escalation process due to a number of concerns some of which related to services and functions delegated to the 4 Lothian Integration Joint Boards (IJBs). A 'whole system approach' was supported by NHS Lothian and the 4 Lothian IJBs to address those areas. The recovery plan developed spans the entirety of those areas for which NHS Lothian is responsible. This includes Mental Health and Learning Disabilities for Adults – including Psychological Waiting Times. Recovery and improvement Boards have been established and in terms of the delegated functions; the Mental Health and Learning Disabilities Board is chaired by the EIJB Chief Officer.

9. The plan sets out the additional capacity being put in place funded by NHS Lothian to deliver sustainable improvement including the role of Director of Improvement, with Programme Director posts also being secured to support the individual Recovery and Improvement Boards in developing and delivering their action plans. Initial reporting to Scottish Government on actions towards improvement was undertaken on a fortnightly basis until 5 November 2019. Thereafter a single integrated Recovery Plan was submitted to the Scottish Government on the 29 November 2019. The Scottish Government are currently considering the appropriate level of escalation for NHS Lothian given the progress made in a number of areas.

10. In terms of mental health, one of the significant challenges relating to escalation was the availability of beds for acute admissions. The action taken to date has supported a reduction from around 106% occupancy to between 85- 90% at the time of reporting which is positive in ensuring bed availability.

11. Performance in relation to Psychological Therapies 18-week target has steadily deteriorated over the past few months with the adult treatment list increasing by 30-40 patients per month. The number of people waiting on this list was 2,743 at the end of November 2019 with performance against the 18-week standard currently at 79.9%. To address these issues, the Lothian system is investing in additional short-term capacity to tackle the longest waits, is implementing a number of changes in Standard Operating Policies (SOPs) and is taking part in a number of initiatives to extend the use of a computer based Cognitive Behavioural Therapy (CBT) and other CBT digital services.

12. While further improvement is both necessary and possible, it is recognised that the whole system approach has started to demonstrate a positive impact in a number of areas and that trajectories for improvement for areas not currently demonstrating improvement have been set. The EIJB received a formal update on progress on 4 February 2010.

13. Following widespread concerns raised in the Scottish Parliament in May 2018 about the provision of mental health services in Tayside, NHS Tayside commissioned an Independent Inquiry to examine the accessibility, safety, quality and standards of care provided by all mental health services in Tayside. The Independent Inquiry published an interim report in May 2019, which identified six key themes emerging from the evidence it had received[1]. These themes were:

[1] The Independent Inquiry into Mental Health Services in Tayside. (2019). Interim report: inquiry update and emergent themes. https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf

- Patient access to mental health services,
- Patient sense of safety
- Quality of care
- Organisational learning
- Leadership
- Governance

14. The final report of the Independent Inquiry, *Trust and Respect*, was published on 5 February 2020[2] and was been shaped by the voices of people who have provided evidence, many of whom had felt that their voices were not being heard. Over 1,500 people contributed evidence to the Independent Inquiry, including patients, families, carers, staff, partner organisations, professional bodies, third sector organisations and community representatives.

15. The report sets out 51 recommendations framed within 5 cross cutting themes:

- Strategic Service Design
- Clarity of Governance and Leadership responsibility
- Engaging with people
- Learning Culture
- Communication

16. The recently established Healthcare Improvement Scotland (ihub) "Mental health Inpatients – Designing the future Model Project" will be focusing on these recommendations as part for the progression of this workstream. The pan-Lothian Mental Health and Recovery Board will consider these recommendations as part of their improvement and redesign work.

17. The Thrive Edinburgh Adult Health and Social Care Commissioning plan details 6 workstreams which are incorporated into the Strategic Plan 2019-2022. The 6 commissioning work streams:

Building Resilient Communities	A Place to Live
Get Help When Needed	Closing the Inequalities Gap
Rights in Mind	Meeting Treatment Gaps

detail aspirations, what is happening now and what needs to happen in the future to achieve these aspirations.

18. Several change programmes are being progressed through "business as usual" and within the Transformation Programme. As we progress with whole systems change

[2] https://independentinquiry.org/wp-content/uploads/2020/02/Final-Report-of-the-Independent-Inquiry-into-Mental-Health-Services-in-Tayside.pdf

implementation it is essential that due cognisance is taken in relation to quality assurance and governance across commissioning, planning, delivery and quality assurance structures. A schematic diagram included in Appendix 2 sets out the range of services and commissioning and operational management arrangements.

19. The following paragraphs (20 to 46) in this report briefly summarise the change programmes with each workstreams which are informed by data and evidence, and current quality assurance systems in place. Paragraphs 47 to 52 detail the recommended the additional quality assurance components that the Committee are invited to consider.

20. The Manchester Study of Suicides in Scotland[3] found that 80% of people who end their life are not known to mental health services at the time of death. "Building Resilient Communities" and "Addressing Inequalities" work streams will encompass work to prevent suicides focusing on the actions detailed in the national "Every Life Counts" Suicide prevention action plan,[4] paying particular attention to high risk groups in Edinburgh and support for those impacted upon by suicide. For those that are known to mental health services there is a learning review process ensuring that lessons learned are fed into service improvement and delivery. Appendix Three includes the recent "lessons learnt" themes from Community Mental Health SAERs.

21. The National Records of Scotland produce an annual report in relation to drug-related deaths in Scotland. Edinburgh and Alcohol Drug Partnership (EADP) provide the EIJB and Edinburgh Chief Officers Group with an update on the national information and Edinburgh specifically.

22. The city has a rigorous review system to make analysis of all the circumstances at the time of death and this informs an action plan to improve the level of engagement and support for people who are vulnerable to overdose or drug-related death. The new Scottish Government Strategy Alcohol and Drug Strategy for Scotland has a focus on how Alcohol and Drug Partnerships will innovate and invest in services aimed at reducing drug and alcohol related deaths in Scotland.

23. Four locality-based Drug Related Deaths Review Groups work to learn lessons from individual drug related deaths. These groups are attended by local professionals who are responsible for local service delivery. Key issues and lessons are fed into the Pan Lothian Strategy Group to develop a strategic response across organisations. Appendix 4 sets out more detail in relation to drug related deaths.

[3] http://documents.manchester.ac.uk/display.aspx?DocID=37591

[4] https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters

24. "A Place to Live" workstream focuses on ensuring that people with mental health problems have a safe place to call home in which they feel safe, receive the support they need and are able to connect to and be part of their local community. This work is closely aligned to the strategic principles of Home First and seeks to minimise institutionalisation, maximise community provision and ensure that when hospital care is required, it is a safe and therapeutic experience which reflects the person's needs, levels of acuity and functioning.

25. EHSCP spends approximately £14 million per annum through purchasing a range of services to support people at home. Throughout the year the Care Inspectorate carry out a series of announced and unannounced visits to assess the quality of care, leadership, environment and service user and carer feedback. Appendix 2 provides an overview of the gradings awarded to these services.

26. A number of 'A Place to Live' change programmes are underway focusing on current community capacity (256 supported places) by increasing choice and control for clients and improving throughput. The Care Inspectorate have a year long announced and unannounced visiting programme. The findings from these visits are included in Appendix 5.

27. This workstream includes the development of a new framework agreement for supported accommodation and support at home services which will increase the ability for providers to respond flexibly to fluctuating levels of need, enable providers to carry out reviews and assessments in defined circumstances where longer term adjustments to the levels of support are required. This will increase the level of flexible and collaborative working between providers and health and social care staff around clusters and localities.

28. Acceleration of Technology enabled care service has a major role to play across the mental health model and work set to commence in February 2020 as part of the EHSCP Transformation programme will accelerate our Change Programme around this, making maximum use of the opportunities afforded by Digital Health Scotland.

29. The introduction of an innovation test site for 3 Conversations across statutory and third sector providers which will allocate resources based on a single shared care and treatment plan will further increase client choice and control and collaborative working across statutory and 3rd sector services.

30. "Get Help When Needed" workstream is focused on ensuring that when people need help they are able to access the support they need in a timely manner, for both planned and unplanned care. The introduction of "Thrive Welcome Teams and the

Thrive Collective will reduce barriers to access and ensure that there is clear assessment and formulation which in turn leads to care, support and treatment being matched to the individual's needs. This co-produced redesign is supported by the UK Living Well Programme (funded by the Big Lottery) to implement the lessons learnt from the Lambeth programme across four sites in the UK.

31. In recent years there has been a consistent increase in the demand for psychological therapies and significant numbers of people are waiting over the recommended Government standard of 18 weeks to receive the treatment they have been assessed as requiring. An Improvement Plan (which forms part of the Lothian Recovery Plan) is in place focusing on those who have waited longest, this is supported by additional investment over an 18 month period. Performance on improving access to psychological therapies forms part of the EHSCP performance report which is reported to the Performance and Review Committee.

32. Substance misuse services provide a range of early intervention, prevention of harm, access to treatment interventions and programmes to different populations including children and young people, people who are in contact with community justice system and initiatives to reduce substance misuse related offending. A quarterly report is produced and submitted to Edinburgh Chief Officers Group (COG). The Scottish Government recently announced that further targets will be issued in response to the new strategy Rights, Respect and Recovery.

29. Two additional funding streams Seek, Keep, Treat and Action 15 Funding have supported a number of new developments. The impact and outcomes of these new developments will be measured using agreed key performance indicators specific to the development / intervention.

33. The Seek, Keep, Treat comprehensive plan builds on long established Edinburgh recovery orientated services and support for people with substance misuse problems. The plan has 8 domains:

- Local needs assessment ensuring we are responding to issues that are specific for Edinburgh's population;
- Increased involvement of those with lived experience of addiction and recovery in the evaluation, design and delivery of services;
- Reduced waiting times for treatment and support services, particularly waits for opioid substitution therapy (OST);
- Improved retention in treatment particularly for those detoxed from alcohol and those accessing OST;
- Development of advocacy services;

- Improved access to drug/alcohol treatment services amongst those accessing inpatient hospital services;
- Whole family approaches to supporting those affected by problem drug/alcohol use;
- Continued development of recovery communities.

34. The Action 15 commitment aims to deliver on the national strategy for mental health commitment to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons was confirmed by the Scottish Government to Chief Officers. In Edinburgh this includes:

- **Thrive Centres/ Networks -** Allocation to Edinburgh's four wellbeing locality partnerships to build on the robust partnerships comprising of third and statutory sectors which will support the creation of wellbeing open access Thrive Centres with statutory and third sector contribution across a range of community settings.
- **Adult A & E at Royal Infirmary Edinburgh (RIE)** 3.00 WTE Additional nurses to deliver evidenced based intervention (IPT- Acute Crisis) for people who have attempted to commit suicide.
- **Children and Young People, A & E, New Sick Children's Hospital at** RIE - 3.00 WTE nurses to deliver evidenced based interventions to children and young people who have presented with serious self harm and suicidal ideation.
- **Edinburgh Prison (Males):** Maximize the opportunities for meaningful activities within prison and enhance psychological interventions in prison setting through the employment of 5.5 WTE Occupational therapists and clinical psychologists.
- **Edinburgh Prison (Females**) to provide evidence based psychological therapies to women in community and prison settings; enhance capacity of prison staff to work in psychologically informed way through the employment of 3.00 WTE staff members
- **Court diversion and custody settings** - to provide specialist mental health assessment (2.2 WTE) in partnership with Court Diversion Service
- **Clinical Psychology Pilot** (1.5 WTE) in North East GP Cluster: test of concept to explore the role of clinical psychology as first line responder using a 20 minute formulation model in GP settings
- **Enhance capacity for the training and delivery of the Prospect Model interventions** - adapted evidence-based interventions which can be delivered by a range of staff across agencies and settings. (1.00 WTE Principal Psychologist)

35. The "Rights in Mind" workstream is committed to ensuring that people understand their overarching human and legal rights and that staff working in mental health statuary and voluntary sector services ensure that their clients, along with their families, friends and carers, are afforded their rights. The PANEL principles - Participation, Accountability, Non-discrimination and equality, Empowerment, and Legality need to be embedded in all our Thrive Edinburgh commitments.

36. John Scott QC is the government lead for the review of Adults with Incapacity, Mental Health Care and Treatment, and Adult Support and Protection legislation. We are currently exploring with John Scott QC the potential for Edinburgh to be a test site for innovative practice in rights-based care which will help inform the legislative review and future practice. We are also planning to host an Edinburgh Summit on Human Rights and Care chaired by Professor Jill Stavert from Napier University.

37. The Mental Welfare Commission (MWC) regularly visits hospitals providing psychiatric care. The Commission carry out local visits to look at the experiences of people receiving treatment in these wards and publish these local visit reports. Their annual reports focus on the use of detention highlighting differences in practice across Board and Local Authorities. The recent Chief Social Work Officer's report highlighted a sharp increase in the use of Emergency Detention Orders and a steady increase in all compulsion orders.

38. The MWC also undertake themed visits, where they visit people using similar services across a short period of time, with key questions for patients, staff and visitors. In their most recent themed visit they focused specifically on NHS in-patients in rehabilitation services.[5] The function of a specialist inpatient rehabilitation service is to help patients gain or regain the skills and confidence needed to progress their recovery. Inpatients in rehabilitation services are likely to have severe and complex mental health needs and will often have spent months or years in hospital which significantly affects their skills and abilities needed to live back in the community.

39. This themed visit was arranged as the Commission recognised it was some time since they looked at rehabilitation. In comparison with acute inpatient services where the length of stay is short (averaging 40 days in the inpatient census for Scotland) the length of stay for people in rehabilitation services is much longer (582 days) and a higher percentage are likely to be detained under the mental health act (73% of patients in rehabilitation wards compared with 43% in acute psychiatry wards. [6]

40. Given these differences and the impact on people of being in hospital for a prolonged length of time, the Commission wanted to visit all rehabilitation services to review the

[5] https://www.mwcscot.org.uk/sites/default/files/2020-01/20200130_ScotlandsMHRehabWards_ThemedVisitReport_1.pdf
[6] Scottish Government Annual Inpatient Census 2019 https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disabilityinpatient-bed-census-part-2-out-scotland-nhs-placements/pages/5/

standard of care in these wards and to hear from patients about their experience of being treated in a rehabilitation service.

41. They visited 22 wards in 15 hospitals between June and September 2018 and met every patient who was able and willing to talk to them. They also spoke with staff, and reviewed case files and drug prescription sheets, including those of patients we had not been able to talk with. In addition, they also spoke to 26 family members to find out their experiences of the care and treatment of their relative.

42. The report was published on 30 January 2020 and set out a number of recommendations:

- NHS Boards should consider seeking accreditation under the AIMS standards for inpatient mental health rehabilitation services, or benchmark their service against these standards, with particular attention to factors such as delivery of physical healthcare, participation in purposeful and meaningful therapies and activities which reflect the preferences of patients and evaluation of outcomes using structured measurement tools.
- NHS Boards should ensure that no-smoking perimeters they have set around hospital buildings are clear to patients and staff, and that patients are supported to comply with no smoking policies.
- NHS Boards should ensure that processes are in place at ward level to audit the prescription of medication for detained patients and the certification of this under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to ensure that all such treatment is properly authorised.
- NHS Boards should develop plans to promote the knowledge and use of advance statements in rehabilitation services.
- Integrated Joint Boards should review on an individual basis, rehabilitation patients whose discharges have been delayed by over 3 months in order to develop a clear plan for discharge within an acceptable timescale.

43. The Place to Live Commissioning and Review group will prepare a formal response to these recommendations which will highlight work underway to address them. This includes a quantitative investigation of the association between social and physical features of the environment and participation in meaningful activity for individuals with complex mental health difficulties living in supported accommodation and the use of standardised assessment tools including the Residential Environment Impact Scale, Model of Human Occupation Screening Tool and Camberwell Assessment of Need Short Appraisal Scale In rehabilitation settings in hospital and community.

44. The ”Meeting Treatment Gaps” work stream is focused on working effectively to integrate service provision in localities and across the city to further develop and enhance person, carer and family support to maximise the life opportunities for people with mental health problems and mental illness and to reduce the requirement

for acute and long-term care. This clearly links with the "Rights in Mind" work stream and the MWC report on Rehabilitation is a good example of how attention to rights needs to be embedded in care planning and service delivery.

45. This work stream will also focus on Integrated Care and Support Pathways for severe mental illness including Bipolar, Schizophrenia, Eating disorders, Personality Disorder, Perinatal Mental Health and Depression to ensure that our services are rights based, provide evidenced based clinical treatment as defined by SIGN and NICE[7], and there is a comprehensive focus on meaningful days.

46. There are well established multi-professional Community Mental Health Teams, Social Work Teams, Mental Health Officer Service, and a wide range of third sector agencies, providing a range of biopsychosocial interventions. Over the last few years these services have experienced increasing demand set against a reduced workforce. The introduction of open access services will change the demand on these services, and it is important that we have a refreshed and up to date understanding of the current secondary mental health care provision across the city.

47. To assist with this, it is recommended that the EHSCP sign up to the Royal College of Psychiatrists Standards for Adult Community Mental Health Services (ACOMHS)[8] . This is an accreditation programme which works with staff to assure and improve the quality of community mental health services for people with mental health problems, and their carers. Accreditation assures staff, service users and cares, commissioners and regulators of the quality of the service being provided. It engages staff in a comprehensive process of review, through which good practice and high-quality care are recognized, and teams receive support to identify and address areas for improvement. The programme has involved service users and carers as a priority, and people with firsthand experience of using community mental health services have been encouraged to get involved in all stages of the development process. The standards are set out in Appendix 6.

48. Standards used within the network are designed specifically for community mental health services. They are developed in consultation with frontline staff, managers, patients and carers and are aligned with NICE guidelines. Participating members are able to demonstrate that they are working towards and achieving these measures, as well as our wider standards, while showing their commitment to quality improvement. The backbone of the network is peer review and accreditation but member services

[7] SIGN: Scottish Intercollegiate Guidelines Network: NICE – National Institute for Health and Care Excellence https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/adult-community-teams-(acomhs)/acomhs-standards-first-edition-2016.pdf?sfvrsn=4dcf4a70_2

[8] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/adult-community-teams-(acomhs)/acomhs-standards-first-edition-2016.pdf?sfvrsn=4dcf4a70_2

are also able to benefit from specialist events, publications, and the knowledge and experience of peers.

49. There are good opportunities for networking, tools for self -assessment and peer review visits are facilitated between member services. These visits are a key element of both developmental and accreditation processes. A peer-review team review evidence provided by the service to assess whether they meet the standards. Those meeting the required level are accredited by the Royal College of Psychiatrists.

50. The network allows services to create a learning community, where they share and benefit from best practice and updates in the field. It enables staff to regularly consider ways to improve the quality and efficiency of their work and the care that they provide.

51. The EHSCP **Quality Hub** led by the Chief Nurse has been established. It is recommended that there is further discussion to ensure that the Hub can support the quality improvement and assurance functions that are critical to ensure that we continue to use data, evidence and research to drive practice change and redesign. Having a recognised single point is crucial to ensure that we continue to develop and embed a culture of learning and reflection that drives service improvement and delivery. This will also provide a single point where the Care Inspectorate and MWC reports can be reviewed and any subsequent action and improvement plans developed and monitored.

Implications for Edinburgh Integration Joint Board

Financial

52. There is an annual charge of £2,250 per year per team to join the Adult Community Mental Health Services Accreditation Scheme. The annual cost would be £9,000 to cover the four community mental health teams.

Legal / risk implications

53. There are several pieces of law that ensure people with mental illness, learning disabilities, dementia and related conditions get appropriate treatment and have their rights respected. The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to people who have a mental illness, learning disability, or related condition. The Act calls this mental disorder. The Adults with Incapacity (Scotland) Act 2000 provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 or over) who lack capacity due to mental illness, learning disability, dementia or a related condition, or an inability to communicate. The Criminal Procedure Act includes provisions for people who are accused of a criminal act and who may have a mental disorder. The Adult Support and Protection Act protects people - “adults at

risk" - who may find it more difficult to stop harm happening to them. The Act calls people in this situation 'adults at risk'

54. The MWC has duties under the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. The Commission monitors the Acts to see how the law is being used. Every year the MWC produce an independent overview of the operation of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Equality and integrated impact assessment

55. Service users, carers and third sector partners are involved in any proposal for investment or disinvestment and proposals would be subject of an Impact assessment.

Environment and sustainability impacts

56. None noted.

Quality of care

57. The recommendations within this report will improve the governance and assurance of mental health services across the city.

Consultation

58. Thrive Edinburgh has full participation of all stakeholders in all work streams which are focussed on in terms of service development and delivery.

Report Author

Tom Cowan
Head of Operations, Edinburgh Health and Social Care Partnership

Contact for further information:

Name: Dr Linda Irvine Fitzpatrick
email: Linda.irvinefitzpatrick@nhslothian.scot.nhs.uk 07815592362

Name: Colin Beck 0131 553 8200
Email: colin.beck@edinburgh.gov.uk

Background Reports

National Mental Health Strategy
Thrive Edinburgh Adult Health and Social Care Commissioning Plan
Every Life Matters – Scotland' Suicide Action Plan
Rights, respect and recovery – Scotland's drug strategy

Appendices

Appendix 1	National Quality Improvement indicators and the publication schedule.
Appendix 2	Schematic diagram -Mental Health Services
Appendix 3	Learning from Experience: Themes from Community Mental Health SAERs
Appendix 4	Drug related deaths
Appendix 5	Mental Health Services: Quality Assurance Summary
Appendix 6	Standards for Adult Community Mental Health Services

Appendix One: All mental health related publications for November 2019 to December 2020

Topic		Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
Mental Health Inpatient Activity												A			
Scottish Suicide Information Database (ScotSID)					Q							Q			
Suicide - ScotPHO									A						
Dementia (Dates To be confirmed)															
Mental Health Quality Indicators Profile						Q						Q			
Medicines for Mental Health													A		
Outpatient Activity (Psychiatrist)		Q			Q			Q						Q	
Child and Adolescent (CAMHS) Waiting Times			Q			Q			Q			Q			Q
Psychological Therapies Waiting Times			Q			Q			Q			Q			Q
Electroconvulsive Therapy(To be confirmed)															
Learning Disability Inpatient Activity															A
Alcohol related discharges from Psychiatric Hospitals		A												A	

Key: A : Annual Publication Q : Quarterly publication

Mental Health Quality Indicators Profile

The Mental Health Quality Indicators profile provides information about quality outcomes for services for people with mental health problems located within the context of Integrated Authority provision.

Website: Mental Health Quality Indicator Profile

Most recent publication: Adult Mental Health Benchmarking Toolkit [1.4Mb]

Medicines for Mental Health

ISD maintains a detailed database of details of NHS prescriptions dispensed in the community in NHS Scotland that is augmented by information on prescriptions that originate in NHS Scotland but dispensed elsewhere in the United Kingdom. The publication shows medicines and prescriptions used in mental health, specifically Insomnia & Anxiety, Psychoses & related disorders, Depression, Attention Deficit Hyperactivity Disorder (ADHD) and Dementia.

Annually published in October.

Website: Prescribing and Medicines

Most recent publication: Medicines using in Mental Health 22 October 2019 [1.4 Mb]

Mental Health Inpatient Activity

Mental health inpatient activity trend data until March 2019 has now been published.

Website: Mental Health

Most recent publication: Mental Health Inpatient Activity, 2019 release 10 September 2019

Outpatient Activity (Psychiatrist)

An outpatient is a patient who attends (outpatient attendance) a consultant or other medical clinic or has an arranged meeting with a consultant or a senior member of their team out with a clinic session. Outpatients are not admitted to a hospital and do not use a hospital bed. The tables on the link below include information on outpatient attendances with consultant psychiatrists.

Quarterly published in November 2019, February 2020, May 2020 and November 2020.

Website: Outpatient Activity

Most recent publication: the Outpatient Activity section provides some data on psychiatic outpatient activity in its annual figures.

Scottish Suicide Information Database (ScotSID)

The overall aim of the ScotSID is to provide a central repository for information on all probable suicide deaths in Scotland, in order to support epidemiology, preventive activity, and policy making.

The database covers demographic information, contact with health services and related health data, and will eventually provide details relating to the suicide event and individuals' wider social circumstances.

Annually, most recent publication in December 2018:

Website: Mental Health

Most recent publication: A profile of deaths by suicides in Scotland 2011-2017: A report from the Scottish Suicide Information Database (ScotSID) 4 December 2018 [2.3Mb]
Data tables: View Data Tables

Advice on how to access ScotSID data [109kb]

Suicide - Scottish Public Health Observatory (ScotPHO)

Annual update of suicide information in Scotland including numbers and rates of suicide at Scotland, NHS board and LA level and by deprivation decile at Scotland level.

Published annually.

Website: ScotPHO website, Suicide: key points

Most recent publication: Suicide Statistics for Scotland - Update of trends to 2017 27 June 2018 [193 Kb]

Psychological Therapies Waiting Times

The Scottish Government has set a target for NHS Boards to deliver a 18 week referral to treatment for Psychological Therapies by December 14. This publication shows the Psychological Therapies Waiting Times in Scotland.

Quarterly published in March, June, September and December. First published in August 13.

Website: Psychological Therapies Waiting Times

Most recent publication: Psychological Therapies Waiting Times in NHSScotland 3 December 2019 [1011 Kb]

top of page

Psychology Workforce

NHS Scotland Psychology workforce statistics.

Published annually in March.

Website: Psychology Workforce Planning Project

For new publications visit: www.isdscotland.org/Health-Topics/Workforce/NES-Publication/

Electroconvulsive Therapy (ECT)

ECT, a treatment reserved for people with serious mental illness, still attracts polarised views with respect to acceptability in contemporary practice. The formation of the Scottish ECT Accreditation Service (SEAN) with its focus on audit and adherence to nationally agreed standards and guidelines provides assurance about practice within Scotland. Publication is an annual report on the work of the SEAN.

Annually published in October.

Website: The Scottish Electroconvulsive Therapy (ECT) Accreditation Network (SEAN)

Most recent publication: Scottish ECT Accreditation Network Annual Report 2016

Alcohol related discharges from Psychiatric Hospitals

Alcohol-related hospital discharge statistics are published annually by ISD in two different publications, which are released in alternate years. They are included in this Alcohol-related Hospital Statistics report, which is published every two years. They also form part of the Alcohol Statistics Scotland release, which is also published every two years (in alternate years to the Alcohol Hospital Statistics publication). This publication includes data on alcohol-related psychiatric discharges (from SMR04). These are presented by age, gender, deprivation and Health Board area.

Annually published in November.

Website: Drugs and Alcohol Misuse

Most recent publication: Alcohol-related Hospital Statistics Scotland 2018/19  19 November 2019 [150 kb]

Quality Indicators

Timely

T1
Psych access
% of people who commence psychological therapy based treatment within 18 weeks of referral

T2 CAMH access
% of young people who commence treatment by specialist Child and Adolescent Mental Health services within 18 weeks of referral

T3 Sub misuse access
% of people who wait less than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

T 4 4 hour Emergency Assess.
% of unscheduled presentations referred to specialist mental health services, who have had direct assessment by MH specialists within 4 hours

T5 First present. psychosis
% of first presentation psychosis patients that start SIGN or NICE guideline evidence based treatment within 14 calendar days of referral to specialist mental health services

Safe

S1 Suicide rates
Suicide rates per 100,000 population

S2 Discharge FU
% of all discharged psychiatric inpatients followed-up by community mental health services within 7 calendar days

S3 Emerg. Self harm
% of all unscheduled care presentations where self-harm is a presenting feature

S4 Medication safety
% of people prescribed lithium who experienced lithium toxicity in the last 12 months

S5 Inpatient Safety
Incidents of physical violence per 1000 occupied psychiatric bed days

Person-Centred

P1 Caring support
% of carers for people with mental health problems who feel supported to continue in their caring role (Integration indicator 8)

P2 Quality of life
% of adults with mental health problems supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (Integration indicator 7)

P3 Matters to me
% of replies for people with mental health problem that agree with statement “people took account of the things that
mattered to me” in Health and Social Care Experience Survey

P4 Advance statements
Number of people with advanced statements registered per year with the Mental Welfare Commission for Scotland

P5 Personal outcomes
% of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month

Effective

E1 Delayed discharge
Number of days people spend in hospital when they are ready to be discharged per 1,000 population (Integration indicator 19)

E2 Antipsychotics
% people prescribed antipsychotics for reasons other than psychoses and bipolar disorder treatment

E3 BMI
% people with severe and enduring mental illness and / or learning disability who have had their BMI measured and recorded in the last 12 months
.
E4 functioning
% of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month

E5 symptoms
% of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month

Efficient

Ef1 Emergency bed days
Rate of emergency bed days for adults (Integration indicator 13)
services.

Ef2 readmission
% Readmissions to hospital within 28 days of discharge (Integration indicator 14)
Ef3 beds
Total psychiatric inpatient beds per 100,000 population (NRAC adjusted)

Ef4
Mental health spend
Total mental health spend as a % of total spend.

Ef5 DNAs
% of did not attend appointments for community based services of people with mental health problems

Equitable

Eq1 Mortality rate
Premature mortality rate (Integration indicator 11) = Standardised mortality rate for persons in contact with mental health services

Eq2 CTOs
Number of emergency detention certificates (EDCs) per 100,000 population
.
Eq3
LD health checks
% of people with severe and enduring mental illness and/ or learning disability who have had an annual health check within previous 12 months

Eq4
CAMH admissions
% of under 18 psychiatric admissions admitted outwith NHS specialist CAMH wards

Eq5 ACPs
% of caseload with an active anticipatory care plan

Appendix Two- Mental Health Services Schema

Key

Operationally Managed by Health and Social Care Partnership

Operationally Managed by REAS

Operationally Managed by 3rd Sector Services

North West Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Pilton Community Health, Health in Mind

North East Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
The Stafford Centre, NE Counselling Services

Statutory City Wide
Intensive Home Treatment Team
Rapid Response Team
Psychological Therapies Team
Mental Health Assessment Service (REH and RIE (24/7)
Behaviour Support Service
Lothian Older People's Psychology Service
Rivers Centre; Cullen Centre; Lothian V1P

Commissioned Services (3rd Sector/ City Wide)
Edinburgh Crisis Centre[2]
Stafford Centre[1]
Barony Contact Point
256 Supported accommodation places[3]
Plan to Change- Peer Workers[1]
Individual and Collective Advocacy

Royal Edinburgh Campus
Acute Admission Wards
Intensive Psychiatric Care
Rehabilitation
Older People's Wards
Community HPCCC
Ferryfield
Ellen's Glenn
Finlay House

Royal Edinburgh Campus (regional and national)
Medium Secure Unit
Brain Injury Unit
CAMHS Unit
St John's - regional
Mother and Baby Unit
Eating Disorder Unit

South West Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Redhall - SAMH, Cyrenians, Broomhouse Space, health in mind

Notes

1. Services in place until 31 July 2020. New service being commissioned in line with Thrive Open Access Model.
2. Service in place until 31 July 2020- redesign of out of hours and crisis provision underway
3. Framework agreement being developed which will increase capacity and flexibility of support

South East Locality
Primary Care Liaison Team
Community Mental Health Team
Older People's CMHT
Commissioned 3rd Sector Services[1]
Barony Contact Point, health in mind

Appendix 3: Learning from Experience: Themes from Community Mental Health SAERs

March 2018; Updated May 2019 and Jan 2020

Pathways Into and Through Services

Quicker access to mental health care or treatment was identified as being needed, and this should be monitored and improved to ensure people can get help when they need it.

This must include much easier ways for primary care, or other agencies, to discuss people they are seeing with psychiatrists or other members of the mental health team and to seek advice when needed

Teams should carefully consider the ways they engage people into the service and adopt assertive approaches where there are high levels of risk accompanied by a low likelihood of people engaging with services through their own volition.

Where referrals are not accepted there should be clear feedback loops to referring teams and an opportunity to challenge that decision

Discharge protocols/SOP's should be reviewed, with a particular focus on ensuring plans for post discharge review of all patients discharged from hospital within a maximum of 7 days. Further consideration should be given to reduce this target to 3 days. When there are transitions between teams there are clear strategies to ensuring the person's care moves safely over from one team to the other and that they and their family, friends or carers are kept informed throughout

Where third or independent sector services are part of someone's agreed plan then workers must share as much information with them as the client will allow, particularly around risk and they must be as involved as much as possible in overall care planning.

Localities to develop robust ways to routinely share adult concern forms and other risk information across the locality.

Some reviews noted that conventional clinic settings were not suitable to some people who struggled to attend them. They recommended that localities use their outward focus to identify suicide hotspots or potential areas of risk and develop ways to work with the local community and carry out suicide prevention work.

Assessment and Decision Making

Opportunities to improve assessment and care planning were identified in many SAERs. This included:

- Where referrals are made which are considered urgent by the referrer, but not felt to be urgent by the receiving team and downgraded, that this decision is communicated to the referrer to allow alternative arrangement to be made or a further discussion carried out. To ensure that such referrals are seen within a reasonable timescale, not exceeding 8 weeks, and their progress monitored.
- That the routine timescale to initial assessment is monitored and does not exceed 12 weeks

- Much greater involvement of family, friends or carers in assessment and planning whenever it is possible to do so
- Using all agreed tools in the Mental Health ICP documentation to come to a clear view of the person's difficulties, shared with them, but acknowledging that at times the worker and the person may not agree.
- Taking a longitudinal view of someone's needs or appropriate treatment not just relying on brief one-off assessments – particularly where the person has emotional instability or who may have attachment difficulties and so present very differently in different settings or times.
- Using agreed treatment guidance such as SIGN and NICE to make evidence based but individualised treatment decisions and documenting the rationale for doing so – particularly around treatment for depression (NICE CG90)
- Ensuring that if someone is declining treatment or support without which they are at risk of serious harm that an assessment of capacity to make that decision is made and documented

Complex Difficulties

Not surprisingly, many recommendations focused on how to ensure good care when the person faced complex difficulties. Many of these overlap with other issues, for example, assessment, treatment, drug use and so on, but the key recommendations included:

- Ensuring that risk assessment and safety planning takes into account all factors in the person's life. Assessment should not be based on narrow or one off assessments but take into account all the information available, including past history, views of others including family, friends or carers and other agencies and consider the way the person is likely to relate to services, considering, for example, their attachment style.
- On occasion, staff needed to improve the way they understood and related to people with relational difficulties or personality disorder, particularly in the assessment of risk.
- Where there is longstanding ongoing risk to self or others CMHTs should keep an open mind about the need for their involvement and avoid therapeutic nihilism

To help improve these aspects of care some organisational strategies should be put into place:

- Developing a common language for talking about complex difficulties particularly relational difficulties using a common model of care
- That all teams have the ability to support practitioners to work with people to develop psychological or psycho-social formulations of their difficulties and strengths developed with the person, with their wider teams and , whenever possible, with family, friends or carers.
- Ensuring that the Care Programme Approach (CPA) is considered and applied consistently whenever it is likely to be helpful to keep someone safe and well
- Ensure that Adult Support and Protection measures (ASP) are considered and applied consistently whenever it is considered that criteria for ASP may be met
- Consider the use of GIRFE meetings where CPA or ASP meetings are not appropriate but that a wider view of professionals with the ability to escalate issues that appear intractable might be helpful.
- Developing use of Anticipatory Care Plans (ACPs) to ensure all members of extended out of hours care team understand the person's needs and their care plan

- Developing close links and ways of communicating freely with GPs and other primary care workers to be able to quickly share information. In particular to offer opportunities for general practice to consult mental health or substance misuse services in complex cases, for example, where someone is at significant risk of harm, but is not engaging with services.

Drugs and Alcohol

Drugs and alcohol played a role in a number of SAEs, both in terms of their effects and of the impact of withdrawing from them on people's mental state.

Specific recommendations included:

- Teams should ensure they routinely identify all prescribed medication of people who use substances, in case those medications potentiate the effect of drug use and increase risk of death
- The risk of patients resuming drug use after a period of abstinence should be considered in care plans, for example, on discharge from hospital
- Developing improved pathways between substance misuse and mental health. In particular being able to consult with substance misuse teams to gain advice and recommendations or to co-work if that is required.
- To seek advice as to how to encourage and support pole into substance misuse treatment
- Specifically to consider the risks of poly-pharmacy of drugs such as opiate replacement drugs, painkillers including gabapentinoids, or benzodiazepines

Family, Friends and Carers

Perhaps the most common learning was the need to involve family, friends or carers in all aspects of care wherever it is possible to do so, from initial assessment right through to support if someone takes their life.

Several recommendations suggested we need to go much farther than we currently do into obtaining the views of family, friends or carers in making assessments. It was acknowledged that this sometimes runs counter to our desire to put clients at the centre of assessment and may require a significant change in the way we help identify people's problems and make plans.

As a result of recommendations Guidance for Involving Family, Friends and Carers was developed and this for should be revised for EHSCP and made available to all staff.

- Teams were encouraged to develop some means by which carers can keep in touch with teams during or after their treatment to communicate increased risk and to provide support for carers
- If a discharge plan relies on family friends or carers, they must be fully aware of the risks and the plan and how to seek help if the person deteriorates
- After death or other traumatic incident teams should identify a senior single point of contact for families and follow the Being Open approach to support them

Physical Healthcare

We know there is hugely increased mortality for people with severe mental illness, and this was reflected in some of the learning.

- Teams must consistently and systematically deliver physical healthcare checks for those with severe mental illness.
- Teams should develop systems and strategies to support intervention where there are identified physical health problems or where factors may increase risk of physical illness, for example, cardio-vascular events. This may include supporting the person to receive treatment in general practice or to third sector organisations supporting healthier lifestyles
- Where someone is identified as being potentially acutely physically unwell, assertive efforts must be made to connect them with the right physical healthcare

People receiving Clozapine were particularly at risk of death due to their medication and special care is prescribed for them: Learning included

- Annual Clozapine levels being taken as a minimum as directed by the Clozapine Handbook June 2017
- The physical healthcare of people, receiving Clozapine is governed by SGHD/CM(207)4 and teams must adhere to that standard as well as being able to demonstrate they are doing so by audit
- If a Red result is identified teams must be aware of the need to stop Clozapine immediately and to communicate to patients or carers to stop taking their medication

Documentation

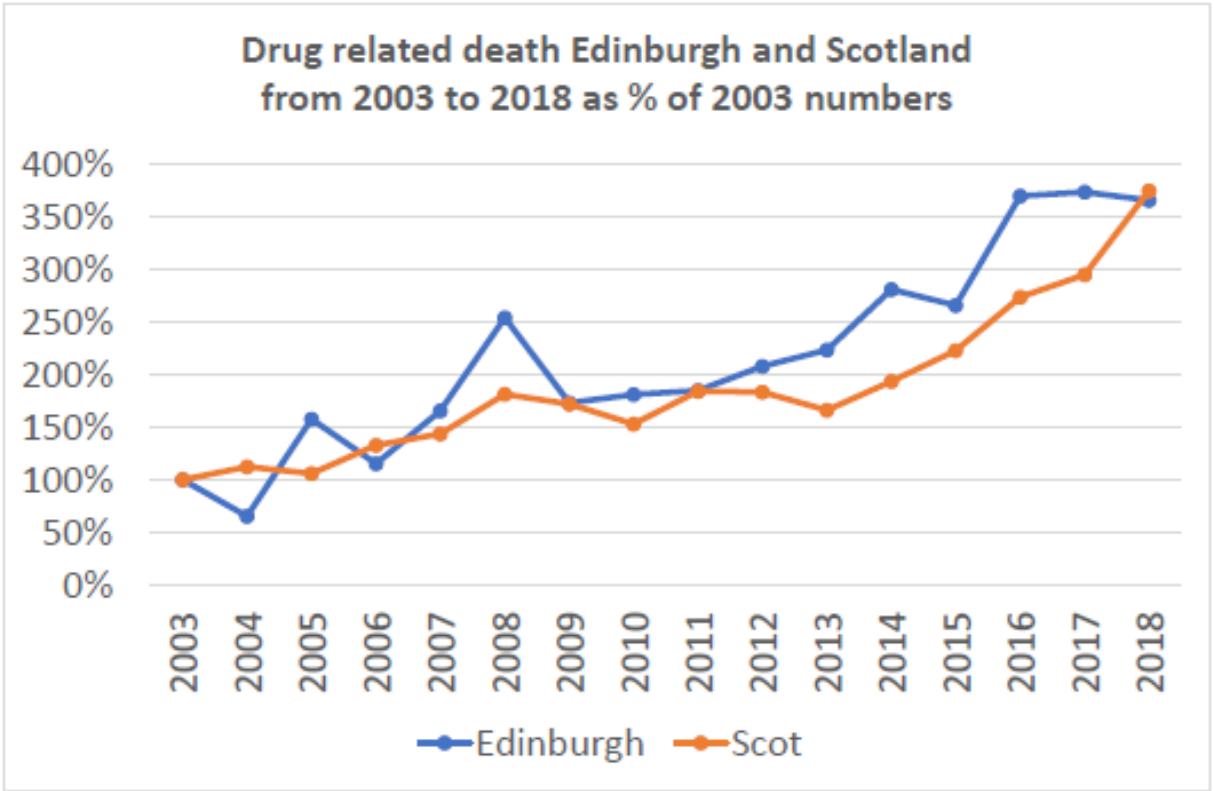
Unfortunately documentation continued to need some improvement in particular reminding all staff that records ***must be contemporaneous*** i.e. written on the day of the contact and that this includes TRAK entries. If it is impossible to write on the day it must be written by 12.00 the following day.

Decision making, particularly where there is high risk or complex presentations needed to be better documented. Where there are complex decisions made or positive risk taking (where a more risky course of action is taken in the person's best interest), a clear rationale for those decisions must be clear in the documentation. Where patients are declining treatment or are not engaging with offered treatment or support special care must be made to ensure that there is clear documentation of risk and plans with a clear rationale for this. Team discussions should be documented and communicated. Where someone is declining treatment which is potentially lifesaving then their capacity to make that decision should be documented at the time and at appropriate points thereafter.

Mike Reid, Mental Health and Substance Misuse Manager.

Appendix 4: Drug related Deaths in Edinburgh 2018: Issues and responses

There were 95 drug related deaths in Edinburgh in 2018. As the chart below shows, there has been a steady increase in Drug- related deaths in Edinburgh since 2003. Between 2015 and 2016 the numbers had a significant upturn and since that time have plateaued over the last three years. In 2017 Edinburgh recorded that 97-people died from a Drug-related death and in 2018 this number reduced to 95.



Drug related Deaths figures

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Edin	26	17	41	30	43	66	45	47	48	54	58	73	69	96	97	95
Scot	317	356	336	421	455	574	545	485	584	581	526	613	706	867	934	1187

2 The number of drug related deaths recorded in NHS Lothian in 2018 was 151.

The number of drug related deaths recorded in NHS Lothian in 2018 was 151. This compares with 161 in 2017.

Drug related deaths in the City of Edinburgh have been steady for the past three years. Whilst this is better than many other areas in Scotland, this is a plateau at a maximum level. The aim for EIJB and EADP is to commission services that will reduce the number of people who die from a drug overdose and alcohol related death.

The median number of drugs implicated in death was 4 with an interquartile range of 3 to 6. Poly-drug use is the norm in drug related deaths and may be a significant factor in the ongoing high numbers. Of significance is the prevalence, potency, and affordability of substances such as “street Valium”.

The median age at death in drug related deaths has not changed over the period of 2014 to 2018. It is the same for men and women and has roughly the same interquartile range over that period.

Whilst heroin use has declined in relative terms, opioids are implicated in the majority of drug related deaths in Edinburgh and usually with at least one other drug group. Benzodiazepine and gabapentinoids also implicated in a majority of deaths although not always in combination.

Of the benzodiazepines, diazepam is still the most frequently implicated but etizolam is emerging as a particular local concern.

Whilst the majority of people who had drug related deaths were not currently engaged with specialist services, many had been up until around a year before death. Around 50% had no engagement with services within the previous year and that includes a group of people who had no history of drug misuse. Engagement with specialist treatment services reduces the risk of death significantly

Comparison with drug related deaths recorded in 2014, the number of drugs taken together has doubled and the drugs taken have changed markedly in only 4 years.

Actions and responses:
The National Records of Scotland produce an annual report in relation to Drug- related deaths in Scotland. Edinburgh and Alcohol Drug Partnership (EADP) provide the EIJB and Edinburgh Chief Officers Group with an update on the national information and Edinburgh specifically.

The city has a rigorous review system to make analysis of all the circumstances at the time of death and this informs an action plan to improve the level of engagement and support for people who are vulnerable to overdose or Drug- related death. The new Scottish Government Strategy Alcohol and Drug Strategy for Scotland has a focus on how Alcohol and Drug Partnerships will innovate and invest in services aimed at reducing drug and alcohol related deaths in Scotland.

Four locality-based Drug Related Deaths Review Groups work to learn lessons from individual drug related deaths. These groups are attended by local professionals who are responsible for local service delivery. Key issues and lessons are fed into the Pan Lothian Strategy Group to develop a strategic response across organisations.

The Take Home Naloxone Programme - Naloxone is an opioid antagonist, which can temporarily reverse the effect of an opioid overdose; this provides more time for emergency services to arrive and further treatment be given. Naloxone continues to be distributed within key settings: injecting equipment provision outlets, drug services, homeless services GP surgeries and pharmacies. Over 4000 kits have been distributed in the city at £18 per kit.

Responding to non-fatal overdose - A non-fatal overdose is the strongest indication that an individual is likely to die a drug related death in the near future and EADP has developed a number of interventions to prevent these deaths –the Scottish ambulance service notify drug services following an overdose. The locality service review and intensify support to the individual (if the person is already in treatment) and try to reach out to them if they are not.

A drug liaison nurse is employed at Edinburgh Royal Infirmary and works to reach those in the hospital who need to begin drug treatment while admitted and to have it continued discharge.

New government strategy - National and local drugs strategy is increasingly focussing on the needs of the highest risk and most vulnerable individuals and on the key life-saving measures needed to minimise harm and extend life. According to the Programme for Government, The new Scottish Government drugs policy will be "guided by a principle of ensuring the best health outcomes for people who are, or have been, drug users, our aim being to seek, keep and treat those who need our help". This determination is based on the increasing rates of drug related deaths and the recognised needs of an ageing drug using population.

Locally, a health needs assessment was initiated in 2016/17 to identify the needs of injecting drug users and the efficacy of the response provided by services. This was steered by a multi-agency group which included representatives from Police Scotland, NHS Lothian, City of Edinburgh Council and the third sector. The final needs assessment was published July 2017, and a summary infographic on its findings can be found here: https://www.nhslothian.scot.nhs.uk

At its meeting in June 2019 EIJB agreed to the proposed EADP investment plan amounting to £1.4 million. This money will fund services to respond to the priorities outlined below:

Priority population groups in need:
Currently / recently dependant, adult, high risk opiate / benzodiazepine / poly drug users in the community. Drinkers at high risk of/ experiencing alcohol related death, alcoholic liver disease, alcohol related brain disorder, or other severe alcohol-related physical and mental illness.

Priority unmet/under met need:
Speed of initiation of Opiate Substitute Therapy (OST) and titration in for those presenting at the hubs who were not on a script

Reaching hardly reached vulnerable groups by providing assertive outreach and accelerated treatment access for those at highest risk. Including more actively following up after: hospital contact; referral or attending drop in and whom we consider high risk; police custody and prison; vulnerable persons processes; those using pharmacy Injection Equipment Provision; those at risk of discharge from or disengaging from prescribing

More emphasis on evidence-based care in the prison which links with an effective transition of care at release

Reduce isolation by providing access to meaningful activity and social engagement, especially for those in medication assisted recovery and those who are not seeking abstinence

Improving the offer of psychosocial interventions for the primary care Opiate Substitution Therapy patients

Matching care to need, particularly those on OST (i.e. stepped care model)

Improving general medical care for those in substance use treatment via the hubs, primary care and pharmacy contacts. Identification and treatment of physical and mental co-morbidities, learning disabilities, polypharmacy and addiction to prescription drugs.

Developing psychologically informed environments, improving our response to trauma in the target groups and availability of high quality psychological therapies to people in all settings.

Access to effective alcohol treatment and alcohol related brain disorder interventions in line with national guidelines

Operation Threshold - Police Scotland worked closely with partners in EADP to engage those most at risk of overdose and death with the treatment system. This has been a programme of assertive outreach between police officers and Aid & Abet. This was followed up with a major exercise in June 2019 to address supply and those most at risk. Again, partners worked together to motivate and engage people seek support and treatment. The investment described above will build and continue the good work of operation Threshold.

- • Drinkers at high risk of/ experiencing alcohol related death, alcoholic liver disease, alcohol related brain disorder, or other severe alcohol-related physical and mental illness.

Priority unmet/under met need:

- • Speed of initiation of Opiate Substitute Therapy (OST) and titration in for those presenting at the hubs who were not on a script

- • Reaching hardly reached vulnerable groups by providing assertive outreach and accelerated treatment access for those at highest risk. Including more actively following up after: hospital contact; referral or attending drop in and whom we consider high risk; police custody and prison; vulnerable persons processes; those using pharmacy Injection Equipment Provision; those at risk of discharge from or disengaging from prescribing

- • More emphasis on evidence-based care in the prison which links with an effective transition of care at release

- • Reduce isolation by providing access to meaningful activity and social engagement, especially for those in medication assisted recovery and those who are not seeking abstinence

- • Improving the offer of psychosocial interventions for the primary care Opiate Substitution Therapy patients

- • Matching care to need, particularly those on OST (i.e. stepped care model)

- • Improving general medical care for those in substance use treatment via the hubs, primary care and pharmacy contacts. Identification and treatment of physical and mental co-morbidities, learning disabilities, polypharmacy and addiction to prescription drugs.

- • Developing psychologically informed environments, improving our response to trauma in the target groups and availability of high quality psychological therapies to people in all settings.

- • Access to effective alcohol treatment and alcohol related brain disorder interventions in line with national guidelines

- 18. **Operation Threshold -** Police Scotland worked closely with partners in EADP to engage those most at risk of overdose and death with the treatment system. This has been a programme of assertive outreach between police officers and Aid&abet. This was followed up with a major exercise in June 2019 to address supply and those most at risk. Again, partners worked together to motivate and engage people seek support and treatment. The investment described above will build and continue the good work of operation Threshold.

Recommendations

19. That the COG • Note the national increase of drug related deaths in Scotland.

• Note that Edinburgh drug related deaths have plateaued over the last few years and decreased slightly in 2018.

• Note the Edinburgh actions aimed at reducing future drug related deaths.

Appendix 5: Mental Health Services: Quality Assurance Summary

Introduction

This report provides a summary and overview in respect of independent voluntary and Council mental health services. The focus is placed upon the findings of inspections by the Care Inspectorate.

The Edinburgh Integration Joint Board (EIJB) and Edinburgh Health and Social Care Partnership (Partnership) has a minimum expectation of all service providers achieve Grades of 4 in all themed inspection areas. Where providers are not achieving this expectation, they are referred to the Multi Agency Quality Assurance Groups for Care and Home and Support Services.

During an inspection, the Care Inspectorate will select a number of themes to inspect which includes:

Previous Quality Inspection Framework	New Quality Inspection Evaluation Framework
Care and Support	How well do we support people's wellbeing?
Environment (for services with buildings only)	How good is our leadership?
Staffing	How good is our staff team?
Management and Leadership	How good is our setting?
-	How well is care and support planned?

Each theme inspected is awarded a grade using the following approach:

Grade	Description
6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

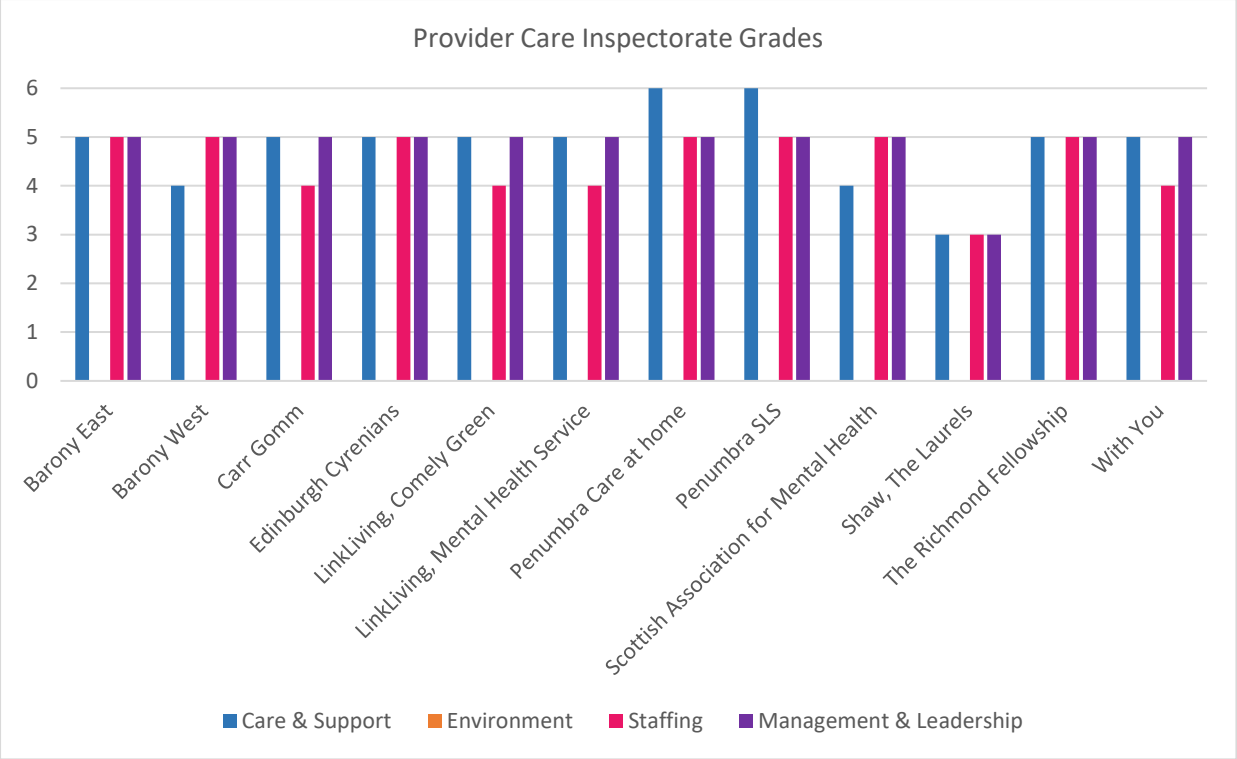
Edinburgh Registered Mental Health Services

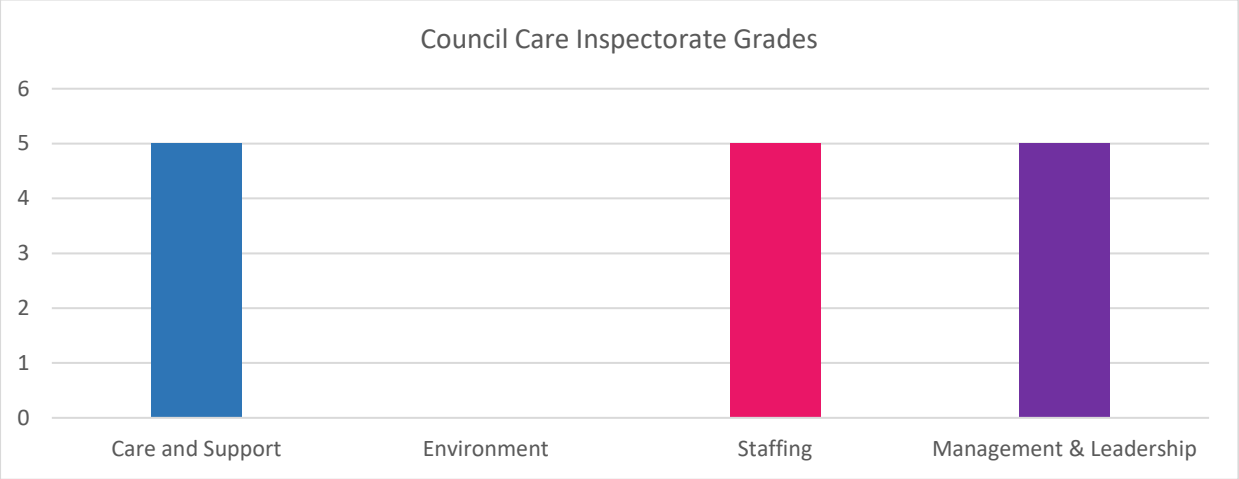
The tables below provide a summary of the Care Inspectorate grades for registered services as at 27 January 2020 for (a) Care and Support Services and (b) Other Registered Services.

(a) Care and Support Services – Mainly Adults Under 65 years of age

The Council contracts with 9 voluntary sector providers, with 12 services, which deliver care and support services, mainly to adults under the age of 65 years with mental health support needs. The Council operates one comparable registered service, Positive Steps.

The grades of these services range from 3 (adequate) to 6 (excellent). We do not have any contracts with services with grades of 1 or 2.

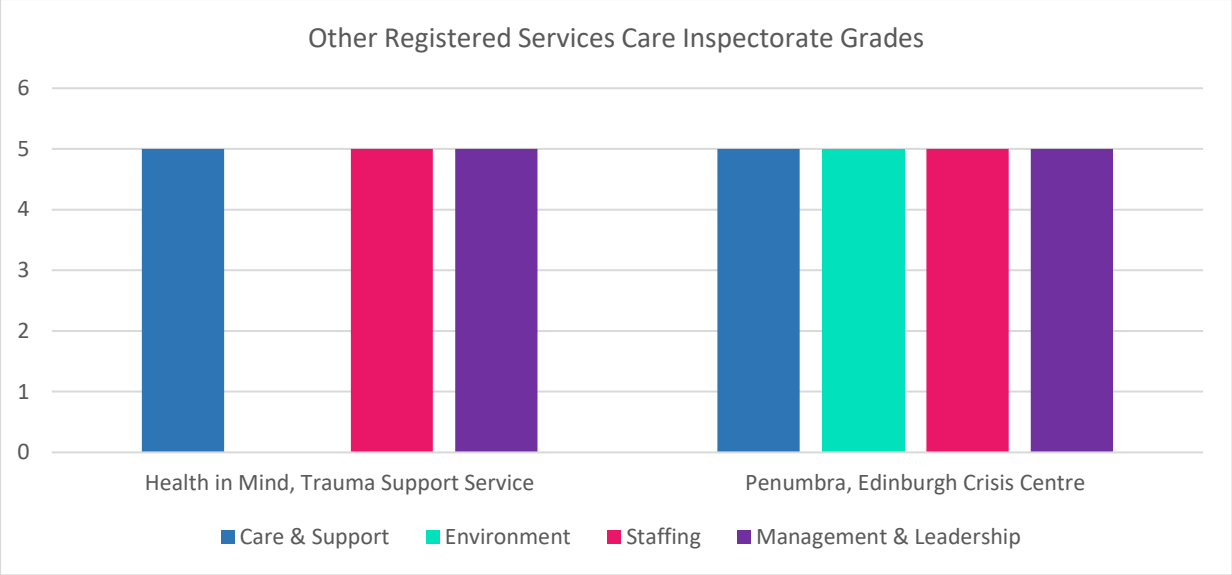




- 92% of our providers are achieving grades of 4 and above.
- 42% being graded at 5 and above.
- Providers with grades of 3 in one or more themed areas are the subject of contract monitoring activity and supportive challenge.

(b) Other Registered Services

The Council contracts with 2 voluntary sector providers of Other Registered Services for people with mental health support needs. There are no comparable Council services.



- Both of these services are achieving grades of 5 (very good) across all quality themes.
- Reviews of these inspection reports will be undertaken with a view to highlighting and sharing details of their very good practice in service delivery.

Services which are not Registered with the Care Inspectorate

The Partnership funds a further 16 wellbeing services which are not registered or regulated by the Care Inspectorate. These services will be subject to procurement and contract management arrangements.

Contract Management

The Partnership has adopted a risk-based approach to managing contract quality assurance arrangements and a new Contract Management Framework is being implemented. This framework involves an assessment of each provider on the basis on a number of risk factors which helps prioritise monitoring activity:

- infrastructure,
- management and staffing,
- annual spend,
- service specification and contract position,
- routine monitoring,
- external sources including Care Inspectorate,
- service type/client risk,
- strategic fit and financial assessment.

A key objective of service provider monitoring is for Partnership staff to gain insight into and understanding of the work service providers are doing on our behalf. This understanding can be best achieved through a balance of observation and formal processes.

All contracted providers will be asked to provide a summary report on a six-monthly basis which outlines the service and performance information, activities undertaken and share a small selection of Stories of Difference.

Appendix 6: Standards for Adult Community Mental Health Services – First Edition (September 2016)

1. Access, referral and waiting times

1.1 The service reviews access data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access where identified.

1.2 Clear information is made available, in paper and/or electronic format, to service users, carers and healthcare practitioners on:

- A simple description of the service and its purpose;
- Clear referral criteria;
- How to make a referral, including self-referral if the service allows;
- Clear clinical pathways describing access and discharge;
- Main interventions and treatments available;
- Contact details for the service, including emergency and out of hours details

1.3 A clinical member of staff is available to discuss emergency referrals during working hours.

1.4 Where referrals are made through a single point of access e.g. triage, these are passed on to the community team within one working day

1.5 The service provides information about how to make a referral and waiting times for assessment and treatment.

1.4 A clinical member of staff is available to discuss emergency referrals during working hours.

1.5 Outcomes of referrals are fed back to the referrer, service user and carer (with the service user's consent). If a referral is not accepted, the team advises the referrer, service user and carer on alternative options

1.6 Acceptance to the service is based on need and risk; the service does not use specific exclusion criteria
Guidance: Self-harm, substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service

1.7 There is sufficient car parking for visitors to the service

1.8 Everyone is able to access the service using public transport or transport provided by the service

2. Waiting Times

2.1 Service users receive an assessment within 3 weeks of referral

2.2 There are systems in place to monitor waiting times and ensure adherence to local and national waiting times standards
Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment
Guidance: If the service sees people with suspected psychosis, they are assessed within 2 weeks of referral

2.3 The team provides service users with information about waiting times for assessment and treatment
Guidance: Service users on a waiting list are provided with updates of any changes to their appointment, as well as details of how they can access further support while waiting

2.4 Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:

- Their rights regarding consent to treatment;
- Their rights under the Mental Health Act;
- How to access advocacy services;
- How to access a second opinion;
- Interpreting services;
- How to view their records;
- How to raise concerns, complaints and give compliments.

3. Preparing for the Assessment

3.1 For planned assessments the team sends letters in advance to service users that include:

- An explanation of the assessment process;
- Information on who can accompany them;
- How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there

3.2 Service users are provided with information and choice about their assessment and appointments
Guidance: This includes choice of time, day, venue, gender of staff or access in another language

3.3 The service has access to independent advocates to provide information, advice and support to service users, including assistance with assessment, advance statements and Care Programme Approach reviews

3.4 The assessing professional can easily access relevant clinical information (past and current) about the service user from primary and secondary care

3.5 Service users are given verbal and written information on their rights under the Mental Health Act if under a Community Treatment Order (or equivalent) and this is documented in their notes

4. Initial assessment

4.1 Service users have a comprehensive assessment which includes their:

- Mental health and medication;
- Psychosocial needs;
- Strengths and weaknesses

4.2 Immediate social stressors and social networks are identified and recorded, including financial, housing, employment, educational and vocational issues

4.3 A physical health review takes place as part of the initial assessment. The review includes but is not limited to:

- Details of past medical history;
- Current physical health medication, including side effects and compliance with medication regime;
- Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use;
- Consideration of risk of cardiovascular disease, metabolic disorders, and excessive weight gain

4.4 An assessment of practical problems of daily living is recorded

4.5 Service users have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of:

- Risk to self (including self-neglect);
- Risk to others;
- Risk from others

4.6 The team discusses the purpose and outcome of the risk assessment with the service user and a management plan is formulated jointly

4.7 The service user is asked if they have a carer, and if so, the carer's name is recorded

4.8 Any dependants are identified and recorded, including their wellbeing, needs, and any childcare issues
Guidance: This includes the names and dates of birth of any young people

4.9 Staff members are easily identifiable (for example, by wearing appropriate identification)

4.10 Staff members address service users using the name and title they prefer

5. Completing the initial assessment

5.1 All patients have a diagnosis and a clinical formulation
Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised

5.2 The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment

5.3 All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner

6. Following up service users who don't attend appointments

6.1 The team proactively follows up service users who have not attended an appointment/assessment or who are difficult to engage, with consideration of risk, in line with the service's engagement policy
Guidance: This could include visiting service users at home or another suitable venue, using text alerts, or engaging with their carers

6.2 If a service user does not attend for assessment, the team contacts the referrer
Guidance: If the service user is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan

6.3 Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist
Guidance: This should include monitoring a service user's failure to attend the initial appointment after referral and early disengagement from the service

7. Reviews and care planning

7.1 The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments, reviews and service users on the waiting list
Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting

7.2 Every service user has a written care plan, reflecting their individual needs
Guidance: This clearly outlines:

- Agreed intervention strategies for physical and mental health;
- Measurable goals and outcomes;
- Strategies for self-management;
- Any advance decisions or stated wishes that the service user has made;
- Crisis and contingency plans;
- Review dates and discharge framework

7.3 The practitioner develops the care plan collaboratively the service user and their carer (with service user consent)

7.4 The service user and their carer (with service user consent) are offered a copy of the care plan and the opportunity to review this

7.5 The service uses the Care Programme Approach (CPA) framework (or equivalent) when necessary for the needs of the service user, which is applied in line with Trust/Social Services policy, based on effective care coordination in mental health services

7.6 Managers and practitioners conduct clinical review meetings at least annually, or according to clinical need (in line with the Care Programme Approach)

7.7 Risk assessments and management plans are updated at least annually, or according to clinical need (in line with the Care Programme Approach)

7.8 There is a single record for each service user and all contacts with the service user and their carers are recorded

8. Care and Treatment

8.1 **Therapies and activities**

8.1.1 Service users are offered evidence-based pharmacological and psychological interventions and any exceptions are documented in the case notes
Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base

8.1.2 Service users begin evidence-based pharmacological and psychological interventions within 18 weeks of accepting the intervention

8.1.3 Service users' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible

8.1.4 Service users have access to occupational therapy

8.1.5 Service users have access to art/creative therapies

8.1.6 The team signposts service users to structured activities such as work, education and volunteering

8.1.7 The team provides information, signposting and encouragement to service users to access local organisations for peer support and social engagement such as:

- Voluntary organisations;
- Community centres;
- Local religious/cultural groups;
- Peer support networks;
- Recovery Colleges

8.1.8 Service users and carers are offered written and verbal information about the service user's mental illness
Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets, websites, etc.

8.1.9 Carers are given information on mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access

8.1.10 All healthcare professionals have received training and supervision in providing psychologically informed care, including evidence-based low-intensity talking therapies

8.1.11 All staff members who deliver therapies and activities are appropriately trained and supervised

8.1.12 The service is able to provide care to people with a personality disorder, or signpost/refer them on for care
Guidance: Care for service users with a personality disorder is provided in a team approach with a consistent clinical model and good understanding of this group

8.1.13 The service user and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment

8.2 Medication

8.2.1 When medication is prescribed, specific treatment targets are set for the service user, the risks and benefits are reviewed, a timescale for response is set and service user consent is recorded

8.2.2 Service users and their carers (with service user consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications, to enable them to make informed choices and to self-manage as far as possible

8.2.3 Service users have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime
Guidance: Side effect monitoring tools can be used to support reviews. Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum

8.2.4 The service has rapid access to medication during working hours

8.2.5 The service is able to use or access blood tests and other physical investigations to monitor outcomes and side effects of medications

8.2.6 When service users experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this

8.2.7 The service has a shared care protocol with primary care which defines responsibility for prescription and administration of medication

8.2.8 The safe use of high risk medication is audited at a service level, at least annually
Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines

8.2.9 There is a written protocol governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self-harm, which includes the need to notify the GP

9. Physical healthcare

9.1 Physical healthcare and substance misuse

9.1.1 Where concerns about a service user's physical health are identified, the team arranges or signposts the service user to further assessment, investigations and management from primary or secondary healthcare services

9.1.2 The service gives targeted lifestyle advice to service users when appropriate. This includes:
- Smoking cessation advice;
- Healthy eating advice;
- Physical exercise advice

9.1.3 The service has a policy for the care of service users with dual diagnosis of mental health problems and alcohol or substance misuse that includes:
- Liaison and shared protocols between mental health and substance misuse services to enable joint working;
- Drug/alcohol screening to support decisions about care/treatment options;
- Liaison between mental health, statutory and voluntary agencies;

- Staff training;
- Access to evidence based treatments

9.1.4 The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:
• Assessment;
• Care and treatment (particularly relating to prescribing psychotropic medication);
• Referral to a specialist perinatal team/unit unless there is a specific reason not to do so

9.1.5 The team understands and follows an agreed protocol for the management of an acute physical health emergency
Guidance: This includes guidance about when to call 999 and when to contact the duty doctor

9.2 Managing the physical health of service users on mood stabilisers or antipsychotics

9.2.1 Service users who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the service user:
- A personal/family history (at baseline and annual review);
- Lifestyle review (at every review);
- Weight (at every review);
- Waist circumference (at baseline and annual review);
- Blood pressure (at every review);
- Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review);
- Lipid profile (at every review);
- ECG (at baseline and annual review)

Guidance: Service users are advised to monitor their own weight every week for the first 6 weeks and to contact the service if they have concerns about weight gain

10. Risk and safeguarding

10.1 The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on:
- Safeguarding vulnerable adults and children including awareness of domestic violence;
- Assessing and managing suicide risk and self-harm;
- Prevention and management of aggression and violence

10.2 All staff have received training on personal safety issues

10.3 Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral

10.4 If a service user drives and their mental state or diagnosis indicates that there is a risk to their driving ability, they are informed of the necessity to report their mental state or diagnosis to the DVLA (or equivalent vehicle licensing authority)

11. Discharge planning and transfer of care

11.1 Discharge or onward care planning is discussed at the first and every subsequent care plan review

11.2 Service users and their carers (with service user consent) are involved in decisions about discharge or transfer plans
Guidance: This could be through a formal discharge meeting

11.3 There are agreements with other agencies for service users to re-access the service if needed, without following the initial referral pathway
Guidance: There may be exceptions where service users require a generic assessment and it may be appropriate to follow the initial referral pathway

11.4 A letter setting out a clear discharge plan is sent to the service user and all relevant parties within 10 days of discharge. The plan includes details of:

- On-going care in the community/aftercare arrangements;
- Crisis and contingency arrangements including details of who to contact;
- Medication;
- Details of when, where and who will follow up with the service user as appropriate

11.5 The team follows a protocol to manage service users who discharge themselves against medical advice. This includes:

- Recording the service user's capacity to understand the risks of self-discharge;
- Putting a crisis plan in place;
- Contacting the relevant agencies to notify them of the discharge

11.6 When a service user is admitted to a psychiatric hospital, a community team representative attends and contributes to ward rounds and discharge planning

11.7 Service users who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk
Guidance: This may be in coordination with the Crisis Resolution/Home Treatment Team

11.8 When service users are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment

11.9 When service users are transferred between community services there is a meeting in which members of the two teams meet with the service user and carer to discuss transfer of care

11.10 There is active collaboration between Child and Adolescent Mental Health Services and Working Age Adult Services for service users who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer

12. Interfaces with other services

12.1 The team follows a joint working protocol/care pathway with primary health care teams
Guidance: This includes the team informing the service user's GP of any significant changes to the service user's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP

12.2 The service has a physical health care pathway with clearly identified and agreed responsibilities with primary care
Guidance: This could include the agreed use of the Lester UK Adaptation of the positive cardiometabolic health resource, Rethink integrated physical healthcare pathway and NICE guidelines on physical healthcare

12.3 There are regular clinical discussions between the community mental health service and the primary care team to:
• discuss service users with shared care arrangements;
• discuss service users known only to primary care;
• provide information and advice to primary care practitioners on managing common mental health conditions;
• seek advice from primary care on the management of physical health problems

12.4 The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team, in services that have access to one
Guidance: This includes joint care reviews and jointly organising admissions to hospital for service users in crisis

12.5 The service is able to signpost or refer service users on to:
- other health services;
- advocacy;
- peer support;
- employment services;
- voluntary sector services

12.6 The team supports service users to access organisations which offer:
- housing support;
- support with finances, benefits and debt management;
- social services

12.7 The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence

12.8 Health records can be easily accessed by other services who may be involved with the service user's care
Guidance: This could include psychiatric liaison teams, home treatment teams, acute inpatient wards, general wards, primary care and accident and emergency departments

12.9 There are arrangements in place to ensure that service users can access help, from mental health services, 24 hours a day, 7 days a week
Guidance: Joint protocols are agreed, for example, with commissioners, primary healthcare services, emergency medical departments and social services

12.10 The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice
Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as service user and carer representatives

13. Capacity and Consent

13.1 Capacity assessments are performed in accordance with current legislation

13.2 When service users lack capacity to consent to interventions, decisions are made in accordance with current legislation

13.3 There are systems in place to ensure that the service takes account of any advance decisions that the service user has made

14. Service user involvement

14.1 Service users and their carers are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service
Guidance: This might include service user and carer surveys or focus groups

14.2 Service user and carer representatives attend and contribute to local and service level meetings and committees

15. Carer engagement and support

Note: Carer involvement is subject to the service user giving consent and / or carer involvement being in the best interests of the service user

15.1 Carers are involved in discussions about the service user's care, treatment and discharge planning

15.2 Carers are advised how to access a statutory carers' assessment, provided by an appropriate agency
Guidance: This advice is offered at the time of the service user's initial assessment, or at the first opportunity

15.3 Carers are offered individual time with staff to discuss concerns, family history and their own needs

15.4 The team provides each carer with a carer's information pack
Guidance: This includes the names and contact details of key staff members in the service. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities

15.5 Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network
Guidance: This could be a group/network which meets face-to-face or communicates electronically

15.6 The team follows a protocol for responding to carers when the service user does not consent to their involvement

15.7 The service has a designated staff member dedicated to carer support (carer lead)

15.8 The service ensures that children and other dependants are supported appropriately
Guidance: This could include offering appropriate written information to children, or supporting the service user to communicate with their children about their mental health

16. **Treating service users with dignity and respect**

16.1 Service users are treated with compassion, dignity and respect
Guidance: This includes respect of a service user's race, age, sex, gender reassignment, marital status, sexual orientation, pregnancy and maternity status, disability and religion/beliefs

16.2 Service users feel listened to and understood in consultations with staff members

16.3 The service can demonstrate that it promotes culturally and spiritually sensitive practice

17. Provision of information to service users and carers

17.1 Information, which is accessible and easy to understand, is provided to service users and carers
Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures and using plain English, communication passports and signers. Information is culturally relevant

17.2 The service has access to translators and interpreters and the service user's relatives are not used in this role unless there are exceptional circumstances
Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice

17.3 The service uses interpreters who are sufficiently knowledgeable to provide a full and accurate translation

17.4 When talking to service users and carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them

17.5 Service users are asked if they and their carers wish to have copies of letters about their health and treatment

17.6 Service users are given verbal and written information on:

- How to access advocacy services;
- How to access a second opinion;
- How to access interpreting services;
- How to raise concerns, complaints and compliments;
- How to access their own health records

17.7 How to make a crisis/contingency plan, or advance decision/statement if they wish

17.8 Managing their health and wellbeing
Guidance: This may include reference to '5 Ways to Wellbeing'

18. Service user confidentiality

18.1 Confidentiality and its limits are explained to the service user and carer at the first assessment, both verbally and in writing

Guidance: For carers this includes confidentiality in relation to third party information

18.2 The service has confidentiality policies which are regularly monitored and reviewed, and upheld at all times when exchanging information
Guidance: Policies include the provision of information release forms and advanced statements protocols and forms

18.3 All service user information is kept in accordance with current legislation
Guidance: Staff members ensure that no confidential data is visible beyond the service by locking cabinets and offices, using swipe cards and having password protected computer access

18.4 The service user's consent to the sharing of clinical information outside the team (including with carers) is recorded. If this is not obtained, the reasons for this are recorded
Guidance: If the service user does not wish any information to be shared with their carers, staff regularly check whether they are still happy with this decision. Information already known to carers is not considered to be confidential information

19. Service environment

19.1 The environment is comfortable, clean and warm, and areas of privacy are available in the waiting area

19.2 The service entrance and key clinical areas are clearly signposted

19.3 If teams see service users at their team base or other health-based community settings, entrances and exits are visibly monitored and/or access is restricted

19.4 Clinical rooms are private and conversations cannot be easily over-heard

19.5 There is easy access to suitable toilet facilities

19.6 The environment complies with current legislation on disabled access
Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence

19.7 Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed

19.8 There is an alarm system in place (e.g. panic buttons) and this is easily accessible

19.9 There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information e.g. information about services, conditions and treatment, service user records, clinical outcome and service performance measurements

19.10 Staff members follow a lone working policy and feel safe when conducting home visits

19.11 An audit of environmental risk is conducted annually and a risk management strategy is agreed

19.12 A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least 6 monthly

19.13 Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available at the team's base within 3 minutes

19.14 The crash bag is maintained and checked weekly, and after each use

20. Leadership and culture

20.1 There are written documents that specify professional, organisational and line management responsibilities

20.2 Staff members can access leadership and management training appropriate to their role and specialty

20.3 Staff members have an understanding of group dynamics and of what makes a therapeutic environment

20.4 The organisation's leaders provide opportunities for positive relationships to develop between everyone
Guidance: This could include service users and staff members using shared facilities at the team base

20.5 Team managers and senior managers promote positive risk-taking to encourage service user recovery and personal development

20.6 Staff members and service users feel confident to contribute to, and safely challenge decisions
Guidance: This includes decisions about care, treatment and how the service operates

20.7 Staff members feel able to raise any concerns they may have about standards of care

21. Teamworking

21.1 Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises

21.2 The team has protected time for team-building and discussing service development at least once a year

22. Staffing levels and skill mix

The team has dedicated sessional time from:

22.1 A Service Lead
22.2 Registered Mental Health Nurse(s)
22.3 Social Worker(s)
22.4 Occupational Therapist(s)
22.5 Psychologist(s)
22.6 Support Worker(s)
Guidance: An unqualified professional, e.g. healthcare assistant, occupational therapy assistant, psychology assistant etc.
22.7 Consultant Psychiatrist (s)
22.8 GP Link Worker (s)

22.9 Independent Prescriber(s)

The team has dedicated sessional time from:

22.10 Pharmacist(s)
22.11 Employment Advisor(s)

The team has adequate access to:

22.12 Peer Support Worker(s)
Guidance: A service user or carer employed by the team to support other service users and/or carers
22.13 Approved Mental Health Professional(s) (AMHPs)

22.14 Welfare and Benefits Advisor(s)

22.15 Administrative assistance to meet the needs of the service

22.16 Full-time care co-ordinators have a caseload of no more than 35 (reduced pro-rata for part-time staff)

22.17 There is an identified duty doctor available at all times. They are able to attend the team base within 1 hour

22.18 There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service

22.19 The service has a nominated medicines management lead

22.20 The service includes individuals with special interests that cover a range of needs
Guidance: This includes physical health, substance or alcohol misuse, access to and engagement with psychological interventions

22.21 The service has a mechanism for responding to low staffing levels, including:
- A method for the team to report concerns about staffing levels;
- Access to additional staff members;
- An agreed contingency plan, such as the minor and temporary reduction of non-essential services

22.22 There are systems in place to ensure that staffing is sufficient, and caseloads are covered and monitored when members of the team are absent for planned or unplanned periods

23. Staff recruitment and induction

23.1 Service user or carer representatives are involved in interviewing potential staff members during the recruitment process

23.2 Staff members receive an induction programme specific to the service, which covers:
- The purpose of the service;
- The team's clinical approach;
- The roles and responsibilities of staff members;
- The importance of family and carers;
- Care pathways with other services

Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme

23.3 New staff members, including agency staff, receive an induction based on an agreed list of core competencies
Guidance: This should include arrangements for:
- Shadowing colleagues on the team;
- Jointly working with a more experienced colleague;
- Being observed and receiving enhanced supervision until core competencies have been assessed as met

23.4 All newly qualified staff members are allocated a preceptor to oversee their transition into the service
Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body

23.5 All new staff members are allocated a mentor to oversee their transition into the service

24. Appraisal, supervision and support

24.1 All staff members receive an annual appraisal and personal development planning (or equivalent)
Guidance: This contains clear objectives and identifies development needs

24.2 All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body
Guidance: Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications

24.3 All staff members receive monthly line management supervision

24.4 All supervisors have received specific training to provide supervision
Guidance: This training is refreshed in line with local guidance

24.5 Staff members in training and newly qualified staff members are offered weekly supervision

24.6 The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent)

25. Staff Wellbeing

25.1 The service actively supports staff health and wellbeing
Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed

25.2 Staff members have access to reflective practice groups

25.3 There are systems in place to monitor individual caseloads of staff members

25.4 Staff members are able to take breaks during their shift that comply with the European Working Time Directive

26. Staff training and development

26.1 Clinical staff members have received formal training to perform as a competent practitioner, or, if still in training, are practising under the supervision of a senior qualified clinician

26.2 All staff have received training on medication as required by their role
Guidance: This includes storage, administration, legal issues, encouraging concordance and awareness of side effects

26.3 All practitioners who administer medications have been assessed as competent to do so. This is repeated on a yearly basis using a competency based tool

26.4 All staff have received training in reflective practice and debriefing

26.5 All staff have received training in the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent)

26.6 All staff have received training in physical health assessment
Guidance: This could include training in understanding physical health problems, physical observations and when to refer the service user for specialist input

26.7 All staff have received statutory and mandatory training
Guidance: This includes equality and diversity and information governance

26.8 All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality

26.9 All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities

26.10 All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities

26.11 Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months

26.12 Service users, carers and staff are involved in devising and delivering training face-to-face

27. General Management

27.1 The service has an operational policy which covers the purpose and aims of the service, ways of working and defined catchment population

27.2 The team attends business meetings that are held at least monthly

27.3 The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy

27.4 Front-line staff members are involved in key decisions about the service provided

27.5 Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team finds accessible and easy to use

28. Clinical outcome measurement

28.1 Clinical outcome measurement data is collected at two time points (initial assessment and discharge) as a minimum, and at clinical reviews where possible

28.2 Outcome data is used as part of service management and development, staff supervision and caseload feedback
Guidance: This should be undertaken every 6 months as a minimum

28.3 Clinical outcome monitoring includes reviewing service user progress against service user-defined goals in collaboration with the service user

29. Audit and service evaluation

29.1 A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum

29.2 The service has audited the provision of carer education and support programmes in the last 3 years

29.3 An assessment of the extent to which the service is recovery-focused has taken place, using an identified tool within the last 2 years
Guidance: e.g. Scottish Recovery Indicator, Developing Recovery Enhancing Environments Measure (DREEM) or Implementing Recovery through Organisational Change (IMROC)

29.4 The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with College Centre for Quality Improvement specialist standards

29.5 An audit of adherence to Mental Health Act guidance has been undertaken in the last year

29.6 The team, service users and carers are involved in identifying audit topics in line with national and local priorities and service user feedback

29.7 Key information generated from service evaluations and key measure summary reports (e.g. reports on waiting times) are disseminated in a form that is accessible to all

30. The service learns from complaints and serious incidents

30.1 Staff members share information about any serious untoward incidents involving a service user with the service user themselves and their carer, in line with the Statutory Duty of Candour

30.2 Staff members, service users and carers who are affected by a serious incident are offered post-incident support

30.3 Systems are in place to enable staff members to quickly and effectively report incidents.
Managers encourage staff members to do this

30.4 Lessons learned from incidents are shared with the team and disseminated to the wider organisation

30.5 Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice

31. Commissioning and financial management

31.1. The service is explicitly commissioned or contracted against agreed standards
Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders

31.2 Commissioners and service managers meet at least 6 monthly