NHS Lanarkshire Response to Request from Scottish Government

MH & LD Services Baseline - 26th June 2020

1. Overview of All Services

Mental Health and Learning Disabilities in NHS Lanarkshire began to defer cases where the need was not felt to be high in March 2020. Since then, clinical focus has been mainly on the needs of those with higher and more immediate needs, and those who are at risk of developing a greater level of need. During this process people who have had their appointment deferred have been contacted initially by letter and then by phone, to enquire into their current wellbeing and to ensure that they can access the service. As a result of this services have organically redistributed staff to meet the needs of the local population and the needs which are arising, with additional resources begin used to keep in touch with those involved with the service and waiting to be seen. There are additional dependencies however that limit further movement, many of which are common to other services, namely requirements for social distancing; safe home working practices; access to general practice (especially prescribing arrangements); arrangements for obtaining and processing blood tests, radiology tests and ECGs; social work services; and third sector agencies.

Current Position

A more formal step up of the service has now been agreed and plans are being made for imminent resumption of clinical contact for those who previously were waiting. This will be mostly using phone and video consultation. A process was required in order to ensure that the limited amount of IT equipment, staff and buildings were available and is a process that all services are being asked to undertake to ensure that resources are best used. Topics of discussion during the process included financial sustainability of new and proposed ways of working, equality of access especially for those in lower socio-economic groups, group work remotely, staff training and competence, governance, and trade union consultation processes. This process began with a Clinical Reference Group where each service in the Health and Social Care Partnership was risk rated, this was then escalated to both Health and Social Care Partnerships recovery groups. The proposal was then discussed at the NHS Lanarkshire Recovery group, where it was supported. Throughout this process mental health Services were prioritised and were amongst the first to be given approval. The next step in the recovery is increasing the work performed remotely while assessing internal processes including clinic timings on trakcare, administrative support arrangements.

This approval signals the start of our return to normal work, but it is important to note that we are not going back to the way things were. We must take a considered approach as we still face a number of challenges including clinic space, home working arrangement, and childcare. The future is still uncertain and we need to make robust changes, and be prepared to be nimble as a service and potentially step up and down depending on the national situation.

In particular, we cannot yet use shared clinic rooms or waiting spaces. Locality managers are now looking at this, working to prioritise services and modify spaces. Thus in the mean time we will be using phone and Near me for most cases, with a small number being seen face to face (usually in

their homes) in situations where we feel it brings clinical value and the benefits outweigh the risks. We will constantly review the impact of stepping up services in line with NHS Lanarkshire's Redesign and Recovery process .

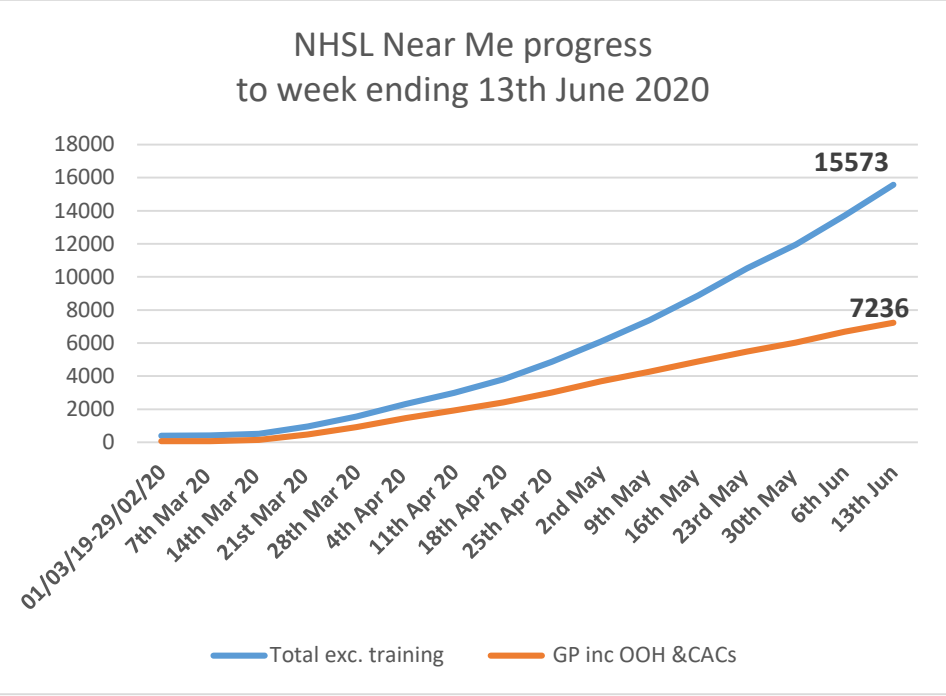
We are asking our clinical teams to:-

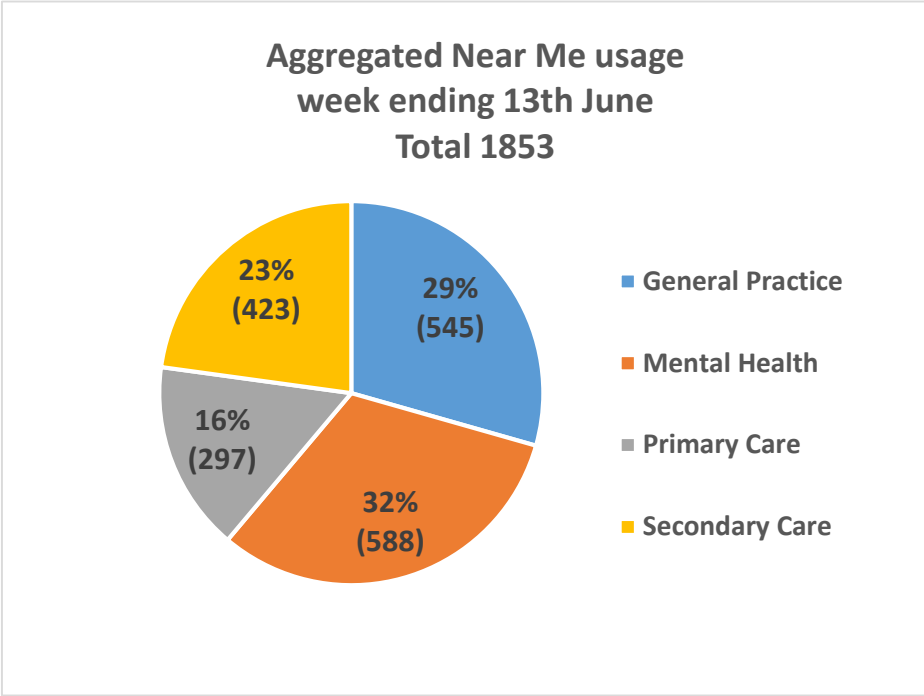
- Continue to see people who have urgent needs, including those with longer term high risk and those who are at risk of deterioration.
- Work with your team to start assessing people who have been referred and who are waiting (including those new patients who were deferred).
- Identify patients on the caseload who have a preference for Telephone or near me contacts and those who will require Face to face contact. This will allow us to plan the logistics around stepping up services to the next stage.

N.B. The Management Team and clinical staff are working with information services to build new reporting structures. We have where possible included relevant data with the following caveats:-

- Referrals are recorded for all members of the MDT within the CMHT
- Outpatient contacts are for medical staffing only
- Nursing staff appointments are not recorded on an electronic system so are not so easily accessible.
- Phone and Near Me contacts have been recorded in a variable way, the above contacts are likely to under represent.
- Near Me being a relatively new system and is not always recorded appropriately and therefore data is not always reliable.

NHS Lanarkshire Weekly Near Me Report 07/06/20 - 13/06/20





Notes:

- 12% increase in consults this week
- GPs incl. 30 OOH & 0 CAC
- Primary care inc. integrated teams, HVs and Family nurses.

2. CAMHS	
Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	**What is level of activity compared to pre-covid? How many new patients seen compared with last April/ May?** Referral number dropped to about 25% of normal during April 2020, but have risen in May 2020. More work is resulting from known cases who are needing additional support. **Referrals received:** April 2019 May 2019 April 2020 May 2020 395 452 104 152 **New case assessments:** April 2019 May 2019 April 2020 May 2020 248 221 57 149 **Return Appointments:** April 2019 May 2019 April 2020 May 2020 2006 2452 1380 1250
Have you prioritised access to services that have continued and how?	All routine work including assessments, individual and group intervention programmes and routine reviews have been deferred. Detail on prioritisation - NHSL CAMHS initiated the same RAG rating system as was used across all mental health services. Clinicians were required to compile active case lists with each case given a RAG rating (clinical decision). Advice was given to clinicians to help inform RAG rating with clinical urgency including physical risk to health, risk of harm or death through risk taking behaviours, requirement for medication or medical review of medication, Mental Health Act work, physical risk associated with eating disorder, child protection. Clinicians have continued to review these lists and RAG rating of each case regularly and status has been amended according to clinical picture at the time. RAG rated case lists were stored in shared electronic areas and can be accessed by

	management. Red cases have continued to ongoing engagement with clinicians. Vast majority of reviews have been carried out by telephone and Near Me consultations. A small number of cases requiring physical monitoring have continued to be seen face to face with PPE/infection control measures as required. Frequency of review is determined by the clinician and is based on the clinical needs presented at any time. Referrals have continued to be received in the normal manner as paper referrals. We accept urgent referrals via telephone but request that they are followed up with written referral. We have no system to receive electronic referrals. We changed our referral vetting system from daily vetting by locality team Co-ordinator to twice weekly vetting (MS Teams) carried out by a small team of Clinical Manager and 2 Team Co-ordinators (organisationally our 7 locality teams and various functional teams have been re-organised into 4 multi-functional Hubs, one Clinical Manager with oversight of 2 Hubs each). Each case is prioritised on the basis of the clinical information available against the service operational policy referral criteria which is in line with the Specialist CAMHS Service Specification produced by Scottish Government in 2020. We are undertaking new assessments by telephone and Near me (now including waiting list cases), referrals not meeting the service threshold where no clinical intervention is indicated are offered advice, access to resources and signposting as appropriate and cases discharged. Urgent cases requiring intervention are offered follow up intervention from an appropriate clinician, again vast majority of cases are receiving telephone or NEAR Me appointment with a very small number of appointments seen face to face where clinically required. Routine cases are being placed on the intervention wait list and we will offer intervention appointments when approval for remobilisation of services is received. At the start of the lockdown period all open Green RAG rated cases received a letter from their clinician/team to tell them clinical activity was on hold. They were also advised that should they have any concerns or changes to a child or young person's mental health they could contact their clinical team at any time to discuss and clinical intervention could resume if deemed clinically urgent. Similarly, all cases on the wait list received a similar letter. We also established a central telephone advice line available for the public and professionals to

	call for advice or help, operating Monday to Friday, 9am to 5pm. We propose to use existing clinical capacity to start telephone and video assessments of cases on **waiting list** and as a return to service as normal. We will provide advice, guidance and signposting of those cases that do not meet the clinical access criteria for the service and these cases will be discharged from the wait list. We will scope delivering the CAMHS service over 6 days to allow for flexible working and ways of spreading out footfall to reduce risk. Those cases that meet the clinical threshold criteria will be assessed and urgent cases will be allocated for intervention using telecoms/video in first line and face to face where unavoidable. Cases able to wait for intervention will be placed on intervention wait list. **Number of cases waiting:** April 2019 May 2019 April 2020 May 2020 1098 1097 1089 946
Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?	All clinically urgent assessments and interventions have been delivered using telephone or Near me videoing conference. Unavoidable face to face clinical contacts have been delivered applying PPE guidance where appropriate. We have stopped all group therapy interventions including parenting interventions and group therapy elements of our Dialectic Behaviour Therapy programme for young people with severe emotional dysregulation, self harming and suicidal behaviours as the virtual platforms available to us do not currently support multi person use to the scale required whilst offering secure connection. We have reduced our accommodation bases and organisational structures into 4 Hubs to provide a sustainable clinical and operational workforce in the event of high sickness rates in clinical staff. Thankfully this did not impact during initial wave of infection.
3. <u>Psychological Therapies</u>	

Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?

All groups were suspended from 23rd March, and this has had a significant impact (i.e. 195 new patients attended group psychotherapies in Mar/Apr 2019, but only 41 in Mar/Apr 2020).

9269 clinic attendances in Mar/Apr 2020, versus 12892 in the corresponding months last year - a drop of 28%.

Whilst the number of patients commencing treatment in Mar 2019 and Mar 2020 were almost identical, in April this year only 209 commenced - and the majority of these were via cCBT.

We have 3260 patients waiting to be seen across CAMHS and Adult Psychology.

Referrals dropped by 59.76% between March and April 2020.

All Psychological Therapies (Adult and CAMHS)

	Mar-19	Apr-19	Mar-20	Apr-20
All Referrals Received	1335	1096	1111	447
Clinic Attendances	6417	6475	5058	4211
Patients starting treatment	504	844	509	209
BTB/Silver Cloud	80	84	166	116
% BTB/Silver Cloud	15.87%	9.95%	32.61%	55.50%
Stress Control	0	195	41	0

<table>
<tr><td></td><td>
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<tr><td>Current Waiting List as at 31/05/2020</td><td>3260</td></tr>
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Referrals received Jan-Apr 2020 and % decrease May to Apr:

<table>
<tr><td></td><td>Jan-20</td><td>Feb-20</td><td>Mar-20</td><td>Apr-20</td></tr>
<tr><td>All Referrals Received</td><td>1407</td><td>1383</td><td>1111</td><td>447</td></tr>
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</td></tr>
<tr><td>Have you prioritised access to services that have continued and how?</td><td>At the point where a decision was taken to defer patients, no service was completely stopped within Psychological Services. Clinicians were asked to assess those patients on their caseload in order to identify level of need/vulnerability/risk. Patients were contacted by phone, Near Me, letter.

Currently, only patients who were deemed to meet the greatest level of need/vulnerability/risk are being seen (by phone, Near Me, and occasionally, f2F where appropriate).

Patients who were deferred in March 2020 are being contacted, typically by letter although some are being telephoned, to establish their current need/priority. Approval is awaited for a move to phase 2, where these deferred/new patients will be picked up for remote consultation and/or treatment.

Longest wait for psychological services in adult services is around 52 weeks. This is due to a small number of outliers. The majority of speciality services have waiting times around 18 weeks. The majority of psychological therapy teams have waiting times under 25 weeks.</td></tr>
<tr><td>Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?</td><td>Standardised materials for remote working, digital forms etc., are being identified/collated; standard letters to service users are being prepared; methods for appropriate recording of clinical sessions on Trakcare have been identified More extensive use will be made of all adjuncts to therapy, including additional signposting resources, use of cCBT, SilverCloud, and ieCBT.

Group-based interventions, central to many department’s routine service delivery, were deferred. Neuropsychological assessment largely ceased, given practicality and reliability of VC-based neuropsychological testing.</td></tr>
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	Psychological Services had already been trialling the use of Near Me in the Clydesdale locality. The current pandemic has meant that all teams are now using this extensively in contact with service users. Whilst some service users have declined Near Me (and phone) contact, there does appear to be a general acceptance of using VC psychotherapeutically. A number of service users advised that they actually preferred this mode of service delivery, and where this is not having a detrimental impact on the reason for input (e.g. with individuals with social anxiety/ agoraphobia), this would be continued.
Planned future service delivery.	Approval has been given for Psychological Services to move to Phase 2 of our remobilisation plan. It is anticipated that Phase 2 will continue for the next several months. Phase 2 includes: **1.** Continued prioritisation of urgent referrals and patients with significant need/vulnerability across all Psychological Services teams and specialities. • Contact will routinely be via Near me/phone in the majority of cases. • Face to Face consultations will take place on a clinical needs basis, where remote consultation is not feasible. **2.** Those patients categorised as amber and green, including new referrals and patients who already commenced therapies, will be contacted by phone/letter. • Patients able to do Near me/phone will be scheduled for a consultation. • Patients who opt to be seen only face-to-face will be waitlisted until such time as clinic access is permitted. The ten adult Psychological Therapies Teams are locality/geographically based. Discussions are now underway around the impact of triaging those patients who opt for remote consultation centrally/HB-wide, whilst patients who want face-to-face appointments continue to be offered local consultation. Phase 3, and a move to increase face-to-face clinical appointments for routine patients is contingent upon the Lanarkshire-wide review of clinical capacity across the estate. Psychological Services will feed our anticipated needs into these plans. The model of future service delivery for Psychological Services will continue to include remote consultation with our patients using a range of telephone, video, and other innovative digital health systems, in addition to traditional face-to-face consultations. Similarly, we are actively exploring the delivery of group-based

	programmes using video-conferencing and streaming options, in addition to the eventual return of physical group meetings.
4. <u>Inpatient Units</u>	
Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity? **Have you prioritised access to services that have continued and how?** **Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?**	No Inpatient services have stopped or have been consolidated, all inpatient units continue to provide inpatient treatment. • Focus on reducing ward footfall • There has been a minimum reduction in Occupational Therapy activity • Restrictions on visiting • Early adoption of Near Me • Clear communication given PPE • There have been restrictions in periods of planned leave (passes) • All new admissions who are symptomatic are subject to testing and a 14 day isolation in a side room • Routes to communication have been adapted and enhanced to ensure a digital presence at multi professional meetings or family consultations which now can take place via Near Me or MS Teams. • New developments included the use of IPads to enable visual communication with relatives and friends with the deferment of Hospital Visiting. **<u>Inpatient Adult</u>** A decrease in both admissions and occupancy overall, although the marked initial decrease has begun to level out. **<u>Inpatient Older Adult</u>** Admissions to older adult functional units have been sustained and at manageable pre Covid levels. Routine swabbing of over 70s admissions is in place. **<u>Inpatient Dementia</u>** After a marked decrease in admissions at the beginning of Covid, this has subsequently reversed and admissions and occupancy are now higher than usual. This is occurring in part to carers becoming ill and unable to sustain

	carer responsibilities to their wife or husband etc. There has also been a decline in respite admissions via care homes due to Covid closure and therefore admissions to inpatients services have provided a default position. Routine swabbing of over 70s admissions is in place. **Inpatient IPCU** This 6 bedded unit is usually at capacity, as was the case prepandemic. During the last 12 weeks there has been a notable increase in acuity and psychiatric presentation.

Inpatient Admissions

	Feb 19	Mar 19	Apr 19	May 19		Feb 20	Mar 20	Apr 20	May 20

Beckford Lodge Iona Ward	1	2	2	
Cleland Parkside North Ward				1
Cleland Parkside South Ward				
Coathill Glencairn		1	1	
Cumbernauld NH Ground Floor Ward		1		
Hairmyres Ward 19	29	22	21	31
Hairmyres Ward 20	17	25	29	32
Hatton Lea Milnewood Ward 1				
Hatton Lea Mossend Ward 1			1	1
Hatton Lea Orbiston Ward 1				
Kirklands Kylepark Ward	1			2
Monklands Ward 24	6	3	7	8
Udston Brandon Ward	6	4	2	2
Udston Clyde Ward	4	7	6	7
Wishaw General IPCU	2	2	1	3
Wishaw General Ward 1	21	28	19	22
Wishaw General Ward 2	18	25	18	33
Wishaw General Ward 20				
Wishaw General Ward 3	4	11	5	6
Total	**109**	**131**	**112**	**148**

Beckford Lodge Iona Ward		3	1	1
Cleland Parkside North Ward				1
Cleland Parkside South Ward		1		
Coathill Glencairn			1	
Cumbernauld NH Ground Floor Ward				
Hairmyres Ward 19	31	22	13	25
Hairmyres Ward 20	23	11	11	21
Hatton Lea Milnewood Ward 1	1			
Hatton Lea Mossend Ward 1				
Hatton Lea Orbiston Ward 1	1			
Kirklands Kylepark Ward	1	1	3	1
Monklands Ward 24	6	3	8	10
Udston Brandon Ward	6	7	3	11
Udston Clyde Ward	8	2	4	6
Wishaw General IPCU	1	5	2	2
Wishaw General Ward 1	18	24	23	22
Wishaw General Ward 2	26	21	26	22
Wishaw General Ward 20				
Wishaw General Ward 3	5	6	6	9
Total	**127**	**106**	**101**	**131**

Inpatient Discharges

	Feb 19	Mar 19	APR 19	MAY 19

Feb 20	Mar 20	Apr 20	May 20

Beckford Lodge Gigha Ward			1	
Beckford Lodge Iona Ward		2		
Cleland Parkside North Ward				1
Cleland Parkside South Ward			1	1
Coathill Glencairn		1	1	
Cumbernauld NH Ground Floor Ward			1	
Cumbernauld NH Upper Floor Ward				
Hairmyres Ward 19	33	21	24	31
Hairmyres Ward 20	20	27	26	31
Hatton Lea Milnewood Ward 1				
Hatton Lea Mossend Ward 1				
Kirklands Kylepark Ward	1	1	1	
Monklands Ward 24	4	6	6	4
Udston Brandon Ward	4	3	2	7
Udston Clyde Ward	4	4	6	8
Wishaw General IPCU	2	2	2	2
Wishaw General Ward 1	16	29	19	17
Wishaw General Ward 2	23	21	14	34
Wishaw General Ward 3	13	9	9	11
Total	**120**	**126**	**113**	**147**

Beckford Lodge Gigha Ward				
Beckford Lodge Iona Ward	1	3	1	4
Cleland Parkside North Ward				
Cleland Parkside South Ward	1			
Coathill Glencairn				
Cumbernauld NH Ground Floor Ward	2			
Cumbernauld NH Upper Floor Ward		1		
Hairmyres Ward 19	31	37	14	21
Hairmyres Ward 20	26	20	11	17
Hatton Lea Milnewood Ward 1				
Hatton Lea Mossend Ward 1			2	
Kirklands Kylepark Ward	2	4		1
Monklands Ward 24	3	6	8	3
Udston Brandon Ward	10	7	1	8
Udston Clyde Ward	9	5	5	5
Wishaw General IPCU	2	3	4	
Wishaw General Ward 1	22	32	14	23
Wishaw General Ward 2	23	29	25	29
Wishaw General Ward 3	10	13	5	5
Total	**142**	**160**	**90**	**116**

5. Addictions / Substance Misuse Services

	Referrals/Demand and Activity

Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	The info being provided is a collective North/South Addiction Service provision position. It is inclusive of statutory service delivery (ART/CAReS/Acute and SPS Shotts). Limitations of data should be highlighted. It does not provide data on referral to other services which are delivered by third sector organisations but are supportive of a whole system approach to service delivery across Lanarkshire. Additionally, referrals to specialist services within Addictions are not included. These services include Addiction Psychiatry and Psychology. Colleagues within these services have still been accepting and triaging referrals to their services. Assessment and support by these specialities is being offered via telephone and/or electronic means. Referral numbers started to show a decrease in March and by April showed significant reduction from February position. By May referral numbers had started to pick up again. This is likely due to the return of the Substance Misuse Liaison Nursing (SMLN) Service who had been diverted to other duties in the initial stages of Covid Response. Data from second graph clearly substantiates that position. We were able to have SMLN Service brought back to post following Ministerial Letter directing the protection of Alcohol and Drug services. HMP Shotts had very few new referrals in the time period. This is likely due to reduced new admissions to Prison estate during the time period.
Have you prioritised access to services that have continued and how?	**<u>Referrals</u>** Referrals are still being taken from all services and include self-referrals. Referrals are received verbally, electronically and occasionally faxed. We continue to receive referrals from:- • Social Work Colleagues (Child and Family Teams, Community Justice, Community Care. • Health Colleagues (CMHT, Acute Psychiatric Liaison Services, Acute Substance Misuse Liaison Nurses Health Visitors, District Nurses and GP's- This is not exclusive to these services). • Third Sector Organisations including ADP commissioned services (Phoenix Futures, Barnardo's Recovery Development Team). All referrals are screened by the Team Lead on a daily basis (North) and Allocation Meeting (South). They are allocated for assessment to individual workers within the Team. Prioritisation is given to new referrals by:- • Review of referral information • Review of previous contacts with service • Review of SWIS

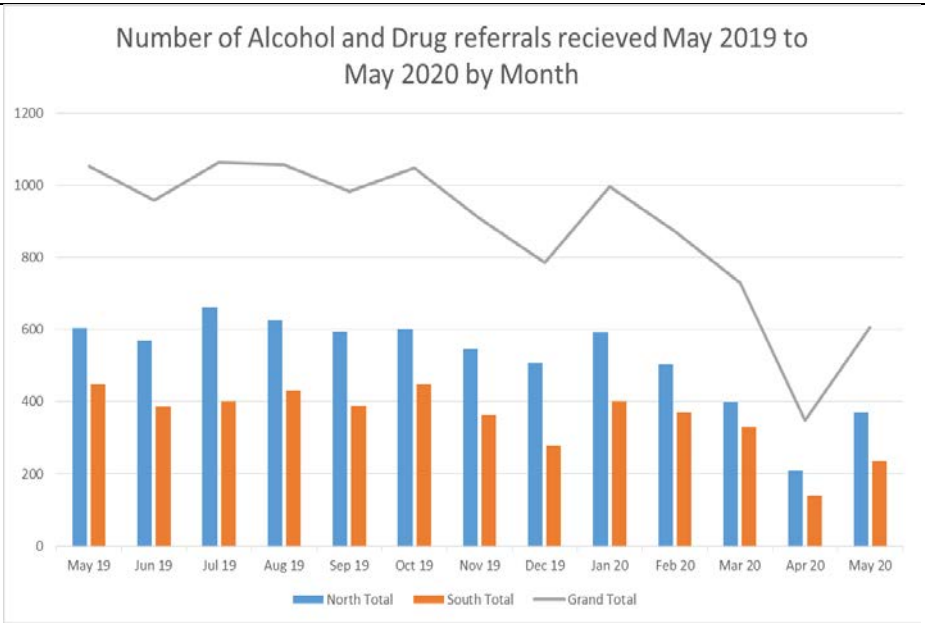
	• If required contact with the individual and /or referrer All are allocated immediately. No individuals have been placed on a waiting list to be allocated at a later date. Method of contact and assessment has changed. Telephone contact and assessment has been primary route of communication during this period. Efforts are being made to contact all individuals for whom a referral has been made. If they cannot be reached on contact number provided a letter is sent. If there is evidence of increased concern from referral info or from research of electronically held information details case is reviewed and decision made between Team Lead and worker whether visit is required before decision made to close case. Average wait for contact has been reduced from 9 days to 7 days with some areas managing to turn around urgent cases within 2 days. **<u>Current Caseload</u>** It is difficult to capture the comparison of caseload size from pre Covid until now as the national database measures new referrals and closed cases which does not account for significant numbers of individuals who are on a caseload for significant time. It would be easier to calculate service users affected by drug use as their data is collated via nation SMR database. Going forward DAISy will be able to collate this for all service users regardless of substance history. No significant reduction in caseload size has been noted during time period. All caseloads have been reviewed and in conjunction with Team Lead a RAG status has been applied. The RAG status focussed on:- • Level of Alcohol/Drug Use • Physical Health Compromise • MH Compromise • Social compromise and lack of support (including housing/ personal safety) • Financial Compromise The RAG status has dictated the level of contact provided. ***High (Red) RAG Status*** have had 2 levels:-

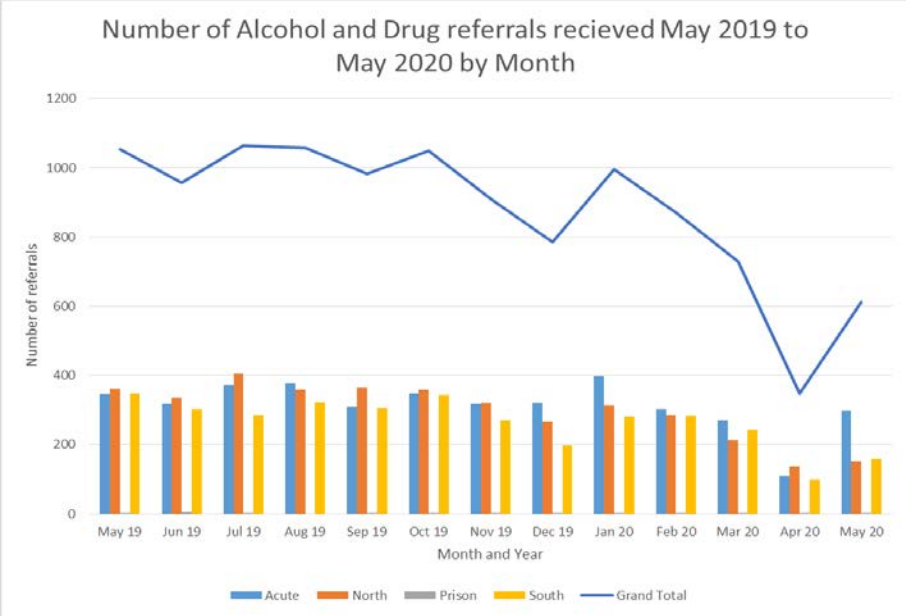
	1. Regular face: face contact maintained with service and with attendance at Pharmacy 2. Three times a week contact by telephone (This has been dictated by assessment of risk and co-existent mental or physical conditions). ***Medium (Amber) RAG Status*** have been contacted weekly and agreement made between individual and worker if that contact is not made what next steps should be (i.e. Review of dispensing arrangements/ alternative contacts). ***Low (Green) RAG Status*** - Telephone contact requirements agreed between worker and individual. This has ranged between fortnightly and monthly. Signposting and links to additional supports have been made to supplement statutory service provision (linkage to virtual Recovery Communities and agreed additional telephone contacts from commissioned services). There is no waiting list to come into service. All service users are being offered assessment and intervention within the Scottish Government Target of 21 days. Supervision of caseload management is being undertaken within Team or via electronic platform to provide level of assurance required that there is continued senior oversight and regular review of RAG Status of individuals and caseloads. Discharge from services is coordinated in same way as pre Covid. Alternatives to statutory care support are discussed and where appropriate gradually introduced to ensure a seamless handover. **<u>Routine Work</u>** Work has moved in general to a non-face: face contact. This has reduced opportunity to routinely provide important interventions. These include:-

	• Community based alcohol detox's • BBV Testing • Hepatitis B immunisation • Pabrinex injections • LARC provision All new referrals and existing service users were notified of changes in service delivery verbally and by letter. They have been kept updated of this position throughout. **Work Maintained** Services have continued to provide flexibility to respond to crisis as and when they have occurred. These include:- • Rapid response to Public Protection issues • MH Crisis • Social Crisis Teams continue to work collaboratively with colleagues to ensure necessary assurances in place to assure safety around public protection plans that are in place for individuals in our care. **Additional Work/Responsibility** • Service users who are in the shielding category have had special arrangements put in place to ensure their access to ORT has not been compromised. • Service users who have become symptomatic of COVID during the time period have had arrangements for ORT delivery and increased telephone contact from the Team. • Practitioners have been provided with resources and support from Addiction Psychology Team to ensure they have appropriate tools to support the psychological support required for individuals at this time. • Individuals in need of ORT are being fast tracked through the service and into treatment. Naloxone is being delivered to them at home or provided when they collect prescription. • OD Training is being provided in new ways (over telephone) or by direction with supporting websites if they have access.

	• Prescriptions have been reviewed and lengthened. Dispensing arrangements have been reviewed. The Recovery phase of how this will be looked at going forward that is considerate of risk is also being addressed via Prescribers in conjunction with colleagues.
Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?	We have had to completely stop the delivery of group work or activities. This position is unlikely to change going forward. This has affected a range of groups:- • ART Group • Football • Pabrinex- Health and Well Being • Emotional Resilience • Behavioural Activation The gap for many of the groups has been filled with support from Third Sector and Mutual Aid Organisations who have been offering a range of virtual groups. These groups offer Recovery based support in a range of ways (Music, yoga, mutual aid meetings etc). Going forward the OT's and psychologists will review and assess whether the professionally lead groups can be safely provided in a virtual way. A range of clinical interventions have also been stepped down during the time period. These include:- • Community alcohol detox • BBV Testing • Pabrinex Injection • Urine/Saliva screening. These have been identified as a priority for reinstatement via local Recovery Planning Groups. Strategically the new government monies aligned with the 6 National Drug Death Task Force Recommendations have provided an opportunity to review how we can engage with communities and individuals in different ways. This is inclusive of Statutory Services. The 6 key recommendations are:- • Targeting distribution of Naloxone

	• Having an immediate response pathway for non-fatal over doses. • Optimisation of medication- assisted treatment (MAT) • Targeting people most at risk • Optimising public health surveillance • Ensuring equivalence of support for people in criminal justice system This will influence North and South Lanarkshire's ADP Strategic Planning for the delivery of services that take a whole system approach considerate of Rights, Respect and Recovery Strategy Document (SG, 2018). The focus of delivery of these recommendations will be driven by environmental (neighbourhood houses, @home centres, hubs etc) and individual assets (Recovery Development Team and volunteers) within the community which will draw from local community knowledge and lived experience. Statutory services will have a vital part to play in ensuring operational delivery of extension of Naloxone provision and MAT is realised.
Substance Misuse Service	





6. Community LD & ASD

Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?

ASD - Referrals continue to be received for both diagnostic assessment and support for individuals who already have an autism diagnosis, however since the start of the pandemic have reduced, comparing the referral figures from Jan-March 2020 to April 20 to current date the referrals have reduced by 66%.

For autism assessment requests, assessments are all started with the background information gathering to support the assessment process- no direct visits as per guidelines. Previous ALDS assessments requested, review of referral information and autism screening tool, review of early developmental information, school reports, educational psychology & speech and language assessments accessed via child health records (if person is under 25).

CAMHS LD

Jan 20	Feb 20	Mar 20	Apr 20	May 20
12	11	14	2	8

Two urgent referrals were picked up immediately, 3 referrals had initial input to stabilise situation and then were put back on waiting list.

Waiting list prior to Covid 19 was 8 in Jan 20, now at 21 June.

LD Adult Service

Referrals to the LD Service reduced significantly during the months of April and May 2020.

Jan 20	Feb 20	Mar 20	Apr 20	May 20
55	41	41	19	26

Pre Covid, LD service was experiencing on average 7/8 referrals a week. New referrals are increasing week by week.

June referrals are presently sitting at 4/5 referrals a week with 17 referrals received to date.

	All referrers and those referred have been contacted by phone. Some initial therapeutic work has been done by phone. No urgent referrals received during the lockdown period. Risk is assessed via discussion with Referrer, patient (if appropriate), carers and Social Workers (if known – SW are asked if any info is known). Referrers, families, carers etc. have LD Service details and are aware of how to contact Community Nurses should presentation change or if there are any concerns. Face to face meetings (including Care Groups, CPA) suspended and when required are now carried out via Microsoft Teams or Conference Call. Suspension of healthy improvement group work. Day care services and respite offered by social work services has changed. Lifestyle day facilities are not open but social care staff maintain contact with service users. A number of families finding it difficult to cope with patients at home and calling for support with managing behaviours perceived as challenging. As lockdown continues it is envisaged that this may increase and a greater need for home visits may be required. Within one locality AP1 submission increased due to lack of available supports. An increase in inappropriate referrals seeking support in absence of social care. An increased need for support to access healthcare out of hours as no facility or carers available. Increased phone calls from families supporting young people leaving school- complex transitions and/or care package breakdown. Increased liaison with community police to negotiate community access beyond recommended Scottish Government guidance. Much less face to face but increased frequency of routine check in and telephone support. A few referrals were deferred at patient/family request shielding/self-isolating and requested we wait until after covid.

Have you prioritised access to services that have continued and how?	Adult LD Service - No waiting list. CAMHS LD - Waiting list prior to Covid 19 was 8 in January 20, as of June 20 is 21. Prior to any domiciliary visits, utilising NHSL guidance and MH & LD Pathway for referrals. **New Referrals** Electronic Referral. Initial telephone contact/email others involved. Establish risk and ability to engage with electronic assessment. Agree an action plan. Option 1-need to be seen or supported to access other appointments using PPE. Option 2-Patient/carer able to participate with telephone screening assessment, gather information from other sources to inform assessment, identify health needs, assess level of priority/risk- if required, offer face to face (with PPE)/ telephone/email support or be deferred to wait for other appropriate supports. So all new referrals have nursing contact but waiting for other disciplines e.g. OT, SLT. **Existing Caseload** All staff reviewed patients already open in terms of vulnerability i.e. living on own, mental health, risky behaviours, underlying health conditions, understanding and following guidance etc. This informed a congregated list of all open cases, traffic lights system used to highlight daily, weekly, fortnightly telephone appointments with information recorded in notes. Care plans developed for patients that required depots with back-up plan in place if nursing staff became unwell. Care planning, support package reviews etc. completed using combination of MS teams and Email with social work, other professionals etc. some routine work e.g. desensitisation deferred until lockdown restriction ease. General progress/delays/ concerns discussed, recorded and progressed in weekly service huddle. Where the referral is in relation to someone's behaviour/support in relation to autism, regular telephone consultation is provided, this is agreed with family/carers which has been weekly or fortnightly with contact information given should advice be needed out-with the agreed contact schedule. **CAMHS LD** Referrals are telephoned and prioritised according to identified need/risk, initial screening is offered over the phone if urgent, otherwise a deferred letter is sent.

	The CAMHS LD caseload is colour coded red, amber, green. All red cases are telephoned weekly, amber 2-3 weeks and green were all initially called and agreed to telephone if they required a service. We are currently phoning all green cases again. We are now offering more near me reviews to cases other than red. A letter was sent out to everyone at the beginning with useful numbers, websites, visuals etc. and we have set up a team CAMHS LD email address to send out useful information.
Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?	Families/patients have been provided with easy read information on COVID-19 in terms of testing, social distancing etc to aid understanding. Essential domiciliary visits continue, depot administration, mental health assessments and physiotherapy assessments. Domiciliary visits wearing PPE completed on two occasions due to patient's deterioration in mental health and possible family breakdown. Patient also accessing social media more than usual and family raised concerns regarding vulnerability. Education completed and strategies/planning completed with patient/family. Support provided to patient experiencing a miscarriage and requiring easy read information to help patient to understand need for hospital admission and process thereafter. Significant increase in the use of Microsoft Teams, Near Me.
7. <u>Community Services for Older People</u>	

Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	The service continues to provide an ongoing response to all existing caseloads. Staff have adapted their method of response accordingly due to the restrictions imposed by the covid pandemic. This has mainly been telephone contact though face to face appointments and/or domiciliary visits continue depending on degree of urgency e.g. mental health/social crisis and public protection issues. Referral rates have reduced by approximately 60% from April to May 2020 compared to April to May 2019. Telephone demand on the service has increased due to contact with patients on waiting lists and caseload patients. 100% of patients waiting to be seen in the period April-May 2020 have been risk assessed and have had a minimum of monthly telephone contact as per Covid 19 deferring guidance for Lanarkshire Mental Health and Learning Disabilities - only routine referrals are deferred. All patients are therefore receiving a service.
Have you prioritised access to services that have continued and how?	All referrals are risk assessed and prioritised based on the information contained within the referral. Referrals come via SCI Gateway and are discussed at the MDT with the nursing team, consultants and AHP's where a decision is made on level of priority, and whether face to face, attend anywhere of telephone contact is appropriate. Caseloads are prioritised also utilising risk rating system and all have a risk assessment and needs assessment to identify clinical need, face to face or telephone and frequency of contact. There has been no reductions in staff caseload size. All face to face contacts with patients and carers are telephone triaged prior to attending and appropriate PPE worn by all staff and hand hygiene adhered to. Deferred waiting lists exist only for routine patients only. All patients on waiting list are contacted by telephone every 3-4 weeks and given advice and also written information is posted out to every individual including practical tips on memory management, stress management and depression support. Again, utilising RAG rating system patients are assessed as to whether they need to be re prioritised and seen sooner. All face to face contacts with patients and carers are telephone triaged prior to attending and appropriate PPE worn by all staff and hand hygiene rules adhered to.

Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?	Routine medical clinics are currently suspended though medics are utilising Attend Anywhere technology to review patients. We have had to adapt services and their delivery to maintain the safety of our patients, carers and staff at all times. Staff are adapting to changes in working practice with increased telephone contact, less face to face consultations and often a component of working from home to accommodate social distancing within the workplace. More written information posted to patient group with advice and sign posting to on line and alternative, available supports. The nursing staff within North Lanarkshire's Integrated Day Services (IDS) have consolidated with the North Lanarkshire Older Adult CMHT's as due to Covid restrictions, IDS service users have not been attending IDS premises and have been supported at home. Memory management groups and carers groups are currently suspended.
8. <u>Adult CMHT</u>	
Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	Referral number dropped to approximately 25% of normal activity during April 2020, but have risen to half of normal activity during May 2020. Demand is increasing and there has also been a significant increase noted in the number of crisis referrals being received i.e. approximately 5 per day. **<u>Nursing Referrals per locality (10 localities in NHSL)</u>** • Average referrals April 2019 - 172

	• Average referrals April 2020 - 42 (75% reduction) • Average referrals May 2019 - 149 • Average referrals May 2020 - 79 (52% reduction) Clinical teams have continued to offer ongoing support to existing caseloads and adapted their working practices to ensure appropriate interventions continue at times of crisis i.e. mental health crisis, social crisis, or public protection concerns. **<u>All existing caseloads have been RAG rated as are any new referrals.</u>** As per RAG rating, existing caseloads are broken down as follows (average):- • Red - 37% • Amber - 29% • Green - 34%
Have you prioritised access to services that have continued and how?	Referrals continue to be received by CMHTs and they are screened in the same manner as before i.e. via a one door access meeting. Referrals are RAG rated/prioritised based on the information contained within the referral. They are then allocated or placed on a deferred list. Allocated referrals are offered assessment either face to face or via telephone/near me. Face to face contact is only provided where there is a clear clinical rationale, and with screening processes and PPE in place to minimise risk. Deferred referrals have initial contact made to determine level of need and signposting to other services if required. There is then 4 weekly contact maintained by the team mainly by telephone. If there are any changes to the mental health needs of individuals, they are allocated to a member of staff for full assessment. Deferred lists have significantly reduced over the past 3 – 4 weeks due to staff having capacity to assess and support patients although a small number have advised their preference is to wait for face to face contact to resume. Telephone contact continues with this small minority. 100% of existing caseloads continue to receive a service.

Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?	**<u>New ways of working</u>** Suspension of routine face to face consultations within Community Mental Health outpatient clinics. (Existing caseloads and referrals triaged with interventions provided via telephone contact or Near Me platform). Suspension of routine domiciliary visits to caseload. (Home visits continue for high risk/vulnerable individuals). Suspension of all community based support groups i.e. walking group, allotment group. Suspension of anxiety management, behavioural activation groups. Suspension of physical health clinics due to restriction of footfall within buildings. Clozapine clinics: a move toward locality Clozapine clinics (instead of hospital based) has been positive and is likely to remain. MARAC, MAST and any public protection meetings continue via conference calls or Microsoft teams. Various feedback on use of technology for patient contact - younger generation preferring same, however a number of older patients do not have access to appropriate equipment. Reduction noted in rate of 'Did Not Attends' for assessments carried out digitally resulting in increase in initial assessments being completed. Reduced travelling for both staff and patients cited to be beneficial.
<u>Comparison of Referral Numbers</u>	

	Feb 19	Mar 19	Apr 19	May 19
G1 General Psychiatry	1,541	1,741	1,492	1,670
G2 Child and Adolescent Psychiatry	498	595	395	452
G3 Forensic Psychiatry	24	29	29	22
G4 Psychiatry of Old Age	328	382	353	405
G5 Learning Disability	26	26	25	28
G63 Adult Psychotherapy	24	18	11	16

	Feb 20	Mar 20	Apr 20	May 20
G1 General Psychiatry	1,600	1,189	340	589
G2 Child and Adolescent Psychiatry	492	423	104	152
G3 Forensic Psychiatry	24	25	8	11
G4 Psychiatry of Old Age	360	253	96	194
G5 Learning Disability	20	14	1	5
G63 Adult Psychotherapy	8	13	5	3

New Psychiatry Outpatient Clinic Contacts (Medical Staff only)

	New Bookings	New Attendances	New DNAs	New DNA Rate
Feb-19	1,258	1,032	226	18.0%
Mar-19	1,228	1,010	218	17.8%
Apr-19	1,364	1,112	252	18.5%
May-19	1,531	1,247	284	18.5%

	New Bookings	New Attendances	New DNAs	New DNA Rate
Feb-20	1,234	974	260	21.1%
Mar-20	850	686	164	19.3%
Apr-20	226	201	25	11.1%
May-20	439	379	60	13.7%

Return Psychiatry Outpatient Clinic contacts (Medical Staff only)

	Return Bookings	Return Attendances	Return DNAs	Return DNA Rate
Feb-19	9,615	8,230	1,385	14.4%
Mar-19	9,575	8,211	1,364	14.2%
Apr-19	9,475	7,978	1,497	15.8%
May-19	10,586	8,996	1,590	15.0%

	Return Bookings	Return Attendances	Return DNAs	Return DNA Rate
Feb-20	9,002	7,704	1,298	14.4%
Mar-20	7,549	6,346	1,203	15.9%
Apr-20	5,700	5,037	663	11.6%
May-20	5,759	5,080	679	11.8%

Total OPC Attendances (Medical Staff) (Combined New and Return)

	Total Bookings	Total Attendances
Feb-19	**10,873**	**9,262**
Mar-19	**10,803**	**9,221**
Apr-19	**10,839**	**9,090**
May-19	**12,117**	**10,243**

	Total Bookings	Total Attendances
Feb-20	**10,236**	**8,678**
Mar-20	**8,399**	**7,032**
Apr-20	**5,926**	**5,238**
May-20	**6,198**	**5,459**

Current Waiting Lists (Psychiatry Medical)

	1 to 4	5 to 8	9 to 12	13 to 16	17 to 20	21 to 24	>24	Total

G1 General Psychiatry	174	48	32	164	132	48	28	626
G1A General Psychiatry Addictions	10	1	0	37	21	3	0	72
G1B Psychiatry Eating Disorders	4	0	0	2	0	0	0	6
G3 Forensic Psychiatry	2	0	0	0	0	1	2	5
G4 Psychiatry of Old Age	122	51	22	126	115	33	36	505
G4ZA YOD Psychiatry of Old Age	0	5	5	7	4	2	8	31
G5 Learning Disability	2	1	1	2	3	0	0	9
Psychotherapy	0	4	5	10	9	7	125	160
Total	**314**	**110**	**65**	**348**	**284**	**94**	**199**	**1,414**

9. OOH & Crisis

Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?

Crisis Response CMHT

The aim of the duty service is to provide patients who are experiencing acute mental health issues with assessment and timely intensive interventions.

The function of the duty nurse within the CMHT is to provide brief and rapid therapeutic interventions to individuals suffering from acute mental health symptoms.

The following referral pathway supports ease of access to CMHT Duty Service:-

- Referral received from GP, self-referral from active patient on caseload, other services within mental health network.
- The referrer will have had contact with the individual being referred within a 4 hour period.
- Duty worker completes referral pro forma with referrer (usually over telephone) Referral process includes completion of risk assessment.
- Assess urgency of referral with referrer.
- Referred individual will be seen, assessed and offered appropriate intensive interventions.
- Where the duty worker cannot provide an immediate response the duty worker will refer on to the Psychiatric Liaison Nursing Service based within the ED department at one of the 3 District General Hospital.

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Outcome(s) of assessment will be shared with referrer.

Crisis referrals to CMHTs during the last three months of Covid are rising and are now on average 4/5 referrals per day, which is an increase in referrals which were previously on average 5/7 per week. All referrals are screened using the above process, and face to face assessment completed if required. If a referral is not deemed to require immediate support, they are allocated to a CPN for assessment via Telephone or Near Me.
<u>Mental Health Assessment in Emergency Departments Across NHSL</u>
The Psychiatry Liason Service provide 24/7 response to all inpatient and emergency departments within all 3 NHSL District General Hospital sites. The team offer telephone advice and/or formal mental health assessment for inpatients in any hospital department across the NHSL sites. Out of Hours they also provide a telephone link to offer support to NHSL individuals contacting NHS 24 for mental health support or advice. Alongside this out of hours provision the Liaison team offer community police triage and Scottish Ambulance Service triage to again offer mental health support to individuals who come into contact with either service.
ED Activity Mental Health Assessment Centre
<table>
<tr><th></th><th>2019</th><th>2020</th></tr>
<tr><td>March</td><td>266</td><td>174</td></tr>
<tr><td>April</td><td>279</td><td>196</td></tr>
<tr><td>May</td><td>320</td><td>309</td></tr>
<tr><td>June</td><td>323</td><td>154</td></tr>
</table>
Numbers have reduced during the Covid outbreak, but progressively picking up.
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<tr>
<td>Can you specify if any services have stopped entirely, consolidated and/or if they have</td>
<td>Mental health assessments that were previously carried out by Liaison Psychiatry within the Emergency Departments in Monklands, Hairmyres and Wishaw have now been relocated to mental health assessment areas which have been developed within our inpatient service environment. This change of practice required a dedicated environment and additional staffing resource.</td>
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</table>

been adapted and provided in a different way?	
10. <u>NHS Lanarkshire Forensic Inpatient & Community Service</u>	
Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?	Referral numbers have been largely consistent. New patient demand for this service is small as the case load tends to be small numbers of highly complex patients. The Forensic Service has developed a Route Map to the delivery of services in line with the Scottish Government paper. This plan includes all disciplines. Both NHS Lanarkshire and the Forensic Service Clinical Psychology Team will continue to offer support and guidance for staff throughout this progressive delivery plan. **<u>Stage 1</u>** • Inpatient services have been in contact with out of area Forensic Services to prepare plans for transfer to NHS Lanarkshire's Low secure unit. This is an individually considered patient centred plan based on a number of factors. Advice has been given by Infection Control and this will be incorporated as part of the transfer process. • Unplanned admissions to the Low Secure continue and there continues to be capacity for this to happen. • The Forensic Rehab unit has re-commenced planning for patients with a re-engagement of community supports and Care Programmes Approach meetings via Microsoft Teams • Relatives and visitors are now able to visit the site and have visits with patients in the garden area. Advice has been given regarding social distance. Numbers are limited and planned to ensure safe social distance. No visitors are able to access the buildings. • The Forensic CMHT continue to visit patients at home, work within the Court and now have access to a 'virtual court' if required. Plans are in place to increase support to patients in stage 2

	• Patients who were thought to be de-stabilising have been given access to on-site activity co-ordinated by the Occupational Therapy and nursing team. The community and inpatient groups are kept separate and refreshment areas have been set up to allow for social distance. **Stage 2** • Planned transfer of patients will take place when it's the right time to do so. Advice from Infection Control will be adhered too. • Inpatients will have increased time out in line with Government guidance. This will be both on their own and with staff support. • Route and adhoc risk management measures will be re-introduced as patient's activity increases. This will include drugs of abuse screening alcohol monitoring and searches. • Visits may take place in a designated are of the unit if the Scottish Government guidance changes and support is given from NHS Lanarkshire. • Small integrated therapeutic groups will be possible outdoors if social distance rules are applied. • The use of remote access consultations will continue. All disciples will consider the need for face-face consultation and this will take place on an urgent basis. Social distance rules must be adhered to. • Community support for patients at home will increase. **Stage 3** • An increase in face-face contact will be considered although multi-disciplinary meetings will still be conducted remotely. • Inpatients who required progressive, careful re-integration to the community including discharge planning will increase. Access to community support will be established. • Support in the community should be determined by the needs of the patient with increased support available. • Integrated inpatient and community activity will increase. • Outpatient accommodation will have been risk assessed and modified for safe use.

<table>
<tr><td></td><td><u>Stage 4</u>

• Social distance and adherence to government guidelines will allow for as ‘near normal’ return to practice for all parts of the service.</td></tr>
<tr><td>Have you prioritised access to services that have continued and how?</td><td>The Forensic CMHT continue to visit patients at home, work within the Court and now have access to a ‘virtual court’ if required. Plans are in place to increase support to patients in stage 2.</td></tr>
<tr><td>Can you specify if any services have stopped entirely, consolidated and/or if they have been adapted and provided in a different way?</td><td>The Forensic Rehab unit has re-commenced planning for patients with a re-engagement of community supports and Care Programmes Approach meetings via Microsoft Teams.</td></tr>
<tr><td colspan="2">11. <u>Community Specialist</u></td></tr>
<tr><td>Can you please describe the current level of service provision in these service areas: e.g. referrals/demand and activity?</td><td><u>Eating Disorders</u>
Referrals have significantly reduced in April and May as compared to March.

<table>
<tr><th></th><th>2019</th><th>2020</th></tr>
<tr><td>February</td><td>7</td><td>7</td></tr>
<tr><td>March</td><td>16</td><td>14</td></tr>
<tr><td>April</td><td>17</td><td>3</td></tr>
<tr><td>May</td><td>6</td><td>3</td></tr>
<tr><td>Total</td><td>46</td><td>27</td></tr>
</table>

<u>Perinatal</u>
Comparing 2019 to 2020. Mar – May show 13% reduction in referrals however referrals Jan to May show an increase of 10 %.</td></tr>
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<table>
<tr><td></td><td><u>Rehabilitation</u>
No real change to referral rates between 2019 and 2020.

<table><tr><th></th><th>2019</th><th>2020</th></tr><tr><td>February</td><td>1</td><td>2</td></tr><tr><td>March</td><td>0</td><td>2</td></tr><tr><td>April</td><td>1</td><td>0</td></tr><tr><td>May</td><td>0</td><td>0</td></tr><tr><td>Total</td><td>2</td><td>4</td></tr></table></td></tr>
<tr><td>Have you prioritised access to services that have continued and how?</td><td><u>Eating Disorders</u>
The team has been offering ‘treatment as usual’ (predominantly via video call) for all patients on the TESS existing caseload. Caseload management is discussed on an individual basis and where face to face engagement is risk assessed to be required then this is offered. The referral process has remained the same over the pandemic period with the only team modification being the introduction of Microsoft teams to facilitate referral management and MDT discussion.
No waiting list.

<u>Perinatal</u>
All patients offered Near me or telephone contact there has been a mixed response in terms of patient preference Near me vs phone contact. Domiciliary Visiting has been carried out on occasion due to significant clinical concerns. The Perinatal referral process has remained the same with the only team modification being the introduction of Microsoft Teams to facilitate referral management and MDT discussion. Anecdotally in relation to referral management there appears to be an increase in referrals from Health Visitors where it would normally be primarily from Midwifery services. The team are gathering data on this currently.
No waiting list.

<u>Rehabilitation</u>
Continue to receive referrals. Restriction on ability to work through discharge planning arrangements with provider organisations due to current restrictions. Community patients continue to receive face to face visits as required. Both services using Microsoft Teams and Near Me to carry out MDT reviews and care planning</td></tr>
</table>

	meetings. Waiting list in place due to lack of community support packages available due to COVID19 restrictions. There is no significant service delivery change as a direct result of Covid other than as previously mentioned, the patient pathway for discharge depending on availability of community supports. The Community Rehab Team have continued to provide a mixture of Near me and domiciliary visits due to the complex nature of the mental health needs as well as individual identified risks.