Alcohol and Drug Recovery Services
Crisis Outreach Service

(Glasgow City HSCP)

SERVICE SPECIFICATION

(Updated October 2021)

Review date December 2021

Contents

Appendices

1. Introduction

1.1 Across the NHS Greater Glasgow and Clyde Health Board (NHSGGC) area Alcohol and Drug Recovery Services (ADRS) are identifiable within the boundary of the Local Authority or Health & Social Care Partnership (HSCP). Drug related deaths (DRD's) have consistently increased year on year across the NHSGGC board area with 394 DRD's in 2018 and 404 DRD's in 2019 a 2.5% increase. Between 24th February 2019 and 23rd February 2020 the Scottish Ambulance Service (SAS) recorded the administration of 1,194 doses of Naloxone. This averages out at approximately 22.96 doses of Naloxone administered weekly across the NHSGGC board area by the SAS alone. This does not take into account figures from additional A&E attendances, Police Scotland, Community Pharmacies and other areas of Naloxone availability. Out-with SAS figures it is estimated the number of Non-Fatal Overdose across the board area is significantly higher, increasing the risk of Fatal Overdose for individuals using drugs of abuse.

1.2 New monies were made available via the Scottish Government's Drug Death Task Force (DDTF) to tackle the continued rise in Drug Related Deaths (DRD's) and Non-fatal Overdose (NFOD). A proposal was submitted to develop a team to serve Glasgow City HSCP, East Dunbartonshire HSCP, East Renfrewshire HSCP, Glasgow Royal Infirmary (GRI) and Queen Elizabeth University Hospital (QEUH).

1.3 Service users attending Accident & Emergency (A&E) or admitted to the GRI / QEUH with a suspected NFOD or addiction crisis who live out-with Glasgow City will not be directly followed up by this service. Agreed pathways of communication / notification with all HSCP areas within GG&C Board Area ADRS will be put in place to ensure local services are informed of the service user's attendance with a NFOD or addiction crisis at either the GRI or QEUH.

1.4 The team will comprise Team Co-ordinator, Senior Addiction Nurses, Addiction Nurses, Peer Support Workers, Qualified Social Worker and Social Care Addiction Workers. Administrative support will be drawn from existing resources. The service will initially be based in Eriskay House, Stobhill Hospital and link with the Mental Health Assessment Unit (MHAU) in Stobhill and Leverndale Hospitals. The service will also accept referrals from Scottish Ambulance Service, A&E departments and Police Scotland. The service will operate over a 7 day period, including out of hours work.

1.5 The service specification provides a framework of principles which will be embedded within the team ethos. The principles require local service support for the development of Standard Operating Procedures (SOP) and Information Sharing Agreements (ISA) to be implemented.

2. Service Ethos

2.1 The ethos of the service is to work alongside all our partners with the ultimate aspiration to reduce the number of DRD's within the target areas through early intervention with service users known and unknown to locality services, engaging them in treatment with wraparound support networks.

2.2 The service will provide a high quality, continually improving, efficient and evidence based service which will work with vulnerable people at the point of drug related crisis.

2.3 The service will provide a range of approaches which will include harm reduction, assertive outreach and engagement with local services. There will be a strengths based focus with harm reduction at the heart of care and treatment.

2.4 The service will have the individual patient (and their carer / family, where agreed) as key partners in service planning and delivery.

2.5 The service will work closely with partners including MHAU, ADRS CAT, A&E, SAS, Police Scotland, the Third Sector, service users and their families / carers.

3. Objectives

3.1 The service will ensure all service users are seen and assessed by an experienced Nurse or Social Care Worker.

3.2 The main functions of the service are the engagement, assessment, support and management of people with problematic substance use who have recently experienced a non-fatal overdose or addiction related crisis intervention. The assessment will include evaluation of substance use, physical and mental health, to assist in identifying requirements for treatment through assessment and onward referral or engagement with relevant services if necessary.

3.3 Develop an evidence base to demonstrate need for similar or ongoing service.

3.4 Provide evidence of positive outcomes for people engaged by the service

3.5 Developing pathways to improve collaborative working across services

3.6 Monitoring governance processes through continual review of the service, specification, targets and outcomes achieved.

3.7 There is potential scope to consider future expansion to include commencement of ORT on same day for those at high risk.

4. Target Population

4.1 Service provision is targeted at people:

- Age 16+.
- Recent non-fatal overdose
- Problematic substance use as indicated in non-fatal overdose / fatal overdose
- Risk of further overdose
- History of difficulty engaging with services

5. Services Provided

5.1 The core characteristics of service are;

- Service will be delivered on a 7 days per week including out of hours input.
- Access to a multi-disciplinary team with experience in mental health, physical health and addictions.
- Provision of a period of assessment, engagement and brief interventions for people with highly complex needs to support their recovery journey.
- Promoting a harm reduction approach and offering harm reduction interventions, such as Naloxone, Dry Blood Spot (DBS) Testing, Needle Replacement, Foil and Condom provision, safer injecting advice among others.
- Liaison and interface with MHAU, ADRS CAT, A&E, Scottish Ambulance Service, Police Scotland and Third Sector, among others
- Provide a support network for families / carer's through direct involvement with care planning in agreement with service users.
- Promoting recovery and preventing relapse through the provision of a flexible range of clinical and psychosocial interventions.

5.2 The Clinical remit/Core functions of service will be:

- To fully assess the service user in terms of their problematic opiate use and engagement / re-establishment with community based treatment services.

- Assessment of mental health, including identification of co-morbid psychiatric

conditions and capacity for consent to treatment.

- Identification of any physical health needs and referral / liaison with relevant service
- Assessment of psychosocial factors, particularly those which may be impacting / maintaining problematic opiate use OR which may maintain or compromise treatment / recovery.
- Immediate assessment of risk utilising the CRAFT risk assessment tool, with review set at agreed intervals
- To deliver a range of effective evidence based psychosocial interventions within a therapeutic stepped care approach.
- Identifying high risk behavior and care planning appropriate interventions to minimise harm.
- Assess longer term clinical / treatment needs of individuals in conjunction with the community / primary care services.
- Formulate an appropriate discharge care plan.

6. Referral Pathways

6.1 Referrals to service are made directly from:

- Mental Health Assessment Unit
- Accident and Emergency
- Scottish Ambulance Service
- Police Scotland
- Acute Addiction Liaison

6.2 Referrals can be made directly to service through:

- **Ggc.Prog@ggc.scot.nhs.uk**.
- EMIS Tasking
- Direct contact with local A&E
- Direct notification from Police Scotland, MHAU, SAS and Acute Addiction Liaison

6.3 The Team Coordinator, Senior Addiction Nurse / Social Worker will review and allocate referrals on a daily basis for same day follow up and outreach by the service.

6.4 Pathways and Standing Operating Procedure's will be developed for referrals.

6.5 All referrals, assessments and interventions will be recorded on EMIS.

6.6 All referrals will be open on Carefirst with direction to contact service directly for further

information.

7. Assessment Process

7.1 Initial assessment should take place same day or within 24 hours of referral being received.

7.2 All assessments will include a CRAFT risk assessment

7.3 Involvement of family / carer's in the assessment process is key to providing background and current information by maintaining a support network for high risk vulnerable service users.

7.4 Assessment will provide information on current substance use, social circumstances, level of risk, recent non-fatal overdose and level of engagement with local treatment services.

7.5 Liaison and information gathering from other agencies will also be key.

7.6 In collaboration with the service user a joint care plan will be agreed through full assessment taking into consideration current need, goals and aspirations to achieve sustainable recovery.

8. Discharge Planning

8.1 The majority of service users should be discharged from the team within two to four weeks from engagement and assessment. Length of time in service will be part of agreed plan of care based on collaboration with service user and risk assessment

8. 2 DNA/Default from service will result in multi professional risk assessment to agree appropriate actions and consider referral on to other teams/services as required. Assertive outreach is a key component of the service with all avenues of engagement exhausted prior to any discussion on discharge.

9. Monitoring/Evaluation

9.1 Performance Monitoring:

- Referrals
- Successful engagement
- Assessments
- Duration of input with service
- Harm reduction / minimization interventions – Naloxone, foils, IEP, etc.
- New start OST
- Re-engagement with treatment

9.2 Outcome measures:

- Reduction in non-fatal overdose
- Increased Naloxone provision
- Increased OST provision

9.3 Service user, relative and carer's views will be a core element of care planning through continued development of the service.

10. Governance

10.1 The Service will be hosted within Alcohol and Drugs Recovery Service and will be managed through Tier 4 and City Centre Services.

10.2 All recording of referrals, assessment and interventions will be on EMIS Mental Health. All referrals will be opened on Carefirst.

10.3 The service is partially funded via new monies from the DDTF, with top up funding coming via new allocations of money, reporting mechanisms will be through the ADP Drug Harms Sub Group.

10.4 All incidents will be reported through existing ADRS incident reporting mechanism – Datix.

10.5 Significant Adverse Events (SAE's) will be managed through existing ADRS processes.

10.6 The process for completing RABN following a Severity 4/5 Incident, such as a death is detailed below:

For deaths where the Service user has a care manager in a locality, the completion of Datix and RABN will be undertaken within the locality, and COS will be required to input and share learning with locality.

For those where there is no open referral within a locality, COS will lead with Datix and RABN. If the individual had been open to locality within last 12 months, then the locality Operational Manager will be contacted to consider what input is required.

All deaths involving COS within a four week period will be notified to Head of Service and Associate Medical Director.

Appendix A – Scottish Ambulance Service Non-Fatal Overdose List - Information Sharing across NHSGGC HSCP's

Appendix B – Reducing Risk and Maintaining in Treatment Individuals Released from Custody