West Dunbartonshire COUNCIL

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Chief Officer: Keith Redpath

'How we deliver CAMHS Quality Assurance in our team'

Dr. Kirsten Atherton
Clinical Psychologist

West Dunbartonshire CAMHS
May 2016

Your CAMHS Team:

- Who are we?
- Who do we see?
- What do we have available?

Who are we?

- **Child & Adolescent Psychiatrists** (1.5 wte):

  Dr Kate Towlson, Consultant
  Dr Jane Duthie, Associate Specialist

- **Clinical Psychologists** (2.3 wte):

  Dr Karen Ferguson, Consultant
  Dr Lindsey McCaughern
  Dr Kirsten Atherton

- **CAMHS Nurses** (3.8 wte):

  Sharon Campbell, Clinical Nurse Specialist
  Julie MacAllister
  Helen Barclay
  Varri Engleby

- **Admin staff:**

  Jackie Donnelly
  Claire Donnelly

Who do we see?


Very specialist services, incl. children away from home
Specialist Multi-disciplinary Teams
Individual Professionals Trained in Children and Young People's Mental Health e.g. Psychiatrists, Psychologists, Therapists etc
GPs, Paediatricians, Teachers, School Nurses, Youth Justice Workers, Health Visitors, Social Workers, Voluntary Agencies etc
Primary Mental Health Workers etc
Tier 4
Tier 3
Tier 2
Tier 1

NHS GGC CAMHS Referral Criteria & Information for West Dunbartonshire

- Up to 18th birthday
- **Condition 1 (basic threshold)**
- A child/young person has or is suspected to have a mental disorder or other condition that results in persistent symptoms of psychological distress.
- **Condition 2 (complexity and severity threshold)**
- There is also the existence of **at least one** of the following:
- An associated serious and persistent impairment of their day to day social functioning.
- An associated risk that the child/young person may cause serious harm to themselves or others.

What do we have available?

- Mental health assessment and formulation
- Consultation and liaison
- Treatments:
  - Talking therapies
  - Medication
  - Systemic work

Quality Assessment

- Discussion of referral criteria and appropriateness
- Multiagency assessment pathway
- CHOICE Appointments
- Psychometric assessments –clinical and service utility
- Experience of service questionnaire
- Idiosyncratic outcomes
- Audit

Risk management

- Multidisciplinary working within CAMHS
- Systemic working
- Ongoing clinical risk assessment
- FACE CARAS
- STORM

Service User feedback

- CORC: SDQ and ESQ
- Thank you letters
- Verbal feedback
- Systemic feedback

Continuous Improvement

- CPD
- Peer supervision: Case discussion
- Journal club
- Multi-agency consultation
- Discussion of Service User feedback
- Development of care pathways

Staff Governance

- Personal Development Plan
- eKSF
- Mandatory training
- Clinical Supervision
- Peer supervision
- Revalidation of Professions

Thank you for listening

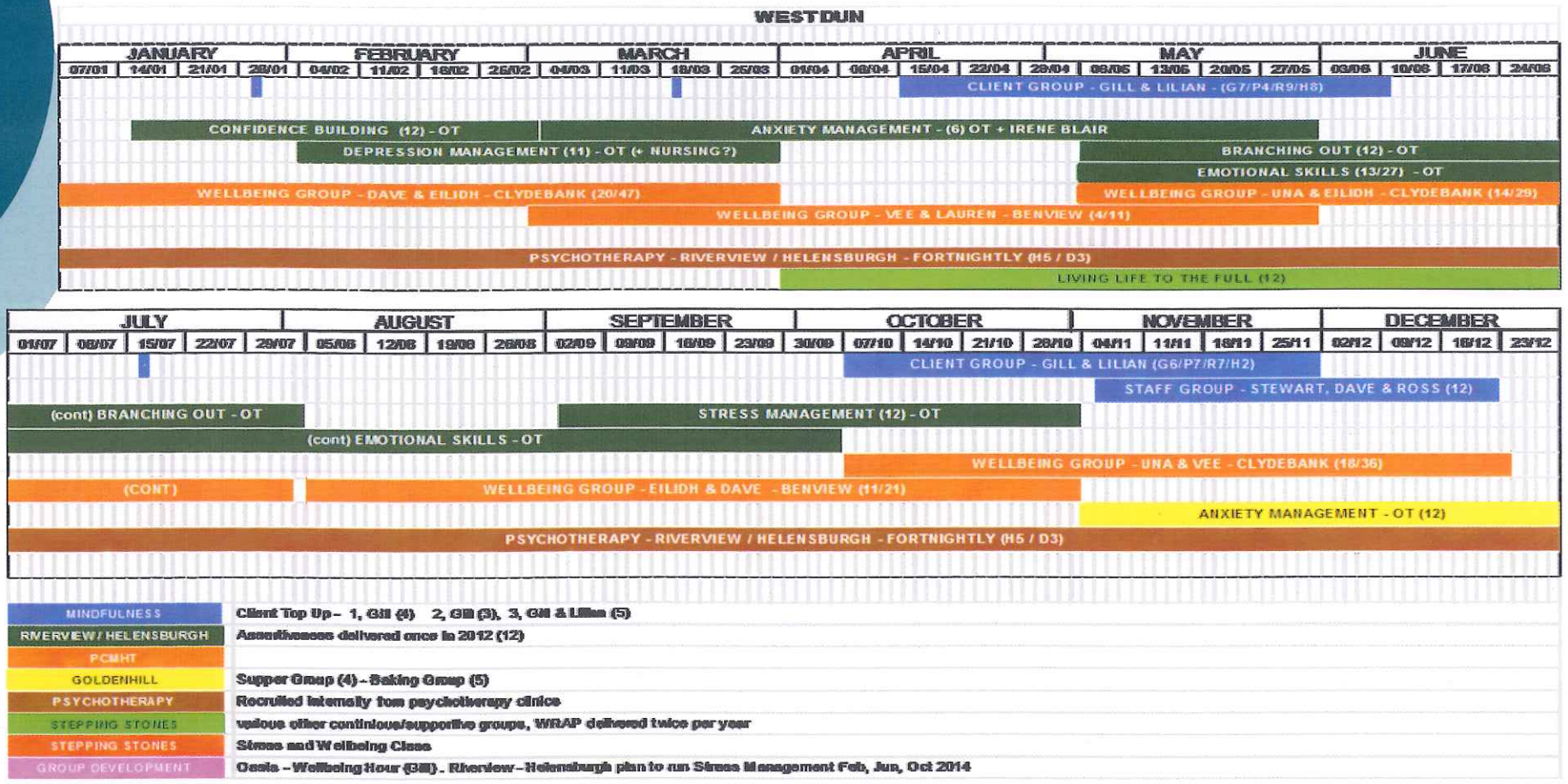
Improving access to Psychological Therapies

West Dunbartonshire
Integrated Group Programme

Background

- Virtual Psychological Network since 2010.
- Local scoping exercise 2014.
- SLWG delegated to agree aims/ structure of IGP.
- Aims of IGP:
- increase access to evidence based psychological treatments
- extend range of interventions offered in group format
- ensure rolling group programme; minimise wait times/ promotes equity of access to groups across WD as a whole
- develop a sustainable pool of facilitators to support ongoing development of groups

Appendix 1: Original review of groups running across WD prior to the IGP



Developing a Quality Assured programme

- All teams canvassed re. needs of their patients
- Group agreed which therapies to prioritise.
- CBT in action/ Mindfulness/Emotional skills and STEPPS
- Programmes/timetables and supporting literature for each group.
- Review of staff skills and training programme.

Who are these groups aimed at?

- CBT in action: Patients with depression/ anxiety.
- Mindfulness: Patients primarily with recurrent depression but also other recurrent Mental Health Problems
- Emotional skills: Patients with emotional regulation difficulties
- STEPPS: patients with an existing diagnosis of Borderline Personality Disorder

Embedding Continuous Improvement

- Referrals into the IGP:
  211 across West Dunbartonshire
- Attendance rates:
  Average 73%
- Breakdown of referrals:
  50%+ from PCMHT
  40%+ from CMHT
  5% from OACMHT

Staff development: we now have over 30 staff trained in facilitating IGP across West Dun.

Reviewing our first year…

- Referral rates: more then trebled numbers of people accessing groups.
- Attendance rates: vary according to group.
- Where do our referrals come from: Most from PCMHT.
- Interesting questions for the future:
  -demographics.
  -?unmet needs.
  -use of opt in.
  -back-up facilitator
  -centralised admin essential.

Patient feedback

- " ..I'm not the only one who is struggling and suffering with depression and anxiety. It's good to know, and talk to people the same as me."
- "The group practice, together with the discussion element, had a profound and beneficial effect upon my health. This really surprised me as I though I was not a particularly group orientated person"
- "Have found it hugely beneficial, and it's difficult to put into words how different (better) I feel compared to how I was at the start of the year. Was not comfortable with group settings to begin with but have even found myself enjoying taking part in discussions – change indeed!"

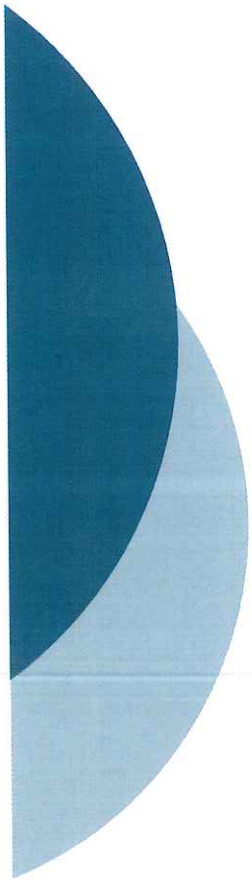
Supporting staff development

- **Positives**:" I think it helps relationships with staff between the two services"
- "…joint working between service staff helps overcome barriers"
- " Greater access across the area and a more equal spread of staff facilitating groups and giving more experience to CMHT staff that haven't done groups in the past"

- **Learning points**:" format needs to be adapted to meet CMHT client needs"
- Sustainability in relation to staff changes/sickness absence.

Next steps…

- Explore opportunities to increase uptake amongst males and Older Adults.
- Consistent use of Corenet, which will facilitate robust data review and demonstrate outcomes.
- Feedback from those who don't attend/drop-out.
- Review courses and materials.



Thanks for listening.

Any questions?

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An integrated approach by Health & Social Care is integral in the delivery of Palliative & End of Life Care to patients living with life limiting illness which can be cancer or non cancer

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Palliative & End of Life Care

In 2015 the WHO defined…

Palliative care is an approach that improves the quality of life of patients and

their families who are facing problems associated with life-limiting illness.

It prevents and relieves suffering through:

- early identification
- correct assessment and
- treatment of pain and other problems, whether
- physical, psychosocial or spiritual.

Palliative Care is an integrated team approach to support patients and family to help patients live as full and as dignified a life, as possible until death.

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How do we do that ?

- The Palliative Team have available an education programme on Palliative Care for all our social work and health staff.
- We therefore have an enhanced contribution of a wider range of health and social care staff for the provision of aspects of Palliative care.
- Palliative Nurses – have established Palliative Link Nurses in all Care Homes.
- Staff who have participated in our Palliative education programme feel very well informed & supported to provide Palliative Care & importantly know who & where to go for further support and advice both for themselves and for the patients & families.

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Palliative Care & End of Life Care

It is important that patients receive care based on their individual needs

We aim to have the patients' and family carers' needs met .... by having timely and significant conversations with them to plan for their Palliative and End of Life Care.

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Anticipatory Care Planning

Timely & significant conversations are recorded on the patients within CNIS. Anticipatory care planning is a process that should be developed over time through evolving conversation, and shared decision making

It should include information about the patient's:

1. understanding about their illness and prognosis.
2. their views about the degree of treatments and interventions
3. their wishes for End of Life care, including preferred place of care for end of life.
4. As the condition becomes more complex it may be helpful to discuss legal and practical issues.
5. The plan should be reviewed and updated as the condition or the personal circumstances change and different things take priority.
6. Key information should recorded on Clinical Portal (e-kis) by DN/ GP so that OOH staff have this information.

The District Nurses take a lead role in supporting patients and their families through Palliative to End of Life, working very closely with social carers either at home or in a Care Home setting.
The aim is to manage all aspects of the patient's care, ensuring needs are met sensitively, efficiently and effectively – when the patient is dying DN's

Regular visits to patient as needed (24 hr service)

1. Regular review of nutrition and hydration needs.
2. Anticipatory prescribing including for symptom management for Pain/ Nausea &/or Vomiting, and Terminal Agitation.
3. Use of continuous subcutaneous infusion, McKinley driver if patient is struggling to swallow, or has uncontrolled symptoms not helped by oral or subcutaneous (SC) breakthrough doses.
4. Support from GP and Hospice Consultant for symptom management.
5. Verification of Death.

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Outcomes

- Patients have the opportunity to discuss and plan for the future decline in their health, preferably before a crisis occurs
- Patients receive health and social care that optimises their wellbeing.
- Staff empowered to exercise their skills and provide high quality person-centred care.

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Risk Management

- Health and Safety
- Risk Register
- Datix reporting
- Shared Learning from integrated teams

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Staff Governance

- PDPs developing emotional intelligence re Palliative / End of Life Care
- Supervision
- Regular meetings are held with the palliative care staff representative from each home in order to share best practice and discuss issues relating to palliative care.
- Reflective sessions to promote shared learning and peer support.
- Maintenance of log of registration / re-validation for relevant professions
- Post bereavement support for staff – complex and / or long term cases

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Quality Assessment

- Regular Case File Audits & feedback via supervision
- Patents on Palliative Care Register all have a key information from ACP on the Clinical Portal on the electronic key information system (e-kis)
- Volume of front-line staff participation in Palliative Care Education Programme to develop confidence in role and processes
- Number of patients who have been able to remain at home or in a homely setting at end of life
- Post bereavement visits tailored to individual needs

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Continuous Improvement

- Audit of Palliative Education Programme…impact on practice
- Ongoing discussion with staff to encourage them to identify topics for further education.
- Case File Audits and highlighting common themes for development.
- Development of agile working & better access to shared systems, particularly in interface with acute settings (i.e. clinical portal).
- Mechanism for regular multi-disciplinary case analysis
- Care Inspectorate

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Service User Feedback

- 'How are we doing?' questionnaires sent to patients/carers.
- Multidisciplinary sessions to discuss service user feedback to develop practice and support staff confidence
- Meetings with families and carers to provide opportunity for reflection
- Letters of appreciation from families