



Specialist Drug & Alcohol Service

Annual Report

2010-2011

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1. SUMMARY

The most significant impact on Alcohol and Drug Services in Dumfries & Galloway during 2010-2011 has been the commissioning of the element of the Integrated Drug Service provided by our third sector partners. The process was completed late in 2010 with the new agency taking over from 1st April 2011. The new service will also be providing the relapse prevention support work for people with alcohol problems. Development of services with existing partner agencies was effectively put on hold, but it is hoped that systems will be established quickly to clarify treatment pathways and agree and changes to incorporate the principles of the recovery model of care.

The average monthly sickness absence rate recorded for this year dropped by a further 1.5% to 5.5%. Although this remains above target figures from the last quarter of this year indicate continuing improvement across the Service. CRES targets were met in full.

The number of referrals received by the Service rose by 6% to 918, with 33% of referrals for people who had no previous contact with this Service. The number of appointments offered rose by 7.5% with a 1% rise in DNA rate. The DNA is significantly higher for people with drug problems and strategies have been developed with the aim of addressing this issue.

The HEAT target for waiting times both for assessment and initiation of treatment have been met across the Region. Waiting times for assessment for people with alcohol problems have ranged between 5 and 10 weeks. This is in line with the proposed HEAT target for March 2012. There was a 65% increase in alcohol referrals to the hospital liaison service. Options for service redesign are being explored to bring waiting times for access to alcohol treatment in line with longer term HEAT target set at 3 weeks by March 2013

Staff have completed training in evidence based psychological interventions provided by NHS Education Scotland with plans being developed to embed these in practice.

This report also provides details of clinical governance initiatives and service development plans for 2011-12.

2. RESOURCES

Budget

The CRES saving target for this year, £47k, was met in full. Significant under spends were accrued in the Cameron House Team core budget and the non-recurring funding for alcohol treatment services. This was primarily due to vacant posts and associated recruitment challenges. Most of the vacancies arose from the cascade effect caused when the Unit Manager at Cameron House left in August 2010. At time of writing this report it is expected that the Dumfries Team will not return to full establishment until June 2011.

	Annual Budget	YTD Actuals	YTD variance
Substance Misuse Community Team	216311	230305	-13994
Cameron House Management	735158	746624	-11466
Cameron House Team	288807	215258	73549
Drug Treatment and Testing Orders	0	17788	-17788
Cameron House Alcohol Plan	454691	410030	44461
Total	1694967	1620005	74762

Staffing

The key changes to the staffing establishment during this year have been in relation to the delivery of Drug Treatment and Testing Orders (DTTO). There were 2 posts funded for this element of service delivery both full-time, one at band 6 and the other band 5. The band 6 nurse, who was based in Wigtownshire, retired in December 2010, providing the opportunity to review skill mix across the Team to support treatment for DTTOs. The decision was made to transfer the Band 6 post to Dumfries and convert the band 5 hours to band 3. Two part-time Healthcare Assistants have been recruited for Wigtownshire. The post holders provide direct interventions related to DTTOs and also release registered nurse time to meet the other treatment requirements of the Orders including report writing and attending reviews at the Sheriff Court.

Staffing Establishment at 31 March 2011

Consultant Psychiatrist/Lead Clinician	1.0wte
Core Trainee 2	0.8wte (Med Directorate)
Service Manager	1.0wte
Community Team Leader	2.0wte
Community Nurse – Addictions/Community Alcohol Liaison	7.8wte
Dual Diagnosis Liaison Nurse	1.0wte
Alcohol Liaison Nurse – DGRI/Galloway	2.0wte
Specialist Community PHN/HV	1.0wte
Unit Manager	1.0wte
Deputy Unit Manager	1.0wte
Staff Nurses	4.0wte
Healthcare Assistant	2.4wte
Senior Drug Outreach Worker	1.0wte
Specialist OT	0.77 wte
Administration Officer	1.0wte
Secretary/Receptionist	1.51wte
Receptionist/Admin Assistant	0.8wte
Total	30.08wte

Sickness

This year has seen a further improvement in the overall sickness absence levels from the average of 7.0% recorded in 2009-10 and the 10.4% recorded in 2008-09. The recorded rate has fallen below the target level of 4% since December 2010. The above-target levels from May to September were linked to 2 episodes of long term sickness of 21 weeks each. All sickness absence is managed in line with the Organisational policy with support from the Occupational Health Service.

	Establishment		Hours Lost	Percentage
	WTE	Hours		
April 10	28.68	4732.2	142.5	3.0%
May 10	28.68	4517.1	442.5	9.8%
June 10	28.68	4732.2	397.5	8.4%
July 10	28.68	4732.2	411.0	8.7%
August 10	28.68	4732.2	442.5	9.4%
September 10	28.68	4732.2	255.0	5.4%
October 10	28.68	4517.1	264.0	5.9%
November 10	28.68	4732.2	274.0	5.8%
December 10	28.68	4947.3	114.0	2.3%
January 11	29.28	4611.6	99.5	2.2%
February 11	29.28	4392.0	115.5	2.6%
March 11	29.28	5050.5	99.25	2.0%
Total			3057.25	Average 5.5%

3. ACTIVITY

Referrals

A total of 918 (66.8% male, 33.2% female) people were referred to the Service during 2010-11, a 6.3% increase on the previous year. Referrals for people with alcohol problems increased by 12.4%, whilst referrals for people with drug related problems fell by 10.1%. The rise in alcohol referrals, although less than last year, was expected as part of the continuing development of services for people with alcohol related problems especially in secondary care settings. The last few years would appear to indicate a stabilisation and perhaps now a downward trend in the number of drug referrals. The drop in referrals this year should be monitored over the coming years to establish whether this is the start of a downward trend or a plateau in the numbers of people with problems related to dependent drug use.

The following table shows the pattern of referrals over the past 5 years

	1 Apr – 30 June	1 July – 30 Sep	1 Oct – 31 Dec	1 Jan – 31 March	Total
2006-07	227	217	191	194	829
2007-08	180	181	158	161	680
2008-09	163	164	180	221	728
2009-10	207	227	232	198	864
2010-11	241	232	208	227	918

Client Contact Data

The following table shows the number of referrals received per client group, with information relating to current caseload, number of sessions provided and total number of contacts during the year.

	Total	Alcohol	Drugs
Number of clients on books at 31 March 2010	609	160(26.3%)	449(73.7%)
Number of referrals	918	705(76.8%)	213(23.2%)
Number with no previous contact with Service	303(33.0%)	249(35.3%)	54(25.4%)
Number of clients taken on 1 April 10 – 31 March 11	588	417(70.9%)	171(29.1%)
Number of clients on books at 31 March 2011	601	133(22.1%)	468(77.9%)
Number of clients on waiting list at 31 March 2011	62	62	0
Number of admissions for inpatient detox/assessment	37	37	0

Number of individual sessions offered	11607
Number of individual sessions attended	7626
Number of cancelled appointments	1148(9.9%)
Number of DNA appointments	2836(24.4%)
No of drop-ins, non-client contacts	975
Total number of contacts	8601
Initial Assessments offered and not taken up	73

The percentage of people referred to the Service for the first time was the same as that recorded in 2009-10. As in previous years a greater proportion of alcohol referrals are for people who have been referred for the first time.

The number of appointments offered by the Service increased by 7.5%. There was no change in the rate of appointments cancelled by service users, 9.9%, but the rate of DNA appointments rose by 1% to 24.4%. The overall DNA rate masks a difference between service user groups with a DNA rate of 17.7% for people with alcohol problems and a DNA rate of 44.2% for people with drug problems. Although the DNA rate for people with alcohol problems was the same as that recorded last year the DNA rate for people with drug problems dropped by 9% from that recorded in 2009-10. It is hoped that the use of Community Reinforcement Approach (CRA) in service delivery will further improve levels of engagement and reduce the rate of failed appointments.

The number of planned admissions via this Service to Crichton Royal Hospital for detoxification or assessment was 37, the same as in 2009-10. Of these 37 admissions, 6 also had problems related to opiate dependency. 26 admissions were to Ettrick, 10 to Nithsdale and 1 to Glencairn. Over the same period, the total number of admissions to Crichton Royal who had substance related problems was 153:

- Alcohol – 117
- Drugs – 24
- Both – 12

This represents a 23% increase from 2009-10. Of the 153 admissions, 84 were to Nithsdale, 68 to Ettrick and 2 to Glencairn.

Of the 213 referrals for drug problems, 91% (compared with 94% in 2009-10) were for opiate dependency. Polysubstance misuse, including alcohol, remains a common pattern in Dumfries and Galloway but referral information often focuses only on the primary drug of choice. The following table shows the spread of drug referrals received during this year.

Drug	Females	Males	Total
Amphetamine	1(1.6%)	2(1.3%)	3(1.4%)
Cannabis	2(3.1%)	4(2.7%)	6(2.8%)
Cocaine	0(0%)	0(0%)	0(0%)
Benzodiazepines	3(4.7%)	5(3.4%)	8(3.8%)
Heroin	33(51.6%)	76(51.0%)	109(51.2%)
Methadone	21(32.8%)	58(38.9%)	79(37.1%)
Dihydrocodeine	4(6.3%)	2(1.3%)	6(2.8%)
Over the counter	0(0%)	2(1.3%)	2(0.9%)
Total	64(100%)	149(100%)	213(100%)

Waiting Times

The HEAT target for waiting times for people with drug problems required that

- *By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received, with nobody waiting more than 8 weeks*
- *By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received, with nobody waiting more than 8 weeks*

Both of these targets were achieved in Dumfries & Galloway with levels of 98% and above.

Waiting times for alcohol services have been collected since January 2010, with 2010 – 2011 being viewed as a developmental year.

A staged approach to a joint waiting times target of 3 weeks for alcohol and drugs treatment by 31 March 2013 has been set. For people with alcohol problems the targets are that

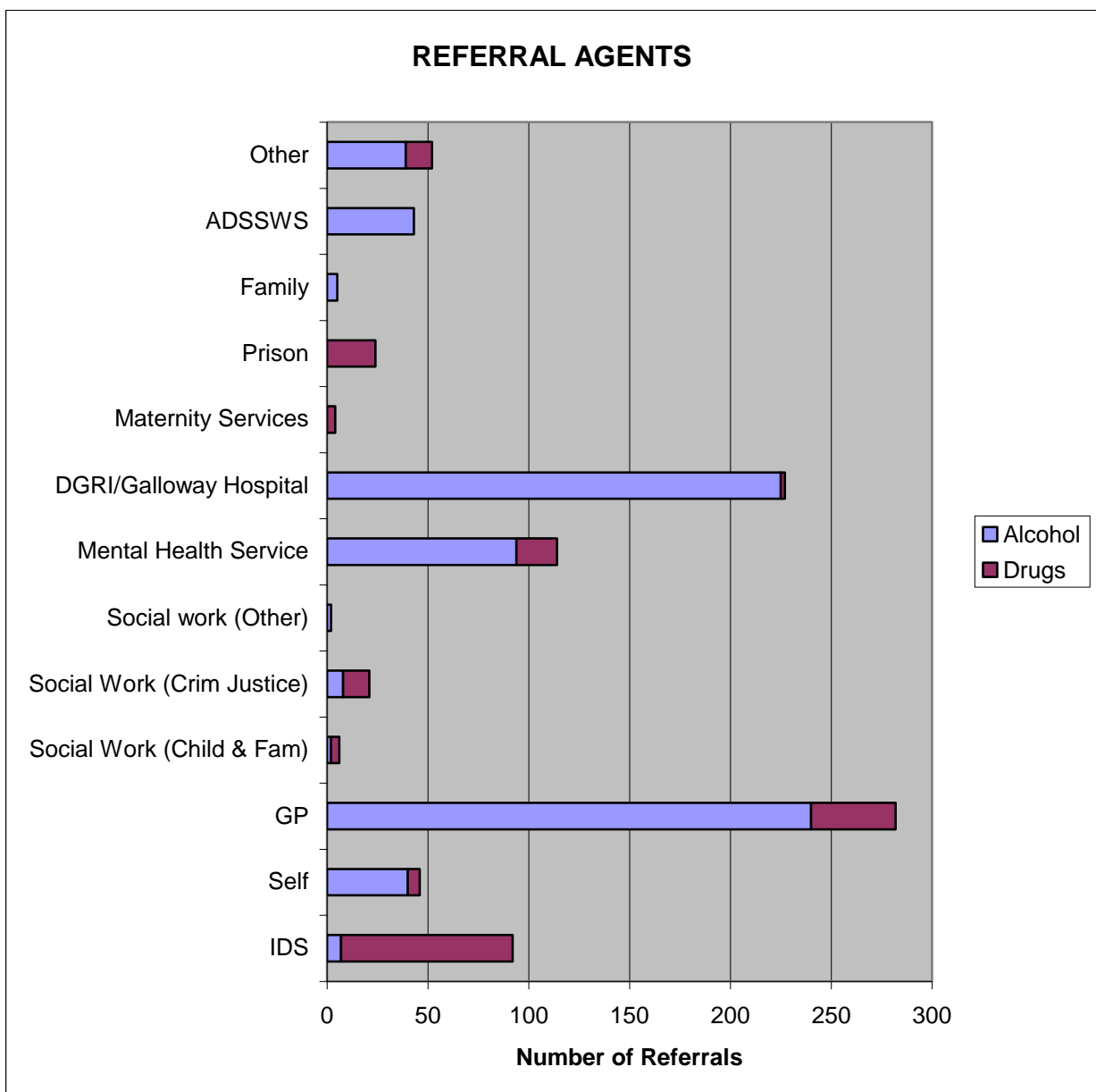
- *By March 2012, 90% of clients will wait no longer than 5 weeks from referral received to appropriate alcohol treatment that supports their recovery.*
- *By March 2012, clients will wait no longer than 10 weeks from referral received to appropriate alcohol treatment that supports their recovery*

Waiting times for people with alcohol problems at 31 March 2011 ranged from 5 – 10 weeks, due mostly to vacancies, which have primarily been in alcohol funded posts this year. The exception to this is people referred to the hospital liaison services who are assessed within 24-72 hours. It was recognised that having separate funding streams for alcohol or drug related treatment was limiting the flexibility of the Team to deliver services. Following agreement with the ADP, nursing posts have changed from specific alcohol or drug posts to more generic caseloads. This has increased flexibility to manage case loads and assisted with cover for vacancies and periods of extended leave. The Service Management Team is exploring further options for service redesign to make maximum use of existing resources.

Referral Agents

The overall referral patterns were broadly similar to last year, but within this a 65% increase in referrals for people with alcohol problems was recorded across DGRI and Galloway Community Hospital as the Liaison Service continues to develop. The following table and chart illustrate the routes of entry into this Service.

Referral Agent	Alcohol	Drugs	Total
Integrated Drug Service	7(1.0%)	85(39.9%)	92(10.0%)
Self	40(5.7%)	6(2.8%)	46(5.0%)
General Practitioner	240(34.0%)	42(19.7%)	282(30.7%)
Social Work (child & fam)	2(0.3%)	4(1.9%)	6(0.7%)
Social Work (Crim Justice)	8(1.1%)	13(6.1%)	21(2.3%)
Social Work (other)	2(0.3%)	0(0%)	2(0.2%)
Mental Health Service	94(13.3%)	20(9.4%)	114(12.4%)
DGRI/Galloway Hospital	225(31.9%)	2 (0.9%)	227(24.7%)
Maternity Services	0(0%)	4(1.9%)	4(0.4%)
Prison	0(0%)	24(11.3%)	24(2.6%)
Family	5(7.1%)	0(0%)	5(0.5%)
Alc & Drug Support - SW Scotland	43(6.1%)	0(0%)	43(4.7%)
Other	39(5.5%)	13(6.1%)	52(5.7%)
Total	705(100%)	213(100%)	918(100%)

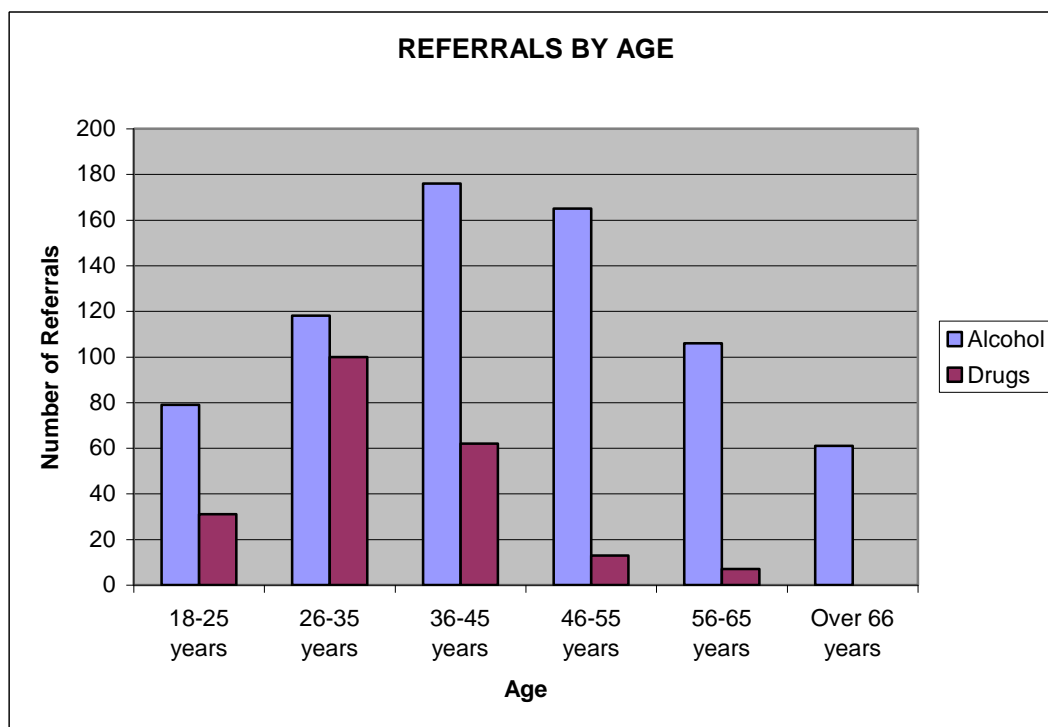


Referrals by Age

The age profile of referrals is generally in line with that of previous years. One trend that has been noted is that the majority of referrals for people with drug problems continue to be in the 26-35 years band. The percentage of referrals in the 18-25 age bracket shows a further drop. In the last 5 years the percentage for this group has fallen from 40% (130) to 17% (31) of drug referrals. Although part of the drop could be attributed to improved retention in service, the percentage of people referred with no previous contact dropped by only 7% over the same 5 years. This trend may be further evidence of the reduction in opiate use identified in the latest prevalence studies.

This age profile is illustrated in the following chart and table.

	Alcohol	Drugs	Total
18 – 25 years	79(11.2%)	31(14.6%)	110(12.0%)
26 – 35 years	118(16.7%)	100(46.9%)	118(12.9%)
36 – 45 years	176(25.0%)	62(29.1%)	238(25.9%)
46 – 55 years	165(23.4%)	13(6.1%)	178(19.4%)
56 – 65 years	106(15.0%)	7(3.3%)	113(12.3%)
Over 66 years	61(8.7%)	0(0%)	61(6.6%)
Total	705(100%)	213(100%)	918(100%)

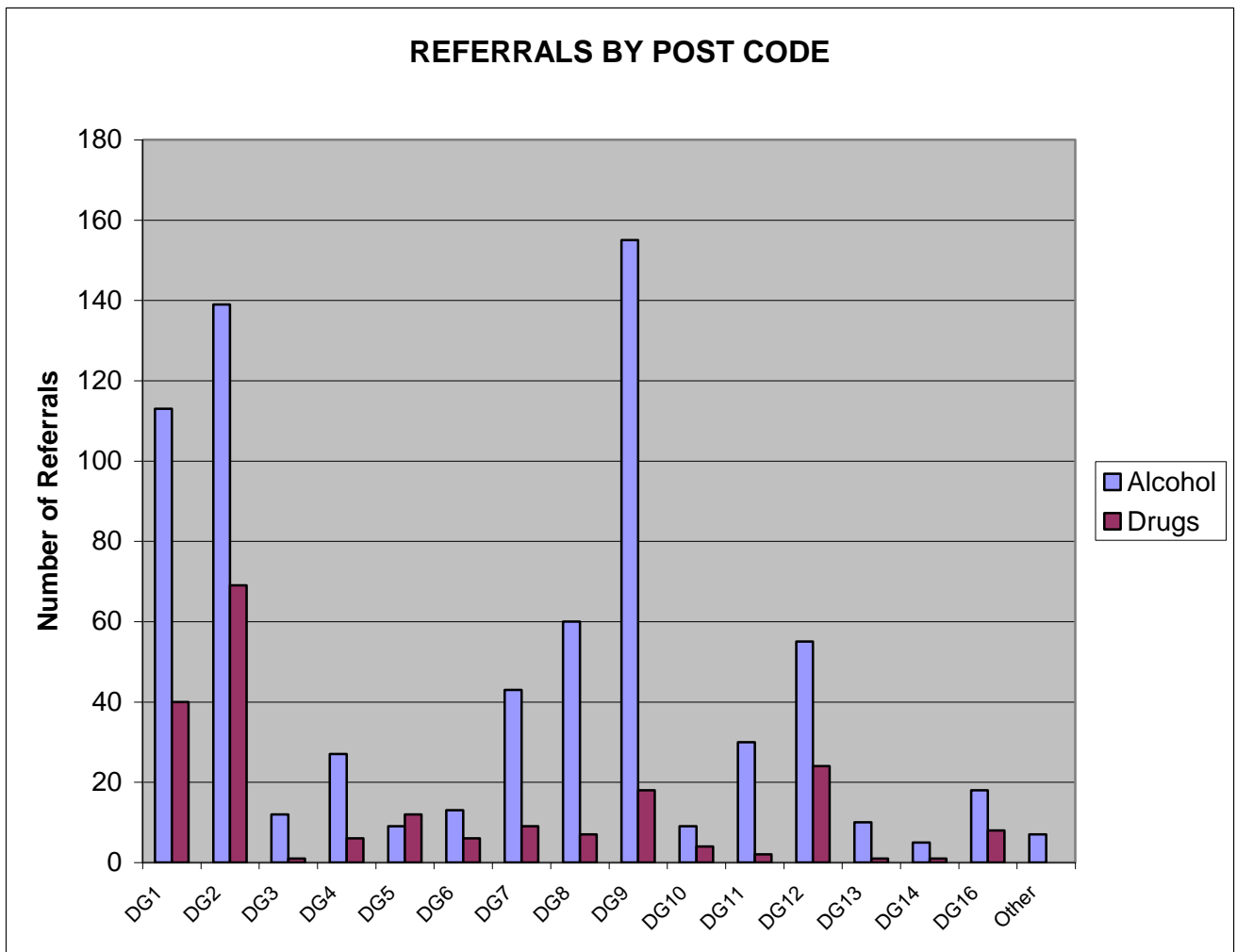


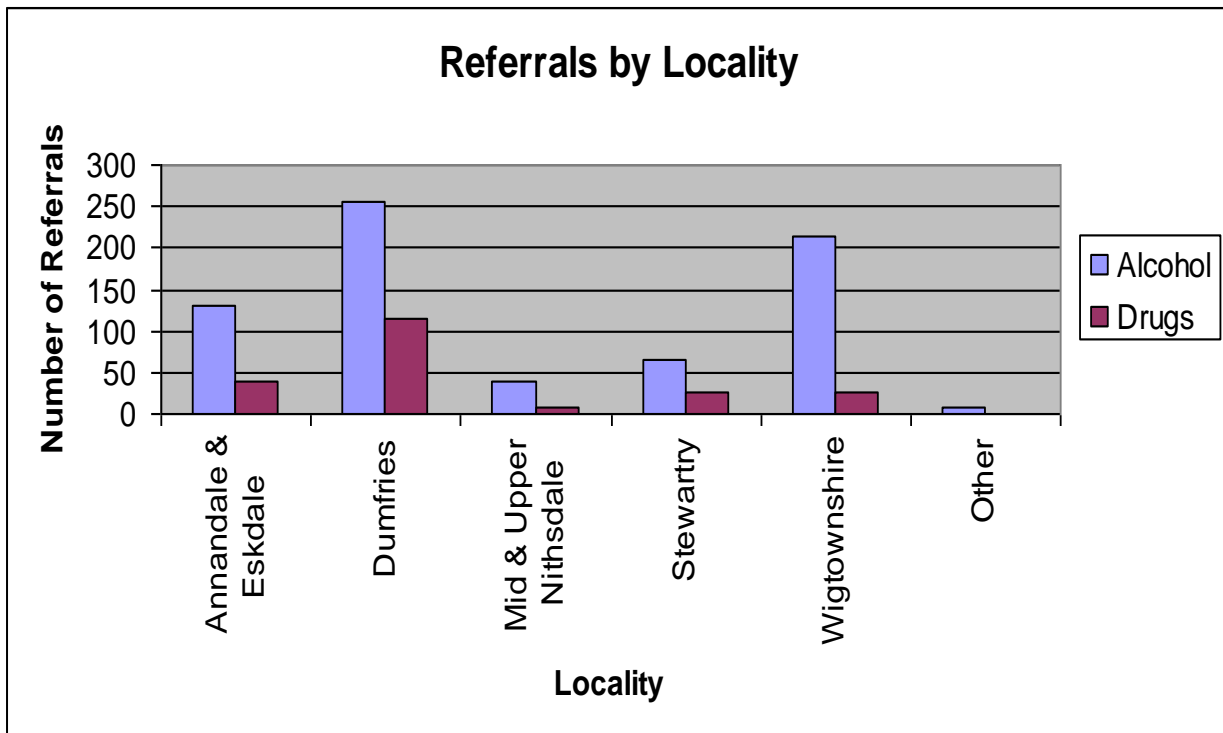
Referrals by Locality

The spread of referrals across the Localities is broadly in line with that recorded to 2009-10. The one key difference was the increase in referrals in Wigtownshire, almost completely due to the increase in alcohol referrals in the DG9 area which rose by 65 (43%).

A small number of referrals (7) were received for people who live outwith Dumfries and Galloway. The geographical spread of referrals is represented in the following table and charts.

	Alcohol	Drugs	Total
DG1	113(16.0%)	40(18.8%)	153(16.7%)
DG2	139(19.7%)	69(32.4%)	208(22.7%)
DG3	12(1.7%)	1(0.5%)	13(1.4%)
DG4	27(3.8%)	6(2.8%)	33(3.6%)
DG5	9(1.3%)	12(5.6%)	21(2.3%)
DG6	13(1.8%)	6(2.8%)	19(2.1%)
DG7	43(6.1%)	9(4.2%)	52(5.7%)
DG8	60(8.5%)	7(3.3%)	67(7.3%)
DG9	155(22.0%)	18(8.5%)	173(18.8%)
DG10	9(1.3%)	4(1.9%)	13(1.4%)
DG11	30(4.3%)	2(0.9%)	32(3.5%)
DG12	55(7.8%)	24(11.3%)	79(8.6%)
DG13	10(1.4%)	1(0.5%)	11(1.2%)
DG14	5(0.7%)	1(0.5%)	6(0.7%)
DG16	18(2.6%)	8(3.8%)	26(2.8%)
Other	7(1.0%)	0(0%)	7(0.8%)
Total	705(100%)	213(100%)	918(100%)





Outcome Data

The ADP made the decision that the Integrated Drug Service stop using the Christo Inventory to collect outcome data at the beginning of 2010. There is therefore no data to report for 2010-11. It is expected that the Outcome Star outcome measuring tool will be introduced in local alcohol and drug services during 2011-2012, once service delivery pathways are agreed with Addaction and Alcohol & Drugs Support South West Scotland (ADS).

Discharge Data

Of the 883 people discharged from the service, 542 (61%) were planned discharges. Looking at differences between service user groups, there was a 4% increase in planned discharges for people with alcohol problems but a 15% drop in planned discharges for people with drug problems. Imprisonment was the reason for 10% of the rise in unplanned discharges for people with drug problems. Where death was the reason for discharge there was no change in the number of people with alcohol problems, the number of people with drug problems rose from one in 2009-10 to six during 2010-11.

The following table and chart provide details of recorded discharge data.

	Alcohol	Drugs	Total
Completed programme of care	186	43	229
Transferred to another agency	77	73	150
No longer seeking help	132	31	163
Planned Discharges	395(66.3%)	147(62.0%)	542(61.4%)
Did not complete programme of care	38	26	64
Did not attend	149	22	171
In prison	2	36	38
Deceased	12	6	18
Unplanned Discharges	201(33.7%)	90(38.0%)	291(38.6%)
Total	596(100%)	237(100%)	883(100%)

4. DEVELOPMENTS

4.1 *Service Development Day April 2010*

The theme for our Development Day on 27th April 2010 was service user involvement and how service delivery could be changed to improve service user experience. The Service User Group led the key session at the beginning of the day looking at aspects of customer services and meaningful involvement. The issues raised were used to underpin group discussions reviewing existing treatment pathways to identify opportunities for improvement. The key elements were then taken to form the Service Development Action Plan for 2010-11. The key areas of development are outlined within the Clinical Governance section of this report.

4.2 *Alcohol Liaison Service, Galloway Community Hospital*

The first year of the Alcohol Liaison Service based in the Galloway Community Hospital, GCH, has provided the opportunity to introduce some of the services already available in DGRI. The Alcohol Liaison Nurse, Farrah Heron has found that staff within the Galloway Community Hospital have been very supportive of developments including screening for alcohol problems and Alcohol Brief Interventions, ABIs. A weekly clinic has also been established at GCH to provide follow-up appointments for people after discharge from hospital or those who have screened positive for alcohol problems during an A&E attendance. Farrah has also worked closely with Julie Currie, Health Improvement Practitioner to establish the provision of screening and ABIs in other primary care settings.

The Alcohol Liaison Nurse would normally provide support for up to four weeks, vacancies and other periods of leave within our Community Team in Wigtownshire has meant that Farrah has provided support for some service users over a more extended period. This has helped to maintain service delivery in Wigtownshire but also provided the opportunity for her to develop skills in other alcohol treatment interventions.

4.3 *Replacement of Prescribing Software*

The software currently used to generate prescriptions is no longer fit for purpose and following work on a development application with colleagues in IM & T, an updated package (Poppie) was purchased in February 2010. The aim was that this would be fully operational by August 2010 but to date it is still not operating to the required standard. Plans are in place to address the remaining problems with a target date for full implementation of August 2011. This software package also replaces the data handling system for supply and return of injecting equipment.

4.4 *Lochfield Road*

The service manager has continued to work as a member of the Project Board. The Project Board is now working to the target completion date of September 2012 and a multidisciplinary Project Team will be identified shortly to progress planning for the move to the new premises. The new building should address a number of concerns that service users in Dumfries have with the current environment at Cameron House and also increase flexibility in relation to operating clinics.

5. DRUG OUTREACH SERVICE

New software was introduced for recording needle exchange data along with the new prescribing software. It had been decided that all data for 2010-11 would be entered into the new system. As mentioned earlier in this report there have been considerable delays in the software package becoming fully operational. At time of writing this report the Outreach Worker still has approximately 5 months of back data to enter. There are therefore no numerical data to report for this year.

The Outreach Worker distributes an average of 2000 needles per week. However from Dec 2010 – March 2011 there was evidence of a significant drop in heroin availability and quality, with distribution levels dropping to around 1000 needles per week. Anecdotal information would appear to indicate that the changes in availability were not entirely due to local police activity and that there may be issues further up the supply chain affecting Dumfries & Galloway. This period also saw a significant drop in non-fatal overdoses reported to the ambulance service.

	Non- fatal overdoses Oct - Dec	Non- fatal overdoses Jan - Mar
2009-2010	14	22
2010-2011	11	5

All 5 overdoses reported for January to March this year happened in the second half of the month with 2 individuals overdosing on 2 separate occasions. Reports from the Outreach Worker that heroin availability and quality were starting to improve was shared with colleagues in other agencies in order to ensure advice was available to service users in relation to risk taking when personal tolerance levels for opiates had reduced.

The Outreach Worker has played a key role in the training programme for provision of Take Home Naloxone both in term of identifying and supporting individuals to attend and providing training sessions with nursing colleagues from the Team.

6. CLINICAL GOVERNANCE

Patient/Public

Service User Information

The Service is informed of all non-fatal accidental overdoses treated by the Scottish Ambulance Service. A letter is sent to people not in contact with the Service or Drug Outreach Worker, advising them of how to contact local treatment services. Work in the previous year had identified that many of the available information leaflets were too wordy and would be improved by increased use of graphics. A leaflet providing people with advice on how to reduce risk of overdose and what do in event of someone else overdosing has been developed, with information on how to access training for “Take Home Naloxone” included.

Pilot projects in other parts of the UK had identified the benefits of running groups for carers and/or family members to meet with clinical staff. Monthly group sessions were provided in the evening in Lincluden Community Centre. The purpose was not to discuss personal treatment plans but to provide people with the opportunity to ask questions in general terms about the physical and psychological effects of alcohol and drug misuse, medications and other treatment interventions. Service users were given information about the group. Leaflets and flyers advertising the groups were supplied to community pharmacies, GP practices, libraries and partners agencies. Numbers attending the groups were very small (5 attendances over 8 sessions) and although those attending said that they had found the opportunity to talk to staff very helpful it was felt that this was not a cost effective use of clinical time.

Feedback from some families was that although they liked the idea of a support system they did not want to attend group meetings that would make neighbours or others living locally aware that they had a family member with a problem. This Service believes that support for families and carers is important but at this time there are no plans to try running groups in other parts of Dumfries & Galloway. It may be that a more effective way to provide “meet the clinician” sessions would be for staff from this service to attend family sessions provided by other Services and options to take this forward will be explored with partner agencies.

Service User Feedback

We continue to use the comments cards with 3 questions to collect feedback from service users. The questions are:

1. What have we done well?
2. What did we not do well?
3. What would you like us to do better?

Although there has been some reduction in the number of cards completed, it does remain an easy way for people to record their views, positive and negative. Positive comments were linked either to the service delivery or to individual members of staff who service users had perceived had been particularly helpful in supporting their treatment plan.

The negative issues fall in to common categories, although the number of reports is small in comparison to the number of contacts with the Service throughout the year. The Team is looking actively at how these issues can be addressed:

1. communication – problems with phone system, calls being returned
2. staff attitude – a perception that staff do not always treat service users with respect
3. prescribing/dispensing issues
4. traveling expenses

The comments collected from the Feedback cards are attached in **Appendix 1**.

Clinical effectiveness

6.2.1 Clinical Guideline Development/Review

The process for people who have completed an opiate self-detoxification and have requested access to Naltrexone therapy to support abstinence has been simplified. The protocol has therefore been amended to replace the need for intramuscular naloxone with a negative opiate urine drug screen with a signed disclaimer from the service user before naltrexone is commenced.

Dry blood spot testing is recognised as an effective and simple procedure to test for blood borne viruses especially with people who have poor venous access. Training has been provided for nursing staff across the Team and processes agreed to include the offer of dry blood spot testing as part of the assessment process.

6.2.2 Audit

Case File

The case file audit was repeated in March 2011, progress was recorded over all the criteria identified for improvement with the overall compliance increasing from 61% to 78.7% with 70% of the criteria achieving a 75% plus compliance rating compared with 35% for the audit completed in March 2010. The audit tool measures compliance across a range of criteria covering:

- Ensuring GPs are kept up to date re treatment plans
- Assessment processes, including mental health and risk assessment
- Service policies re child care/child protection
- Service policies re BBV testing, vaccination, specialist referral
- Care planning process

Child Protection Activity

A repeat of the audit undertaken by trainee psychologist, Allyson Turnbull last year that took a snapshot of staff involvement in child protection processes over a 3 week period was repeated in November/December 2010. The same audit tool was used and as previously staff were asked to record time spent over a three week period:

- With service users where the focus was child protection
- In preparation for and attendance at case conferences, core groups, looked after reviews etc
- Liaising with social work and health child protection colleagues

The results found that the amount of clinical time spent on child protection related issues over a 3 week period had risen from 145 to 287 hours. This equated to 14.6% of available clinical time compared with 9.3% recorded in the previous audit. The information collected for this audit was broken down to identify differences per grade and also between staff working primarily with alcohol or drug cases.

Band	Number of staff in each band		Hours spent on child protection related issues in total over 3 week period		Mean amount of hours spent across all staff on child protection related issues per week		Mean amount of time spent per staff member per week (hours) on child protection related issues	
	2009	2010	2009	2010	2009	2010	2009	2010
5	4	4.64wte	56.05	69.75	18.7	23.25	4.7	5.01
6	4	6.40wte	21	36.85 Alcohol	7	12.28 Alcohol	1.75	1.91 Alcohol
6		3.40wte		72.35 Drugs		24.11 Drugs		
6 HV		1wte		42.25		14.08		14.08
7	3	2	55.5	57.0	18.5	19.0	6.7	9.5
8	2	1	12.85	9.0	4.3	3.0	2.2	3.0
Total	14	18.44	145.4	287.25	48.5	95.75	Mean Per individual 48.5 ÷ 14 = 3.5 hr Approx 9.3% of working hrs	Mean Per individual 95.75 ÷ 18.44=5.2hr Approx 14.64% of working hrs

The outcome of this audit shows the clear distinction between child protection workloads for alcohol and drug related problems and further supports the plans to move to more generic caseloads to spread more challenging work across the Team. The smaller child protection workload linked to alcohol problems is linked to fact that people in contact with this Service tend to be older and therefore less likely to have children under 16 years of age.

6.2.3. *Service Review*

Opportunities for service review and redesign have been limited in the past year whilst elements of the Integrated Services provided by our third sector partners were recommissioned. This process took longer than had been initially hoped with the new service, Addaction, due to take over on 1st April 2011. Their remit will be to provide the drug services previously provided by Turning Point and ADS. They will also provide the relapse prevention support work for people with alcohol problems that was provided by the previous partners. ADS will continue to provide alcohol counselling and befriending services.

Workforce

Mandatory training/KSF

Mandatory training compliance at 31st March 2011 was 90%, showing a 2% improvement on rate recorded at March 2010. Systems are in place to monitor compliance on a monthly basis with the aim of maintaining a consistent level throughout the year.

All Annual Development Reviews (ADR) and Personal Development Plans are recorded on eksf. With the exception of staff members on extended leave all staff met the HEAT target that required an ADR to be recorded on eksf by 31st March 2011.

6.2.2 *Staff Training*

NHS Education Scotland provided training for people working in alcohol services focusing on Motivational Interviewing and Community Reinforcement Approach (CRA). Three nurses (Farrah Heron, Garry Morrison and Sara Redpath) and the Specialist Occupational Therapist (Lynda Wilson) undertook CRA training, with the plan that the techniques will be introduced across the Team. The Community Reinforcement Approach (CRA) is an evidence based, comprehensive behavioural program for treating alcohol and drug problems. It integrates several treatment components including involving significant others in the recovery process, building the clients motivation, helping the client initiate change, analysing the clients substance use pattern, increasing positive reinforcement, and learning new coping behaviours.

Two nurses (Lynne Rhodie and Stuart Tilbury) attended the Motivational Skills training with Stuart completing extra training to take on the role of a coach. Motivational Interviewing (MI) is recognised as a core skill for staff within alcohol and drug services. Despite the fact that MI has long been well-established as an evidence-based intervention with a variety of introductory workshops available, systematic application to practice in a consistent way has been difficult. Whilst much of the training has been offered as one-off workshops, there is a growing recognition that effective training needs to take place within a context of ongoing support, coaching and facilitation. This training programme was designed to be a part of an ongoing process of skills development, with a series of events over an estimated 18 months, establishing a structure for supporting the application of MI to practice. The goal is to identify an initial group of staff within the Team who will receive support and coaching from Stuart in MI practice development. The aim is then to cascade this development across the whole Team. Stuart will be linked to a National Coach Group of MI facilitators

Eileen Carruthers, Unit Manager at Cameron House was awarded the Andrew Little Mentorship Award for her achievement on the UWS mentorship course.

Organisation

6.3.1 Risk Management

The third audit of our IOSH control book at Cameron House was completed on 11th February 2011 with an overall score of 89% achieved. Although a drop from the previous level of 99% this represented a significant achievement by the new Unit Manager who had only taken up post 4 weeks prior to the date of the audit. The Community Team Leader for the east of the Region has now completed his IOSH training and plans are in place for the Team Leader based at Masonfield to complete training during 2011-12.

All risk assessments are recorded on Datix and current assessments are all rated medium or low.

6.3.2 Adverse Incidents

15 adverse incidents were reported during 2010-11, 2 less than last year

- 3 x verbal aggression and abuse
- 2 x physical violence
- 1 x needlestick
- 2 x staff accidents (no serious injury)
- 5 x administrative/documentation incidents
- 2 x medication/clinical waste

All incidents were reviewed by the relevant manager as soon as possible after the incident and were also reviewed at operational team meetings to ensure that any identified learning points are incorporated to changes in practice as required.

7. FUTURE SERVICE DEVELOPMENTS

The Team agreed that one of the key elements of the Development Plan for 2011-12 should focus on development of psychological interventions within the Team aimed at enhancing service delivery. The staff who have recently completed Community Reinforcement Approach and Motivational Interviewing training will lead the Service Development day in May 2011, with the aim of exploring how these approaches could be incorporated into current treatment approaches.

Customer service issues will be monitored using the audit tool (**Appendix 2**) developed for work undertaken as part of the Delivering Dynamic Improvement initiative. The results from the audit will then be used to raise awareness amongst staff in relation to positive and poor behaviour. Other areas for improvement set out in the Service Development action Plan for 2011-12 include a music group for service users, newsletter for service users and options for service redesign. (**Appendix 3**)

MOIRA COSSAR
SERVICE MANAGER

NHS Specialist Drug & Alcohol Service

We want to hear your comments on the Service

☺ What have we done well?

- The waiting times are good x 3
- Speed of initial appointments and back up service
- Keeping on time with appointments
- Everything x 7
- Pretty much everything
- Welcoming is great
- Made sure we have had the proper help
- Giving me help with my problems
- Lots of seats and leaflets
- Helped me out
- Helped me get clean and successfully stay clean
- Everyone is kind, helpful and friendly
- Give support x 2
- I have no complaints, happy with things
- Good service, helped me with coping
- Sorted out my script out for me quickly and helpfully at short notice
- Made sure I got my methadone every day
- Helping those who work with scripts
- Helped me understand what I'm doing with my drinking both the good and the bad
- No problems with nurses I've worked with
- Good workers who have an actual interest in how you are doing
- Staff are polite and professional, everything is satisfactory
- Employing Stuart Tilbury
- Maureen has been good to me
- Raye Currie is best worker I've had
- Raye is very good
- Nothing it's shit

☹️ What did we not do well?

- The reception is too wee
- Answer the phone x 3
- Pass on messages x 1
- Turned up to see my keyworker and they weren't there
- Unorganized sometimes
- Not always on time for appointments x 2
- Shut at lunchtime
- Takes a while to sort stuff
- Explain to us why we can't get our methadone on day of appointment
- Took too long to get my subutex
- Titrate methadone quickly enough x 2
- Takes too long to get onto medication
- Sometimes you think it's easy but it's not
- Could understand me a bit better and my needs
- Went behind my back and phoned social services
- Location, it's a long way from a bus stop

√ What would you like us to do better?

- Provide bowl of sweets and juice, tea, coffee in the waiting room
- More magazine in waiting room
- Less appointments x 4
- Better time keeping
- Answer the phone rather than using answering machine x 2
- Use stacking system for calls rather than answer machine x 3
- Disagree with idea of call queuing system x 2
- Provide a free phone number x 2
- Respond more quickly to telephone messages
- Would like some kind of reminder service i.e. text to remember appointment in a hour
- Send out appointments recorded delivery
- Give bus passes
- Reimburse bus fares at Cameron House rather than at the hospital
- Be able to pick up needle pack after appointments
- Set it up so that I can take my week's methadone home
- More medication
- Stop chemists from discriminating against us x 3
- Have staff who are older and have more knowledge about drugs
- Maybe have staff that are ex alcohol or drug users
- Have nice reception staff x 2
- Treat us like normal people
- Listen x 3
- Trust us x 2
- Like the option to change keyworker
- Realising I have a drug problems but that I want to beat it
- Give us a purpose
- More home visits for patients, ill or disabled

Guidelines for use of Tool

- A score is recorded for each criterion (not separate bullet points) every 15 minutes, with the score reflecting the average of that time slot. Can then get an average score for the period of observation but also the range of scores
- The scores used are -5, -3, -1, 1, 3, 5 where -5 means the expected behaviour/presentation was missing completely or the behaviour was totally unacceptable up to 5 when the behaviour/presentation met the maximum standard expected
- The comments box is used to record items of note (positive and negative) that the observer would want to feedback to staff

Service Development Action Plan 2011-12

	Development	GROUP MEMBERS	COORDINATOR	TIMESCALE	COMMENTS
1	Development of Motivational Interviewing skills across the Team 1. First Stage will be to identify staff to “sign up” for focused case work with Stuart 2. Skills development group established 3. Plans agreed for further development in this team and with partner agencies		Stuart Tilbury	First group members identified June 2011 Initial Group fully operational by March 2012	
2	CRA & C-Bit 1. Identify group within the Team to focus on use of CRA & C-Bit tools 2. Evaluate effectiveness of CRA & C-Bit interventions 3. Agree plans for further use of these approaches across the Team	Sara Redpath Debbie Parker Farrah heron Garry Morrison Eileen Carruthers	Lynda Wilson	January 2012	
3	Music Group for Service users		Lewis Fergusson	August 2011	
4	Newsletter for Service Users	Justin Murray John Miller	Lynda Wilson	1 st edition Sept 2011	
5	Review of NICE Guideline Alcohol-use Disorders Diagnosis, assessment and management of harmful drinking and alcohol dependence		John Waterhouse	September 2011	

6	<p>Management of Alcohol Detox in DGRI/GCH</p> <ol style="list-style-type: none"> 1. Explore options of managing planned alcohol detoxification in GCH 2. Explore option of continuing alcohol detoxification in the community post discharge from acute hospital setting 	<p>Farrah Heron Jackie Aindow Eileen Carruthers</p>	<p>John Waterhouse</p>	<p>October 2011</p>	
7	<p>New Build/Lochfield Road Development</p> <ol style="list-style-type: none"> 1. Establish planning group to manage transfer of Dumfries and Team East service from Cameron House to Lochfield Road 2. Identify elements of planning programme and agree timetable 3. Liaise with Lochfield Project Planning Group 		<p>Moira Cossar</p>	<p>September 2012</p>	
8	<p>Redesign of Assessment and Treatment Pathways</p> <ol style="list-style-type: none"> 1. Clarification of links with partner agencies Addaction & ADS 2. Review of Service delivery to meet HEAT targets for waiting times 3. Establish care pathway that makes most effective use of current resources and meets service users' needs 		<p>Management Team</p>	<p>October 2011</p>	
9	<p>Review of Assessment Documentation</p> <ol style="list-style-type: none"> 1. Identify areas for improvement, including areas for self-assessment by service users 2. Assessment documentation will support a process for early identification of people with alcohol problems who can be signposted to partner agencies 	<p>Community Team East</p>	<p>Maureen Fair</p>	<p>September 2011</p>	

10	Information Management & Technology 1. Introduce and embed Topas and Winscribe 2. Project planning for the introduction of eMRec, Midis		Moira Cossar		
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