A WAIT OFF OUR SHOULDERS

A GUIDE TO IMPROVING ACCESS TO RECOVERY FOCUSED DRUG AND ALCOHOL TREATMENT SERVICES IN SCOTLAND

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SECTION 1:
Introduction

Nobody likes to wait, especially when it is for help with a problem. For people with a drug or alcohol problem, getting treatment that enables them to recover from their problem at a time of need is crucial. We need to make sure that people do not have to wait an unacceptably long time for treatment and we want to ensure that this is the same for everyone in Scotland regardless of where people live. That is why we have, for the first time ever, a target to make sure the NHS reduce waiting times for drug treatment services and we will extend this target to alcohol treatment services in April 2011.

Reducing waiting times for treatment is not new to the NHS. Successes have been made in reducing waiting times for a range of treatments including cancer services, Accident & Emergency and Outpatients. While the needs of clients may be different, there is learning that we can take from how services have changed the way that they operate to make significant improvements for their client group, ensuring that access is quicker, while not compromising on the service quality.

We also have a lot to learn from drug and alcohol treatment services throughout the UK. In England, the National Treatment Agency (NTA) has a 3 week referral to treatment indicator and in 2008/09 93% of all clients waited less than 3 weeks to start drug treatment. In Scotland, there are strong examples of good practice where Alcohol and Drug Action Teams, now Alcohol and Drug Partnerships (ADPs), and their partners have worked to redesign their local treatment services to improve access and reduce waiting times.

This document is for NHS Boards, ADPs and specialist substance misuse service providers. It aims to share learning from across the country on good practice to improve access to treatment and reduce waiting times through service redesign. This document provides:

- Clarity on what the drug and alcohol waiting times target is and who it applies to
- An explanation of the principles supporting improvement support and service redesign
- Case studies of services and partnerships that have successfully reduced waiting times through service redesign

It is our hope that over time we can expand on our examples of good practice that are taking place across the country as we make a true difference for people with drug and alcohol problems in Scotland. The case studies included in this document should provide evidence that positive changes can be made through reviewing and redesigning the way that services work. They are not extensive reviews of processes but instead provide a flavour of issues that services and partnerships worked through together.

If you want to find out more about specific issues flagged up in this document then please contact the Scottish Government Drug Delivery Team for more information on ***DrugsStrategyWebsite@scotland.gsi.gov.uk***. As we discovered through compiling these case studies, there is a great deal of knowledge, experience and willingness to share.

SECTION 2:
Introduction to the HEAT A11 waiting times target

HEAT stands for **H**ealth improvement, **E**fficiency, **A**ccess to services and **T**reatment. It is an internal NHS performance management system that includes targets that support National Outcomes, from the Scottish Governments National Performance Framework. NHS Boards are accountable to the Scottish Government for achieving HEAT targets.

The HEAT A11 target

In 2008, the Scottish Government announced a new HEAT target 'to offer drug misusers faster access to appropriate treatment to support their recovery'. During the spring of 2009, Scottish Government officials within the HEAT A11 Project Team consulted with NHS Boards and a range of stakeholders on a target that was achievable, that was best for people with drug problems and the possibility of the target being expanded to alcohol treatment services. This resulted in the following target being approved by Ministers in November 2009:

By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery

Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by April 2011

As a milestone to deliver 3 weeks from referral to drug treatment by March 2013, by December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received; and 90% of clients will receive a date for treatment that falls within 4 weeks of their recovery plan being agreed

What the HEAT A11 target means for people with drug problems in Scotland

In some parts of Scotland, people with drug problems are waiting too long for specialist treatment. This HEAT target is based on the principle that people with drug problems are entitled to the same level of care as other patients in the NHS. Reducing waiting times for drug treatment services will mean that people with drug problems will be able to access services, at the point of need, to support their recovery.

Services that the HEAT A11 target applies to

The HEAT target applies to NHS services and the services NHS Boards fund to act on their behalf. However, since 2004, waiting times data have been collated for all drug treatment services, including those within the voluntary sector services and local authorities. This will continue, as the principle is to ensure that a wide range of drug treatment services are available, at the point of need, to support individuals' recovery. It is the Scottish Government's aim that all drug treatment services, no matter who they are funded by, will work to ensure that people with drug problems get access to the treatment they need within 3 weeks of referral.

Enabling people with drug problems to recover

An early step in enabling people with drug problems to recover from their drug problem is providing them with access to treatment at the time they need it. To achieve the HEAT A11 target in the context of recovery, NHS Boards will need to work closely with their partners in local authorities and the voluntary sector to ensure that their local recovery pathway addresses the needs of people with drug problems in their area. This means ensuring that a full range of high quality, recovery focused services are available at the point of need to enable people to move on, when they are ready to do so.

Are alcohol services included in the target?

At present, waiting times information is not as robust for alcohol services as it is for drug services. Therefore 2010–2011 is a developmental year for alcohol treatment services. A measurable target for alcohol treatment services will be based on the outcome of a detailed audit of alcohol waiting times during April–June 2010. This means that an alcohol treatment services waiting times target will be introduced from April 2011.

Guidance

To support drug services to achieve the HEAT target we have consulted widely with a range of stakeholders and developed Guidance on Referral Pathways (please see useful documents section).

This document embeds the reduction of waiting times in Scotland's strategy to help individuals to recover, move on from their problem drug use, and be active and contributing members of society. The guidance also outlines what services the HEAT target applies to, how waiting times will be monitored and what the reporting mechanisms are.

Scottish Government officials are currently embarking on work to reaffirm and update the principles that underpin essential services for alcohol treatment and support, taking into account the current evidence base on effective interventions; how services should be delivered, Integrated Care Pathways (ICPs) and the outcomes that should be monitored. The Alcohol Essential Services Working Group will report in December 2010, informing future development and delivery of specialist alcohol treatment and support services.

How we know people with drug problems are getting fast access to the right treatment or that the treatment is of good quality

The access to treatment target is firmly embedded in the context of the drugs strategy, *The Road to Recovery* (please see the Guidance on Referral Pathways) as we are looking to improve access to appropriate treatment. The target applies to services that deliver tier 3 and 4 interventions only, and we are currently consulting extensively on the definition of the different types of intervention that clients may need. We want to reflect the full range of appropriate services, so that we can understand how long people are waiting for different types of recovery focused interventions.

It is, however, for local services and local partnerships to ensure, via quality improvement frameworks and performance management arrangements, that the treatment is of good quality and recovery focused.

How we find out if people are satisfied with the treatment they receive

Very simply, we need to ask them. Some services routinely run user-satisfaction surveys; sometimes a service's perception of the quality of treatment can be quite different from the service user's, in which case it may become necessary to pin point why. We would advise local services to continually engage service users in reviewing the effectiveness of their service.

How we can ensure that we look at treatment outcomes as well as access to treatment

The Scottish Drug Misuse Database will be able to provide treatment outcome information for everyone in drug treatment in Scotland by December 2012. At a local level it is important that services engage with clients as much as possible, to find out what the outcomes of treatment were for them.

SECTION 3:
Improvement and service redesign – key principles

To find further sources of help for undertaking improvement work, please refer to section 5. A lot of the following information has been adapted from materials developed by the Scottish Mental Health Collaborative as many of the principles and approaches apply equally to drug and alcohol treatment services.

What improvement work is all about

It would be naïve to imagine that none of us have ever been involved in service change, and that this is all something new. It can be helpful to consider what type of service change you have been involved in before and what the process was like.

- As someone directly providing services to clients, were you consulted about the changes that were made and did you feel you had a chance to say anything about what might be best?
- Did you make use of information about how the service worked at the time to inform what changes to make?
- Did you keep measuring how things worked as you made changes; could you tell which changes had an impact in a good way and which maybe did not?
- Did you ever test out an idea for a week to see if it really worked before it became the 'new way'?
- Did you involve service users in discussions about how to change things for the better?

If your answer is yes to all of these, then you may not need to read any further; however, if your answer was no to one or more of these questions, you will find it useful to read on.

Current thinking about improving the quality of services for clients is based on some key principles:

- Those who provide services and those that use them are involved in developing ideas for improving things, testing out these ideas and implementing those which are successful
- Understand what actually happens at the moment through looking at services from the stand point of the client; how do they move through the process or system? How are things organised around them?
- Information is collected that illustrates what is actually happening in order to understand what to change
- Develop a clear idea of what the service should look like, based on the needs of your clients; local needs assessments, strategies and policies should help with this
- Before making any changes, work out what to measure to understand whether a change is having the desired effect
- Changes are broken down into small, easily do-able parts where possible in order to test out whether something works and to give people a chance to get used to a new way of working
- There is much you can do to reduce long waiting times, improve the way clinics run and reduce what seems like wasted time chasing paperwork, without having any more resource and without anyone having to work harder and faster

The rest of this section is a brief guide to give you an introduction to some of the ways you can begin to go about making changes to your services. This is not an extensive improvement guide, but in section 5 we have added some links to other resources you can make use of if you want some more detail.

Getting started – bringing everyone together and understanding what happens at the moment

Health and social care systems and processes are often complex and fragmented. It is unlikely that a single member of staff would fully understand the complete pathway or process that a client experiences when they make their way through drug treatment services.

Bringing people together who work across all the different agencies that are involved in providing drug treatment services in your area is a powerful way to begin to understand how clients and information flow through the health, social care and voluntary sectors and how various parts of the system link together.

Think about how your services currently work and bring together people who are involved at each stage of the client pathway. This will include those who have direct contact with clients, and those that provide the vital administration processes that happen along the way. You will not be able to get everyone together, just make sure that someone from each step is involved. You can always share the results with those who could not be there.

The aim is to first develop a shared understanding of what you are setting out to achieve. What outcome are you aiming for in providing drug treatment services? For example:

- More service users recover from problem drug use
- Service users have a less chaotic lifestyle
- Service users stop/reduce drug misuse and drug-related harm
- Service users have improved employment opportunities

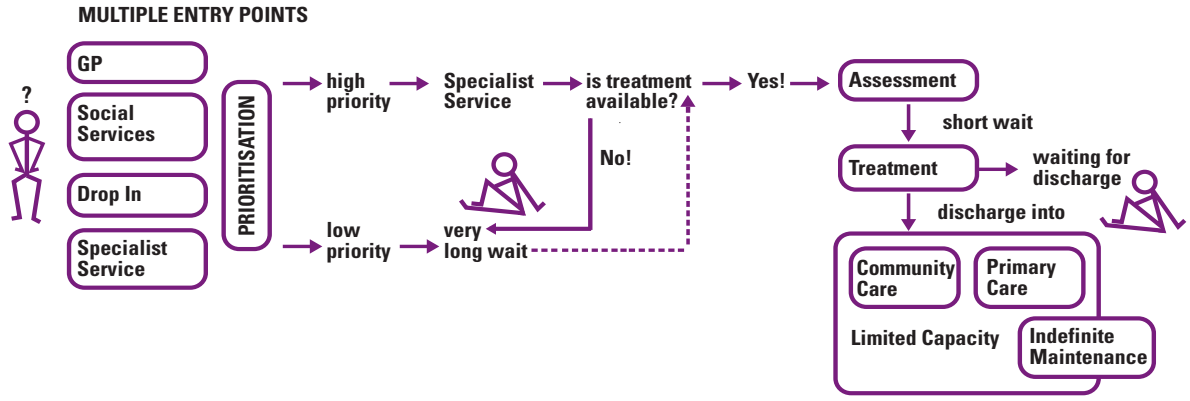
It is useful to have this discussion; people from different parts of the health, social care and voluntary sectors will have different outlooks from each other about the purpose and structure of services. It is important that before you begin to change the way your services work, you have discussions about what you are aiming to achieve through that change. This includes what you are aiming at beyond improving waiting times, as until you have a clear picture of what the service is for, it is difficult to design it to work. Think about reducing waiting times in the context of helping an individual achieve their full potential, enabling them to recover from their drug problem.

Understanding the client pathway at this point in time

Bringing everyone together is an opportunity to produce a map of the client's journey as a visual representation, which illustrates how the client moves through the drug treatment pathway and how the administrative processes are linked to this pathway.

The map should shows how things often are and what happens, rather than what should happen.

St Elsewhere Drug Treatment services – high-level map of current service user pathway



You will find that you will want to be able to check any map you generate against some real life examples in your local area – it is really useful to have some information attached to this map that gives you information about the process.

For example, looking at the sample pathway:

- How many different routes are there through which clients access services?
- How many different agencies provide assessment?
- How long do people wait for an assessment? Does this vary? And how long does an assessment take?
- How long do people wait between assessment and their first treatment appointment?
- Who undertakes treatment?
- What types of treatment are available?
- What proportion of clients receive each type of treatment?
- How long do people stay in treatment?
- How do staff decide that clients can move on from their care?
- What happens after the client's treatment is completed? Who do the clients move on to?
- Do clients have to wait to move on?
- Which staff groups are doing which tasks? Are everyone's skills being appropriately used?
- Do you prioritise people and if so, how and why? What impact does this have on those people that are never a priority?
- What are the connections between different sections of the pathway?

You will probably not have all this information at the time of your event; this is why you are likely to need to bring people back together again, to review the map and to begin to build a picture of how the service should look.

This helps everyone involved see other people's views and roles. It can also help you diagnose problems and identify areas for improvement.

Deciding what you are setting out to achieve

Spend some time with the group working out what the pathway should really look like and how long each part should take. Start to think about who does what, when and why.

Get some agreement from the team about what you are setting out to achieve, for example – by December 2010, 90% of clients will be able to access drug treatment services through a single point of contact. This first contact will take the form of an assessment, and 90% of people will receive their first treatment 4 weeks after this first assessment visit.

There is much to think about if you take that statement; who will provide the single point of contact? Does it need to be a health professional? What is an assessment; when does it start and end? How will you measure how long people are waiting at each stage of the pathway? What about the rest of the pathway; do you need to work out some similar statements for each part of the pathway?

Once you have worked through what the pathway looks like at the moment and what it should look like in the future, you will also need to spend some time understanding how you manage the amount of work that flows through your service. This means looking at the whole system to identify where blockages may be or where people may remain in treatment for longer than they need to be.

Understanding demand, capacity, activity and queues

Most of the targets our services face are about **queues**. Queues are about managing service **demand** and service **capacity**. Requests to increase service resources are actually about increasing service capacity. Does increasing resources solve queues? Often not without work on **demand** and **capacity**.

At first glance the world of demand and capacity appears to be full of jargon, but it can be kept quite simple. For example:

- **Demand** is *not* how many people are referred, it is the time they need to be treated
- **Capacity** is *not* the number of staff we have, it is the total resource available to do the work which includes staff and any equipment needed (such as rooms)
- **Activity** is *not* the same as capacity – activity is how much work we actually do and is often less than we have the capacity to do (because so often we spend time doing things we do not need to, such as chasing around trying to find notes, re-booking appointments etc.)
- Our waiting list is actually a **Queue**

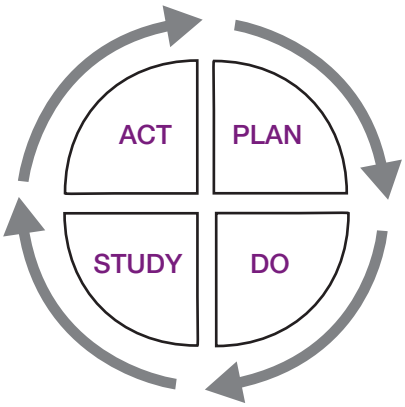
Why work on demand and capacity is important

It helps us understand what we do, who we do it for and how we work. Knowing this helps us to make sensible changes and think about whether we can make better use of the resources we already have.

The Scottish Mental Health Collaborative has recently produced some very useful practical guides on understanding demand, capacity, activity and queue; these are applicable to drug and alcohol treatment services and can be found at: ***www.scotland.gov.uk/Topics/Health/NHS-Scotland/Delivery-Improvement/1835/74***. Click on the news/resources link on the left-hand side of the page.

These documents are very helpful in helping service managers work out what demand there is for their service and how this can be matched against capacity within the system. The guides provide templates that service managers can use to help work out what the actual demand for the service is and how that can be matched against capacity within the system.

Making changes – Plan, Do, Study, Act (PDSA)



PDSA is

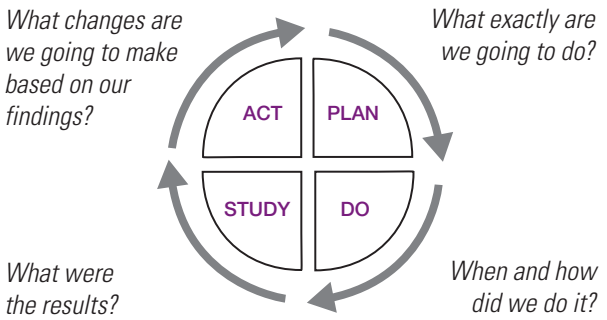
- A simple tool for staff to test out ideas that will improve health and social care systems and processes
- A structured approach for making small incremental changes to systems
- A way of helping you to move to action, even where some uncertainty exists about whether the change will lead to improvement
- A full cycle for planning, testing, studying and acting on the learning gained from the first 3 phases

Principles of PDSA

- Breaks down change into manageable, bite-sized time-limited chunks
- A PDSA cannot be too small
- Small changes can be tested without causing upheaval to the whole system
- If it does not work, try something different based on your learning

Advantages of PDSA

- It is small in scope and builds incrementally – small rapid cycles lead to improvement
- It is highly effective, changes are quick and immediately evident
- It is a powerful tool for learning; as much is learned from ideas that don't work as from those that do



Start with three key questions

PDSA cycles are the second part of 'a model for improvement'. The first part consists of 3 fundamental questions that need to be considered before you do any improvement work (though you can answer them in any order).

What are you trying to accomplish?

Improvement work requires clear aims that will guide the work and focus your efforts. Ideally you want to be able to measure whether you have achieved your aim and for it to have clear timescales.

For instance, you might be working in a service where you wish to:

- Improve access to treatment
- Reduce (Did Not Attend) DNA rates
- Make best use of staff time, skills and expertise

Only once you are clear about what your aims are, can you actually then look at any baseline information and monitor against any changes that arise from your improvement work.

How will you know that a change is an improvement?

We live in a constantly changing world – but how will you know if the changes you are making are actually resulting in an improvement? Is it possible that the changes have actually made things worse? We know it is not always easy to measure the impact of what we do and all measures have their limitations. However, used appropriately, data can be really helpful. And what is the alternative – keep making changes in the absence of any measurement about whether they work?

It is best to use quantitative and qualitative data to see if the changes being made are actually making a difference – including views from those who use our services. If you are worried that a change to improve one bit of your service might make other things worse, then you need to collect data to see if that happens. And remember, it is not a research project, you only need to gather enough data to learn if the test was an improvement. For example:

So for the below example, what is happening to the DNA rate as we make changes?
You might be concerned that actions to improve your DNA performance will increase demand to the point where service capacity cannot cope, i.e. you are so used to 40% of your clients routinely not turning up, that if most people do start arriving for appointments as planned, your queues – and waiting times – will increase. You will need to be able to measure your DNA rate, the activity you undertake, the capacity available, the number of people in your queue and waiting times to understand if you are having an adverse impact anywhere in the system.

What changes can you make that will result in improvement?

So now you know what you are trying to achieve and what data you will collect to know if you have achieved it. The next step is to think about what actual changes you are going to make to deliver those improvements. Ideally you want to involve everybody who might have to make the change in generating ideas for change.

It is often difficult to know in advance what the impact of a change will be – and even if something has worked in one area – it does not mean it will work for you. This lack of certainty about whether a change will work and a fear of the consequences if it does not, can lead teams to just talking over the same issue again and again. One way through this is to use PDSA cycles to initially test the change at a small scale.

More information about undertaking small tests of change and choosing what to measure can be found at ***http://www.improvingnhsscotland.scot.nhs.uk***. Click on the improvement tools tab.

The last few pages have been a brief practical introduction on how to go about undertaking improvement work. Over the coming months, we will be working to develop some materials that are specifically tailored to support teams to apply these ideas to improving access to drug and alcohol treatment services.

If you and your team would be interested in working with us to develop these resources, we would like to hear from you. You may have already undertaken this kind of work and if so, we are interested in learning from your experience. Alternatively, you may want some support in getting started. Either way, your input would be really valued. Please contact us on ***DrugsStrategyWebsite@scotland.gsi.gov.uk***.

CASE STUDIES

SECTION 4:

Examples of good practice from across the United Kingdom

Improvement and service redesign is not a new concept to many drug treatment services across the UK. Drug treatment services in England are currently measured against a 3 week referral to treatment performance measure and some services in Scotland have also made significant improvements in making services more accessible to individuals with problem drug use through redesigning their processes and systems.

Over the past year, Scottish Government officials have identified several areas where improvements have been made in waiting times through service redesign. We are conscious that there is much more work that has, and continues to, take place throughout the country. We are therefore keen for services and ADPs to share their experiences of how improvements were made, the challenges that were faced and how these were overcome.
This section shares some experiences from drug treatment services that reduced waiting times through service redesign, what they went through and what they learned.

This is a live document. We welcome your input for future development. If you would like to share your experiences please contact us on:
***DrugsStrategyWebsite@scotland.gsi.gov.uk*.**

CAMDEN

Camden has, in the recent past, had the highest number of individuals with problem drug use in treatment of any London Borough. The NHS sees approximately 1500 people with problem drug use per year. If you include figures from other sectors, the number in treatment each year is closer to 2000. It has one of the highest prevalence rates in London, with an estimated 4000 individuals with problem drug use of which the majority are heroin users.

How things were…

Seven years ago Camden had a very traditional service with very long waits for treatment. At the worst, the average length of wait for treatment was 18 months. Assessment appointments were all based on 'booked in' appointments and the DNA rate was as high as 60%. Something needed to change as this was not an efficient way of operating.

The process we went through to improve our situation…

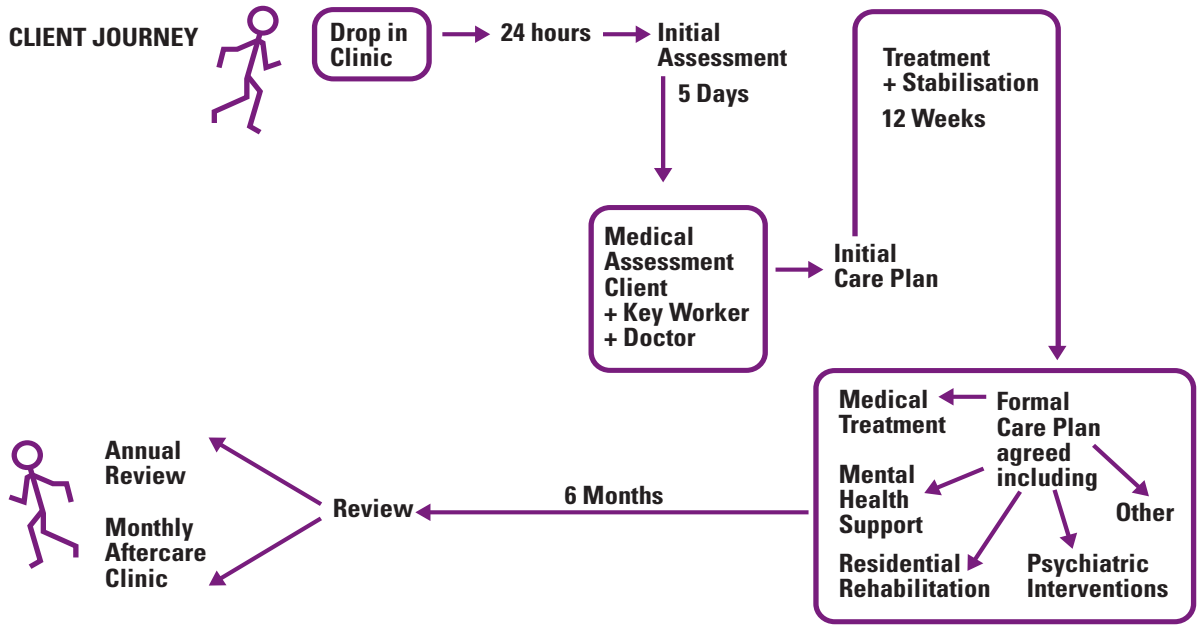
The NTA's 'Opening Doors' workshops introduced change management techniques to partners and this kick-started service redesign to improve access to treatment.

As a result of reviewing the process for how people accessed treatment, Camden removed the need for an appointment for the initial assessment and set up clinics with a structured drop-in service; this meant people were seen within 24 hours. This is particularly important, as it allowed people to be assessed at their highest point of motivation. This change 'eradicated waiting times overnight'. This took a cultural change in the staff, as they needed to make the nursing staff and drugs workers much more accessible, removing all possible barriers to accessing treatment. Motivating partners was key and it was essential that there was buy in at every level. As the majority of service users are heroin users, many needed a methadone prescription as a starting point, to help stabilise their chaotic lifestyle. It was, therefore, particularly important to get medical staff buy-in.

Understanding demand and flow are very important and can be as simple as knowing your service is likely to have a rush in demand on, for example, a Tuesday morning, as this is when service users collect benefits at the office nearby. Staff therefore need to plan for this and also need to cope with having a varied workload.

There used to also be fairly rigid requirements of service users in treatment. As a result of the service redesign, this is no longer the case with services being more flexible to accommodate that it can take a number of months for people to stabilise. For those with complex needs there is more intensive one-on-one support within the first 12 weeks. This initial phase of treatment is used to allow service users to get used to coming into treatment, attending appointments and getting the methadone prescription right. Once stabilised, it is our experience that clients are much more ready to engage in structured casework and address other issues going on in their lives.

Example of a client's journey



To maintain continuity, ideally the person who first completes the triage, becomes the keyworker for the client.

TOP TIPS

- Changes need to be sustainable rather than one off
- All stakeholders need to understand what is in it for them
- If it doesn't work do something different
- Should have been more radical with re-design earlier in the process

DUMFRIES AND GALLOWAY

Dumfries and Galloway is a very large and very rural area with an estimated 1200 problem drug users.

In the Stewartry and Nithsdale area 72% of referrals are for heroin. In the east of the region, towards Carlisle there is a slightly higher percentage of cocaine usage.

How things were…

In 2005 one NHS Board covered the whole of Dumfries and Galloway. Nurses had a limited case load and when nursing capacity reached saturation this caused the waiting lists to rise.

Some people were waiting up to 22 weeks for assessment.

The process we went through to improve our situation…

In 2006 the service applied for Scottish Government funding to deal with drug waiting times. In April 2006 the voluntary sector took over the role of assessing people for treatment and set up 5 localities. They set a target of referral to assessment in 4 weeks. Turning Point Scotland and Alcohol and Drug Support South West Scotland did all the assessment work. They took all referrals including self-referral, GP referral, social work referral and criminal justice referral.

Training was offered to staff through Scottish Training on Drugs and Alcohol (STRADA).

Within a year, waiting times were reduced to 2 weeks from referral to assessment.

Partnership working

Case managers identify agencies to refer clients onto. The service works closely with Job Centre Plus, the Benefits Maximisation Team, Housing Support and the Citizens Advice Bureau. The focus is on empowering the individual. People are encouraged to contact the agencies themselves.

Flexibility is key to improving the service. It is important to focus on the needs of the individual. Staff have a lot of autonomy to tailor their approach to the needs of the individual.

Forming strong relationships with the nurses and the voluntary service at management and ground level is very important.

Sustainability

Sustainability has been achieved through continuous development of drug treatment waiting times.

1) We started dealing only with time from referral to first assessment and psycho-social treatment interventions.
2) Then we looked at freeing up nurses' caseloads to improve time from assessment to medical treatment.
3) This meant shared care between voluntary sector and NHS.
4) Then we introduced stabilising prescribing by voluntary sector with a GP delivering and issuing prescriptions.
5) During the anthrax outbreak, we moved everything again to ensure that assessment is done on the day of referral and now no one waits more than 6 days for prescribing and a full medical check up.

Client's journey through the pathway:

1. Client in —(10 weeks)→ Assessment

Clients had to wait 10 weeks due to the GP surgery they registered with and the nurses' caseload.

2. Client in —(6 days)→ Assessment —(7 days)→ Treatment

The waiting time was still linked to nurses' availability so we moved again to improve.

3. Client in —(1 day)→ Assessment —(1 day)→ Treatment

Client comments

I would have referred myself here earlier if I had realised how quick things were.

I'm glad my girlfriend made my referral, I thought I would still have to wait ages and didn't see the point.

You actually are helping me this time, it is not just about methadone.

TOP TIPS

- There must be honesty about what people are good at and what people are employed to do. Remember, nurses are there to nurse
- Look at everyone's expectations, fears and hopes
- Service user engagement is key, find out what service users want from the service
- Deal with shared care first
- Deal with the more stable clients first

ABERDEEN CITY

Aberdeen City has an estimated 2597 drug users (1.8% of the population) with an estimated 2246 injecting drug users (1.5% of the population)[1].

How things were…

In April 2007, 799 people were waiting for drug treatment – some of whom had had to wait a number of years for treatment. Whilst a number of services were on offer across the city 90% of referrals were from individuals looking for substitute prescribing. Analysis showed that demand for treatment outstripped capacity by 50% therefore the problem was projected to get worse. Once people had been assessed, generally 90% were starting treatment within a few days.

The process we went through to improve our situation…

A number of initiatives were undertaken to address the issue. Broadly these fell into 3 categories:

- Physical – we invested in temporary accommodation and a further £3.5m in a purpose designed and built treatment and rehabilitation centre due to open in Feb 2011
- Structural – we redesigned the structure of services along a process based model and into smaller cluster-based teams. Moved from 27 routes into treatment to one central point of access and reduced the process time by 50%
- Staffing – NHS Grampian invested an additional £500k in staffing capacity and we have restructured the nursing and medical establishment. Aberdeen City Council invested an additional £500k in social work family support, rehabilitation services and the routes out of treatment

What improvements have been seen…

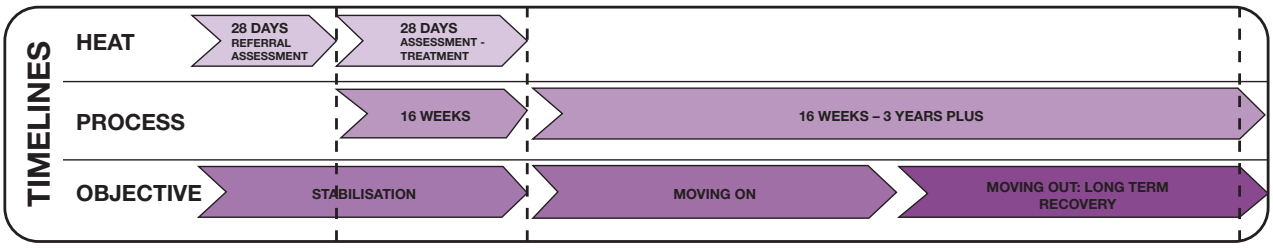
The number of people waiting has reduced from 799 to around 30. The number of people being assessed within 28 days of referral has moved from 9% to 53% as of the end of December 2009 with further targets established.

Sustainability…

The redesigned services are more cost effective and cost efficient and offer a better mix of clinical and non-clinical supports. Appointments of team leader staff and investment in the infrastructure supported the redesign.

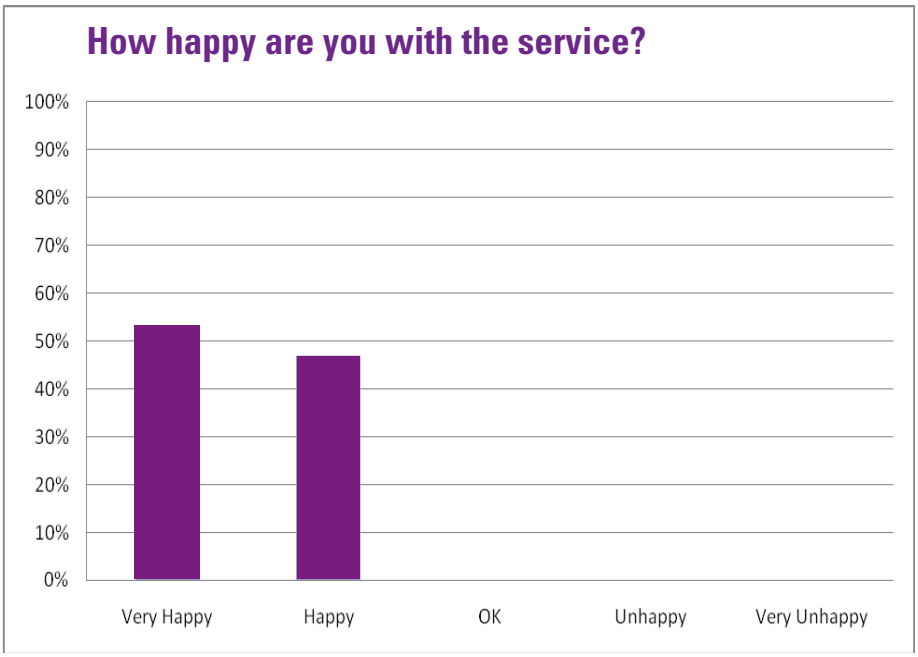
[1] Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland

Client's journey through the pathway



Client benefits:

Clients have indicated a high level of satisfaction with the service



LANARKSHIRE

Approximately 1800 service users receive Methadone, with another 300 prescribed Suboxone.

The majority of substance use involves alcohol or heroin, although many people have poly-drug use problems and mix heroin with alcohol and benzodiazepines. There is limited use of cocaine.

How things were…

Until service re-organisation in 2004, nurses had caseloads of more than 100 and were reaching saturation point. Staff kept taking more people on, but found it difficult to discharge from the service.

The Scottish Waiting Times Framework began collecting information on the activity of specialist alcohol and drugs services from April 2004. At that time, waiting time for assessment and treatment within Lanarkshire varied widely from team to team. Whilst some locality teams were able to see 100% of referrals within 3 weeks, in others no-one was seen within 3 weeks of referral. Waiting times also differed significantly for alcohol versus drug referrals.

The process we went through to improve our situation…

Service redesign began in 2004. Teams in North Lanarkshire became integrated, with nurses, occupational therapists, psychologists, psychiatrists, addiction workers and social workers working together on the same site. It became clear that providing a service was more than medically stabilising someone and providing a prescription for methadone or antabuse. With the publication of the NTA's "Methadone and More" document, it was recognised that psycho-social interventions were as important, if not more so, than medication. Staff were therefore encouraged to spend more time with patients, asking about their mental health and well-being. Nurses, in particular, felt this gave them more job satisfaction than simply handing out a prescription.

It was clear that the focus should be on more than simply stabilising drug/alcohol use, and beyond mental health to look at housing, benefits and general welfare issues. Staff are offered supervision to help them with the more difficult clients. More effective ways of using non-statutory agencies were found and resources were used more effectively. Through the ADP the service has a good relationship with other services.

In Lanarkshire, there are now 10 locality teams providing specialist addiction services. Six of these are integrated addiction teams in North Lanarkshire. In South Lanarkshire, the remaining 4 NHS teams, along with social work substance misuse teams, are in the process of exploring what integration will look like.

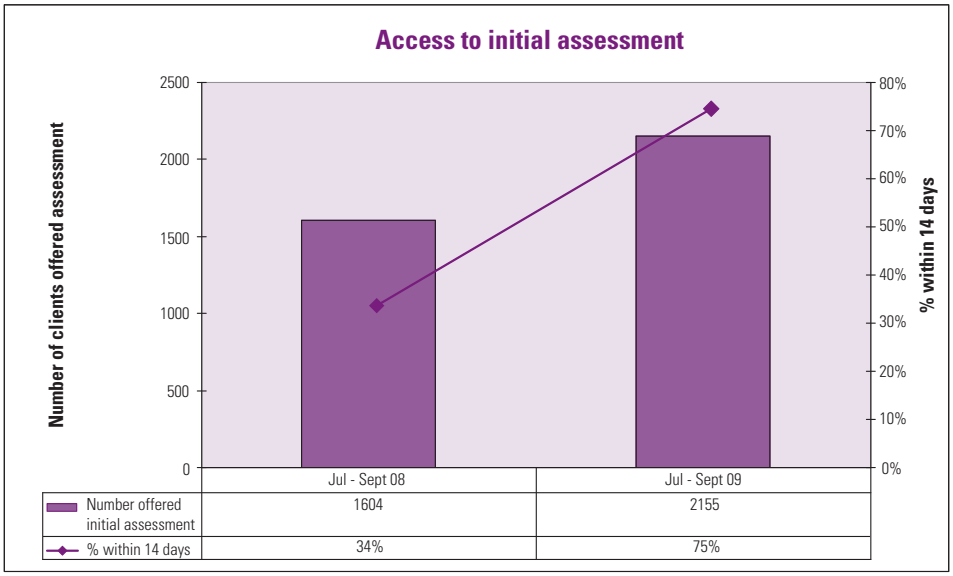
Lanarkshire ADP has recently published a document outlining plans to develop a recovery-based approach to services. This recovery strategy sets out Lanarkshire's vision for a recovery orientated system of care and is available at http://www.lanadat.org.uk/ladat/440.202.220.html

Lanarkshire also have a clinical governance workplan, which incorporates regular casenote audits designed to improve the quality of treatment. Care plans are regularly reviewed, with service users playing an active role in their treatment and care.

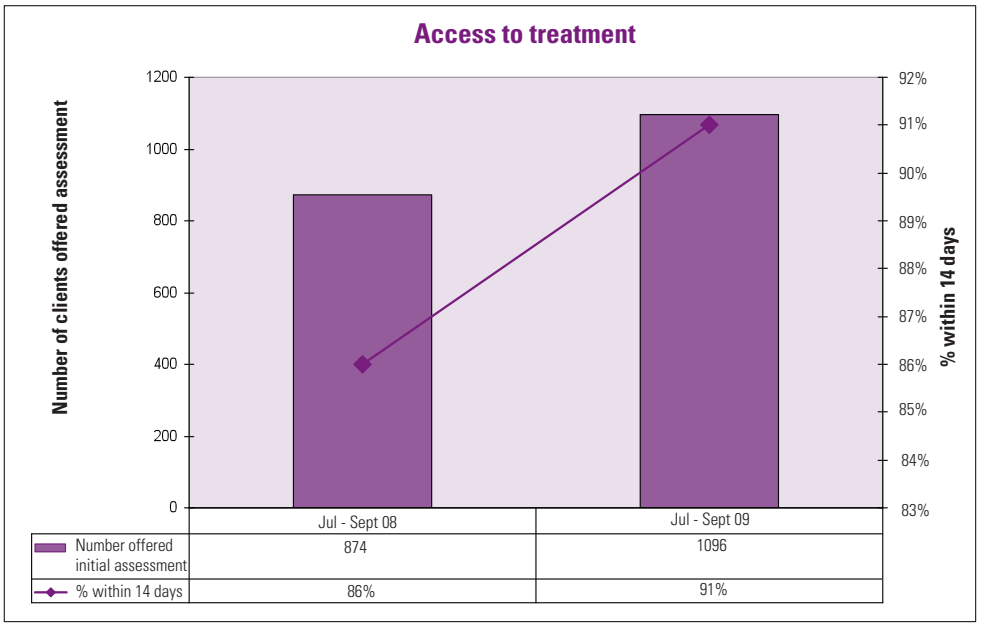
A lot of work has been done to build relationships with primary care. The service has a well developed specialist GP prescribing service, based around full-time, part-time, and sessional doctors. This is complemented by a number of community pharmacist supplementary prescribers. These have proven to be an excellent resource as they know the patients very well, given daily contact at pharmacies. Both the specialist GPs and the pharmacist prescribers are integrated into addiction services, linked via the GPASS system which facilitates both appointment scheduling and prescribing.

What improvements have been seen…

Percentage of people offered assessment within 14 days of referral



Percentage of people offered initial treatment within 14 days of assessment



TOP TIPS

- Work with the ADP and get to know the people in it
- Understand the needs of the service users, and work to remove roadblocks to effective, efficient treatment and care
- Recognise that recovery often begins outwith formal services
- Support community recovery champions
- Make use of non-statutory services
- Psychosocial services are important in moving clients along the road to recovery
- Clients require a holistic package, encompassing medical, psychological, social, welfare, vocational, etc., support

USEFUL DOCUMENTS

USEFUL DOCUMENTS

SECTION 5:
Useful documents

The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem 2008:
http://www.scotland.gov.uk/Publications/2008/05/22161610/0

Changing Scotland's Relationship with Alcohol: A Framework for Action 2009:
http://www.scotland.gov.uk/Publications/2009/03/04144703/0

Scotland Performs Website:
http://www.scotland.gov.uk/About/scotPerforms

HEAT A11 – Guidance on Referral Pathways:
http://www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/deliverystrategy/HEAT/referral-pathways

NHSScotland Healthcare Quality Strategy
http://www.scotland.gov.uk/Publications/2010/05/1010230710

The Scottish Mental Health Collaborative:
http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Delivery-Improvement/1835/74

NHS – High Impact Changes:
www.ogc.gov.uk/documents/Health_High_Impact_Changes.pdf

Essential Care SACDM 2008:
http://www.scotland.gov.uk/Publications/2008/03/20144059/0

Integrated Care for Drug or Alcohol Users: Principles and Practice Update 2007:
http://www.scotland.gov.uk/Publications/2008/05/27154207/0

National Quality Standards for Substance Misuse Services 2008:
http://www.scotland.gov.uk/Publications/2006/09/25092710/0

ISD Waiting Times Reports:
http://www.drugmisuse.isdscotland.org/wtpilot/reports.htm

Drug Misuse Statistics Scotland 2009:
http://www.isdscotland.org/isd/6164.html

Local Alcohol Profiles:
http://www.alcoholinformation.isdscotland.org/alcohol_misuse/statisticssection.jsp

SECTION 6:
Acknowledgements

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