



TO: ALL MEMBERS, ELECTED MEMBERS AND
OFFICER REPRESENTATIVES OF THE
DUNDEE CITY HEALTH AND SOCIAL CARE
INTEGRATION JOINT BOARD

(See Distribution List attached)

Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

10th December, 2019

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I would like to invite you to attend a meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 17th December, 2019 at 2.00 pm.

Apologies for absence should be submitted to Willie Waddell, Committee Services Officer, on telephone 01382 434228 or by e-mail willie.waddell@dundeecity.gov.uk.

Yours faithfully

DAVID W LYNCH
Chief Officer

AGENDA

1 APOLOGIES/SUBSTITUTIONS

2 DECLARATIONS OF INTEREST

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

3 MINUTE OF PREVIOUS MEETING - Page 1

The minute of previous meeting of the Integration Joint Board held on 29th October, 2019 is attached for approval.

4 APPOINTMENTS COMMITTEE – MINUTE OF MEETING - Page 5

(Minute of meeting of the Appointments Committee held on 28th October, 2019 and 19th November, 2019 is submitted for information and record purposes, copy attached).

5 MEMBERSHIP OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

(a) MEMBERSHIP – NHS TAYSIDE - POSITION OF VOTING MEMBER

Reference is made to Article IV(b) of the minute of meeting of this Integration Joint Board of 29th March, 2019 wherein it was noted that Professor Nic Beech had been nominated by NHS Tayside to serve as a member of the Integration Joint Board in the capacity of voting member.

It is reported that due to taking up other employment Professor Nic Beech has resigned from NHS Tayside Board. The Integration Joint Board will be advised of his replacement in due course.

(b) MEMBERSHIP – POSITION OF REGISTERED MEDICAL PRACTITIONER

Reference is made to Article III(c) of the minute of meeting of this Integration Joint Board of 30th October, 2018 wherein it was noted that Dr Frank Weber had been nominated by NHS Tayside to serve as a non-voting member on the Integration Joint Board in the capacity of Registered Medical Practitioner whose name is included in the list of primary medical service performers prepared by the Health Board.

It is reported that, due to work commitments, Dr Weber has resigned from this position effective from 14th November, 2019 and that the Integration Joint Board will be advised of his replacement in due course.

6 PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF PREVIOUS MEETING OF 26TH NOVEMBER, 2019 - Page 7

(Copy attached for information and record purposes).

(b) CHAIR'S ASSURANCE REPORT - Page 11

(Report No DIJB57-2019 by the Chairperson of the Performance and Audit Committee, copy attached).

7 PARTICIPATION AND ENGAGEMENT STRATEGY - Page 13

(Report No DIJB49-2019 by the Chief Finance Officer, copy attached).

8 CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2018/2019 - Page 23

(Report No DIJB50-2019 by the Chief Social Work Officer, copy attached).

9 JOINT INSPECTION (ADULTS) : THE EFFECTIVENESS OF STRATEGIC PLANNING IN PERTH AND KINROSS (SEPTEMBER 2019) - Page 73

(Report No DIJB51-2019 by the Chief Officer, copy attached).

10 LARGE HOSPITAL SET ASIDE - Page 123

(Report No DIJB52-2019 by the Chief Officer, copy attached).

11 FINANCIAL MONITORING POSITION AS AT OCTOBER 2019 - Page 127

(Report No DIJB53-2019 by the Chief Finance Officer, copy attached).

12 DUNDEE DRUGS COMMISSION REPORT – RESPONDING TO DRUG USE WITH KINDNESS, COMPASSION AND HOPE - Page 145

(Report No DIJB55-2019 by the Chief Officer, copy attached).

13 DUNDEE INTEGRATION JOINT BOARD BUDGET UPDATE 2020/2021 – DEVELOPMENT UPDATE (DIJB56-2019)

At the meeting of the Integration Joint Board held on the 29th October 2019 the Integration Joint Board received Report No DIJB49-2019 Delegated Budget 2020/21 – Initial Outlook (Item VI of the minute refers) which set out the initial forecast of the cost pressures anticipated within the delegated budget 2020/21. The Integration Joint Board remitted to the Chief Finance Officer to bring updated reports to each of the remaining Integration Joint Board meetings to the end of the current financial year culminating in the presentation of a proposed budget for 2020/21 for consideration by the Integration Joint Board at its meeting in March 2020.

As a result of the UK General Election being called for the 12th December 2019, the Scottish Government has had to delay the announcement of the Draft Scottish Budget. The exact timescale for this announcement is currently not known however it is anticipated that this will be towards the end of January 2020.

The Chief Officer and Chief Finance Officer continue to engage with Dundee City Council and NHS Tayside in relation to developing an understanding of the implications of the various cost pressures and possible funding levels following the publication of the Scottish Government's Draft Budget, however at this time there is no further update available in relation to the development of the the Integration Joint Board's 2020/21 budget.

14 MEETINGS OF THE INTEGRATION JOINT BOARD 2019 – ATTENDANCES (DIJB54-2019) – Page 235

(A copy of the Attendance Return for meetings of the Integration Joint Board held to date over 2019 is attached for information and record purposes).

15 DATE OF NEXT MEETING

The next meeting of the Integration Joint Board will be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 25th February, 2020 at 2.00 pm.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD **DISTRIBUTION LIST**

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

<u>Role</u>	<u>Recipient</u>
VOTING MEMBERS	
Non Executive Member (Chairperson)	Trudy McLeay
Elected Member (Vice Chairperson)	Councillor Ken Lynn
Elected Member	Councillor Roisin Smith
Elected Member	Bailie Helen Wright
Non Executive Member	Jenny Alexander
Non Executive Member	Professor Nic Beech
NON VOTING MEMBERS	
Chief Social Work Officer	Diane McCulloch
Chief Officer	David W Lynch
Chief Finance Officer (Proper Officer)	Dave Berry
Registered medical practitioner (whose name is included in the list of primary medical services performers)	VACANT
Registered nurse	Kathryn Brechin
Registered medical practitioner (not providing primary medical services)	Dr James Cotton
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Third Sector Representative	Eric Knox
Service User residing in the area of the local authority	Linda Gray
Person providing unpaid care in the area of the local authority	Martyn Sloan
Director of Public Health	Dr Drew Walker

(b) DISTRIBUTION – FOR INFORMATION ONLY

<u>Organisation</u>	<u>Recipient</u>
NHS Tayside (Chief Executive)	Chief Executive
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership (Secretary to Chief Officer and Chief Finance Officer)	Pauline Harris
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie
Dundee University (PA to Professor Nic Beech)	Lynsey Mcirvine
NHS Tayside (PA to Dr James Cotton)	Jodi Lyon



At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 29th October, 2019.

Present:-

<u>Members</u>	<u>Role</u>
Trudy McLEAY (<i>Chairperson</i>)	Nominated by Health Board (Non-Executive Member)
Ken LYNN (<i>Vice-Chairperson</i>)	Nominated by Dundee City Council (Elected Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Nic BEECH	Nominated by Health Board (Non-Executive Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Kathryn BRECHIN	Registered Nurse
Diane McCULLOCH	Chief Social Work Officer
Drew WALKER	Director of Public Health
Jim McFARLANE	Trade Union Representative
Eric KNOX	Third Sector Representative
Linda GRAY	Service User Representative
Martyn SLOAN	Carer Representative

Non-members in attendance at request of Chief Officer:-

Dr David SHAW	Dundee Health and Social Care Partnership
Kathryn SHARP	Dundee Health and Social Care Partnership

Trudy McLEAY, Chairperson, in the Chair.

Prior to commencement of the business, the Chair paid tribute to the Chief Officer, David W Lynch who would be retiring from service with Dundee Health and Social Care Partnership in December 2019 and the personal contribution he had made over the period of his appointment as the first Chief Officer of Dundee Integration Joint Board and wished him well for his retirement.

These sentiments were echoed by Bailie Helen Wright and the Vice Chair, Councillor Ken Lynn.

The Chair also took the opportunity to welcome Eric Knox of Dundee Voluntary Organisation to his first meeting of the Integration Joint Board. Mr Knox gave a brief summary of his background and that he welcomed his membership of the Integration Joint Board.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

<u>Members</u>	<u>Role</u>
Jenny ALEXANDER	Nominated by Health Board (Non-Executive Member)
James COTTON	Registered Medical Practitioner (not providing primary medical services)
Raymond MARSHALL	Staff Partnership Representative

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Integration Joint Board held on 27th August, 2019 was submitted and approved.

IV PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF PREVIOUS MEETING OF 24TH SEPTEMBER, 2019

The minute of the previous meeting of the Performance and Audit Committee held on 24th September, 2019 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB48-2019 by Ken Lynn, Chairperson of the Performance and Audit Committee, providing an Assurance Report to the Integration Joint Board on the work of the Performance and Audit Committee.

The Integration Joint Board agreed to note the content of the report.

V FINANCIAL MONITORING POSITION AS AT AUGUST 2019

On a reference to Article XII of the minute of meeting of this Integration Joint Board held on 25th June, 2019, there was submitted Report No DIJB47-2019 by the Chief Finance Officer providing an update of the projected financial monitoring position for delegated health and social care services for 2019/20.

The Integration Joint Board agreed:-

- (i) to note the content of the report including the overall projected financial position for delegated services to the 2019/2020 financial year end as at 31st August, 2019 as outlined in Appendices 1, 2 and 3 of the report;
- (ii) to note the progress with implementation of savings initiatives as outlined in Appendix 4 of the report;
- (iii) to note that officers within the Health and Social Care Partnership were progressing with a number of actions required to effect a recovery plan as outlined in section 4.7.1 of the report; and
- (iv) to instruct the Chief Finance Officer to formally write to the Chief Finance Officer of Perth & Kinross Integration Joint Board to request an update on progress of the Transformation of In-Patient Mental Health Services as outlined in paragraph 4.3.6 of the report.

VI DELEGATED BUDGET 2020/2021 – INITIAL OUTLOOK

There was submitted Report No DIJB49-2019 by the Chief Finance Officer providing an initial forecast of the cost pressures anticipated within the delegated budget 2020/2021. The report formed phase one of a series of budget development reports to be presented to each Integration Joint Board meeting leading up to the Integration Joint Board meeting in March, 2020 when the delegated budget would be laid before the Integration Joint Board for approval.

The Integration Joint Board agreed:-

- (i) to note the content of the report including the potential implications to the delegated budget of the impact of the Scottish Government's Budget on Dundee City Council and NHS Tayside's financial settlements as set out in sections 4.2 and 4.3 of the report;
- (ii) to note the potential implications of these and the range of increased costs and cost pressures to Dundee Integration Joint Board's delegated budget and subsequent indicative level of budget requisition to Dundee City Council and NHS Tayside as set out in section 4.4 and Appendix 1 of the report to enable the Integration Joint Board to deliver the priorities as set out within its Strategic and Commissioning Plan; and
- (iii) to remit to the Chief Finance Officer to bring updated reports to each of the remaining Integration Joint Board meetings to the end of the financial year culminating in the presentation of a proposed budget for 2020/2021 for consideration by the Integration Joint Board at its meeting in March, 2020.

VII WINTER PLAN (2019/2020) – NHS TAYSIDE AND PARTNER ORGANISATIONS

There was submitted Report No DIJB50-2019 by the Chief Officer informing of the Winter Plan (2019/2020) – NHS Tayside and Partner Organisations (the Winter Plan) to be submitted on behalf of NHS Tayside and its partner organisations to the Scottish Government. The Winter Plan set out the arrangements across Tayside to support seasonal variations across health and social care services and described the level of preparedness. A copy of the Winter Plan was attached to the report as Appendix 1.

The Integration Joint Board agreed:-

- (i) to note the content of the report and the associated Winter Plan which was attached to the report as Appendix 1;
- (ii) to approve the Winter Plan as presented at Appendix 1 of the report and the submission of the Winter Plan to the Scottish Government;
- (iii) to note the detailed actions for the Dundee Health and Social Care Partnership as detailed in section 4.6 of the report and section 4.4 of the Winter Plan; and
- (iv) that the submission of the Winter Plan to the Scottish Government be accompanied with a statement from the Chief Officer emphasising that whilst every effort had been made to anticipate the potential implications of the winter period should there be unprecedented exceptional circumstances, the Winter Plan may be insufficient to manage the increased demand for services and any implications for staffing, capacity or service delivery.

VIII APPOINTMENT OF CHIEF OFFICER DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

There was submitted Agenda Note DIJB51-2019 reporting on the announcement of the retirement by of the current postholder of the position of Chief Officer, Dundee City Health and Social Care Integration Joint Board and the steps being taken to appoint his successor.

The Integration Joint Board agreed to note that recruitment and selection processes were being undertaken to identify a successor and agreed that the voting members of the Integration Joint Board and the Chief Executives of NHS Tayside and Dundee City Council be authorised to act as an appointments committee with powers to interview candidates on a date to be confirmed and, if so minded, to make an appointment to the post.

IX PROGRAMME OF MEETINGS – DUNDEE INTEGRATION JOINT BOARD – 2020

The Integration Joint Board agreed that the Programme of Meetings of the Dundee City Health and Social Care Integration Joint Board over 2020 be as follows:-

<u>Date</u>	<u>Venue</u>	<u>Time</u>
Tuesday, 25th February, 2020	Committee Room 1, 14 City Square	2.00 pm
Friday, 27th March, 2020	Committee Room 1, 14 City Square	2.00 pm (Budget Meeting)
Tuesday, 28th April, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 23rd June, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 25th August, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 27th October, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 15th December, 2020	Committee Room 1, 14 City Square	2.00 pm

X PROGRAMME OF MEETINGS – PERFORMANCE AND AUDIT COMMITTEE – 2020

The Integration Joint Board agreed to note that the Programme of Meetings of the Performance and Audit Committee over 2020 would be recommended as follows:-

<u>Date</u>	<u>Venue</u>	<u>Time</u>
Tuesday, 11th February, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th March, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 30th June, 2020	Committee Room 2, 14 City Square	2.00 pm
Tuesday, 22nd September, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th November, 2020	Committee Room 1, 14 City Square	2.00 pm

XI MEETINGS OF THE INTEGRATION JOINT BOARD 2019 – ATTENDANCES

There was submitted a copy of the attendance return DIJB51-2019 for meetings of the Integration Joint Board held to date over 2019.

The Integration Joint Board agreed to note the position as outlined.

XII DATE OF NEXT MEETING

The Integration Joint Board noted that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on 17th December, 2019 at 2.00pm.

Trudy McLEAY, Chairperson.



At MEETINGS of the **APPOINTMENTS COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 28th October, 2019 and 19th November, 2019.

Present:-

On 28th October, 2019:-

Trudy McLEAY (<i>Chairperson</i>)	Nominated by Health Board (Non-Executive Member)
Ken LYNN	Nominated by Dundee City Council (Elected Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Jenny ALEXANDER	Nominated by Health Board (Non-Executive Member)
Dr Robert PEAT	Nominated by Health Board (Non-Executive Member)

On 19th November, 2019:-

Trudy McLEAY (<i>Chairperson</i>)	Nominated by Health Board (Non-Executive Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Jenny ALEXANDER	Nominated by Health Board (Non-Executive Member)
Dr Robert PEAT	Nominated by Health Board (Non-Executive Member)

Trudy McLEAY, Chairperson, in the Chair.

The Committee resolved under Section 50(A)(4) of the Local Government (Scotland) Act 1973 that the press and public be excluded from the meeting for the undernoted items of business on the grounds that they involved the likely disclosure of exempt information as defined in paragraph 1 of Part I of Schedule 7A of the Act.

I DECLARATION OF INTEREST

No declarations of interest were made.

II APPOINTMENT OF CHIEF OFFICER, DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

At the meeting held on 28th October, 2019, there were submitted details of the applications received and the Committee agreed the candidates to be invited for interview on 19th November, 2019.

At the meeting held on 19th November, 2019, the Committee interviewed the candidates. Following an exchange of views, and after hearing the officers, the Committee unanimously agreed to offer the post of Chief Officer, Dundee City Health and Social Care Integration Joint Board to Vicky Irons who intimated her acceptance.

Trudy McLEAY, Chairperson.



At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 26th November, 2019.

Present:-

Members

Role

Ken LYNN (Chairperson)	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Dave BERRY	Chief Finance Officer
James COTTON	Registered medical practitioner employed by the Health Board and not providing primary medical services
David LYNCH	Chief Officer
Diane McCULLOCH	Chief Social Work Officer

Non-members in attendance at the request of the Chief Finance Officer:-

Liz BALFOUR	ISD Scotland
Kara BROWN	Audit Scotland
Barry HUDSON	Internal Audit
Clare LEWIS-ROBERTSON	Health and Social Care Partnership
Anne Marie MACHAN	Audit Scotland
Kathryn SHARP	Health and Social Care Partnership
Judith TRIEBS	Internal Audit
Sheila WEIR	Health and Social Care Partnership

Councillor Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

Jenny ALEXANDER	Nominated by Health Board (Non Executive Member)
Nic BEECH	Nominated by Health Board (Non Executive Member)
Raymond MARSHALL	Staff Partnership Representative
Martyn SLOAN	Person providing unpaid care in the area of the local authority

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Committee held on 24th September, 2019 was submitted and approved.

IV AUDIT SCOTLAND REPORT : NHS WORKFORCE PLANNING – PART 2

There was submitted Report No PAC40-2019 by the Chief Finance Officer providing an overview of the Audit Scotland's NHS Workforce Planning – Part 2 report which focused on the clinical workforce in general practice.

Dharshi Santhakumaran, Audit Manager, Audit Scotland, gave a presentation in supplement to the report.

The Performance and Audit Committee agreed:-

- (i) to note the content of the presentation;
- (ii) to note the content of Audit Scotland's NHS Workforce Planning – Part 2 report which was set out in Appendix 1 to the report; and
- (iii) to instruct the Chief Officer to consider the findings of the report when developing the Dundee Health and Social Care Partnership's Integrated Workforce Plan prior to submission to the Integration Joint Board for approval in addition to the Primary Care Improvement Plan.

V CLINICAL, CARE AND PROFESSIONAL GOVERNANCE GROUP – CHAIR'S ASSURANCE REPORT

There was submitted Report No PAC39-21019 by the Clinical Director providing an update on the business of the Dundee Health and Social Care Clinical, Care and Professional Governance Group (CCPGG). An exception report would be submitted to the Clinical Director, in his role of the Chair of the CCPGG to each Performance and Audit Committee to provide assurance of the governance systems and processes within the Dundee Health and Social Care Partnership.

The Performance and Audit Committee agreed:-

- (i) to note the content of the report and the exception report which was attached as Appendix 1 to the report; and
- (ii) to note the assurance provided by the Clinical Director that the governance systems and processes operating within the Health and Social Care Partnership were identifying, monitoring and striving to address the clinical, care and professional governance issues raised within the Partnership.

VI FALLS PERFORMANCE REPORT

There was submitted Report No PAC41-2019 by the Chief Finance Officer providing assurance that in-depth analysis of falls related hospital admissions in Dundee continued to be progressed and provided to relevant professionals and groups in order to support targeted improvement activities.

The Performance and Audit Committee agreed:-

- (i) to note the content of the report and the analysis of falls related hospital admissions detailed in section 5 of the report and Appendix 1 of the report;
- (ii) to note the proposed next steps detailed in section 6 of the report; and
- (iii) to note that further analysis would be carried out and a more clinical report with recommendations would be brought to a future Committee.

VII GOVERNANCE ACTION PLAN PROGRESS REPORT

There was submitted Report No PAC42-2019 by the Chief Finance Officer providing an update on the progress of the actions set out in the Governance Action Plan.

The Performance and Audit Committee agreed to note the progress made in relation to the actions set out in the Governance Action Plan as outlined in Appendix 1 of the report.

VIII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC43-2019 by the Chief Finance Officer providing a progress update in relation to the current Internal Audit Plan.

The Performance and Audit Committee agreed to note the progress in delivery of the 2018/19 Internal Audit Plan as well as the anticipated position in relation to the 2019/20 Plan as outlined in Appendix 1 of the report.

IX QUARTERLY COMPLAINTS PERFORMANCE – 2ND QUARTER 2019/20

There was submitted Report No PAC44-2019 by the Chief Finance Officer summarising the complaints performance for the Health and Social Partnership in the second quarter of 2019/20. The complaints included complaints handled using the Dundee Health and Social Care Partnership Social Work Complaint Handling Procedure, the NHS Complaint Procedure and the Dundee City Integration Joint Board Complaint Handling Procedure.

The Performance and Audit Committee agreed:-

- (i) to note the complaints handling performance for health and social work complaints set out in the report;
- (ii) to note the work which had been undertaken to address outstanding complaints within the Health and Social Care Partnership; and
- (iii) to note the ongoing work taking place to improve complaints handling, monitoring and reporting within the Health and Social Care Partnership.

X PROGRAMME OF MEETINGS – PERFORMANCE AND AUDIT COMMITTEE – 2020

The Performance and Audit Committee agreed that the programme of meetings over 2020 be as follows:-

<u>Date</u>	<u>Venue</u>	<u>Time</u>
Tuesday, 11th February, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th March, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 30th June, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 22nd September, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th November, 2020	Committee Room 1, 14 City Square	2.00 pm

XI MEETINGS OF THE PERFORMANCE AND AUDIT COMMITTEE 2019 - ATTENDANCES

A copy of the Attendance Return for meetings of the Performance and Audit Committee held over 2019 was submitted for information and record purposes.

XII DATE OF NEXT MEETING

The Committee noted that the next meeting of the Performance and Audit Committee would be held in Committee Room 1, 14 City Square on Tuesday, 11th February, 2020 at 2.00 pm.

Ken LYNN, Chairperson.



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD -
17 DECEMBER 2019

REPORT ON: PERFORMANCE AND AUDIT COMMITTEE CHAIR'S ASSURANCE
REPORT

REPORT BY: CHAIR, PERFORMANCE AND AUDIT COMMITTEE

REPORT NO: DIJB57-2019

This assurance report relates to the meeting of the Performance and Audit Committee of the 26 November 2019.

Instructions Issued by the Committee

The committee issued the following instructions and made the following decision in relation to the business laid before it:

- Item IV – Audit Scotland Report: NHS Workforce Planning – Part 2 – instructed the Chief Officer to consider the findings of the report when developing the Dundee Health and Social Care Partnership's Integrated Workforce Plan and Primary Care Improvement Plan.

Issues to highlight to the Board

- The Committee received a presentation from Dharshi Santhakumaran from Audit Scotland who was part of the team responsible for the development and publication of the Audit Scotland Report on NHS Workforce Planning – Part 2. She explained that this report focussed on the Scottish Government's approach to workforce planning in Primary Care and took the Committee through the detail of the report, the predicted numbers of GP's and nurses in Primary Care now and in the future and challenges of meeting projected shortfalls in the required level of primary care provision. While the recommendations of the report are primarily aimed at actions the Scottish Government should take, the IJB needs to consider its own future requirements at a local level and reflect these in the Integrated Workforce Plan.
- The Committee was provided with assurance from the Chair of the Clinical Care and Professional Governance Group that there were no issues of concern arising from the latest meeting of the group and that the governance systems around clinical care and professional governance were working effectively.
- The Committee also considered a further report on Falls Performance which has been an area of concern for the committee for some time. Dundee continues to perform poorly in relation to falls rates with the highest falls rate in Scotland. The report provided more data and analysis with Coldside, East End and West End all driving the higher than average rate for those over 65. The Committee discussed the findings and possible reasons for this, including connecting this information with the poor state of pavements in certain areas of the city. There was significant interest in the recommendations to explore further the way that admissions as a result of falls are responded to in Ninewells which could explain increases in readmissions, the fact that Dundee doesn't have a minor injuries unit therefore all fall related hospital admissions Dundee are recorded in this way (i.e. comparative under reporting in areas with a minor injuries unit). The Committee looks forward to receiving further analysis.
- The Internal Audit Plan progress report was discussed and it was noted that there had been some further slippage in the delivery of the 2018/19 substantive audit reviews which has in turn impacted on the delivery timescales of the 2019/20 reviews. The Chief Finance Officer and Internal Audit leads in attendance agreed that the 2020/21 audit plan needs to take cognisance of this slippage.
- The latest Quarterly Complaints Performance information was discussed and it was noted that there had been some good progress made in responding to Social Work and NHS complaints

within the appropriate timescales. However it was recognised that there was still further work to be done to improve the approach to responding to complaints.

Councillor Ken Lynn
Chair

3rd December 2019

ITEM No ...7.....



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD –
17 DECEMBER 2019

REPORT ON: PARTICIPATION AND ENGAGEMENT STRATEGY

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB49-2019

1.0 PURPOSE OF REPORT

- 1.1 The purpose of this report is to present the reviewed Participation and Engagement Strategy to the Integration Joint Board for approval.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Approve the Participation and Engagement Strategy attached as Appendix 1.
- 2.2 Instructs the Integrated Strategic Planning Group to further develop the Framework for Engagement referred to at section 4.5 of this report.
- 2.3 Instructs the Chief Finance Officer to ensure that progress in implementation of the Participation and Engagement Strategy is reported to the IJB as part of its ongoing governance arrangements.

3.0 FINANCIAL IMPLICATIONS

- 3.1 None.

4.0 MAIN TEXT

- 4.1 At its meeting on 29 March 2019 the Integration Joint Board approved the Strategic and Commissioning Plan 2019-2022 and noted progress being made in revising the suite of companion documents to the plan. The Strategic and Commissioning Plan includes a commitment to revise the Participation and Engagement Strategy of the IJB by the end of 2019. The reviewed Strategy (attached as Appendix 1) is submitted to the IJB in fulfillment of this commitment.
- 4.2 The review of the Participation and Engagement Strategy has been overseen by the Communication and Participation Sub-Group of the Integrated Strategic Planning Group. This group includes representation from the Health and Social Care Partnership, Dundee City Council, NHS Tayside, Dundee Carers Centre and the Third Sector Interface.
- 4.3 During the review it was identified that two complementary resources are required by the Health and Social Care Partnership to support effective Participation and Engagement with patients, service users their carers and families, and our workforce. Firstly the Partnership needs a clear and succinct Strategy which sets out the overall vision for our engagement work; this requirement is fulfilled through the Participation and Engagement Strategy. Secondly the

Partnership requires an operational framework which provides tools and resources to help services and supports to actively engage.

- 4.4 The Participation and Engagement Strategy has been simplified significantly to make it more accessible and relevant to those with whom we wish to engage. It has been updated to take into account the developments which have taken place over the last 3 years, particularly within the Community Planning Partnership.
- 4.5 Work has begun on the development of an Engagement Framework, again under the leadership of the Communication and Engagement Sub-Group. The sub-group aim to make best use of technology to provide a comprehensive resource to all within the Health and Social Care Partnership to support engagement work. This will link with the Community Planning Partnership's development of CONSUL (an on-line engagement tool widely used nationally and internationally). This work will be overseen on behalf of the IJB by the Integrated Strategic Planning Group.

5.0 POLICY IMPLICATIONS

- 5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	The development of services and supports for health and social care are not adequately well informed by the knowledge skills and experiences of service users, carers, communities and the workforce.
Risk Category	Operational, Governance, Political.
Inherent Risk Level	Likelihood 2 x Impact 4 = Risk Scoring 8 (which is Medium risk level).
Mitigating Actions (including timescales and resources)	<ul style="list-style-type: none"> • Implementation of Participation and Engagement Strategy. • Development and implementation of Engagement Framework. • Continued operation of Communication and Engagement Sub-Group.
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is Moderate risk level).
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is Moderate risk level).
Approval recommendation	Given the risk mitigation actions in place the risk is deemed to be manageable and should be accepted.

7.0 CONSULTATIONS

- 7.1 This paper has been developed by the Communication and Engagement Sub-Group, which includes representation from the Health and Social Care Partnership, Dundee City Council, NHS Tayside, Dundee Carers Centre and the Third Sector Interface. The draft strategy has been circulated widely throughout the Partnership and input actively sought from our Partners. The Head of Service – Finance, Business Planning and Strategic Commissioning, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

- 8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

- 9.1 None.

David W. Lynch
Chief Officer

DATE: 17 December 2019

Allison Fannin
Planning and Development Manager

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PARTICIPATION AND ENGAGEMENT STRATEGY – 2019-2022 Introduction

1

**Ensuring that the voices of the citizens of Dundee are heard and listened to,
to improve their health and well being and the
quality and delivery of health and social care services.**

This strategy outlines how Dundee Health and Social Care Partnership (the Partnership or “we”) will ensure that those who use health and social care services in Dundee, their families and carers (“you”), will remain at the centre of our work.

We are committed to understanding the needs of people from different communities in Dundee and believe that meaningful engagement and participation with you means we need to take into account your individual and collective characteristics; in particular the protected characteristics of age; disability; gender reassignment; race; religion or belief; sex; sexual orientation. We also want to make sure that people who are affected by poverty and its effects (such as poor mental health and substance misuse) are key partners.

You have a unique contribution to make in shaping, improving and developing health and social care service. You are experts by experience, bringing skills, qualities, knowledge and life experience from the communities you are part of.

Our colleagues in the public and voluntary sectors already have well developed frameworks for engagement, locally and nationally. This strategy is complementary to our Partners’ arrangements and our Partnership arrangements.

We are always aiming to improve our systems, services and supports in an ever changing world. Reform never stops, and neither should engagement. It is an ongoing process that demonstrates our commitment to listening, and acting on the voices, stories, contributions and ideas which we gather.

It is fundamentally about us all working together to maintain an open and honest dialogue that supports trust, confidence and respect.

Principles of Engagement

2

We will

1. Build on what we already know works.
2. Use a variety of ways to engage, to make sure that everyone who wants to be is involved
3. Make sure that those who provide services and support to people in Dundee are involved and have opportunities to engage. This will include finding ways to offer opportunities across our entire workforce including those from the third sector, the private sector and unpaid carers and volunteers.
4. Develop ways to measure the differences engagement has made, linking these to what we have already said we will do and what people have told us is important to them.
5. Let people know as soon as possible what difference their involvement has made
6. Make sure that the workforce is confident, well trained and is able to engage with people in local communities, service users and their carers.
7. Make sure that people in local communities, carers and service users are supported to feel confident and able to engage with us.

Approach to Engagement

3

We provide services in different ways. The Partnership provides some health and social care services directly and others are delivered through the independent sector and many voluntary sector organisations. This means that engagement happens in different ways and, in every circumstance, our Principles of Engagement (shown above) apply.

People who use our services

People who receive a service from us should be equal partners in their own care. As well as having a say in planning their own care, individuals and their carers should be able to contribute to the way services are delivered in their own localities and across the city.

We will ensure that our Strategic Planning Groups are given support to engage effectively with the people who use the services they commission. We want the people who use our services and their carers to be engaged in improving the services and supports we provide.

When we receive feedback on any aspect of our work, we will share the learning across the organization. Our practice will inform colleagues in Tayside and nationally.

With health and other inequalities in mind, we will actively encourage contributions and involvement from people whose voices are less likely to be heard and will consider how best to learn from people most likely to experience health inequalities and other barriers and disadvantages.

Our Workforce

Engaging with our workforce helps create a workplace where all colleagues are involved in decisions, feel valued and are treated with dignity and respect. It also allows our workforce to share ideas and have good open communication with everyone around us. We recognise that there will be many people within our workforce who will also have experience of health and social care matters as patients, service users and carers. We will implement ways to communicate and engage with our workforce, irrespective of who employs them. We will do this in Partnership with any formal staff engagement structures already agreed by employers of our workforce.

This Strategy should be read alongside our Workforce and Organisational Development Strategy which details how “we will support and develop our whole workforce to work in a co-productive, engaged, flexible way to improve outcomes for the citizens of Dundee”.

In summary

We will learn from ...

- engagement with individuals
- engagement with communities
- engagement with our workforce
- examples of best practice across the City
- practice and developments from outside Dundee

Further Development

4

We recognize that innovative and effective methods of engagement are already happening, and we want those to continue.

We have identified some priorities for further, complementary, development.

Information

We will provide Dundee citizens and their carers with the information they need to:

- Maintain and improve their health and wellbeing
- Make the best use of available services and supports
- Contribute to service development and improvement.

Locality Engagement

We will work with our Community Planning Partners to communicate well with people in their own localities. We will share our learning across the Health & Social Care Partnership. By working within the Dundee Community Learning and Development Strategy, we can use all of our resources most effectively.

Sharing knowledge and learning

We will capture the broad range of methods, tools, models and examples of participation and engagement, and the learning from this, in a “virtual” Toolkit. This will be available for everyone to use.

We will use e-mail, newsletters, online briefings and other relevant media as appropriate. Dundee Partnership and the Third Sector have developed engagement processes, and we will use these to ensure our work is coordinated and effective.

We will ensure that formal and informal opportunities to learn from each other are accessible to all.

Monitoring and Evaluating our Performance

We will evaluate our engagement activity to ensure that people are given the opportunity to provide feedback on what worked well and where improvements are needed.

We will evaluate how our engagement has impacted on our service planning and delivery and identify areas for improvement.

We will evaluate the impact of this strategy to identify successes and areas for improvement.

Role of the Integration Joint Board

The Integration Joint Board (IJB) has overall strategic responsibility for ensuring that the principles of this strategy are adhered to across Health and Social Care Dundee. The IJB itself has wide representation from across Partner agencies, the voluntary sector, staff, patient and carer representatives.

Support is available to enable IJB members to make effective contributions.

We will review this Strategy and report progress regularly to the IJB in line with an agreed implementation plan.

Role of the Integrated Strategic Planning Group

The Integrated Strategic Planning Group (ISPG) will retain responsibility for overseeing progress of this strategy and is responsible for ensuring that links across the broader partnership in Dundee are developed and sustained, in line with the agreed principles of participation and engagement.

This is an ongoing and evolving document. We will review it along with the Strategic and Commissioning Plan.

The ISPG will report progress made and milestones achieved to the IJB.

Strategic Priorities

Our strategic priorities are set out in our second Strategic and Commissioning Plan 2019-2022, which was agreed in March 2019.

These are:

1. Health Inequalities
2. Early Intervention and Prevention
3. Localities and Engaging with Communities
4. Models of Support/Pathways of Care

National legislative and policy context

- Public Bodies Joint Working (Scotland) Act 2014
- Community Empowerment (Scotland) Act 2015
- Patient Rights (Scotland) Act 2011
- Equality Act 2010
- Chief Executive Letter (CEL) 4 (2010) Informing, Engaging and Consulting people in developing health and community care services
- Chief Executive Letter (CEL) 8 (2012) -Guidance on Handling and Learning from Feedback, Comments, Concerns and Complaints about NHS Health
- Our Voice
- Listen, Learn Act, (National Education for Scotland)
- Public Sector Reform Act 2010
- Carers (Scotland) Act 2016
- The Participation Standard for the NHS in Scotland
- The National Standards for Community Engagement

Local structures and supports include:

- Dundee Partnership Community Learning and Development Strategy
- Local Community Planning Partnerships Plans & Structures
- Dundee Partnership Community Engagement Model
- Voluntary Sector Networks & Forums
- Learning Disability Providers Forum
- Mental Health Providers Forum
- Private Providers Forum
- NHS Tayside Public Partners
- Care Group Strategic Planning Group Engagement Plans and mechanisms



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD –
17 DECEMBER 2019

REPORT ON: CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2018-19

REPORT BY: CHIEF SOCIAL WORK OFFICER

REPORT NO: DIJB50-2019

1.0 PURPOSE OF REPORT

- 1.1 This report brings forward for Integration Joint Board Members' information the Chief Social Work Officer's Annual Report for 2018/19, attached as Appendix 1.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Note the content of the Chief Social Work Officer's Annual Report for 2018/19, attached as Appendix 1.
- 2.2 Note the key developments and achievements across Social Work functions achieved during 2018/19 (section 4.3) and priorities for future development during 2019/20 (section 4.4).

3.0 FINANCIAL IMPLICATIONS

- 3.1 None.

4.0 MAIN TEXT

- 4.1 The requirement that every local authority has a professionally qualified Chief Social Work Officer (CSWO) is set out in Section 3 (i) of the Social Work (Scotland) Act 1968, as amended by Section 45 of the Local Government (Scotland) Act 1994. Associated regulations state that the CSWO should be a qualified Social Worker and registered with the Scottish Social Services Council (SSSC).

- 4.2 The CSWO provides a strategic and professional leadership role in the delivery of Social Work services, in addition to certain functions conferred by legislation directly on the officer. The overall objective of the role is to ensure the provision of effective, professional advice and guidance to Elected Members, members of the IJB and officers in the provision of Social Work and Social Care services.

The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain Social Work functions to an integration authority but the CSWO's responsibilities in relation to local authority Social Work functions continue to apply to services which are being delivered by other bodies under integration arrangements. Responsibility for appointing a CSWO cannot be delegated and must be exercised by the local authority itself.

- 4.3 National guidance requires that the CSWO produces and publishes an annual summary report for local authorities and IJBs on the functions of the CSWO and that the approved report is forwarded to the Scottish Government to contribute towards a national overview of Social Work services. The 2018/19 Annual report was approved by Dundee City Council Policy and Resources Committee on 18 November 2019 and was subsequently submitted to the Scottish Government. The information in this report complements other more detailed service specific reports on Social Work and Social Care services which have been reported in other ways.

As can be seen in this year's report, Social Work and Social Care services have continued to deliver quality support which improves lives and protects vulnerable people, whilst also responding to many challenges across the wider public sector and Social Work specific landscape. There are a number of highlights in the report alongside a description of ongoing challenges and priorities ahead. Some specific achievements include:

- The implementation of a wide range of approaches to service user and carer involvement and empowerment which demonstrate that co-production is increasingly becoming embedded in the way in which we work to plan, improve and deliver Social Work and Social Care services and supports.
- The production of a revised Strategic and Commissioning Plan for Health and Social Care, that has a key focus on addressing health inequalities that impact disproportionately on some of the most vulnerable people in the city, including people affected by substance misuse and mental health issues.
- The completion of a range of self-evaluation activities the findings of which will inform future improvement activities. This includes a multi-agency audit of child protection and Looked After Children cases that identified a number of aspects of good practice within Social Work services.
- The development and implementation of a range of learning and development activities to support the Social Work and Social Care workforce to deliver high quality services and acquire the knowledge and skills to lead and manage increasingly integrated responses to health and social care needs.
- Positive performance across a range of services, including stabilising placements for Looked After Children, maintaining low usage of secure care for children and young people, increasing the number of people diverted from prosecution, performing above the Scottish average in the majority of national indicators of citizen's perceptions of health and social care and achieving further reductions in the use of unscheduled care by people aged 18 and over.

4.4 The report is also forward looking and identifies the key challenges and opportunities for the coming year across Children's Services, Community Justice and Health and Social Care. Given the recent retirement of the former CSWO, these will now be taken forward by her replacement, who will continue to work alongside a range of partners and local communities to strengthen and improve services. This will include work on:

- Across all services, strengthening our approaches towards protecting the public through the implementation of a Transforming Public Protection Programme with the Care Inspectorate to improve practice and processes in respect of assessments, chronologies and plans.
- Across all services, strengthening our approaches towards vulnerable women, including through the New Beginnings Team, Pause Programme, new Community Custody Unit, Caledonian Programme and Safe and Together.
- In Children's Services, continuing to lead on a GIRFEC Improvement Programme which focuses on prevention through the related initiatives of a Centre of Excellence for Looked After Children (CELCIS) Addressing Neglect Programme, What Matters 2 U and a Fast Online Referral Tracking system.
- In Children's Services, continuing to improve the placement stability of Looked After Children and Care Leavers to fully meet their health and wellbeing needs and support them towards positive destinations in adulthood.
- In Children's Services, working with the Centre for Excellence for Looked After Children on a PACE programme to improve approaches towards children and young people moving into permanent fostering and adoptive placements.
- In Children's Services, responding to the findings and recommendations of the Independent Care Review, which will cover the care system as a whole and apply to both Social Work and other partners.
- In Community Justice, work with the Scottish Prison Service to develop a new Community Custody Unit in Dundee, along with work to implement the extension of a presumption against short-term sentences from 3 to 12 months.
- In Health and Social Care, aligning statutory service delivery to localities and taking forward major service re-designs in mental health services and substance misuse, with each informed by the recommendations of the Dundee Drug Commission and pending Mental Health Inquiry.
- In Health and Social Care, to continue to target improvement activity to prevent falls and to increase the number of people accessing self-directed support options 1 and 2.

- In Health and Social Care, to work with communities to better understand performance information that demonstrates inequalities in outcomes between Local Community Planning Partnership areas and to identify ways to reduce these inequalities.
- In all areas, addressing major financial challenges which will continue to require new ways of working, the active involvement of communities in service redesign, joint work with neighbouring authorities and prioritisation of resources towards key needs.

5.0 POLICY IMPLICATIONS

- 5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

- 6.1 This report has not been subject to a risk assessment as it does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

- 7.1 The Chief Officer, Chief Finance Officer, Council Management Team and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

- 8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

- 9.1 None.

Diane McCulloch
Chief Social Work Officer

DATE: 17 December 2019

Dundee City Council

Chief Social Work Officer Annual Report

2018-19





This year, publication of the Chief Social Work Officer Annual Report occurs shortly after the retirement of the previous post holder but as the new CSWO, I am pleased to present the report and determined to respond to the many opportunities and challenges ahead. As in previous years, the report has been written for Elected Members, Social Work staff, other Council staff and partner organisations to provide a summary of activity over the last 12 months. It includes information about leadership; partnerships; statutory decisions made on behalf of the Council; finances; the involvement of service users; and on performance across all service areas. The report is not intended to be exhaustive but gives an indication of key trends, achievements, challenges, opportunities and priorities. Once again it has been an exceptionally busy year for Social Work staff and a privilege to be part of a profession which contributes towards the support and protection of our most vulnerable people.

This year I have been particularly proud of the way in which Social Work and Social Care services have worked to involve and empower service users and carers. The wide range of approaches that have been developed and used through the year demonstrates that co-production is increasingly becoming embedded in the way in which we work to plan, improve and deliver Social Work and Social Care services and supports. The production of a revised Strategic and Commissioning Plan for Health and Social Care, that has a key focus on addressing health inequalities that impact disproportionately on some of the most vulnerable people in the city, reflects our commitment to core Social Work values and to work with others across the Community Planning Partnership to deliver on the Fairness agenda.

Throughout the year a number of self-evaluation activities have been undertaken, supplemented by external scrutiny of our services and supports. The findings from this activity will inform future improvement activities. This year our self-evaluation programme included a multi-agency audit of child protection and Looked After Children cases that identified a number of aspects of good practice within Social Work services. Next year we plan to undertake a similar audit in relation to young people transitioning into adulthood. Positive performance has been achieved in the last year across a range of services, including stabilising placements for Looked After Children, maintaining low usage of secure care for children and young people, increasing the number of people diverted from prosecution, performing above the Scottish average in the majority of national indicators of citizen's perceptions of health and social care and achieving further reductions in the use of unscheduled care by people aged 18 and over.

The development and implementation of a range of learning and development activities to support the Social Work and Social Care workforce has also been a highlight during 2018-19. This activity is essential in supporting the delivery of high quality services and ensuring that our workforce can acquire the knowledge and skills to lead and manage increasingly integrated responses to health and social care needs. I have also been particularly pleased with developments that have supported the young workforce, including Care Experienced Young People to access employment and development opportunities.

None of these achievements could have been reached without a professional and committed staff group and the close involvement and support of partner agencies. As a profession, we continue to have a strong value base which emphasises the importance of social justice, anti-discrimination, empowerment, human dignity and worth. We know issues such as inter-generational poverty, mental health and substance misuse interact to affect the lives and life chances of people in our communities. We therefore work in partnership with both service users and partner agencies because we know that this is most likely to achieve the best outcomes. I am proud to be part of the profession and recognise the significant contributions all our staff, whether managing and delivering services or providing technical support. I hope this report helps to explain our services and the positive impact they have on the people of Dundee.

Diane McCulloch
Chief Social Work Officer

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This report details the arrangements within Dundee which enable the Chief Social Work Officer (CSWO) to fulfil their responsibilities as outlined in Section 5 (1) of the Social Work (Scotland) Act 1968, as amended by Section 45 of the Local Government (Scotland) Act 1994. The post is a senior one designed to promote leadership, standards and accountability for Social Work services, including commissioned services. Statutory guidance outlines requirements of the CSWO to:

- Report to Elected Members and the Chief Executive any significant, serious or immediate risks or concerns arising from his or her statutory responsibilities.
- Provide appropriate professional advice in the discharge of the Local Authorities functions as outlined in legislation, including where Social Work services are commissioned.
- Assist Local Authorities and their partners to understand the complexities and cross-cutting nature of Social Work, including corporate parenting and public protection.
- Promote the values and standards of professional Social Work, including all relevant National Standards and Guidance and adherence to Scottish Social Services Council Codes of Practice.
- Establish a Practice Governance Group or link with relevant Clinical and Care Governance Arrangements designed to support and advise managers in maintaining high standards.
- Promote continuous improvement and identify and address areas of weak and poor practice in Social Work services, including learning from critical incidents and significant case reviews.
- Workforce planning, including the provision of practice learning experiences for students, safe recruitment practice, continuous learning and managing poor performance.
- Make decisions relating to the placement of children in secure accommodation and other services relating to the curtailment of individual freedom.
- In co-operation with other agencies, ensure on behalf of the Local Authority that joint arrangements are in place for the assessment and risk management of certain offenders who present a risk of harm to others.

The statutory guidance also states that the CSWO must produce and publish a summary Annual Report for Local Authorities and Integration Joint Boards. This report therefore provides details on how the CSWO functions are being discharged within Dundee, including the systems and processes in place to ensure the safety of children and vulnerable adults and the management of those who present a risk to others, in the period 2018-19. The report ends with an outline of key priorities over the next 12 months.

2 Summary

In the last Annual Report covering 2017-18, the CSWO set out the focus for developments in the forthcoming year. The priorities were informed by a variety of factors, including opportunities and challenges afforded by new and anticipated legislative requirements, national or local structural changes, ongoing financial pressures, internal self-evaluation, external inspections and SSSC Codes of Conduct. We committed to:

- Strengthening our approaches towards protecting the public through the implementation of a Transforming Public Protection Programme supported by the Care Inspectorate to mutually share and improve practice and processes across partnerships and services.
- In Children's Services, work with partners to continue to implement the Tayside Plan, the local GIRFEC Improvement Programme, local placement capacity for Looked After Children and the requirements of Continuing Care. We anticipated much of this work would be informed by the work and findings of the Independent Care Review, which is now due to report in early 2020.
- In Community Justice, work with the Scottish Prison Service to develop new approaches to women, employability, prison release, electronic monitoring, males aged 21-26 years and young people.
- In Health and Social Care, aligning statutory service delivery to localities and take forward major service re-designs in mental health services and substance misuse.
- In all areas, addressing major financial challenges which will continue to require new ways of working, the active involvement of communities in service redesign including people, with lived experience, joint work with neighbouring authorities and prioritisation of scarce resources.
- Respond to any recommendations that might arise from the Dundee Drug Commission and the NHS Tayside Mental Health Inquiry which may impact on Social Work.

This year's Annual Report describes how the CSWO supported the progression of each of these areas of work. It shows how there were a number of key achievements in each of our service areas and how, in particular, all service areas strengthened their approaches to integrated working and co-production with local communities.

Partnerships Structures/ Governance Arrangements

In Dundee during 2018/19, the role of CSWO was undertaken by the Head of Service for Integrated Children's Services and Community Justice, with the Head of Service for Health and Community Care deputising as required. The CSWO Governance Framework sets out the ways in which they will discharge the requirements of the role and provide assurances to Elected Members throughout the year.

The CSWO has direct access to Elected Members, the Chief Executive, Chief Officer of the Integration Joint Board, Directors, Heads of Service, managers and front line practitioners both within the Council and Health and Social Care Partnership, and with partner agencies in relation to professional Social Work issues. During 2018/19 they attended a broad range of Council leadership and strategic partnership meetings with varying terms of reference as follows:

- Reporting to the Executive Director of Children and Families and regular meetings with the Chief Executive and Chief Officer of the Integration Joint Board.
- Member of the Integration Joint Board and IJB Performance and Audit Committee.
- Member of the Tayside Clinical Care Professional Governance Forum, alongside CSWOs from Angus and Perth and Kinross.
- Member of three Executive Boards which oversee the implementation of local community planning priorities.
- Member of the Adult Support and Protection (ASP) Committee, providing advice on Social Work matters relating to vulnerable adults.
- Member of the Alcohol and Drug Partnership (ADP), providing advice on Social Work matters relating to substance misuse.
- Member of the Child Protection Committee (CPC), providing advice on Social Work matters relating to children and young people at risk of harm.
- Member of the Chief Officer Group for Protecting People, contributing leadership and oversight on all public protection matters.
- Member of the Tayside Strategic Children and Young People Collaborative Group as the representative of the CSWOs in all 3 local authority areas.

The CSWO is also supported by a Joint Social Work Management Team which brings together the Senior Officers (or their representatives) with responsibilities for Social Work functions, alongside supporting officers. The group maintains oversight of:

- Key national and regional developments with implications for Social Work practice, including considering local actions required in response and monitoring implementation of these actions.
- Local developments, both strategic and operational, with specific implications for the Social Work workforce and services.
- Datasets relating to statutory Social Work functions.
- The effectiveness of arrangements to support the CSWO in discharging their statutory role, including the implementation of the CSWO Governance Framework.
- Production and publication of the CSWO annual report.

4 Partnership with Service Users and Carers

Social Work has a strong tradition of engaging with communities and families to mutually explore and identify key risks, needs and strengths; agree plans which protect people and help them to realise their potential; and jointly implement, review and adapt those plans. Given the range and complexity of communities and individuals, the challenge is to find creative methods which best suit their needs and promote the best possible outcomes for them, their families and communities.

Children's Services

In the core Social Work service, increased engagement with service users has been promoted through the 4 areas of Child Protection Case Conferences (CPCC), Looked After Children (LAC) Reviews, the Champions Board and an advocacy services delivered by Who Cares? In CPCCs, parents/carers attended 94% of meetings to inform decisions on the care and protection of children and young people. In LAC Reviews, Reviewing Officers coordinated and attended all meetings to scrutinise plans and enable children and young people to be heard. The Champions Board continued to grow and contributed towards improvements across a range of areas, including through a new film on the experiences of Care Leavers entitled 'Grit'. Who Cares? provided advocacy for 77 children and young people.

The approach being adopted by an Addressing Neglect and Enhancing Wellbeing (ANEW) Programme also involves close engagement with children, young people and parents/carers. Where concerns are identified, school support staff pro-actively engaged with families and provided a buddy service to help them to attend and meaningfully participate in meetings, which are conducted in more informal ways and lead to the shared creation of support plans. This has also led to positive feedback from both families and professionals, who reported that new arrangements are more manageable and effective in promoting the health and wellbeing of children and young people.

Over the year, a Food and Fun Programme was coordinated to provide lunches to children in deprived areas during the school holidays. The purpose was to promote their health and wellbeing and contribute towards narrowing the attainment gap, with children experiencing 'holiday hunger' less likely to progress academically during the new school term. The programme covers all holiday periods and delivers thousands of lunches and vouchers. In 2018-19, the programme became a fully constituted charity known as Dundee Bairns, widened its scope from lunches to breakfasts and extended to offer low cost holidays. It is being extremely well received and many recipients are also Social Work service users.

The Family Placement team has continued to support a high number of carers over the last 12 months (84 foster carers and 16 adopters) to look after in excess of 150 of Dundee City's most vulnerable children.

Alongside directly supporting carers the team and some foster carers have carried out an impressive recruitment drive; having stalls at the first ever Dundee Pride back in September 2018 and a 2nd year at Dundee Flower and Food Festival. As a result of all the recruitment events preparation groups were run for both fostering and adoption and in the 12 month period 5 new fostering households and 4 sets of adopters were approved. Within the period 6 fostering households have been de-registered: 4 of which were due to retirement. September also saw the launch of the new Fostering and Adoption website.

As part of our celebration of foster carers the team hosted 2 garden party/fun days. The first was as part of Foster Care Fortnight with a circus themed garden party welcoming over 100 guests of foster carers, their families and looked after children. The 2nd was a shared services fun day with the fostering teams from Angus Council and Perth & Kinross Council where the looked after children enjoyed many activities including a petting zoo. The team were also part of a shared services practitioners' day where the 3 local authority teams came together to undertake training and share good practice stories.

As a way of building better relationships with other children and families teams 2 family placement information sessions were held to share the work of the teams with new and existing workers and talk workers through the referral process for fostering placement and also the paperwork required for adoption and permanence panels.

In May the team were nominated and shortlisted for an Outstanding Service and Commitment Award: on the night winning the Lord Provost Award.



Community Justice Service

When an individual is made subject to a Community Payback Order with a requirement for supervision their risks and needs are assessed using the accredited LSCMI process, which partly involves the individual's self-assessment of their needs. Similarly the resultant case management plan includes targets agreed with the individual. For example in a recent plan for a woman made subject to Unpaid Work it was agreed that attending Incredible Years Parenting classes could count as Other Activity, as part of her statutory hours. In August 2019 the Community Justice Service introduced a requirement that a Personal Outcome Inventory should be completed at the beginning and end of Orders and it is hoped that this will provide us with both individual and aggregated information on progress made within key areas such as health, housing and employment.

Unpaid Work continues to be one of the most visible aspects of people who have committed offences making a contribution to the community. After every work placement the views of those taking part in Unpaid Work and those who have had the benefit of their work are sought. Recipients of Unpaid Work expressed a 100% rate of satisfaction and those taking part 78%. Some of the comments collected from the individuals who were subject to an Unpaid Work order or recipients at the end of placement included:

“The good parts for me were helping people in the community”.

“It was good being able to do my unpaid hours at night as I also work”.

“I got regular activity, team working and met people”.

“Learned new skills and worked as part of a team”.

“The transformation is absolutely astounding. The gravel, the patio, the fencing, the gate... was just wonderful”

“I want to thank you all for the hard work you put in. It is all looking fabulous and the children can't wait to visit the allotment”.

In terms of engagement to inform service delivery, in April 2018 four focus groups were facilitated inside HMP Perth in partnership with Positive Prison / Positive Futures, Scottish Prison Service (SPS) and members of the Community Justice Partnerships from Dundee, Angus, Fife and Perth and Kinross. These focus groups followed on from those that were carried out 18 months prior, and the purpose was to update on current issues for short term prisoners. Themes of housing, healthcare, welfare, finances and employability/work education were identified. The findings were presented to each respective Community Justice Partnerships and the Throughcare Network for taking forward.

Dundee staff also supported SPS staff in the completion of their Engagement Sessions with the public regarding the proposed female Community Custody Unit (CCU) in Dundee. Planning Permission was granted by Dundee City Council in October 2018; the CCU is due to open in early 2021; and the multiagency Project Board is well aware of the centrality of working alongside the local community as the Unit develops.

Dundee Community Justice Service has also encouraged service users to participate in some key pieces of national research, for example Dundee service users were interviewed by Community Justice Scotland researchers who were seeking to estimate the community support needs of people who will receive community orders instead of custody after the Government extends the Presumption Against Short Term Sentences from 3 months to 12.

Health & Social Care

The Health and Social Care Partnership recognises that co-production is key to making the best use of resources, delivering better outcomes for people who use services and their carers, building stronger communities and developing citizenship. A wide range of activities have been undertaken that demonstrate that the Partnership is actively embedding a culture of listening to citizens, service users, carers and their families and developing and improving services in accordance with this.

The Health and Social Care Partnership Equality Outcomes were developed with people who have Protected Characteristics, people who are affected by poverty and poor social circumstances, organisations who help and support these people and a range of other people and organisations who are interested in Equality issues. The Mainstreaming Equality Report and Equality Outcomes can be found at https://www.dundeehscp.com/sites/default/files/publications/mainsteam_report_and_equality_outcomes-2019-2022.pdf.

The Service Users Representative Group Executive (SURGE) has been established at The Mackinnon Centre. The Centre hosts both a Respite Unit and a Skills Centre for adults with physical disabilities or progressive illness. Up to 12 committee members are voted in by service users. SURGE has monthly meetings and a copy of minutes of the meeting or Newsletter are shared with all service users.

The Community Health Team worked with local people to East End' locality establish and support the Health Issues in the Community (HIIC) Group. Individuals in the group have had a major influence on service design and delivery through a number of activities including volunteering for local developments and sharing their lived experience with others. This work resulted in co-produced, locally led mental health provision. The group has a broad range of achievements across the city including helping produce a user friendly Mental Health and Wellbeing Briefing for people in local communities; hosted a co-design event, providing support at the local 'Healthy Minds' Drop-In Service, delivering a drama performance on self-harm and suicide. Five group members achieved accreditation for completing Part 1 of the HIIC Learning Pack with three people continuing to work towards Part 2.

One HIIC members said:

"....we find it hard to believe the impact we are having locally. We benefit socially, mentally and physically.

The Making Recovery Real (MRR) partnership continues to work together listening to people with lived experience (PWLE) of mental health challenges. As well as having a dedicated post based at Dundee Voluntary Action whose main role is to support the development of recovery locally, work is now progressing to recruit the equivalent of 4 full-time Peer Recovery practitioners to continue recovery story sharing and peer recovery activities. Peer to Peer training continues, with more than 20 volunteers having already been trained and some taking up voluntary roles in mental health organisations in Dundee, others going on to paid employment and one going on to university. The short film 'One City, Many Recoveries' is being

used to promote recovery with front line staff and other PWLE and was recently used with staff and patients at Carseview to raise awareness.

The Health and Social Care Partnership recognises that Volunteering is an excellent opportunity for local people to increase their partnership with services as well as benefit their own health and wellbeing. With support supported from Volunteer Dundee and colleagues in the private sector, we developed a recruitment and support plan for the involvement of volunteers. This was completed last year and culminated in a civic reception on the 28th September 2018 where both Craigie House and Menzieshill House became the first care homes in Scotland to achieve the Volunteer Friendly award.

“As a manager who recruits the volunteers I think their contribution is invaluable to residents, staff and the volunteers themselves. The enthusiasm that the volunteers bring with them rubs off on staff and I see them wanting to be more involved. Residents are attending the sessions and are enjoying them. Staff are seeing the benefits as they can spend time with residents who do not want to participate and focus on them for an uninterrupted period of time. Volunteers are bringing skills into the home that staff may not have. All in all it is a win win situation.”

Two of Dundee’s care homes are the first in Scotland to receive Volunteer Friendly Award Plaques:



From left Angela Smith, Resource Manager Dundee Health & Social Care Partnership, Sarah Clark, Team Manager (Craigie House), Lynn Thain, Team Manager (Menzieshill House), Wendy Taylor, Team Leader Volunteer Dundee

Joint Work across Children's Services and the Health and Social Care Partnership

Both the Children's and Families Service and the Health and Social Care Partnership have worked closely with Community Planning colleagues during 2018-19 as part of the Community Learning and Development (CLD) Strategy Group to develop and agree our Framework for Community Engagement which will:

- Ensure a consistency of approach across the Partnership;
- Improve the quality of Engagement activity across the Partnership; and
- Provide an assurance mechanism for the Partnership about the quality of engagement taking place.

The CLD Strategy Group is developing an on-line resource to allow all members of the Dundee Partnership to record and share engagement activity. This will help us to listen better to individuals and communities, will help avoid duplication and will assist with audit and performance management of our engagement activity.

Joint work has also progressed across Children and Families and Health and Social Care in relation to supporting carers. Over the last 12 months, Children's Services has worked with Young Carers, the Carers Centre and Schools to jointly raise awareness of the needs of Young Carers and increase support, including through short-breaks. There was an emphasis on involving Young Carers in all developments and co-producing new approaches. This has led to significant increases in the number of identified Young Carers, increases in the numbers receiving support, improvements in their educational attendance and engagement and consistently positive feedback from children and young people. The approach adopted at Baldragon Academy was particularly successful and will be extended to all other Primary and Secondary Schools.

The Dundee Carers Partnership developed a Short Breaks Services Statement following research and continuing consultation and involvement. The Carers Partnership developed a clear understanding of people's needs and wants and are committed to continue to co-produce Short Breaks in the City. The statement can be found at https://www.dundeehscp.com/sites/default/files/publications/short_breaks_services_statement_dundee.pdf. The Carers Partnership commissions Dundee Carers Centre to provide a Short Breaks Brokerage Service for Carers in Dundee. Demand for the service continues with 372 people awarded and benefitting from a short break during 2018/19. A carer accessing a short break commented:

"We thoroughly enjoyed our weekend stay in St Andrews. We are grateful for the efforts of the Respite team for arranging this short break for us, as it was really appreciated."

5 Social Service Landscape/Market



Dundee is a dynamic, modern city which is undergoing a period of significant change associated with the development of the Waterfront and opening of the V&A Museum. The city has a thriving port, is a hub for creative industries, media and life sciences, is a UNESCO City of Design and has a strong commitment to fairness and social justice. However the population of 148,000 also faces challenges associated with high levels of poverty, deprivation and inequality. This is accompanied by the range of related social, community and personal problems, including high levels of unemployment, substance misuse, drug deaths, mental health, physical health, domestic abuse, re-offending and morbidity. There are also more people with physical or learning disabilities than the Scottish average. Typically, there are over 9,000 users of social care services in the city at any time.

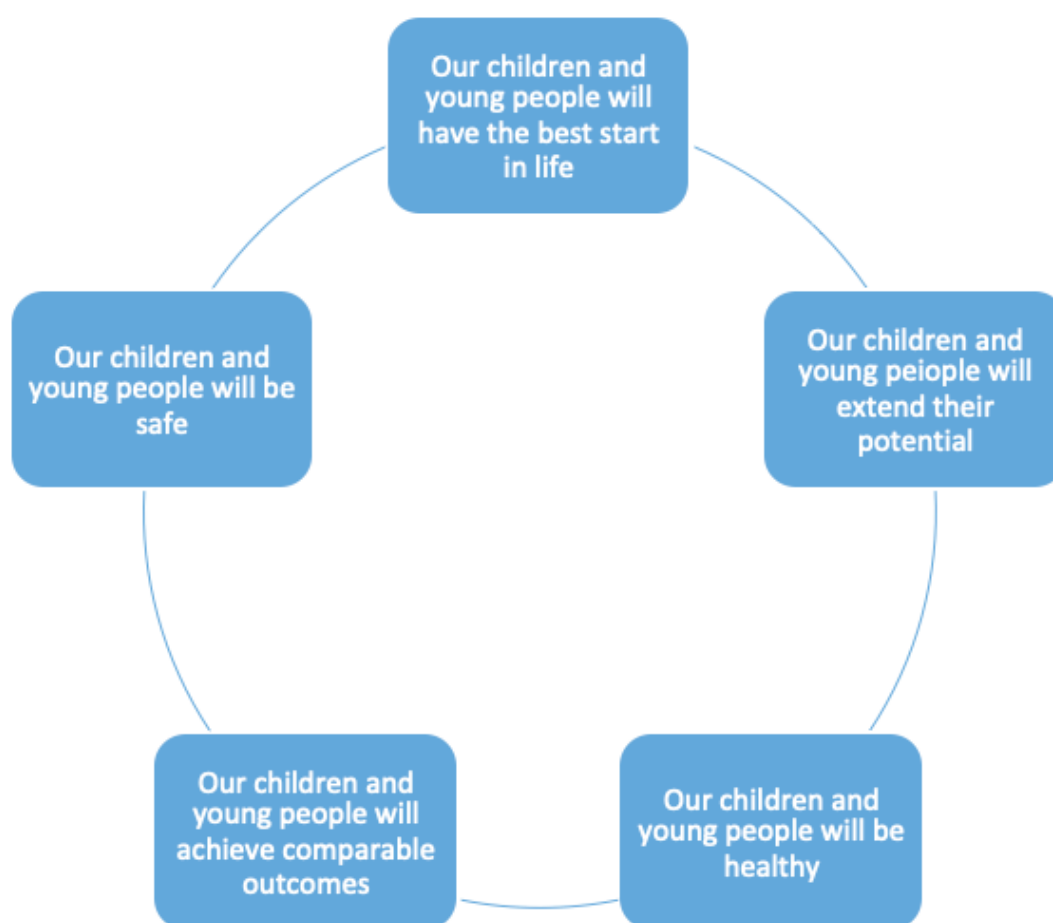
Over the next 25 years, the number of people aged over 75 years is also expected to rise by 45%. There will be similar increases in the number of people aged over 90 years. This is likely to lead to a greater prevalence of problems associated with older age which require health and social care, such as dementia, injuries resulting from falls, osteoarthritis, osteoporosis, immobility and other features of deteriorating mental and physical health.

As a result, in the context of growing financial pressures, there are unusually high and ever increasing demands on health, social care and other relevant local services. It means services must work together in a joint focus on prevention and engage with communities to prioritise and address problems within existing, shared resources. As such, the Dundee Partnership has outlined an aspirational vision for the City which will be realised over the next 10 years. Our shared vision is that:

- We will have a strong and sustainable city economy that will provide jobs for the people of Dundee, retain more graduates and make the city a magnet for new talent.
- We will offer real choice and opportunity in a city that has tackled the root causes of social and economic exclusion, creating a community which is healthy, safe, confident, educated and empowered.
- We will be a vibrant and attractive city with an excellent quality of life where people choose to live, learn, work and visit.

To achieve this, the Dundee Partnership is focusing on 5 priorities of Work and Enterprise; Children and Families; Health, Social Care and Wellbeing; Community Safety and Justice; and Building Stronger Communities. This is supported by themes on Cultural Development, Sustainability, Public Protection and Substance Misuse. We will engage with localities, jointly resource, prevent problems occurring or escalating and reduce inequalities. Given its work with vulnerable groups, Social Work will play a major role.

[The Tayside Plan for Children, Young People and Families 2017-2020](#) sets out the joint vision and priorities across the three local authorities, NHS Tayside and other local and national partners. It has been informed by the views and responses from children and families gathered through the Dartington Social Research Unit in 2014 along with evidence on what works to improve outcomes for children, young people and families. It has a clear focus on reducing inequalities and improving outcomes for all of Tayside's children, with partners committed to working collaboratively in five priority areas:



The Plan identifies a range of ways in which Children and Families will work with the Health and Social Care Partnership to improve outcomes for children, young people and adults. These include developing shared strategies on joint priorities such as parenting, substance misuse and mental health, with a focus on prevention, early intervention and tiered responses to need. It mirrors both the City Plan and the Council Plan, each of which include the same shared 5 priorities within and between partner services.

In Community Justice, a Community Justice Outcome Improvement Plan (CJOIP) focuses on the improvement of key processes across the criminal justice system overall and on the delivery of services to people who have offended. In accordance with whole systems models, this includes a range of priorities and actions relating to Early and Effective Intervention, Diversion from Prosecution, Community Payback Orders and Resettlement. There is a particular focus on pathways into and out of prison involving close partnership work with NHS Tayside, Housing and Employability Services.

In 2018-19 the Integration Joint Board undertook a review of its [Strategic and Commissioning Plan 2016-2021](#) as required under legislation and agreed to revise the plan. The process of revising the Strategic and Commissioning Plan was led by the Integrated Strategic Planning Group (ISPG) and drew from our continuous conversations over the last three years with communities, people accessing health and social care services, their families and with carers. This was supplemented by specific activities across the full range of health and social care stakeholders to consult on the Strategic and Commissioning Plan 2019-2022. The replacement plan was approved by the IJB in March 2019 and complements other strategic plans across the Community Planning Partnership. The vision for the Integration Joint Board remains the same in that “Every Citizen of Dundee will have access to the information and support that they need to live a fulfilled life.” The main change from the previous plan is to focus on the delivery of four of the previous eight strategic priorities:

- Health Inequalities
- Early Intervention and Prevention
- Locality Working and Engagement with Communities
- Models of Support and Pathways of Care

The four remaining priorities from the 2016-21 plan: Person Centred Care and Support, Carers, Building Capacity and Managing Resources Effectively are all now embedded in the Health and Social Care Partnership’s everyday work.

Finance

In 2018-19, the total net Social Work budget of £113,889,000 was allocated across services as follows:

Service Area	2018-19 Budget £000
Children's Services	£35,249
Community Justice Services	£182 (plus additional Grant Funding of (£4,820k))
Adult Social Care Services*	£78,458
Total	£113,889

* Delegated to Dundee Integration Joint Board - net of funding transfer from NHS Tayside

Children's Services continued to experience significant financial pressures around Looked After Children. In response, an action plan has been developed to reduce the overall numbers of Looked After Children and re-model the type and range of local placement options. This includes work with the Third Sector on preventative services; work to support kinship carers; work to increase the number of foster carers; the development of satellite flats attached to Children's Houses; and returning some young people from external residential placements to suitable local alternatives which help promote positive transitions into Continuing Care.

The Community Justice budget continued to be provided by the Scottish Government on a ring-fenced basis, for spending on matters relating to community justice only. It is calculated on the basis of a combination of local demographic factors and workload and continued to be managed in accordance with key priorities.

The delegated budget to the Integration Joint Board to support the delivery of adult Social Work and Social Care services continued to be impacted on by demographic and other cost pressures throughout the year. Given the impact of these pressures, the IJB agreed to release resources of approximately £2.7m from its reserves as part of its 2018-19 budget setting process and Transformation Programme to support investment in social care. The actual gross expenditure on adult Social Care for 2018-19 was around £103.500m with funding transfers from NHS Tayside in relation to Scottish Government funding and resource transfer totalling over £21m providing further support to Social Care spend. The adult social care element of the integrated budget resulted in an overspend of £3,630k at the end of the financial year 2018/19 compared with an overspend in operational services of £403k at the end of 2017/18, indicating the challenges faced in delivering on the IJB's strategic priorities.

7 Service Quality and Performance

Self-Evaluation

In 2018-19 Social Work services led and participated in a number of single and multi-agency self-evaluation activities focused on continuous improvement and improving outcomes for service users, carers and communities. These activities sit within the framework of the Care Inspectorate Performance Improvement Model and include case file audits, case reviews and audits of specific processes/documents. This activity is supported by the Learning and Organisational Development Service to ensure that learning is effectively shared and informs improvement plans at team and service level, as well as contributing to the development of strategic and commissioning plans for Health and Social Care and Children and Families.

Progress has been made transferring the Balanced Scorecards that are used by the Public Protection Committees / Partnerships onto the Council's electronic performance monitoring system during 2018-19. This will allow the scorecards to be more accessible to a range of stakeholders, including senior officers and Elected Members / Board Members who are responsible for the scrutiny of public protections services. It will also allow the input, collation and viewing of data in real time by operational and strategic staff. The Public Protection Committees / Partnerships have benefited from the addition of a Senior Officer (Information) who will specifically focus on the data and analytical needs of the Committees / Partnerships and Chief Officers Group.

Through the Health and Social Care Partnership in-depth analysis has taken place regarding falls, unscheduled care (including readmissions to hospital within 28 days of discharge) and complex delayed discharges. This has supported the Partnership to identify focussed areas for improvement and more effectively target actions to address these. In addition analytical work has also been undertaken to aid understanding of the variation in performance across the 8 LCPPs in relation to key national health and wellbeing outcomes; this work is continuing, with a priority in 2019-20 being engagement with affected communities to better understand the data and findings produced during the initial analysis. Arrangements have also been put in place during 2018-19 to enable the Partnership to expand the analysis previously undertaken to support the Pause project to provide detailed information about the health and wellbeing needs of women and their interaction with health and social care services. The outcomes of this work will be available during 2019-20.

In February 2019 the Children and Families Service completed multi-agency case file audit of Child Protection and Looked After Children (LAC) services in Dundee. Informed consent was gained to audit 14 cases out of an original sample of 30. This process was co-ordinated by a sub-group of the Protecting People Self-Evaluation Group as part of its commitment to learning and continuous improvement. This audit was conducted in order to evaluate the extent to which vulnerable children and their families are being supported by effective joint working across services within Dundee. The audit had a multi-agency focus and included Social Work, Health, and Police records. All these services participated in the audit, along with representatives from Education, the Third Sector and SCRA. The audit aimed to assess both child protection and LAC services. In addition, the audit also included a focus on adult protection issues, specifically parental substance misuse, parental mental health issues, and parental domestic abuse.

Areas of strength identified were:

- Early intervention
- Initial response to child protection concerns
- Improving family resilience and parental confidence
- Improving the wellbeing of children / young people

Areas identified through the audit for improvement were: chronologies; recording of core processes; quality of plans; initial response to wellbeing concerns; involving children / young people and advocacy; and, reviewing the child / young person's progress. An action plan addressing these areas has been developed by operational managers and will be implemented during 2019-20.

The Child Protection Committee and Adult Support and Protection Committee have not considered any Initial Case Reviews during 2018-19. One Adult Protection Significant Case Review remains in progress due to delays associated with legal proceedings. The Tayside MAPPA Strategic Oversight Group oversaw the completion of a Significant Case Review, which was published on their behalf by the Dundee COG in May 2019. An action plan in response to the recommendations made has been progressed by partners, with the majority of actions having been completed prior to the date of publication.

Teams across Children and Families and Health and Social Care have continued to undertake a range of planned self-evaluation activities, including peer auditing, service user satisfaction surveys and stakeholder engagement events. Many of these activities have directly informed changes in service design and practice. For example, in the Health and Social Care Partnership:

- Craigie House (Care Home) improved its garden area and the residents now enjoy watching wildlife in a more inviting, brightly coloured area with central seating area.
- Oakland Centre have involved service users and carers in workforce recruitment and selection process.
- The Mackinnon Centre set up a computer games area for younger adults who use the service; this is now used by people of all ages
- Feedback regarding a delay in care at home service delivery that was directly associated with mobile phone issues has led to:
 - contract with a telephone service being renewed with another approved provider.
 - an improved contingency plan for contacting the IT helpdesk to report mobile phone faults.
 - IT colleagues having information about critical mobile phone numbers.

External Scrutiny

During 2018-19 the Care Inspectorate also continued a programme of inspections of our Children's Houses and an inspection of Fostering and Adoption. In all areas, services were graded as Very Good or Good, with the exception of the quality of the environment in one Children's House. This is being addressed through a programme of renovations. The leadership of services and the quality of care provided to children and young people was consistently noted by inspectors.

Services for adults registered with the Care Inspectorate in Dundee include services directly provided by the Partnership, services commissioned by the Partnership from the third sector and independent providers and services operating independently of the Partnership. Of these contracted services, 81 were inspected during the year, of which 23 were combined inspections, where both the Housing Support and Support Services were inspected together. In 2018-19 Dundee was placed 13th out of 31

partnerships for the proportion of care services rated as good or better in Scotland (86%). This figure now sits above the Scottish average (82%).

Appendix 1 sets out the outcomes of external scrutiny of care services provided directly by the Council and the Health and Social Care Partnership. These grades have remained consistently high in the main and there is a process in place that any issues raised are quickly discussed with the appropriate service and improvement plans put in place. Comments from service users and their relatives/carers during inspections included:

“My mother has become a happy, contented person since becoming a resident in this home.”

“I like living here the staff are really friendly and I get on well with them.”

“They look after me really well here and I am happy.”

“I feel safe here.”

“I love it here.”

Partnerships with Commissioned Services

In 2018-19, services continued to be delivered through a mixed economy of local authority, private, independent and third sector provision. In total, there were **166** contractual arrangements put in place with **114** external providers. Of these, **133** were involved the supply of regulated social care services, ranging from residential care, home care, fostering, homelessness, violence against women, substance misuse, mental health, housing support to care at home. The remaining **36** contractual arrangements were for unregulated services, including meals provision, lunch clubs, shopping deliveries, outreach support, befriending, humanitarian protection, mentoring, advocacy services and family support services.

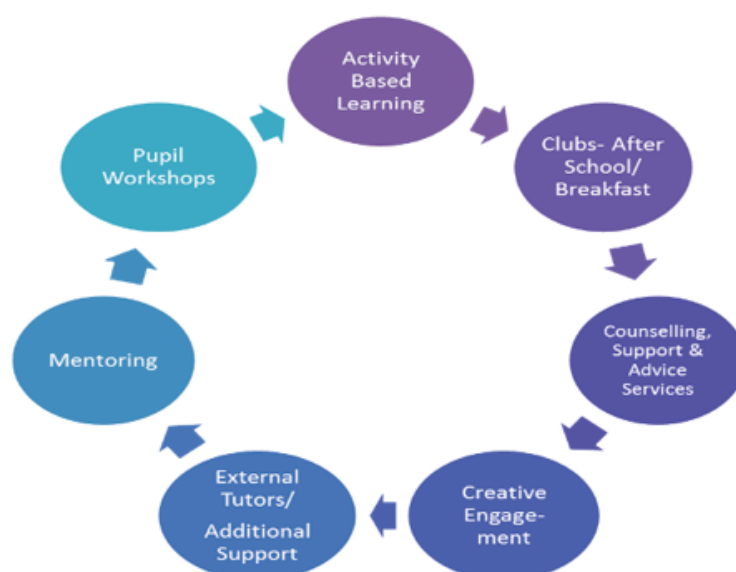
The continued operation of a Social Care Contracts Team supporting commissioning and procurement activity across both Children and Families and the Health and Social Care Partnership has sustained robust contract management and monitoring arrangements.

Partnership work with external providers has continued over the last year with a range of innovative and creative approaches in place to ensure the best use of local resources. Examples of this over 2018-19 include:

- As part of the homelessness and substance misuse transformation programme, Housing First Dundee is an innovative programme that will work positively and proactively with those that have had difficulty in engaging with traditional housing and support services due to a variety of complex needs. It is an exciting opportunity to give participants hope and end the revolving door of homelessness. It is being delivered by a consortium of four Third Sector organisations (Transform Community Development, Dundee Survival Group, The Salvation Army & Addaction Scotland), with acknowledged support of Housing First Scotland Fund.

Housing First is an internationally evidence-based approach, which uses independent, stable housing as a platform to enable individuals with multiple and complex needs to begin recovery and move away from homelessness.

- A Framework Agreement has been established to provide supplies and services to support children and young people. This innovative development now provides the mechanism for staff in Dundee, Angus and Perth and Kinross Council's to access a wide range of support services whilst adhering to the required procurement procedures.



A total of 55 individual providers have been appointed to the Framework covering approximately 200 different support services. A Buyers Guide and Directory has also been compiled and shared with a range of stakeholders who are involved in the procurement of support services for children and young people.

- British Red Cross has continued to test an Assessment at Home model for people who are in a hospital setting and there is uncertainty as to whether the person can return home. The project allows people to go home with a flexible care service delivered by British Red Cross that is appropriate to their needs including the provision of overnight care where this is required. Over a maximum 21 day period an assessment is undertaken to identify if the individual can safely remain at home as opposed to being admitted to long term care, which had been the identified pathway for the person when they were in hospital.

The test of change was extended during 2018-19 to include the provision of a flexible and responsive care at home service by British Red Cross to people who are identified by Dundee Health & Social Care Partnership's Enhanced Community Support/Dundee Enhanced Community Support Acute Services as requiring support to prevent a hospital admission as part of an ongoing assessment.

The two year test of change has now come to an end and an evaluation is being undertaken with a view to procuring an ongoing service from a care at home provider.

- In Children and Families collaboration with the wider Third Sector included respite support for families with children with disabilities commissioned from 6 organisations. As a result, over 120 families received routine support at home and/or overnight breaks to help them to cope with the demands of caring for children and young people with complex needs. These services are extremely well received by families and are also seen to help prevent family breakdown, which can result in children and young people being taken into care. The service also engaged with parents/carers in respect of Gillburn Road Children's House, a dedicated respite facility. It is presently working jointly with them to explore possible improvements in accessing support from the house and/or alternative forms of respite.
- Further collaboration between Children and Families and the Third Sector included continued work to help return some children and young people from external residential placements into suitable local settings with extra supports. This has contributed towards reducing the number of children and young people in external establishments to just 28 from a high of over 40 three years ago. Building on this, the service also worked with one organisation to secure the use of a dedicated building which had previously been used by them to support Looked After Children and Young People towards early adulthood. This building will now be used to temporarily de-cant young people from 2 Children's Houses whilst the houses are being renovated. Longer-term, it may provide capacity to help avoid young people going to external residential placements.
- Over the year, the service also continued to work with Pause partners and the Robertson Trust to develop and start to implement a new programme for particularly vulnerable women who have experienced repeat removals of their babies into care upon them being born. As a result of adverse childhood experiences and corresponding problems into adulthood, including mental health, substance misuse and domestic abuse, these women have previously been unable to care for their children and face ongoing risks of having them removed. They have also been unable to respond to other forms of support and the programme works with them on a voluntary basis to help prevent repeat pregnancies, reduce further trauma and stabilise their lives.

Complaints

9

Since the 1st April 2017 both Dundee City Council Social Work Complaints and Dundee Health and Social Care Partnership Complaints Handling Procedure follow the Scottish Public Service Ombudsman (SPSO) Model Complaint Handling Procedure. Both Complaint Handling Procedures have been assessed by the SPSO as complying with the model complaint handling procedure.

Complaints are categorised by 2 stages:

- Stage 1: Frontline Resolution
- Stage 2: Investigation

If a complainant remains dissatisfied with the outcome of a Stage 1 it can be escalated to a Stage 2. Complex complaints are handled as a Stage 2: Investigation complaint. If a complainant remains dissatisfied with the outcome of Stage 2: Investigation complaint they can contact the SPSO who will investigate the complaint, including professional decisions made.

In 2018-19, the total number of social work complaints received was 84, compared with 71 the year before. There were 46 complaints relating to Children's Services, 35 in Dundee Health and Social Care Partnership and 3 in Community Justice. The outcomes were:

- Upheld - 20%
- Partially upheld 14%
- Not upheld - 66%

Most of the complaints related to a failure to meet service standards or treatment by or attitude of a member of staff. Two complaints progressed to the final stage of the appeal process which is the SPSO. The agreed timescales for finalising investigations was met in 70% of cases, with delays usually caused by the complexity of the complaint and the investigation taking longer than expected.

Given the total number of Social Work service users of 9,000, the number of complaints is a small proportion however services do endeavour to use complaints to improve practice and service improvements which are made as a result of complaints are monitored. In 2018-19, a total of 26 planned service improvements were implemented.

In addition to complaints, a range of compliments have also been received from service users and some examples are provided below:

From Children's Services and Community Justice

"The truth is: if it weren't for the Social Work intervention, I'd probably be dead or worse. You do what could be considered a thankless job. I want you to know how much of a positive effect you have had on me. All of you. Thank you."

"I have a looked after child in my care...I am writing to congratulate the staff and give my heartfelt thanks. The social worker and his senior have encouraged, supported, believed in and NEVER given up hope on this young man. My heart is bursting with pride to inform you that he has just accepted a conditional place at college which is beyond our wildest dreams. None of this would have been possible without the support of the staff involved. They are a true credit to your team"

From Dundee Health and Social Care Partnership

"The professionalism of the Enablement team. The quality of care and expertise shown by the above team under the leadership of its manager is amazing. I will be happy to give you further details but since normally you only get complaints about services I am writing in praise of the dedicated team. I hope you will pass on my thanks and praise of their efficiency, expertise, cheerful and tireless dedication."

10 Performance

In Dundee, the CSWO reports statutory and local performance indicators through the Council Annual Performance Report and the Integration Joint Board Annual Report. This is supplemented by a range of separate reports to Elected Members, the Integration Joint Board and the various governance bodies relating to Children's Services, Community Justice and Health and Social Care. Further oversight is provided by the Chief Officer Group for Protecting People, including scrutiny of balanced scorecards. In 2018-19, trends included:

Children's Services

- The length of time children stayed on the child protection register continues to reduce, with 95% de-registered after less than 12 months. This indicates that measures put in place reduced the level of risk and protected children from harm.
- A total of 41 Child Protection Orders were made, which is a significant increase from 31 the previous year and closer to 2016-17 levels (45). In partnership with the Children's Reporter, the Service continues to scrutinise applications for CPOs and trends are considered at the Child Protection Committee, where the Reporter has noted they have been proportionate responses to the nature and level of risk in certain families.
- The number of Looked After Children has reduced slightly with exactly 500 children on 31st March 2019. Around 88% of Looked After Children are cared for in the community, which is very slightly lower than the national average.
- There were a total of 10 Emergency Placements, which involve authorising an emergency move of a child or young person subject to supervision requirements in cases of urgent necessity. This was a decrease on the previous year of 16.
- Attendance for Looked After Children remains below average at around 87% but exclusion rates have been dramatically reduced from 238 in 2017-18 to 87 incidents in 2018-19
- 76% of Looked After Children are living in Dundee or with Dundee carers in close proximity to Dundee.
- The proportion of care leavers aged up to 26 years old in education, training or employment has risen to 49%. Longer sustained employment, training and education continues to be a key priority, with a range of actions outlined in a Corporate Parenting Plan.
- 140 children with disabilities or complex needs received targeted community based support over the year with a case load of around 110 at any one time. Work is ongoing across Tayside to review arrangements for the provision of respite care.
- Five young people entered secure care in the reporting period but they were all short term placements for less than three weeks each.
- In respect of permanent alternative care and adoption, 21 new Permanence Orders were made and of these, 8 were with authority to adopt. This is about the same as last year. In total 142 children and young people were on Permanence Orders on 31st March 2018, 28% of the LAC population, compared to 149 out of 509 (27%) on 31st March 2018.
- During 2018-19 there were a total of 229 children in internal foster placements, with the majority (61%) aged between 0 and 5 years old. Over the last year there have been 55 emergency admissions to foster placements and 22 emergency moves of placement.
- There continues to be a shortage of carers and adopters for some groups of children and young people, including adolescents, large sibling groups and children with complex additional support needs.

Adult Support and Protection

- In 2018-19 1558 adult protection referrals were received which is a 33% increase on 2017-18. 56 of these referrals resulted in adult protection activity, with 42 Adult Support and Protection Case Conferences taking place over the year. Most referrals (1383- 89%) continue to be made by Police Scotland. Dundee has a single pathway for vulnerable adults and this has resulted in an increase in police involvement for non-crime related referrals eg. mental health and substance misuse.
- Of the 56 referrals which resulted in adult protection investigations, financial and physical harm featured as the highest single areas of adult harm identified. In the other referral reason categories included neglect by carer and risk associated with vulnerabilities due to age, disabilities or health concerns, domestic abuse, fire safety risk, harassment and welfare harm.
- During 2018-19, 811 (52% of all referrals) have been considered by the Early Screening Group providing opportunities for early intervention and prevention.

Mental Health

- There were a total of 115 emergency detentions in hospital and an average of 87 detentions a year in the last 5 years.
- There were a total of 177 short-term detentions in hospital, compared with 146 in 2017-18. There has been an average of 152 short-term detentions a year in the last 5 years
- There were 41 Compulsory Treatment Orders. With an average of 36 Compulsory Treatment Orders in the past five years.
- In 2018-19 95 Social Circumstance Reports were completed. 67 resulted in short term detention and 27 in Compulsory Treatment Order.
- In 2018-19 there were in total 143 guardianship applications of which 87 were Private Guardianship and 56 were Local Authority Guardianship applications. Of them 99 were granted.
- There were 12 people who were subject to Compulsion Orders with Restriction and 3 people to Treatment Orders. This has remained stable in comparison with the year before. There were one Transfer for Treatment Directions (none in 2017-18), 10 Compulsion Orders (9 orders in 2017-18) and 5 Assessment Orders (6 in 2017-18).
- During 2018, there were 1337 Power of Attorney (POA) registrations in Dundee per 100,000 population (18 and over) compared to 1934 registrations in 2017. 2017 had a high number of registrations in Scotland as whole. It is notable that those local authorities with a more aged population have higher numbers of new registrations. In 2018, Dundee had the sixth lowest number of new registrations compared to all Partnerships across Scotland.

Community Justice

- A total of 535 Community Payback Orders (CPOs) were imposed, compared with 656 the previous year. This is the third year this number has reduced and is correlated with a corresponding reduction in the number of Court Reports.
- A higher percentage of CPOs (17%) were issued to women compared to the previous year where 14% were imposed.
- The number of referrals for Diversion from prosecution cases continues to rise, moving from 92 in 2017-18 to 129 in 2018-19. The number of Diversion cases successfully completed has also risen, moving from 55 in 2017-18 to 64 in 2018-19.
- Unpaid work continues to be a disposal that the Court has confidence in, with 45,339 Unpaid Work hours imposed by Court in 2018-19. In addition, over the course of the year, a total of 27,640 hours of unpaid work were carried out (555 of which were other activity hours).

- In respect of Drug Treatment and Testing Orders, the Sheriff Court imposed 3 Orders compared to 5 the year before. These Orders are designed for people with the most persistent substance misuse problems related to offending and require their compliance with stringent conditions.
- There were 156 Registered Sex Offenders subject to statutory supervision under MAPPA. In Tayside, 38% were jointly managed by Community Justice Social Work and Police Scotland because the RSO was subject to both a CPO or License and Notification Requirement.
- There were 15 new Supervised Release Orders (SROs), almost double the number from the previous year. These orders are imposed for prison sentences of less than 4 years where the person is deemed to require supervision on release.
- There were 156 people serving prison sentences of more than 4 years who will be subject to statutory supervision on release, compared with 153 people the year before. The service provides throughcare whilst they are in prison and on their release to community.
- No young people aged between 17 and 18 received a custodial sentence – 1 less than the previous year.

In Community Justice, the service continued to implement Unpaid Work and received consistent positive feedback from both the individuals carrying out their work and from the recipients. In response to requests from members of the community, more than 100 projects & placements and over 27,000 hours of unpaid work were carried out at various locations across the city. There was a particular focus on constructing and refurbishing playground and public play park furniture as well as external furniture such as benches and tables for public spaces. We continued to provide practical assistance to vulnerable groups and work included ground clearance for sheltered & supported tenancy residents, preparing food parcels and placements in charity organisation warehouses.

People subject to unpaid work reported that it got them into better routines and they valued the chance to contribute something back for others. Members of the community reported that they appreciated the positive impact as well as the good quality of the work.



Health and Social Care

- The National Health and Care Experience Survey for 2017-18 (the latest version available) provides feedback to Health and Social Care Partnerships regarding citizen's perceptions of health and social care services and their impact on health and wellbeing. Across eight of the nine key indicators measured by the survey Dundee performed better than the Scottish average, for the remaining indicator Dundee was at the Scottish average. There have been increases in the proportion of adults supported at home who agree that their health and care services seem well co-ordinated (from 75% in 2015-16 to 81% in 2017-18) and in the proportion of adults supported at home who agree they feel safer (from 84% in 2015-16 to 87% in 2017-18).
- There has been further focused improvement work relating to unscheduled care that has contributed to a reduction in the length of time people spend in hospital when they have been admitted in an emergency. During 2018-19 the number of hospital bed nights reduced by 12,506 from the previous year.
- Of the people who died during 2018-19 89% of time in the last 6 months of life was spent at home. This is a positive result (similar to the Scottish average) and could not be achieved without a strong partnership between acute and community teams, the third and independent sectors and patients and their loved ones. The Tay Palliative and End of Life Care Managed Care Network is further exploring information related to those who spent greater than 10% of their last six months in hospital, to understand the role of hospital care at this time and how best to ensure acute admissions are purposeful, positive and person-centred.
- In 2018-19, for every 100 people aged 75 and over, 36.9 bed days were lost due to a delayed discharge. This is a slight deterioration on the 2017-18 figure when there were 34.9 bed days lost for every 100 people aged 75 and over. Throughout 2018-19 Dundee been amongst the best performing Partnership in Scotland. The creation a multi-disciplinary discharge hub and assessment at home service, introduction of 7 day working within the Acute Frailty Team and further development of the Enhanced Community Support Team have all contributed to these reductions in delayed discharge.
- The National Health and Care Experience Survey 2017-18 reported that 38% of Dundee respondents who provided unpaid carer felt supported to continue in their caring role; this is similar to the Scottish average of 37%. Information and advice services are commissioned through Dundee Carers Centre and are a pivotal part of this is the 'Carers of Dundee' website which was launched in May 2018 (<http://carersofdundee.org/>). The website allows carers to find out about relevant support, events, courses and activities to support them in their caring role, without having to search through individual local and national support organisations' websites. The site also lets carers know their rights and how they can get further information and advice.

Dundee Carers Centre have been working in partnership with young people and Dundee City Council to increase awareness of young carers. Young Carers Voice co-hosted 'Young Carer Roadshows' within all secondary schools in Dundee throughout March 2018. The roadshows were a mixture of workshops, assemblies and lunchtime events and reached over 1,200 pupils. The roadshows involved young carers at each school helping with the events, with an opportunity to take part in discussions about improving support for young carers in Dundee which included the Minister for Public Health, our local MSP, the Head of Schools, the Health and Social Care Partnership's Lead for Carers, the Convenor of the Children and Families Committee, and Carers Centre staff.

"Before the roadshows began I was worried people wouldn't listen, it was nerve wracking working with people roughly my own age. I was also excited and thought it would be interesting.

During the roadshows I felt confident and enjoyed taking the lead of groups and was surprised I was able to make a difference. I felt good as I was able to share my experience of being identified as a young carer at 15, when I was actually a young carer from age 6, if I accessed the support sooner things would have been easier. After the roadshows I felt proud and like I actually accomplished something. I wanted to do more as it was a great experience. I can now talk to other young people more. This has helped me become the young person I am now."

- Dundee has a high rate of readmissions to hospital, where the patient had been discharged within the last 28 days. In 2018-19 12.4% of people discharged from hospital following an emergency admission, were readmitted within 28 days. Throughout 2018-19 Dundee has been amongst those Partnerships with the highest readmission rate in Scotland.
- Dundee also has a high rate of hospital admissions as a result of falls, with a rate of 31 admissions for every 1,000 of the 65 and over population. Throughout 2018-19 Dundee has been amongst the most poorly performing Partnership in Scotland. There is now an established multiagency group meeting on a regular basis to share knowledge and skills and support the development of falls services across Dundee. The pathways for patients presenting at the Emergency Department has been reviewed and now provides a more streamlined process for those requiring a falls screening assessment. The falls group has also focused on building capacity for citizens to access a wide range of physical activities to improve health and wellbeing.
- There has been an increased spend on Self-Directed Support options one and two; with an increase from £1.7 million in 2017-18 to £2.2 million in 2018-19. Since the implementation of the Social Care - Self-directed support (Scotland) Act 2013 the spend on packages of care for people opting for Options 1 and 2 has increased year on year although Dundee remains low in terms of proportions of people receiving Options 1 and 2, compared to other Partnerships.

Statutory Functions

As outlined in the legislation and guidance, there are a number of duties and decisions that can only be made either by a CSWO, or by a professionally qualified Social Worker to whom responsibility has been delegated by the CSWO and for which the CSWO remains accountable. These relate primarily to the restriction of individual freedom and the protection of service users from themselves and others and the protection of the public from service users. It includes the following:

- Children and young people on the Child Protection Register
- Looked After children and young people
- Fostering and adoption
- Placement in secure accommodation
- Offenders assessed as very high or high risk of harm to others
- Mental health statutory provisions
- Adults with incapacity and welfare guardianship
- Adult support and protection

The Public Bodies (Joint Working) (Scotland) Act 2014 required NHS Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. The main purpose of integration is to use the available resources to improve the wellbeing of people who use health and social care services, including adult social work services, in particular those whose needs are complex and who require both health and social care support at the same time.

Following the establishment of the Dundee IJB, they became responsible for the planning and delivery of a wide range of adult Social Work and Social Care services. The CSWO's role in relation to these delegated functions continues and the CSWO has continued to play an important role in the leadership and governance of health and social care integration over the last year, ensuring that adherence to Social Work values, principles and standards is central to developing the partnership.

Details on each of the statutory functions are provided in section 10 and the trends are generally positive but with some ongoing priorities including maintaining Looked After Children in local placements where appropriate and possible; increasing fostering and adoption places, especially for teenagers, sibling groups and children with disabilities; assessing and managing risks presented by Registered Sex Offenders with internet convictions; responding to the significant increase in adult concern referrals; better understanding and continuing to monitor increases in Emergency Detentions and Compulsory Treatment Orders; reducing readmissions within 28 days and falls related hospital admissions; continuing to increase use of Self-Directed Support Options 1 and 2; and, increasing the proportion of carers who feel supported to continue in their caring role.

In addition to this the CSWO has had a key role in responding to statutory requests for information from the Scottish Child Abuse Inquiry and supporting subject access requests. In-line with national trends there has been a considerable increase in Subject Access Requests which places additional demands on resources. However, we have continued to promote person-centred responses to those people requesting access to their personal files.

12 Workforce Learning and Development

Social Work and Social Care Workforce Development

The Council's commitment to our employees is reflected within Our People Strategy and includes our approach to Workforce and Succession Planning, Talent Management and Developing the Young Workforce. Within Social Work, there is a culture of shared learning across professional groups and our partnerships. Increasingly we are working across Tayside with our partners in local authorities, NHS Tayside and the private and voluntary sectors. We also continue to contribute to and build on collaborative approaches to Learning and Workforce Development nationally also. We have an excellent track record of working alongside practitioners and services to develop the learning they need to practice safely and professionally and almost all new approaches developed and delivered in 2018 were approached this way.

Newly Qualified Social Work Programme

Dundee and Angus Council have worked in partnership to create an induction process for supporting Newly Qualified Social Workers (NQSW) to feel competent, confident and knowledgeable when working with children and families where there are child protection concerns.

The programme is a blended learning approach which consists of an online resource, learning audit to identify any specific learning needs for use in supervision and to identify relevant shadowing opportunities, a full day practice development session and follow up workshop event. Two cohorts ran in 2018-19, the programme is currently being evaluated and feedback from each cohort used to update programmes for 2019-20.

Participant feedback;

"I really liked the online learning resource, it was really good to see all the information in one place"

"I enjoyed the group interactive work. I think being only NQSW helps people to build confidence".

"joining Dundee and Angus together and feeling as if you're not alone with your feelings/anxieties of being NQWS."

(Dundee NQSW, Cohort 2)

Talking Social Work

Talking Social Work is a Tayside and Fife forum for anyone with an interest in Social Work. The forum is a partnership between Angus, Dundee, Fife, Perth and Kinross councils and the University of Dundee.

The forum was launched on 13th September 2018 to celebrate 50 years of Social Work in Scotland and included a presentation from Dundee's CSWO. The forum continues to go from strength to strength with Social Work students, NQSWs, Social Workers, Social Work managers, practice educators and academics participating and contributing to the talks and discussions. Since the launch of the forum the following themes/topics /research/presentations have been discussed

- 6th December 2018 -Risk
- 14th March 2019 - Social Work values and relationships

SSSC ELearning

An open learn resource has been developed in partnership with HR colleagues to support all employees who are required to, or are registered with the SSSC, and their managers. Alongside this, PRTL sessions will be available to all registered employees. The resource covers the following;

- SSSC codes of practice
- Registration responsibilities
- Clarifying which part of the register(s) the employee is required to be on
- Post-Registration Training and Learning (PRTL)
- Fitness to practise

This resource will be available to all staff by end September 2019.

Registerable workforce

We have invested significantly in our registerable workforce to ensure they are fully equipped with the occupational competences to meet management and leadership standards and our statutory requirements. We have continued to directly deliver a high proportion of the required qualifications across the SSSC registerable workforce groups. The Learning & Organisational Development Service sought approval from SQA to deliver the Professional Development Award Health & Social Care Supervision at SCQF 7. We have now successfully delivered our first cohort to 10 H&SCP employees working as Senior Social Care Officers and Social Care Organisers in homecare to meet their requirements for SSSC Registration. We are planning to deliver a second cohort in conjunction with Angus Council.

TURASLearn

TURASLearn is NHS Education for Scotland's (NES) learning platform. It provides a wide range of educational resources for the health and social care workforce. Dundee City Council, in partnership with Angus and Perth and Kinross Council's, have worked with NES to develop a Tayside learning platform hosted on TURAS. The live Tayside portal will be launched in the coming weeks and will offer Dundee City Council employees and volunteers including DH&SCP, NHS Tayside employees and third or independent sector colleagues the opportunity to access a range of protection E-learning and open learn resources from across Tayside previously unable to them.

This includes:

- Protection - basic Awareness E-learning
- Adult Support and Protection Awareness E-learning
- Human trafficking E-learning
- Self-directed Support (Tayside wide) E-learning
- Protecting children: module 1 (CP in a school setting)
- Emotional health and wellbeing (CP in a school setting)
- Protecting children with a disability E-learning
- Child protection – basic awareness E-learning
- Getting it right for every child (GIRFEC) learning resource
- Adult Support and Protection Open Learn Resource

Case Study: Billy aged 18

Billy was working with the Moving On Team who referred him to the team to support him into work. He was 16 at the time of the referral, had been Looked After for 10 years, was experiencing health and wellbeing issues and was also at risk of homelessness.

Billy worked with our Mental Health practitioner for a number of months to address his anxiety and depression. He also completed our EmployabilityTAY course to develop his employability skills and following the successful completion of this course was supported by our Employer Recruitment Incentive Officer into a Modern Apprenticeship (MA) as an Early Year's Practitioner in a local nursery. Billy was provided with ongoing support for the duration of his MA and following successful completion, he was helped to successfully apply for a job as a support worker with Action for Children.

Billy continues to work in Action for Children and has also secured a sessional Social Care Officer post with DCC.

Leadership Development

Dispersed leadership remains a key priority for our Social Work and Social Care workforce. This year we have continued to offer access to leadership development opportunities, supported employees to gain recognised leadership qualifications, delivered business coaching to those supporting change, facilitated Action Learning, developed resources to assist with an organisation-wide approach to Succession Planning and Talent Management, and worked with a range of teams and services to develop bespoke approaches to how they learn as a team.

Integrated Induction

Dundee Health & Social Care Partnership offers a unique approach to integrated induction. Sessions have been offered throughout the year that brings the integrated workforce together, from Social Work, NHS Tayside, and our Third and Independent partners. This year as part of our induction work we celebrated World Social Work day with displays, dialogue, and encouraged participants to discuss their role in relation to the theme "The Importance of Human Relationships".

Protection

In 2018-19, specific learning programmes relating to the protection of children and adults has remained a priority as in previous years. We have developed and delivered core programmes of multi-agency training on Child and Adult Protection and provided a range of face to face and high quality e-learning programmes across the protection spectrum. We also hosted a Tayside wide multi-agency conference in Dundee 'Connect with Neglect – How can I make a difference?' A Tayside approach to recognising and responding to neglect which was highly commended. This was for frontline practitioners and managers who work with children, young people and families (including unborn babies) in Angus, Dundee and Perth and Kinross.

Good Practice example:

The CLICK: Path to Protection training model

This is a ground-breaking new programme that aims to enable all frontline workers to better protect children harmed online. It is an evidence-based, multi-faceted training and support programme. This new initiative, which is supported by BT, aims to ensure that every professional working with children that are either at risk of or the victims of online abuse, understands not only what his/her role entails but also those of their colleagues from organisations jointly charged with protecting children.

Through experience of working with children harmed online, the Marie Collins Foundation MCF has found that when abuse or exploitation has involved online activity, the impacts on the victims and families are different. This, in turn, requires a specific response tailored to meet their protection needs.

The development of the model entailed a Pilot phase (2014-2016). BT contributed to the funding of the pilot which enabled the MCF to participate.

Special programmes of support for courses including the Postgraduate Certificate in Child Welfare and Protection, Adult Support and Protection, the Mental Health Officer Award, Professional Supervision, and Practice Learning Qualification remain in place and are currently prioritised for funding support in relation to our statutory duties and SSSC work streams. We continue to review effective ways to recruit to the MHO award. A council-wide personal and professional development support process also encourages individualised opportunities for study supported by the organisation. This is widely used by frontline employees as part of both career development and continued learning.

Development work has been carried out with practitioners who have specific functions under the Adult Support and Protection (S) Act 2007. This has included consultation and engagement events which has led to the development of an ASP council officer forum and new learning and development opportunities.

The ASP council officer forum meet on a monthly basis. Every other forum consists of a developmental session which may involve inviting speakers to present specific topics/learning and/or skills based sessions such as MOSAIC, Investigative interviewing etc. The monthly sessions in between the development sessions are case based peer mentoring using an Action Learning approach.

The development of a new Tayside workshop based on adult support and protection defensible decision making and SCR's has also been piloted and a rolling programme now agreed in partnership with Angus, Perth and Kinross Councils and NHS Tayside. 2nd worker (interviewer) ASP Training will also be launching in September alongside an online resource in partnership with Angus Council.

Dundee Mental Health Officers (MHO's) will be delivering workshops on "Crossing the Acts", the interface between Mental Health Care and Treatment, Adults with Incapacity and Adult Support and Protection legislation for practitioners working with children, families and adults where mental health, learning disability, capacity and protection are themes.

We continue to lead the delivery of the PDA Practice Learning (Social Services) Qualification on behalf of 6 local authorities. The leadership and quality of the programme along with the excellence in the partnership arrangements was commended in both our SSSC annual monitoring and SQA External Verification reports. We remain at the fore of the practice learning agenda across Scotland and will continue to contribute to the development of the National Partnership in Social Work Education.

Promoting Social Work Values and Standards

The CSWO has a duty to ensure Social Work values and standards as outlined in the SSSC Codes of Practice are promoted. For employers, the Codes include such requirements as making sure people understand their roles and responsibilities, having procedures in place relating to practice and conduct and addressing inappropriate behaviour. For employees, protecting the rights and interests of service users, maintaining trust and promoting independence. This includes the following:

- Recruitment and selection, including checking criminal records, relevant registers and references.
- Induction, training, supervision, performance management and a range of procedures on such things as risk assessment, records and confidentiality.
- Responding to internal or external grievances or complaints about the conduct or competence of staff.
- Ensuring line managers appropriately support staff and progress self-evaluation activities to identify strengths and areas for improvement.
- Ensuring health and safety policies are in place, including risk assessments and controls for identified hazards such as lone working and moving service users.
- Ensuring that staff required to register with the SSSC do so and are supported to meet the learning and development requirements associated with this.

Within the Health and Social Care Partnership Workforce and Organisational Development Strategy (published in June 2016) a number of guiding principles to support the workforce to deliver on the ambitions of integrated health and social care were adopted. These locally created principles sit alongside existing legislative and clinical, care and professional governance requirements, as well as the SSSC Codes of Practice. The principles include: inclusivity and equality, visible leadership, collaborative co-production and reflective practice.

Improvement Approaches

Planning for Change

The Dundee Child Protection Committee and Children and Family Service in conjunction with the Violence Against Women Partnership is in the process of transforming its response to Domestic Abuse. In October 2018 Dundee (in partnership with Perth and Kinross Council, Action for Children and Perthshire Women's Aid) was successful in attracting Scottish Government funding to implement the Caledonian System. It is hoped that implementation, which involved an extensive programme of staff training, systems change and liaison with the Sheriff Court, will lead to more perpetrators receiving an appropriate intervention, details of which will be provided in the CSWO Report covering 2019-20. The Caledonian system is an integrated system that co-ordinates the input of Women and Children's workers. The woman's perspective is carefully included within the report writing stage and support can continue on a voluntary basis if requested. The children's worker can help obtain the child's views and support any children effected.

Dundee began introducing Safe and Together in 2016 with the first cohort of training taking place. This was followed with another in 2017. The commitment to implementing Safe and Together (S&T) in Dundee has intensified over 2018-19 and we have been working together to develop a structured approach to rolling out S&T. We refreshed the action plan and established a short life working group to develop resources/guidance for Dundee. A short guide to S&T/Risk Assessment tool for domestic abuse has been developed with wider guidance in progress. Our Practitioner Forum has been meeting regularly and an online KHub group established for sharing resources, ideas and challenges. A standardised briefing presentation and guidance will be developed and a programme of cascading briefing sessions will take place over 2019-20.

Working with Vulnerable Women

The partnerships have also been working hard to improve services and responses to vulnerable women in Dundee and developments include the work of Dundee CJS Women's Team and preparation for the Female Community Custody Unit.

Since the 2011 Angiolini Commission into Female Offenders, Dundee CJS has operated a specialist Women's Team. This team includes a mental health nurse and works closely with key voluntary partners such as Tayside Council on Alcohol (TCA) mentoring, Women's Aid and Women's Rape and Sexual Abuse Centre. The whole CJS service has undertaken training in trauma informed practice but the Women's Team has been at the forefront of rolling this out and the Team nurse offers Safety and Stabilisation training to staff as well as offering these techniques through group work with women.

Dundee has been chosen as the site for one of Scotland's first two Female community Custody Units. This 16 bed unit is designed to be an alternative to the large national prison. The unit is not due to open until late in 2020 but negotiations are actively underway regarding how best to ensure the women in the unit receive the most effective, appropriate community support.

In January 2019, the Council agreed to support the establishment of a new service for vulnerable women who have had 2 or more children removed from their care. A scoping study identified 113 women who met the criteria for this service, and following multi-agency preparation work, Pause Dundee began in June 2019, provided by TCA Dundee with funding from the Robertson Trust and the Big Lottery. Pause will be reaching out to some of Dundee's most vulnerable women, most of whom will have a multiplicity of needs such as mental health, housing issues, exposure to domestic abuse, substance misuse etc. The scheme is entirely voluntary and it will be working closely with a range of relevant services to ensure that the women receive the right support to help them to get their lives back on track, whether or not they work with the Pause programme. We anticipate that the lives of women who take part in the programme will be significantly improved - with a consequential positive impact on their relationships with their children - and an evaluation will report back on outcomes in two years' time.

In Health and Social Care there have also been a number of developments that have focussed on planning for change and testing new, more integrated ways of working. These developments have been driven by changes in legislation as well as the implementation of the Health and Social Care Partnership Strategic and Commissioning Plan. They include:

- Dundee is one of a number of sites working with Healthcare Improvement Scotland's ihub to support the implementation of The Scottish Government's Strategic Framework for Action on Palliative and End of Life Care which states that everyone who needs palliative care will have access to it by 2021. The focus is on improving the earlier identification of and coordination of care for those who have palliative care needs as well as testing and evaluating Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model and identifying ways to make improvements in palliative and end of life care for people with dementia.

To gain deeper understanding of the complexity of the system and the experience of people receiving care, a number of person pathways were undertaken to strengthen knowledge. Individual experiences of care were mapped and showed evidence of positive outcomes in care where reviews, conversations and decision-making was evident at the earliest point in the journey. It is clear that planning for transitions, expertise and knowledge to interpret changes in presentation are key in achieving the wishes for end of life that matter to the individual. Identification Tools are being tested within some care homes to determine if the use of the tools supports the identification of changes and decline in a person's presentation and whether this leads to a responsive and timely response in meeting the needs identified. Where deterioration is recognised from application of the tools and/or needs unmet the individual is escalated to the Care Home Team where a coordinated response can be delivered. Initial learning from the care homes is that where tools have been considered for an individual this supports decision making around interventions.

- In April 2018 three teams supporting local care homes integrated and co-located to form the Care Home Team. The team includes a Social Work team manager; two advanced nurse practitioners; four mental health nurses; four general health nurses and five social workers. The team are able to maximize the opportunity for a professional from the right discipline at the right time to provide tailored support in achieving people's identified outcomes. In order to further integrate and improve services the team have held a number of team development and joint training sessions. The sessions have brought increased understanding each other's roles, supported the unification of team processes and built stronger links between colleagues each professional group in order to provide the best support care homes and people living there.

The vision of the Care Home Team is:

“For people living within care homes to have the best experience as possible”.

Care Home Team Case Example:

Mrs H moved into a care home after her husband died. Mrs H had a diagnosis of dementia and as her dementia progressed she frequently became distressed. When distressed she sometimes hit out at other frail residents. The workforce in the care home struggled with this, and the management stated that they would have to terminate her placement.

The Care Home Team undertook a joint adult protection investigation. The team identified processes which will better support the workforce in care homes in reducing risk to individuals like Mrs H and to the other residents.

Support and training was provided to the workforce by the mental health nurse. This increased workforce understanding of dementia and how best to manage the symptoms.

Mrs H's incidents caused by distress have been reduced and there is a reduced risk of further incidents with other residents. The general/physical health nurses will continue to support the workforce in the care home to identify changes/deterioration in Mrs H's overall health which may affect her levels of distress.

The Social Worker from the team reviewed the overall circumstances of Mrs H's care home placement and confirmed that Mrs H had become much more settled and the workforce in the care home were now more able to meet her needs. She has continued living in the care home.

During 2018-19 the Partnership worked with wider Community Planning partners to establish the Transforming Public Protection Programme. The programme was set-up in response to the findings of the Joint Inspection of Adult Support and Protection that was carried out in 2017-18, as well as findings from previous inspections of services for Children and Young People and from Significant Case Reviews that have been carried out in Dundee. The Transforming Public Protection Programme is being delivered in partnership with The Care Inspectorate who have committed to providing active support for the programme through the provision of advice as well as participation of their own staff in programme activities.

The programme aims to ensure that our approach to public protection is of a consistently high quality and is supported by the right range of resources. As well as focusing on improving the leadership of public protection responses, work will also take place to make sure that processes that provide immediate and longer-term responses to people in need of protection are as good as they can be.

The first phase of the transformation programme has focused on 3 frontline practice teams leading activity to improve practice in relation to chronologies, risk assessments, support and supervision of frontline staff and quality assurance of our day-to-day protection work. These teams, with support from the Care Inspectorate, have been researching best practice and testing new approaches in their own practice. As these small tests of change develop the teams will be sharing their learning and successes with practice teams across the Partnership.

Quotes from team members

“I was a bit sceptical to begin with but, as we’ve moved forward, see this as an opportunity to improve things for our service users and the team as a whole.”

The second phase of the programme will focus on improvements relating to leadership of public protection, particularly in relation to the role of the Chief Officers Group and Public Protection Committees / Partnerships. This work began at the start of 2019-20 and will be followed later in the year by a third phase focussed on integration and service redesign of functions that respond to protection concerns, including progressing joined-up approaches to the various multi-agency protection processes that operate across the life span and scope of public protection.

Personalisation and Outcome Focused Practice

The Personalisation Delivery Group has continued to make good progress towards the recommendations that were agreed last year. The tasks completed include:

- The development of a quality charter for direct payment employers. This outlines what people managing a direct payment in a self-directed context should expect from their employees as a minimum standard of quality of care and support.
- The formalisation of a third-party managed account process to support those who may struggle to manage a direct payment due to cognitive capacity or a disability.
- Service specifications for care and support services now allow for the supported person to 'bank' time so that they can then use this time more creatively to meet their own personal outcomes.
- The appointment of a new lead officer for Personalisation.

Community and asset based approaches to assessment continue to develop locally with greater links being made with localities and the locality planning processes. Community resources are currently being mapped and consideration given to how they can support people in collaboration with Health and Social Care services. The number and availability of service providers has also been enhanced so that supported persons have more opportunities to receive a service that is personalised for them.

The outcome focused assessment for adults is currently being reviewed to incorporate a community based approach to assessment and a focus on persons own assets, personal strengths, supports, friends and family.

Additional learning and development opportunities continue to be developed incorporating all aspects of personalised practice, ranging from referral, through assessment, agreeing budgets, offering choice and control through to reviewing outcomes.

Self-Directed Support

In the Health and Social Care Partnership two specialist Social Workers have been employed with a specific focus on supporting the implementation of the Social Care - Self Directed Support (Scotland) Act 2013 across our services. These Social Workers support staff through the application process for options 1 and 2 to ensure that these options are understood and accessible to people using services. Dundee Carer's Centre also continue provide support to people accessing direct payments.

The introduction of the two specialist Social Workers has impacted on the number the numbers of Option 1s and 2s across adult health and social care services. An increase of 39% has been observed for option 1s and 105% increase for Option 2s. The annual comparators with other Health and Social Care Partnerships have not been published yet by Scottish Government for 2017-18, therefore, it is unclear where Dundee is currently sitting compared to others.

	2014-15		2015-16		2016-17		2017-18		2018-19	
Option	n	Cost	n	Cost	n	Cost	n	Cost	n	Cost
Option One - Total	49	£860,256	58	£928,673	60	£1087024	74	£1,522,411.91	103	£1,875,293.80
Option One - Adults only	40	£803,313	50	£865,451	52	£1,016,659	65	£1,413,325.70	79	£1,640,764.55
Option Two	12	£22,691	22	£96,279	30	£308,726	39	£287,817.47	70	£613,366.38

Self Directed Support Case Study

Mrs X is a 95 year old lady living with her son, daughter in law and her grandchildren in Dundee. Mrs X has a diagnosis of Dementia. Although not always able to recognise family she is aware that she is with family and living where she wishes to be.

Due to her Dementia Mrs X can only speak and understand her first language. She requires to be reassured in her native tongue and this can only be achieved within her own home setting.

In Mrs X's culture it is traditional for the family to look after the elders of the family. Mrs X wishes to be cared for within the family unit. The family want her to remain within the family unit and will continue to support Mrs X to have her care and support delivered under Option One of Self-directed Support.

Due to her life experiences Mrs X gets distressed overnight and may shout out overnight. Her family take turns to sit with her overnight and at times get her out of bed to comfort her. This can take a number of hours before Mrs X is comforted and settled.

The family have been able to use Option One of Self-directed Support to employ Personal Assistants who speak Mrs X's first language. This enables Mrs X's care and support needs to be met whilst the family receive much needed support and respite to enable them to continue in their caring roles.

As there is not a care home that can meet Mrs X's individual and unique needs, through receiving a direct payment this is the most flexible way of delivering the support to her in her own home surrounded by her family.

Ms Y is a 44 year old lady who lives with her two children one of whom has additional support needs. She has a number of health conditions that impact on her ability to function and is now registered blind.

Ms Y describes her life as living in a prison for a crime she did not commit.

Ms Y is to use her Option One of Self-directed Support to employ Personal Assistants (PAs) to provide support to her to make meals for her and her family. They will provide support to her when she is carrying out household tasks such as housework and laundry. Ms Y will utilise her PAs to enable her to carry out food and clothes shopping.

Ms Y cannot ensure her younger child's safety when outside and she has never been able to play outside with her, nor has she been able to take her to a play park. Having a PA to support her to play in the garden with her young child is life changing for Ms Y.

Without the provision of support through Option One Ms Y stated she would not be able to continue in her parental role.

Master T is a teenage boy who has Muscular Dystrophy which is a degenerative condition. His parents asked for support to take him out and allow them to have a break. They decided that Direct Payments would encourage Master T to go out with a PA who was younger in the community in his wheelchair which seemed to be a barrier for him.

Having the choice of who to employ makes Master T feel more included and helps him to live his life with choice and dignity as his condition progresses. The PA plays computer games and has similar interests which has helped Master T adapt to his condition and accepting support to be independent in the city. His parents feel supported and have time together and recuperate from caring. They found that Option One was ideal to meet their son's needs.

Challenges for the year ahead

Over the next year our priorities for Social Work and Social Care will be:

- Across all services, strengthening our approaches towards protecting the public through the implementation of a Transforming Public Protection Programme with the Care Inspectorate to improve practice and processes in respect of assessments, chronologies and plans.
- Across all services, strengthening our approaches towards vulnerable women, including through the New Beginnings Team, Pause Programme, new Community Custody Unit, Caledonian Programme and Safe and Together.
- In Children's Services, continuing to lead on a GIRFEC Improvement Programme which focuses on prevention through the related initiatives of a CELCIS Addressing Neglect Programme, What Matters 2 U and a Fast Online Referral Tracking system.
- In Children's Services, continuing to improve the placement stability of Looked After Children and Care Leavers to fully meet their health and wellbeing needs and support them towards positive destinations in adulthood.
- In Children's Services, working with the Centre for Excellence for Looked After Children on a PACE programme to improve approaches towards children and young people moving into permanent fostering and adoptive placements.
- In Children's Services, responding to the findings and recommendations of the Independent Care Review, which will cover the care system as a whole and apply to both Social Work and other partners.
- In Community Justice, work with the Scottish Prison Service to develop new approaches to women, employability, prison release, electronic monitoring, males aged 21-26 years at risk of custody and young people.
- In Health and Social Care, aligning statutory service delivery to localities and taking forward major service re-designs in mental health services and substance misuse, with each informed by the recommendations of the Dundee Drug Commission and pending Mental Health Inquiry.
- In Health and Social Care, to continue to target improvement activity to prevent falls and to increase the number of people accessing self-directed support options 1 and 2.
- In Health and Social Care, to work with communities to better understand performance information that demonstrates inequalities in outcomes between Local Community Planning Partnerships areas and to identify ways to reduce these inequalities.
- In all areas, addressing major financial challenges which will continue to require new ways of working, the active involvement of communities in service redesign, joint work with neighbouring authorities and prioritisation of resources towards key needs.

Appendix 1

Summary of Care Inspectorate Gradings – All Registered Services with the exception of Care Homes in Dundee

Organisation	Name of Service	Service Type	Category LA/Priv/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Dundee City Council	White Top Centre	Adult Respite	LA	16/10/18	6	6	5	6
Dundee City Council	Mackinnon Centre	Adult Respite	LA	1/11/18	5	5	6	6
Dundee City Council	Oakland Centre	Support Service	LA	28/09/16	6	5	6	5
Dundee City Council	Weavers Burn	CAH/HS	LA	17/08/18	5	n/a	5	5
Dundee City Council	Craigie House	Care Home	LA	22/11/18	5	4	5	4
Dundee City Council	Menzieshill House	Care Home	LA	13/10/17	5	5	5	5
Dundee City Council	Turriff House	Care Home	LA	07/03/18	5	5	5	5
Dundee City Council	Janet Brougham House	Care Home	LA	05/10/17	5	6	5	4
Dundee City Council	Gillburn Road	Respite	LA	24/08/18	5	n/a	n/a	4
Dundee City Council	The Junction	Care Home	LA	03/09/18	5	n/a	5	n/a
Dundee City Council	Millview Cottage	Care Home	LA	22/11/18	4	n/a	4	n/a
Dundee City Council	Drummond and Forester House	Care Home	LA	22/11/18	5	3	n/a	n/a
Dundee City Council	Fairbairn St YPU	Care Home	LA	27/02/19	4	n/a	n/a	5
Dundee City Council	Fostering Services	Fostering	LA	20/11/17	5	n/a	n/a	4
Dundee City Council	Adoption Services	Adoption	LA	20/11/17	5	n/a	n/a	4
Dundee City Council	Through-care & Aftercare Service	Housing Support Service	LA	17/03/16	4	n/a	5	3
Dundee City Council	Homecare Social Care Response Service	Housing Support Service	LA	19/10/18	5	n/a	n/a	5
Dundee City Council	Care at Home City Wide	Care at Home and Housing Support combined	LA	17/12/18	5	n/a	5	5

Appendix 1 (continued..)

Dundee City Council	Home Care Enablement and Support City Wide and Community MH Older People Team	Care at Home and Housing Support combined	LA	23/01/19	5	n/a	5	n/a
Dundee City Council	Supported Living Team	Support Service	LA	19/11/18	5	n/a	n/a	5
Dundee City Council	Dundee Community Living	Support Service	LA	28/09/18	6	n/a	n/a	6

n/a - not assessed (including where there is no requirement to be assessed)

Notes



0188-19

2018-

18-19

2018

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REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD –
17 DECEMBER 2019

REPORT ON: JOINT INSPECTION (ADULTS): THE EFFECTIVENESS OF STRATEGIC
PLANNING IN PERTH & KINROSS (SEPTEMBER 2019)

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB51-2019

1.0 PURPOSE OF REPORT

- 1.1 To inform the Integration Joint Board (IJB) of the published inspection report of strategic planning within Perth & Kinross Health and Social Care Partnership and planned activity to identify areas of learning for the Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Note the content of this report and the Perth & Kinross inspection report published by the Care Inspectorate and Healthcare Improvement Scotland (attached as Appendix 1 and summarised at 4.3).
- 2.2 Note that the report will be reviewed by the Clinical, Care and Professional Governance Group and other relevant stakeholder groups to identify areas of learning and associated improvement actions (section 4.4 and 4.5).
- 2.3 Instruct the joint-chairs of the Clinical, Care and Professional Governance Group to provide an assessment of the Dundee position, identified areas of learning and associated improvement actions to the Performance & Audit Committee by March 2020.

3.0 FINANCIAL IMPLICATIONS

- 3.1 None.

4.0 MAIN TEXT

- 4.1 As part of the statutory programme of inspection activity for Health and Social Care Partnerships across Scotland Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to jointly report on the effectiveness of strategic planning by Integration Authorities. Joint inspections of strategic planning have within their scope how Integration Authorities plan, commission and deliver high-quality services in a co-ordinated and sustainable way.
- 4.2 Joint inspections of strategic planning focus on three key areas:
- How well the partnership has improved performance in both health and social care;
 - How well the partnership has developed and implemented operational and strategic planning arrangements and commissioning arrangements; and,
 - How well the partnership has established a vision, values and aims across the partnership and the leadership of strategy and direction.

- 4.3 The inspection of strategic planning in Perth & Kinross took place between January and March 2019, with the inspection report published in September 2019 ([https://www.careinspectorate.com/images/documents/5288/Perth%20and%20Kinross%20joint%20inspection%20\(adults\)%20strategic%20planning_September%2019.pdf](https://www.careinspectorate.com/images/documents/5288/Perth%20and%20Kinross%20joint%20inspection%20(adults)%20strategic%20planning_September%2019.pdf)). The overall evaluation of Perth & Kinross Partnership was:

- Key performance outcomes – WEAK (important weaknesses).
- Policy development and plans to support improvement in service – ADEQUATE (strengths just outweigh weaknesses).
- Leadership and direction that promotes partnership – WEAK (important weaknesses).

Consequently 9 priority areas for improvement were identified by the Care Inspectorate and Healthcare Improvement Scotland:

1. Approaches to performance measurement and management, including developing a performance framework covering data and information about outcomes and that allows benchmarking to inform improvement.
2. Strategic planning and commissioning processes, including ensuring capacity is used effectively to deliver agreed strategic priorities.
3. Establishing a systematic approach to monitoring and reviewing the implementation of the strategic commissioning plan and other strategies and plans that support this.
4. The priority given to evaluating the impact of plans and strategies.
5. Ensuring that workforce planning is maintained as a key priority in all activities and encompasses the workforce across NHS Tayside, the Council and third and independent sector providers.
6. Co-production with care providers and housing services to identify solutions to strategic challenges, including co-producing a market facilitation plan.
7. Review and monitor the effectiveness of participation, engagement and communication strategies.
8. Structure and processes management, strategic planning and governance to ensure they are fit for purpose and understood by all stakeholders.
9. Development and support to IJB members.

- 4.4 This was the 6th joint inspection in the Care Inspectorate and Healthcare Improvement Scotland's current programme of strategic planning inspections. Given the particularly close links between Dundee and Perth & Kinross considering the results of their inspection is particularly relevant in contributing to continuous improvement, particularly in relation to any learning from the inspection that relates to regional issues or interfaces with regional partners (such as NHS Tayside).

- 4.5 The Clinical, Care and Professional Governance Group (CCPGG) for Dundee Health and Social Care Partnership, jointly chaired by the Head of Health and Community Care and the Medical Director, will review the inspection report in detail to identify areas for improvement in Dundee and develop an action plan to address these. The CCPGG will include other relevant stakeholders from out-with the membership of the group in this work. Their assessment of the Dundee position, identified areas of learning and associated improvement actions will be reported to the Performance and Audit Committee by March 2020.

5.0 POLICY IMPLICATIONS

- 5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

- 6.1 This report has not been subject to a risk assessment as it does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

- 7.1 The Head of Service – Finance, Business Planning and Strategic Commissioning, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

- 8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

- 9.1 None.

David W. Lynch
Chief Officer

DATE: 17 December 2019

Kathryn Sharp
Senior Manager, Strategy and Performance

JOINT INSPECTION (ADULTS)
The effectiveness of strategic planning in
Perth & Kinross Health and Social Care Partnership

JOINT INSPECTION (ADULTS)

The effectiveness of strategic planning in
Perth & Kinross Health and Social Care Partnership

September 2019

The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

Healthcare Improvement Scotland works with healthcare providers across Scotland to drive improvement and help them deliver high quality, evidence-based, safe, effective and person-centred care. It also inspects services to provide public assurance about the quality and safety of that care.

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1. About this inspection

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to report on the effectiveness of strategic planning by integration authorities¹. This includes how integration authorities plan, commission and deliver high-quality services in a coordinated and sustainable way. In this inspection the focus was on how well the partnership had:

- improved performance in both health and social care
- developed and implemented operational and strategic planning arrangements, and commissioning arrangements, and
- established the vision, values and aims across the partnership, and the leadership of strategy and direction.

To do this we assessed the vision, values and culture across the partnership, including leadership of strategy and direction. We evaluated the operational and strategic planning arrangements (including progress towards effective commissioning) and we assessed the improvements Perth & Kinross Health and Social Care Partnership (HSCP) has made in health and social care services that are provided for all adults.

Integration brings changes in service delivery, but we recognise that it takes time for this to work through into better outcomes. Indeed, at this early stage of integration, we would expect to see data showing some room for improvement in the outcomes for people using health and care services, even where leadership is effective and planning robust. In these inspections of strategic planning we do not set out to evaluate people's experience of services in their area. Our aim is to assess the extent to which the HSCP is making progress in its journey towards efficient, effective and integrated services that are likely to lead to better experiences and improved outcomes for people who use services and their carers over time.

Both the Care Inspectorate and Healthcare Improvement Scotland undertake a variety of other scrutiny and improvement activities, in collaboration with other scrutiny bodies. This provides assurance about the quality of services and the difference those services are making to people in communities across Scotland.

The HSCP comprised Perth & Kinross Council and NHS Tayside, and is referred to as 'the partnership' throughout this report. The scope of the inspection covered a period of two years from February 2017 to February 2019. The inspection activity took place between January 2019 and March 2019. The conclusions within this report reflect our findings during the period of inspection. An outline of the quality improvement framework is shown in Appendix 2. There is a summary of the methodology in Appendix 3. In order that our joint inspections remain relevant and

¹ The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on integration authorities to develop a strategic plan for integrated functions and budgets under their control.

add value, we may refine our scrutiny methods and tools as we learn from each inspection.

2. Perth and Kinross context

Geographical

Perth and Kinross is located in Central Scotland, covering 5,286 square kilometres, and shares borders with the areas of Aberdeenshire, Angus, Highland, Clackmannanshire, Dundee, Fife and Stirling.

Demographic

On 30 June 2018, the population of Perth and Kinross was 151,290. This was an increase of 0.1% from 151,100 in 2017. In terms of overall size, the 45-64 age group was the largest in 2018, with a population of 43,900. In contrast the 15-24 age group was the smallest, with a population of 15,753.

Demographic projections

Over the next ten years, the population of Perth and Kinross is projected to both increase by 4.5% and shift in composition. Contributing factors are a projected 1.9% decrease due to natural change (more deaths than births) but total net migration is projected to contribute a population increase of 6.5% over the same period.

The average age of the population of Perth and Kinross is projected to increase as the “baby boomer” generation ages and more people are expected to live longer.

Between 2016 and 2026, the 16 to 24 age group is projected to see the largest percentage decrease (-9.9%) and the 75 and over age group is projected to see the largest percentage increase (+33.1%). In terms of size, however the 45 to 64 age group is projected to remain the largest age group.

Service demand impacts

The key challenges for Perth and Kinross in response to the shift in composition of the population include the rising demand for services, whilst managing changes to public services and the impact of a reduction in the financial budget. There is also a predicted increase in the number of people in Perth and Kinross living with dementia and long term conditions. To address this, new models of care are required in order to reduce the use of large hospital services and there needs to be greater investment in community health and social care services. These will enable people to be supported in and by their local community, for example through the Communities First Transformation Project.

Reducing unplanned admissions to hospital and delayed discharges remains a key priority for the partnership. This is a difficult priority as it requires a large number of partners to work collaboratively including GPs, the Scottish Ambulance Service, independent care providers and third sector health and social work staff to deliver person-centred care.

Political

Perth & Kinross Council comprises 12 electoral wards and 40 elected members. Currently the administrative partnership includes the Scottish Conservative and Unionist Party Group and the Scottish Liberal Democrat Group.

At the Scottish Parliament, Perth and Kinross is represented by two constituency seats – Perthshire South & Kinross-shire and Perthshire North, both represented by the Scottish National Party. At the UK Parliament, Perth and North Perthshire is represented by the Scottish National Party and Ochil and South Perthshire by the Conservative and Unionist Party.

Economic

In 2018, 77.9% of people of working age (16–64) in Perth and Kinross were in employment. This shows an increase of 1.1% against the previous full year and is well above the average for Scotland. In 2017, the percentage of workless households in Perth and Kinross remained steady at 15.3% continuing to remain below the average across Scotland (18%) for the same period.

Inequalities

Although Perth and Kinross has relatively low levels of deprivation compared to other areas of Scotland, it has key areas of deprivation. The 2016 Scottish Index of Multiple Deprivation (SIMD) identified that parts of Perth City and Rattray are among the 10% most deprived areas of Scotland. Approximately 85% of the most deprived residents live in Perth City, with the remainder living in North Perthshire, acknowledging the weaknesses in SIMD to understand deprivation across an area of this nature. “Access deprived” people in rural communities have challenges accessing services and support. These inequalities between different communities are in part responsible for the significant health inequalities that exist locally.

Individuals living in an area of high deprivation are more likely to experience poor health over the long term compared to individuals in a less deprived area. Life expectancy in Perth and Kinross for males and females decreased where levels of deprivation increased, particularly for males. Inequalities in health between people living in the most deprived and least deprived areas are evident given that male life expectancy ranges from 75–81 years and female life expectancy ranges from 80–84 years, depending on where people live within Perth and Kinross.

Governance

Perth and Kinross Integrated Joint Board (IJB) was formed in November 2016. The IJB has responsibility for strategic commissioning and planning. It also manages a range of hosted services on behalf of NHS Tayside, Angus and Dundee partnerships. Hosted services include all general adult psychiatry, learning disability, substance misuse, inpatient services for Tayside, prisoner healthcare, community dentistry and podiatry.

Financial position

The budget as at the end of 2018/19 for Perth and Kinross HSCP was £213 million. Strong financial planning is required to ensure that the partnership's limited resources are targeted to maximise the contribution to their objectives. The partnership, like other public sector bodies, is facing financial challenges and will need to operate within tight constraints as a result of the difficult national economic outlook and the increasing demand for services.

During 2017/18, the partnership achieved a balanced budget position despite there being key pressures on the system, where demand is currently outstripping available resources.

3. Inspection findings

Performance

A review of the partnership's performance against national outcome measures showed that across several indicators the partnership's performance was in line with the Scottish average. Senior partnership staff recognised that the performance focus had been on capacity and flow in the hospital. This had resulted in improvements in the number of people delayed in hospital and the number of people being readmitted within 28 days of going home. The progress that the partnership had made in reducing unscheduled care² was evident in the staff survey. Respondents mostly agreed (68%) that the partnership promoted early intervention and prevention to ensure that fewer people were admitted to hospital.

The partnership's delayed discharge levels were historically high. To enable the partnership to address this, a number of initiatives had been implemented. These included the discharge hub, frailty model and the Home Assessment and Rehabilitation Team (HART). The partnership also ensured that each adult in hospital was regularly monitored and had a planned date for discharge from hospital. As a result of this, the number of lost bed days due to delayed discharges had decreased. The partnership was performing slightly better than the national average. There had been a modest decrease for the 18–74 age group and there had been a greater decrease for the older age group aged 75+. Both age groups showed a further reduction over the three or four months prior to the inspection. These are positive developments, however it is too soon to ascertain if this reduction will be sustainable.

The partnership's performance was better than the Scottish average in some areas when measured against a range of nationally published datasets, the national health and wellbeing outcomes³ and the Scottish Government's health and social care integration indicators⁴. These included:

- the number of people attending hospital as a result of an emergency and the associated bed days occupied
- the number of people being readmitted to hospital within 28 days of going home
- delivery of care at home and intensive home care for adults aged under 65
- the percentage of the last six months of life spent at home or in the community, and
- the proportion of people both referred for dementia post-diagnostic support and completing it.

² Unscheduled Care" is defined as NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It follows that such demand can occur at any time and that services to meet this demand must be available 24 hours a day.

³ Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families.

⁴ Criteria that measures the effectiveness of health and social care integration in a partnership area.

Areas in which the partnership did not perform as well as other partnerships in Scotland included:

- delivery of care at home and intensive home care for adults aged over 65
- the use of community alarms and assistive technology to maintain people's independence and ability to realise their choice to remain at home
- the proportion of adults agreeing that the services they received had allowed them to maintain or improve their quality of life
- the number of long stay residents in care homes, and
- the average length of stay for people living in care homes.

Operational performance monitoring

The partnership had not put in place a robust performance framework that allowed it to systematically monitor performance across all its activities and service areas. This meant that whilst there was some performance information available in relation to specific initiatives or for specific teams, senior managers and the IJB did not have a comprehensive picture of how well the partnership was performing. They could not, therefore, routinely identify and capitalise on areas of strength or effectively focus resources and improvement activity where it was needed.

The partnership demonstrated the ability to capture and analyse performance information effectively in a number of key areas which were a focus for their attention. A performance monitoring framework had been implemented in the mental health inpatient unit and for HMP Perth health services, in response to identified operational risks. Other areas where performance information was used effectively included unscheduled care and prescribing.

In unscheduled care, the partnership had developed an integrated discharge hub and frailty models for Perth Royal Infirmary, which were introduced to address the unsustainable use of elective care beds for acute medical care and to ensure timely discharge. Robust performance monitoring of the impact of these services had shown improvement. There had been a reduction in the number of people with acute medical conditions using beds designated for planned surgery. This had reduced the number of planned surgeries being cancelled. The discharge and frailty teams had a clear understanding of their performance and had used this to continually monitor the impact of the improvements. The teams were planning to include personal outcomes in their performance monitoring to make it more robust and meaningful.

In prescribing, the associate medical director of the partnership had reviewed the prescribing budget in order to gain a better understanding of the factors affecting prescribing and ultimately, to reduce costs. This led to the identification of areas of improvement and further discussions relating to the variance in prescribing across different GP clusters. This work identified factors for prescribing which were believed to be specific to the Perth and Kinross population within the NHS Tayside area. This data will be used to seek a review of the funding arrangement with NHS Tayside to

reflect the differential prescribing needs of the three partnerships. Detailed monthly reports have been developed in conjunction with information services division Scotland to assess spend and variance.

Another new initiative, the HART team, could evidence through the use of performance information that it had a positive impact on reducing delayed discharge. However, despite anecdotal evidence of positive outcomes from people as a result of the team's interventions, there was no formal mechanism in place to monitor the performance or wider impact of the team. The HART team focused on supporting people being discharged from hospital and combined care at home and reablement. It was providing a "discharge to assess⁵" model. The HART team provided support for up to six weeks after discharge and carried out assessments in a person's home. The team then agreed the package of care required for the individual and made the necessary arrangements for a provider to deliver. The HART team delivered positive results and reduced the number of delayed discharges. However, for the positive outcomes to be sustained there had to be effective community services with sufficient capacity. The partnership was not monitoring the impact on community services. Specifically, we heard about frequent onward referral from the HART team for 15-minute care at home community check visits. Fulfilling these visits posed a problem for care at home providers as these visits increase travel time between visits. The partnership has not developed an action plan to evaluate or address this impact.

Unfortunately, these positive examples of the use of performance monitoring information were not representative of a more comprehensive approach.

Performance management

The partnership was at an early stage in developing a more systematic approach to performance management which could inform strategic planning. It planned to do this through the clinical and care governance forum and the new strategic programme boards that the partnership has established to support improvement in key areas of service delivery.

The partnership intended that its Care and Clinical Governance Performance Management Framework would be aligned to the national Health and Social Care Standards. It would illustrate demand for services and associated workforce planning requirements. It would also support the allocation of resources, including finances to ensure that both care and support met the partnership's aims. Community health data would be a key component of this framework, however, the partnership and NHS Tayside had so far been unable to agree a process for sharing this.

The partnership had implemented new strategic programme boards to drive the strategic direction for primary care, older people's unscheduled care, support for

⁵ Discharge to Assess is an integrated person-centred approach to the safe and timely transfer of medically ready patients from an acute hospital to a community setting for the assessment of their health and/or social care needs.

unpaid carers and mental health. It is in the terms of reference for each of these boards (with the exception of mental health and wellbeing) that they would be responsible for developing a performance framework. The partnership had set out, in its draft strategic framework for the programme boards, how they would be supported to develop their performance frameworks and use data. However, there was not always capacity to provide this support in practice. There was no mechanism to develop an overall integrated performance framework for oversight of the IJB's performance, or to ensure that the performance frameworks would be aligned with each other to provide a coherent overall picture.

During the two year period of the inspection the partnership had poor strategic leadership of performance. Senior members of staff had responsibilities for leading performance. However, the partnership acknowledged that there was confusion about the different roles and responsibilities. There was no evidence of an integrated approach to monitoring and reporting performance data. Senior staff meetings did not prioritise performance analysis. Meaningful use of data at locality level was hindered by a lack of support resource available to staff. The partnership did not have a robust performance framework aligned to the Strategic Commissioning Plan (SCP) to measure progress, or to measure performance against their strategic priorities.

The partnership also lacked a structure for the development of integrated performance reporting arrangements which are required for risk management, locality managers and the IJB. Performance information did not appear as a routine standing item on the agenda of senior staff meetings. Until recently the IJB audit and performance committees did not regularly receive performance information. It was noted that minimal performance information was shared with the IJB – the exceptions being one delayed discharge report in March 2018 and their own annual report. The Older People's Unscheduled Care Board report in February 2019 was the first of a regular series of reports to be scrutinised by the members. The partnership staff who created the report and IJB members agreed that more work needed to be done to agree the format and content of the report and improve the quality.

There was a lack of clarity about what data was available to staff or how it might be accessed, used or shared. Just over a third (38%) of respondents agreed that the partnership provides feedback to staff on how well they are doing to meet locally and nationally set targets and how this compares to other partnerships around Scotland. Staff need the skills and knowledge on how to make the best use of data to support key outcomes, and to prioritise and allocate resources.

There was a lack of clarity about where the data was routinely sent to and where responsibility for reviewing performance and monitoring of the data was located. Limited performance information was available to locality managers, although they could access caseload and operational activity data from the social care case

recording system and were provided with delayed discharge data. However, similar operational and caseload information is not routinely drawn from community health data. The three localities reported that this had led to difficulties in demonstrating the impact of service provision and delivery and identifying areas of need within their respective localities.

Annual performance report

The partnership published its annual performance reports in line with legislative requirements. The format was useful, and made the reports easy to read and understand. The reports demonstrated how significant decisions had contributed to progress towards the health and wellbeing outcomes. Additionally, the partnership's performance was compared to the national average. However, performance was not assessed against the intentions stated in the strategic commissioning plan. There was no evidence about how stakeholders had been engaged and consulted. The annual reports were missing information which best practice would suggest should be included. For example, the financial statement in the performance reports did not include how the money spent had contributed to achieving the health and wellbeing outcomes. Additionally, there was no information about budgets or expenditure at locality level.

Strategic needs assessment

Strategic needs assessment data was integrated into the partnership's first strategic commissioning plan. This data supported the strategic priorities and actions set out in the plan. However, the entirety of the data had not been published by the partnership and it was not available to the partner organisations to assist them in planning and developing their services. Additionally, the information had not been systematically updated and reviewed on an ongoing basis in order to identify changes in patterns of need, trends and service activity. A number of factors contributed to the inconsistency of updating the information. These included data being on different systems, limited analyst capacity, data sharing restrictions and delays in accessing data.

It was positive that the partnership had developed an improved strategic needs assessment to support its next strategic commissioning plan and locality working. This aimed to provide a wider range of data on demographic profiles, service activity and costs at a locality level. This should support the identification of service gaps, help to predict future need and drive improvement.

Strategic planning 2016–2019

The partnership's first strategic commissioning plan (2016–2019) set out five strategic priorities. These were underpinned by a wide range of ambitious actions across the services and activities for which the partnership had responsibility. The partnership had not maintained a balanced and effective approach to implementing all of its priorities. The partnership had allocated significantly more management

capacity, effort and performance management in reaction to existing operational pressures rather than addressing longer term strategic challenges. As a result, the partnership had made progress in some key priority areas such as reducing delayed discharges and maintaining slightly lower levels of unscheduled care than the Scottish average. Other priorities like workforce and complex care were progressing slowly, without a developed strategy.

The capacity required to take forward the redesign of hosted mental health and learning disability inpatient services had impacted negatively on the delivery of other priorities. However, it was not possible to conclude that this was the single reason for lack of progress in some areas. This is because the partnership had not sufficiently taken into account its capacity to deliver the ambitious range of actions within its plans. It had also not given enough consideration to whether the actions were achievable and realistic or how their success would be measured. Timescales were routinely extended, indicating that plans were not grounded in effective programme and project management. Oversight from management teams was ineffective and there were infrequent attempts to evaluate the impact of actions in order to inform future planning.

The partnership had made significant progress in implementing a number of actions from its strategic commissioning plan (2016–2019), including:

- retendering care at home services
- development of the HART “discharge to assess” model
- redesign of day services
- development of localities
- implementation of communities first (building community capacity to respond to need in different ways)
- engagement with NHS Tayside to establish an integrated clinical strategy, and
- successfully moving resources from inpatient provision for people with dementia to post diagnostic support and care home liaison.

The partnership's approach to unscheduled care and reducing delayed discharges demonstrated its ability to develop and implement a coordinated approach to addressing challenges faced by different parts of the health and social care system. The multi-agency Older Persons Service Improvement Group (OPSIG) coordinated the planning and development of the frailty model, discharge hub and HART team. These services aimed to maintain patient flow from hospital to the community. The plans were founded through the development of positive working relationships with clinicians at Perth Royal Infirmary and other NHS Tayside colleagues.

The partnership had devoted significant effort and capacity to consultation, development and selection of options for the redesign of inpatient mental health and learning disability services, which it hosted on behalf of the three Tayside HSCPs. It was concerning that the partnership did not take a coordinated approach to

redesigning mental health services from the outset. Early plans for mental health and learning disability inpatient services did not include redesign of community services. They also did not take sufficient account of the inpatient care context and ensure that workforce challenges would be addressed and the environments would be suitable for future care provision. The partnership has sought to improve the coordination of planning by the recent development of the Mental Health Alliance. This brought together the knowledge and expertise of the three partnerships to work collaboratively to develop community pathways and improve mental health provision. Recent intelligence gathering from community mental health services also aimed to inform the transformation process. The transformation of inpatient services had been under way for a significant period of time before coordinated planning activities which included community services commenced.

There was limited progress in developing and implementing some key strategies. Workforce challenges were identified clearly in the first strategic commissioning plan. The partnership had not maintained a clear focus on this priority. It was not evident that workforce issues had been a key consideration in the development and implementation of the partnership's plans.

The provision of care for people with complex needs was a source of overspend for the partnership. The partnership's response to this challenge had lacked a wider long term strategic approach. Positive steps had been taken to understand and manage demand. However, these had simply focused on managing budget pressures.

Senior managers took the view that increased demand was unavoidable as it was not possible to predict when the complexity and resources required by some individuals would increase. While this was true, they had not considered if the partnership's existing comparatively high levels of provision of intensive homecare for adults aged under 65 indicated the requirement for a wider strategy. Especially when cost pressures from implementing the Scottish Living Wage and the limited availability of the workforce is taken into account.

The partnership has missed opportunities by not moving early enough to redesign services which combined accommodation with care and support to meet need in a more sustainable way. It had also not fully engaged with key partners such as care providers and housing to co-produce a solution when the budget pressures from complex care were first identified.

This was being improved in relation to housing but co-production with care providers was still underdeveloped. A housing contribution statement had been integrated into the partnership's first strategic commissioning plan (2016–2019). The contribution of housing had been reviewed and reported to the IJB. The IJB had agreed to build on this by integrating housing planning into the revised strategic plan that the partnership was developing. This was focused on the work of the independent living

group which brought together housing staff with managers from the partnership to analyse the demand, supply, pathways and new housing models to support independent living for both older people and adults. The commissioning and contracts team had worked closely with housing to identify a register of adapted tenancies. Housing had worked to respond to individuals identified by social workers requiring specific adaptations in order to live independently.

There was little evidence that the partnership had considered whether it had capacity to deliver the ambitious range of actions within its plans. The partnership maintained a number of existing strategies that had been developed before the development of its strategic commissioning plan (2016–2019). The effectiveness, consistency and relative priority of these existing strategies were not reviewed in relation to the new strategic priorities. There was no reprioritisation of capacity to ensure effort was focused on those priorities. The risk that capacity was not used effectively appeared to have continued when a number of these strategies became out of date. Planning groups continued to monitor progress and review actions despite the plan having expired.

There had been little attempt to evaluate the impact of the partnership's previously established strategies and plans in order to inform and align them to future strategies and plans. Several actions within the strategies had been identified as being achievable within existing resources. This suggested that the partnership was not seeking to achieve significant service redesign and transformation in a way that would overcome the key challenges of increasing demand, limited workforce and increasing budget pressures. For example, the Autism Strategy and Keys to Life Strategy Groups continued with no focus on the increasing demand for people with complex needs. The documentation used to monitor progress against these strategies was confusing and inconsistent, making it difficult to identify which actions remained outstanding and where new actions had been added.

The strategic planning group had not been operating effectively for almost a year prior to March 2018. It did not offer opportunities for a range of stakeholders to review progress. A number of meetings had either been cancelled or postponed. In March 2018 this was recognised and there was a successful revitalisation of the group.

Revised strategic planning and commissioning arrangements

The partnership had taken positive steps to review its strategic planning and commissioning processes. The most significant change as a result of this was to establish four strategic programme boards to improve the development of coordinated and coherent plans in key areas:

- older people and unscheduled care
- primary care
- mental health and wellbeing, and

- carers.

Senior managers explained that this approach was in recognition of the fact that despite excellent work at a locality level, localities by themselves were not able to deliver the transformational change needed to sustain improved outcomes.

Staff and managers recognised the need for developments in localities to be more connected with the partnership's strategic direction and priorities, and that the programme boards were designed to facilitate this. However, concern was expressed about the lack of consultation with locality managers in the creation of the programme boards. IJB members also expressed concern at the length of time it has taken the partnership to establish the programme boards.

The partnership envisaged that the four programme boards will report to a strategic commissioning board, chaired by the chief officer. The strategic commissioning board will report to the partnership's strategic planning group, which reports to the IJB. There will also be links with the care and clinical governance and workforce planning arrangements. The role of the strategic commissioning board is to review the support provided to the programme boards to identify gaps and emerging need. Terms of reference had been developed for the programme boards but had not been developed for the strategic commissioning board. Programme boards were developing their strategic delivery plans but continuing this process without establishing the role of the strategic commissioning board risks a lack of coordination and consistent prioritisation across these plans.

It was too early to assess whether the strategic programme boards will prove to be more effective in ensuring the robust implementation of the partnership's strategies. The existing strategy groups for mental health and wellbeing, learning disability, substance misuse and autism will report to the mental health and wellbeing programme board. The other programme boards will also review any other existing strategy groups which are relevant to their work. This brings a positive opportunity to ensure that strategic planning and commissioning capacity and activities are better aligned with the partnership's priorities. However, if this process does not include an effort to streamline and focus capacity on key priorities there will be a continued risk of slow progress. Senior managers were aware of the need to ensure that strategic programme boards should be supported with robust project management, a clear performance management framework and locality working as a cross-cutting theme. It is too early to tell whether this awareness will result in action being taken to reduce the risk and that the partnership will make better use of its capacity to deliver against its priorities.

The older people and unscheduled care programme board and primary care programme board were at a more advanced stage in developing their strategies than the mental health and wellbeing and carers programme boards. There was clearly identified investment to implement proposals developed by the older people and unscheduled care programme board in the partnership's three-year financial plan.

These proposals are well developed and seek to invest in order to shift the balance of care to achieve savings. Service redesign is planned in a number of areas, including rehabilitation beds, community respiratory teams, enhanced community response teams, advanced nurse practitioners and technology enabled care. The three-year financial plan also identified additional expenditure pressures in relation to people with complex needs and carers. The additional expenditure identified for carers is based on the assumption that all of the associated financial pressure from implementation of the Carers Scotland Act (2016) will be funded from new income from the Scottish Government. The projected savings in relation to services for people with a learning disability and autism are predicated on a transformational review of current models of supported living by the mental health and wellbeing programme board which is at a relatively early stage. Primary care costs are currently outside the scope of the three-year financial plan.

The variance in progress between the different strategic programme boards prevents the partnership from basing decisions on how resources are allocated on a comparison of the benefits each plan will deliver. It also increases the risk that early opportunities for service redesign will be missed and additional resources will need to be allocated simply to maintain existing models that are increasingly unsustainable. It also may mean that resource allocations need to be based on assumptions instead of fully developed strategic plans. This may mean that opportunities to move resources between different priorities are missed.

Senior managers believe that this is unlikely because of the potential to shift resources from inpatient mental health services as a result of NHS Tayside having comparatively high levels of mental inpatient bed usage compared to the rest of Scotland.

Releasing resources to shift the balance of care in mental health provision involves the effective engagement of the partnership with all stakeholders. This will facilitate the development of robust plans that deliver a coordinated approach across the health and social care system. Effective engagement with people experiencing care, their families and stakeholders, such as housing services, registered social landlords and the third and independent sectors, is essential to the success of this approach.

The partnership started the process of revising its strategic commissioning plan (2016–2019) in March 2018. This began with the successful revitalisation of its strategic planning group as mentioned earlier in this report. The plan was in draft format, however senior officers indicated that there would be a delay before the final version was completed. This allowed time for the new chief officer to develop and take ownership of the plan, reflect on the recommendations from the joint inspection report and allow for engagement and ownership of the strategic plan from IJB members which had not been facilitated previously.

Involvement of stakeholders

Engagement and consultation was variable, and had significant scope for improvement. A systematic and consistent approach to engagement and consultation was not evident.

Staff of all grades expressed a commitment to involve people experiencing care, carers, the third and independent sectors, and staff in the partnership's activities. The partnership had endorsed the Perth and Kinross third sector health and social care strategic forum as the main channel for it to engage with third sector organisations. Third sector representatives on the IJB, strategic planning group and care and professional governance group came from the forum. The partnership had both a participation and engagement strategy and a communication strategy. Programme board terms of reference required them to have communication, participation and engagement strategies but stakeholder engagement has been limited because of the pressure of tight deadlines for the development of their plans. This represents a risk that if the partnership consults on completed strategies and plans, external stakeholders will continue to maintain their view that decisions are made in advance. There was no evidence of a process to report on communication and engagement activity or to scrutinise its impact and effectiveness.

There were some areas of consultation and communication which were positive in relation to the integration agenda and the partnership's vision and values. Areas of good practice included the following.

- Consultation with 4,000 people to identify the partnership's priorities in the first strategic commissioning plan (2016–2019). This was supported by the Communities First Initiative.
- Participatory budgets gave local communities the chance to determine which organisations and processes are funded.
- Funding for a staff member from Scottish Care, the national independent sector care providers' umbrella body, to facilitate the involvement of independent sector providers.
- Positive working relationships between the partnership's commissioning and contracts team and care providers from the third and independent sectors, including facilitating a care at home providers' forum and participating in a learning disability providers' forum.

Involvement of stakeholders in the partnership's activities was variable. Feedback from carers, service users and third sector services indicated they viewed much of the partnership's consultation activity as tokenistic. There was a common perception that decisions had already been made before they were consulted and that many decisions were finance driven, rather than needs led.

There was little evidence that the partnership had considered the capacity required by the third sector to engage with the large number of planning groups the partnership has developed and be represented in all community planning priorities.

There was no evidence of a systematic approach to meaningful communicating, consulting or engaging with the workforce and wider population with regards to the partnership's vision and strategic priorities. Examples of these included the following.

- The mental health review and care home review were cited as examples of consultation when the partnership had reached a decision before consultation being carried out.
- Commitments in the Perth and Kinross Carers Strategy (2015–2018) did not resonate with carers. Some carers who had been involved in developing a new carers strategy also commented that while they supported its aspirations, they had concerns about whether it was capable of implementation.
- Specialist care providers felt that they had not had the opportunity to be involved with the development of a strategy nor had they been asked to co-produce solutions to the increase in demand for complex care.
- Almost two thirds (63%) of respondents to our staff survey did not agree that the views of staff are fully taken into account when services are being planned at strategic level.

Locality planning

The partnership has worked hard to develop its three localities: North Perthshire, Perth City and South Perthshire. There was a well-developed locality planning and management structure. The development of localities has been central to the partnership's approach to developing early intervention and prevention as well as joint health and social care teams. This had been led at local level with strategic direction and oversight from the integrated management team and executive management team forums.

A key aspect of locality working is to create opportunities for professionals to contribute across primary care, secondary care, social work and housing teams. The partnership had examples of practical developments across professions at a locality level. Furthermore, locality Integrated Care Team meetings had been established to share good practice. This was a relatively recent development. The meetings were frequent and had focused effectively on delayed discharge, unscheduled care and avoiding crises. Locality meetings relating to complex care had also been established. It was too early to assess the impact of these.

Overall, the positive developments were primarily driven by locality staff. Processes and structures to ensure that developments were contributing to the partnership's strategic priorities were underdeveloped. The opportunities to maximise the benefits of locality working were limited by budgets which were not disaggregated at a locality level. The partnership was finalising locality budgets for the 2019/20 budget monitoring process.

Hosted services

When the IJBs were formed, NHS Tayside delegated health services to be hosted⁶ by each of the three partnerships. For example, Perth and Kinross partnership hosts community dentistry, podiatry, healthcare in prisons and in-patient mental health services, Angus hosts forensic medicine and the Dundee partnership hosts psychology services for the whole of NHS Tayside.

The allocation and arrangements for hosted services were an area of difficulty for the partnership. The need for transformation of mental health inpatient services had already been identified when the service was delegated. It was recognised that significant leadership capacity had subsequently been drawn from the partnership to develop and drive the transformation plan. There had also been inquiries into the quality of care provided in the inpatient units. These highly publicised inquiries have had a damaging effect on staff morale. There had been difficulties recruiting and retaining the number and specialism of staff to deliver a safe model of care. A significant overspend resulted from locum staffing costs. The responsibility for financial planning for inpatient mental health is a collaboration between the partnership and NHS Tayside. This was recognised as an area for improvement and a three-year financial plan for inpatient mental health services was under development.

Leading the transformation of the inpatient mental health service had taken significant amounts of time and resource from the partnership. Despite this, workforce planning, a mental health strategy and a coordinated approach to planning services linking the new inpatient units and community services, were at an early stage.

Hosting prison services also proved to be an area requiring significant leadership investment. A recent inspection report for HMP Perth⁷ highlighted gaps in health and social care provision. Additionally, the changing demographic in prisons was recognised as requiring more specialist health and social care input than had previously been anticipated. The report of a subsequent follow-up inspection, published April 2019, has identified significant improvement and an ongoing improvement plan is in place.

These hosted service arrangements placed a pressure and resource requirement on the partnership which impacted on capacity to focus on other aspects of integration. It was widely recognised as a contributing factor to the slow pace of integration.

There was a lack of structure or identified frameworks across Tayside for the evaluation of the performance of hosted services to provide reassurance to partner IJBs. There was also a lack of formalised communication networks to express

⁶ Hosted services are health services that one partnership manages and provides for people throughout Tayside.

⁷ The full inspection report is available here: <https://www.prisonssinspectoratescotland.gov.uk/publications/report-full-inspection-hmp-perth-14-25-may-2018?page=1>

concern if a service hosted by a partnership was not meeting local need. A regular forum for the NHS Tayside Chief Executive and the three council Chief Executives to meet began in January 2019 to discuss the performance of these services.

Self-directed support

The partnership did not have a separate strategy for the implementation and development of self-directed support (SDS). Instead it saw SDS part of its mainstream processes for providing support. There was an action to increase SDS take-up in the strategic commissioning plan but this was not underpinned by a specific action plan through which progress could be monitored and reviewed. The partnership had not illustrated how SDS links with the partnership's strategic priorities or key challenges such as complex care. In the future, a workstream of the Mental Health and Wellbeing Programme Board will review SDS procedures.

SDS option one refers to people who receive a direct payment. SDS option two refers to people who choose how they will be supported and this is arranged by the council. Option three is when the council chooses and arranges services, and option four is a mixture of options one, two and/or three.

The partnership reported that the number of people using SDS options one and two increased between 2016–2017 and 2017–2018. However, the rate of people choosing these options is still less than the Scotland average. Part of the increase in people choosing option two resulted from adults having a desire to keep their existing provider during the care at home retender. In rural areas, the choice of using SDS option one can be driven by difficulties in securing traditional care at home services (SDS option three). The partnership told us outcomes had been carefully monitored in these situations. During the period 2016–2018, there was a corresponding decrease in the number of adults using option three. However, the rate of people accessing this option was still above the national average. This may be a consequence of the difficulties in maintaining a diverse market of care providers in rural areas. The partnership was also just beginning to develop its approach to facilitating the development of more diverse care markets, to promote innovation and increased choice.

Commissioning managers recognised a challenge in offering adults different choices under SDS in rural areas where there were limited numbers of care providers. To address this they sought to develop an outcomes-focussed approach which will enable people using services to negotiate arrangements directly with providers. The aim is to deliver flexibility and choice in line with each individual's requirements by a single provider instead of relying on a choice of different providers. The commissioning team highlighted that this approach has proven challenging and slow to establish as a result of the pressures on the care at home market.

The partnership was working to move away from traditional service responses through seeking to develop better links with support delivered by third sector organisations and other community groups at a locality level. For example, attending

a local dance group can avoid social isolation and promote physical activity. To support early intervention, the partnership provided investment to stimulate the creation of new third sector organisations. It also developed social prescribing by investing in staff, linked with GP practices. Social prescribing provides opportunities for people with a range of social, psychological and physical issues to access a wide range of local interventions and services provided by the voluntary and third sectors. It aims to help people improve their health and wellbeing, for example by reducing their social isolation or providing opportunities to be more physically active.

Self-evaluation and quality assurance

Overall, there was limited evidence to suggest that the partnership had prioritised self-evaluation and quality assurance. This mirrors the low level of priority given to performance management. It also reflected the apparent absence of a systematic and robust approach to evaluating the impact of the actions set out in the partnership's first strategic commissioning plan and the lack of processes used to monitor and review existing strategies.

One of a few exceptions was the development of outcome-focused service specifications for third sector projects. This moved away from services reporting against high level strategic outcomes and towards service level outcomes. This was completed with support which the partnership commissioned from Evaluation Scotland's⁸ Threading the Needle project⁹. Another good example was the systematic and detailed evaluation of the discharge hub at Perth Royal Infirmary. Evaluation Scotland also offered support to the partnership to pilot integrating third sector data with NHS statistics, but this was unsuccessful due to workload pressures and protocol barriers. The follow-up consultation commissioned from an independent advocacy service following the day services review was also positive.

The partnership undertook a large-scale self-evaluation of its strategic planning and commissioning arrangements in 2018. Senior managers told us that this was in preparation for our inspection. There was a commitment to using the results of the self-evaluation to improve strategic planning and commissioning arrangements.

Finance

The partnership continues to face significant financial challenges, despite a significant increase in the level of funding provided by Perth & Kinross Council for the financial year 2019/20, as well as NHS Tayside allocating a full share of the uplift received from Scottish Government and additional NHSScotland Resource Allocation funding for GP prescribing and prisoner healthcare.

The partnership has focused on the delivery of recurring savings to avoid reliance on non-recurring solutions and the build-up of a 'masked' underlying deficit. Where

⁸ Evaluation Support Scotland is an independent organisation that supports third sector organisations to measure the impact of their activities on improving outcomes.

⁹ Threading the Needle was a Scottish Government funded programme to support health and social care commissioners use third sector evidence to commission outcomes for health and social care.

non-recurring offsets have been available these have been set out separately so that the underlying position is always clear. Being able to report on the underlying position has been critical given that the IJB was not able to sign off the budgets for prescribing or inpatient mental health services as sufficient at inception. The partnership has had challenging savings targets to deliver each year. Significant recurring savings have been delivered each year in line with its financial plan. However, the IJB has been unable to balance its financial plan at the beginning of each year since it was formed. In addition during 2018/19, significant unanticipated pressures emerged. A recovery plan was put in place and is likely to significantly reduce the forecast overspend. In all years, non-recurring budget was required from NHS Tayside at the year-end driven by the underlying deficit in the financial plan. In 2018/19, non-recurring funding is likely to be required from Perth & Kinross Council due to the very significant unanticipated pressures not fully manageable through recovery plan actions.

Ambitious savings plans delivered over the last three years have changed the way in which services are being delivered in line with strategic plan direction. As part of the budget-setting process there is a significant testing of each saving plan to reassure IJB members of the positive impact on service delivery and alignment to strategic plan objectives.

The partnership's budget allocation for the previous two financial years and the current year is as follows:

Financial year	Perth & Kinross Council	NHS Tayside	Total IJB core budget*
2017/18	£49.1 million	£45.7 million	£94.8 million
2018/19	£47.1 million	£46.4 million	£93.5 million
2019/20	£52.4 million	£47.9 million	£100.3 million

*Core budgets relate to the social care and community health and hospital services that have been delegated to the IJB. In addition, the partnership receives a further £100.2 million (2018/19) for hosted services and the large hospital set aside.

There was a significant increase of funding from Perth & Kinross Council of 11%, however resources are still stretched as cost pressures outweigh savings achieved. NHS Tayside has given the partnership a full share of the uplift received from the Scottish Government and additional NRAC funding for GP Prescribing and Prisoner Healthcare.

There is evidence of a strong link between strategic and financial planning. This is more developed in the work of the OPUSC Board which enabled investment and disinvestment priorities to be set out in the three-year financial plan. Cost pressures and projected savings are also identified in relation to the carers and mental health and wellbeing programme board, but the detailed strategies and plans need to

ensure their delivery are still under development. The work of the Primary Care Programme Board was out with the scope of the three year financial plan.

The three year plan from 2019/2021 was approved by the IJB in March 2019. The three year budget setting process was a considerable improvement on previous years and is built on the good practice of Perth and Kinross Council's three-year planning. The budget-setting process is collaborative, with the finance team looking at what has happened in the past, what trends exist and what adjustments they need to make. A forward look is also applied using factors such as demographic change and growth as well as pay and price pressures. This provides an overview of anticipated future need. There is a clear link to strategic planning for 2019/20 onwards. The process of developing the financial plan was time consuming as can be expected in doing a three-year plan for the first time, and should become more streamlined going forward. The need to ensure that effective financial planning can be delivered on a timely basis, within the financial capacity, was recognised by the partnership and senior managers who are meeting to review the lessons learned from the process undertaken this year.

The limited capacity of the finance team aligned to the IJB by the parent bodies, had caused slippage in areas such as a three-year plan for adult mental health services and created a challenge in developing the three-year financial plan. NHS Tayside has not carried out detailed three-year planning before now so this has been a significant change in process for the staff. The three-year plan was very beneficial because it allowed early warning signs to be identified and for both Perth & Kinross Council and NHS Tayside to have meaningful conversations on what future funding needed to look like.

Finance staff from both Perth & Kinross Council and NHS Tayside supported the IJB, as well as dedicated staff in the IJB itself. Three very experienced members of staff have left the finance team in the past 18 months, resulting in a loss of valuable knowledge of social care delivery. The team has returned to almost full capacity. The partnership accountant is providing additional senior financial management capacity to the chief finance officer and the partnership has been unable to recruit temporary backfill. Health and social care finance staff have co-located together at the partnership's offices in Perth which provides strong working relationships and collaboration.

Relationships between the partnership and its parent bodies of Perth & Kinross Council and NHS Tayside had strengthened in recent months. Since the creation of the partnership in 2016/17, relationships have been tested in relation to budget setting. The council held the underspend in an earmarked reserve to meet statutory obligations. A significant amount of time and effort had been invested to improve relationships between the finance teams as well as at executive level. The conversations around funding and expectations are now more open. This has

allowed a more constructive relationship to develop than what had existed previously.

Arrangements for managing risk

The partnership had a strategic risk register and the risk management processes were still being developed. Both the processes and thresholds for escalating risk had recently been clarified and this had been viewed as a positive development. The strategic risk register had identified risks, including workforce recruitment and retention, financial sustainability and leadership. For some risks, the register had identified that current control measures were having no or limited impact in reducing risk. As a result, further treatment actions were required. We acknowledge that there is some consistency between the risks identified in our report and those on the partnership's risk register, together with the treatment actions required to address areas for improvement.

An example of a treatment action was the need to consolidate and complete the framework for care programme boards to mitigate the risk of a lack of clear leadership and direction. A further example would be a recruitment marketing, workforce plan and a joint working agreement which were based on clear models of care and identified as a treatment action to mitigate the risk of being able to both recruit and retain staff. However, some of the areas for development we identified were absent from the partnership's approach to mitigating risk. Including these areas would ensure effective prioritisation together with the alignment of management capacity and effort with strategic priorities. As well as implementing all of the outstanding areas for development, we noted an absence of effective programme and project management together with ways of evaluating these.

The risk register also identified the risk of unclear governance and lack of a performance management framework as 'moderate'. However, the actions to treat this risk were focused on care and clinical governance structures and there were no actions to improve performance management.

Many of the treatment actions set out in the risk register had no time frame against them. It was positive that treatment actions for the areas with highest residual risk all had target time frames. Almost all of these actions (including the two examples included above) were due before the end of March 2019, but good progress towards their implementation was not evident. Very high risks identified in the draft risk register in November 2018 had not yet been mitigated.

Contract management, procurement and market facilitation

The partnership was able to deliver their commissioning intentions through effective approaches to procurement and contract management. This was demonstrated through the retender of care at home services. The new tender sought to increase the sustainability of supply in rural areas by adopting a strategy of commissioning a small number of larger providers. The potential benefits of this approach were in terms of economies of scale. Successful providers would have a larger and more

predictable demand on which to base workforce development. The retendering process was achieved through effective working relationships between the partnership's commissioning manager and Perth & Kinross Council's procurement manager. The partnership worked positively to involve external stakeholders in the retendering process. Providers were invited to comment on the new service specification and service users were directly involved in the evaluation of tenders. It was noted that the process was not underpinned by the use of directions by the IJB.

The contract management and monitoring process had recently been reviewed. This provided a clear and proportionate framework for managing and monitoring contracts. Third and independent sector providers confirmed that they had formed excellent supportive relationships with the contract monitoring team and locality managers.

New contract monitoring performance indicators had been introduced for all care groups. This was a suite of indicators to measure quantitative data which was submitted quarterly. There were no arrangements to capture information on outcomes.

Providers and the partnership worked together to co-produce solutions to shared challenges. However, these were rarely progressed to implementation because of budget pressures and lack of capacity within the partnership. An example of this was the development of the care at home pricing model as part of the process to implement the Scottish Living Wage. Similarly, the floating support tender for housing-related support had a single specification despite providers expressing concern that this would make it more difficult for small providers to complete. There was a risk that this previous experience would discourage providers from co-producing solutions in the future.

The partnership had started to develop a market position statement and care providers confirmed that they had been invited to participate in this process. There had been some delay in progressing this. The current draft required considerable development in terms of the information that it provided. The partnership had no plans to undertake activities to restructure the market, for example by promoting innovation or to intervene by future retendering.

Contractual arrangements for services for people requiring complex care had not been reviewed for some time and focused on supporting people in individual tenancies. Supported living and complex care provision for working age adults were purchased by block contracts¹⁰ with an option to spot purchase¹¹ additional hours when required. There was a plan to review and consider spot purchases. Prices for these purchases were variable. The partnership was seeking to use the National

¹⁰ A block contract guarantees a given volume of business to a service provider, usually over a set period of time, and in advance of the service being delivered.

¹¹ Spot purchasing refers to when the services are purchased as and when needed and the service provider has no guarantee of the volume of service that will be purchased in a time period.

Framework Agreement for support provision that Scotland Excel¹² is developing to improve purchasing arrangements, but this had been delayed.

Vacancies in long term supported living services were filled quickly but there was a growing recognition from managers within the partnership that core and cluster¹³ models needed to be developed to reduce reliance on high-cost individual care packages. In view of the increasing budget pressures from people with complex needs and the likely lead-in time for new developments, the partnership had missed opportunities to make earlier progress to redesign services.

Specialist support providers stated that the partnership was missing opportunities to redesign services to have more sustainable costs through core and cluster models. While they understood that there had been a growth in demand for behavioural support, they suggested that the staffing levels and costs could be managed more effectively through core and cluster developments, rather than relying on large-scale care packages to support people in individual tenancies.

The commissioning and contracts team had worked hard to review service level agreements with small third sector organisations. It was positive that this review would seek to increase the alignment between third sector funding and the partnership's strategic priorities. Third sector providers confirmed that the team had also been successful in developing tailored service specifications and outcome measures to capture the outcomes delivered by diverse services. This was following the Threading the Needle project, where the commissioning and contracts team had worked with Evaluation Support Scotland to develop outcome measures to measure the impact of third sector organisations.

Vision and aims

The partnership's strategic commissioning plan (2016–2019) had a clearly articulated and comprehensive vision and aims. These were underpinned by five key priority themes. However, these were not consistently referenced in other key planning documents.

The vision and aims were reflected in the council's corporate plan and the local outcomes improvement plan. The new chief executive of the council was developing an approach called the 'Perth and Kinross offer', which would focus on shifting the balance of control and responsibility between public services and the community, with an emphasis on co-creation and community empowerment. This approach complemented the partnership's vision. This consistency and alignment of the vision and aims across partner agencies was positive.

¹² Scotland Excel offers a range of procurement, training and consultancy services which deliver savings, efficiency and capability.

¹³ Core and cluster model refers to shared accommodation in which people have their own private bedroom or other single person accommodation unit, but share communal facilities such as kitchens and bathrooms.

There was variance in the extent to which other strategies, action plans and key documents reflected the vision, aims and key themes. The 2016–2019 technology enabled care strategy reflected both the vision and aims. The participation and engagement strategy and communications strategy both included the partnership's vision. The draft organisational development strategy reflected the key themes but not the vision. The third sector health and social care strategic forum action plan and the terms of reference for the four strategic programme boards did not reflect either the vision or key themes. This lack of consistency in reflecting the partnership's vision and aims limited the overall coherence of planning and strategic activity across the partnership.

The strategic commissioning plan identified some principles to underpin the partnership's approach. However, these were not consistently referenced by either the partnership or other stakeholders. The partnership had not agreed a recognisable set of values that was evident throughout its planning and operational activity.

Locality plans were developed by locality managers and their teams, with the involvement of other stakeholders. Encouragingly, the locality action plans were based around the five key priority themes. However, they did not explicitly reflect the partnership's vision statement.

Communicating the vision

Roadshows had been carried out in all three localities to communicate the vision and aims of the partnership. This vision was well known: 72% of respondents to our staff survey agreed that they were aware of the partnership's vision for health and social care services. Leaders, senior managers, locality managers and frontline staff understood and demonstrated commitment to the vision. In at least one locality, there had been joint sessions for staff to develop their local vision for integrated services. However, not all staff groups had subscribed to the vision, or the model of integrated working. In some acute settings, the cultural shift had been slow. Competing priorities from NHS Tayside and Perth & Kinross Council staff had negatively impacted on the development of integrated working in Perth Royal Infirmary. However, the partnership's engagement with clinicians on the Perth Royal Infirmary site impacted positively on existing behaviours and fostered a collaborative approach.

Integrated approaches

Although collaborative working was strong, particularly in the localities the partnership was at an early stage of integrating the workforce. The IJB had responsibility for commissioning and planning, and the responsibility for delivery of services remained with the employing NHS Tayside and the council. A parallel management structure was evident at all levels below the chief officer and chief finance officer, with the exception of finance posts. Despite this, the chief officer directly managed the heads of health and adult social care who had operational

responsibilities. This resulted in some confusion about where the ultimate responsibility for operational delivery of adult services was located.

The partnership had established its three localities on an aligned health and social care model, rather than an integrated approach. Each locality had a health manager and a social work manager, who had differing spans of control. The NHS manager managed considerably more staff in the locality than the social work manager did, whilst the social work manager had responsibility for other staff in the wider partnership area. This meant that the level of focus on locality work differed between health and social work managers.

There was a clear commitment to supporting the development of a shared culture and understanding through close partnership working at locality level. The aspiration was that a positive and collaborative approach would lead to a smooth transition to integrated service delivery. Locality managers and professional leads demonstrated a clear commitment to developing cultures and behaviours that supported collaborative working. For example, joint development sessions to embed a shared culture had illustrated a commitment to collaborative working. Significant progress had been made and frontline staff and locality managers confirmed that joint working in aligned locality care teams was positive. Similarly, occupational therapists from health and social care were positive about working together. However, there were no integrated management arrangements.

Senior partnership staff believed they had the right balance between integrated working and respecting professional roles. However, there was evidence of a desire within the locality teams and occupational therapy to further integrate and to develop new skills and explore new roles. Staff and managers consistently reported that staff were keen to integrate even further. There was frustration that senior management had not responded to requests from staff to integrate management and budgets.

Workforce planning

The development of workforce planning had been slow. Some service areas in the partnership were operating in contingency arrangements and there was difficulty recruiting and retaining staff.

Having the right workforce was recognised as fundamental to the future effectiveness of the health and social care services in the partnership. Workforce recruitment and retention was acknowledged to be particularly challenging in some professional areas (care homes and homecare, mental health services, GPs and registered nurses) and in the more rural geographical areas. Workforce issues impacted on the partnership's ability to deliver services in some areas, which resulted in contingency arrangements being used, for example in the mental health inpatient units and partnership wards in the acute hospital.

Some work had been undertaken to understand future workforce needs in terms of skills and capacity. Activities to support recruitment of the workforce in NHS Tayside,

Perth & Kinross Council and third sectors included recruitment events for care at home providers and entering into discussion with local colleges in order to recruit home care staff. However, there was little evidence of a strategic approach beyond the commitment in the community partnership's local outcomes improvement plan (2017–2027) to develop a skills academy for care by 2021.

Despite a stated intention to develop an integrated workforce plan, the partnership had not yet achieved this. A draft joint workforce and organisational development strategy was approved by the IJB in spring 2016, but workforce plans did not follow this. There was a lack of clarity amongst staff about the status of joint workforce planning. Less than half (47%) of respondents to our staff survey agreed that they were aware of the workforce planning arrangements in place to support the integration of health and social care. The partnership still had separate workforce plans for NHS Tayside and Perth & Kinross Council. Although a formal legal agreement to facilitate further integration and joint management structures¹⁴ had been drafted, it was still to be formally signed off by NHS Tayside. From a strategic perspective, a continued absence of focus on the potential benefits of greater structural integration represented a missed opportunity. Integrated approaches have the potential to make better use of the available workforce, which is one of the partnership's key challenges.

The allied health professions directorate had developed interface guidance on the relationship between operational management and professional support. The principles were in use but the guidance to support the implementation was still in draft. There was potential for this to be used more widely than this staff group which was a positive development. However, work still needed to be taken forward in relation to differential terms and conditions.

Locality management

Locality managers held a highly respected leadership role for frontline staff. They were a role model for integration and encouraged multi-agency working. Most staff (76%) who responded to our survey agreed that they were encouraged to work collaboratively to support meaningful integrated working and good practice. Frontline staff told us they felt listened to by their managers and felt that they could make a contribution at locality level and within their teams. Almost two-thirds (62%) of those responding to our staff survey agreed that they felt valued by their managers. There was a commitment to service delivery in the localities and a desire to meet the needs of the local population. However, only 32% of respondents felt that the quality of services for adults had improved since the integration of health and social care.

In 2016, the partnership had restructured adult care services in the localities from specialist teams into two core teams: one providing early intervention and prevention services and the other dealing with long term and complex care needs. This was

¹⁴ This is when an NHS staff member is managed by a manager who is employed by the Council or vice versa.

now well embedded. Service managers were able to describe a number of projects and initiatives they had under way to provide early intervention and prevention in their locality, for example the social prescribing project which is an important component of the partnership's overall strategy. However, the partnership had not evaluated its approach to early intervention and needed to review the effectiveness of their arrangements.

People working in localities identified a lack of strategic oversight and a disconnect between the overarching strategic plans and priorities, and those for delivery of services at the frontline. . This was partly supported by the results of our staff survey, with 54% of respondents familiar with the partnership's local priorities. Staff expressed frustration at this disconnect and a desire for a clear strategic direction to be established by senior leaders.

Leadership

The perception of staff was that senior leaders had been distant and had not set a strategic direction for service delivery. Change was poorly communicated and a historically challenging relationship between the partnership and NHS Tayside had impacted negatively.

The partnership had new senior leadership. The chief executive of Perth & Kinross Council had only been in post for six months, and the chief executive of NHS Tayside for just three months. At the time of our inspection, the existing chief officer was about to leave post and a new chief officer had been appointed. The NHS Tayside and Perth & Kinross Council chief executives and a number of senior managers and leaders told us that the progress of health and social care integration in Perth and Kinross had been slow. Both new chief executives expressed a commitment to the integration agenda and were keen to take a leadership role to drive the vision and culture of integration. Whilst recognising that they had different perspectives and priorities in some areas, they had already established regular and meaningful dialogue to support the progress of integration.

In our staff survey returns, less than half of the responses to questions relating to leadership were positive. Only one third of respondents agreed that senior managers communicated well with frontline staff. Fewer than half (46%) agreed that leaders were visible or that they created a trusting, positive, sharing and open organisational structure. Team leaders and frontline managers were seen as approachable and engaged. However, senior managers were often seen as distant from the day to day work, with limited understanding of the pressures on frontline staff. Additionally, they were perceived as imposing change without consultation or understanding the impact of the change. This view was also expressed by other stakeholders.

Senior managers felt challenged by heavy workloads and limitations on their capacity to do all the work they needed to. On the whole, they acknowledged that they could be more visible to staff. Some managers were actively working to improve communication with staff and other stakeholders.

Historically, NHS staff had often been absent from key meetings and there had been a lack of allocation of the appropriate number of NHS Tayside non-executive IJB members. This had limited the partnership's ability to make progress in a number of areas. These included budget and workforce planning, data sharing and development of shared performance frameworks and progressing shared partnership priorities. A positive change in this relationship between Perth & Kinross Council and NHS Tayside was evident. There was a commitment to improving the budget-setting process. In 2019/20, it was significantly smoother and more collaborative than in previous years. Frontline staff also perceived an improvement in shared priorities and a culture of collaborative working.

The partnership had been delegated hosted services which demanded a lot of time and leadership capacity and diverted attention from the integration agenda. As mentioned earlier in this report, actions were under way to address this.

The production of the new strategic commissioning plan had been delayed to allow the new leadership to be fully involved and consult on priorities with wider stakeholders. The IJB members had been concerned about their lack of engagement in the draft of the plan and establishment of strategic priorities. This delay could allow them to be actively engaged. These were early positive signs for the quality of the new leadership team in the Perth & Kinross partnership, but the management team had not been in post long enough for the impact to be evaluated.

Leadership of planning and strategic direction

The partnership's strategic commissioning plan (2016–2019) was broad ranging and ambitious. As discussed earlier in this report, it was not well supported by plans for implementation and did not identify clear priorities to support activity at local level or planning for particular service user groups.

Senior managers contributed to the oversight and implementation of the integration agenda through the Executive Management Team (EMT) and the Integrated Management Team (IMT) meetings. The partnership provided a description of the EMT and IMT roles. However, there was a consistent lack of understanding and clarity amongst staff and managers about the purpose of the respective teams. The efficacy of the EMT and IMT was hindered by this lack of clarity and understanding about the role and remit. Some of the managers attended both meetings, including the heads of health and social work. There was a lack of confidence about the membership of each team being correct. The IMT was challenged with balancing aspiration with limited resources and maintaining capacity to deliver operational responsibilities.

The partnership had a number of planning, commissioning and management forums to support its work. Not everyone understood the role and purpose of the different groups and meetings. The linkages and communication routes between groups were not clear. This meant that senior managers and leaders spent a lot of time in meetings that did not always operate as effectively or efficiently as they might have

done if the planning, management and governance forums had been developed in a more deliberate way. It also meant that the partnership did not have a coherent or systematic approach to strategic planning and commissioning or to the management and monitoring of integration and transformation.

There was a commitment in the partnership that the new strategic programme boards would assist with strategic direction in localities and provide the basis for meaningful performance reporting. The development of the programme boards had the potential to strengthen strategic planning and commissioning activity for the identified programmes of care. However, there was no evidence about how the priorities of the programme boards would link to the priorities of the localities; or how their strategic priorities would come from either the strategic commissioning plan, the strategic planning group or the IJB. It was too early to demonstrate the impact.

Integration Joint Board

Poor communication, trust and information sharing between the partnership and the board was evident. There was also a lack of consultation or engagement on the strategic direction and strategic plan development for the partnership. The sharing of financial information was positive and demonstrated improvement. The members lacked training and development opportunities to have the knowledge and confidence required to fulfil their role and provide effective governance. As a result of these factors, the IJB was not fulfilling its role.

IJB members and senior managers had not received training and guidance on the use of directions to ensure that the IJB's commissioning intentions were effectively implemented by NHS Tayside and the council. As a result, the members did not issue directions. The IJB is the central point from which effective integration of resources and services was driven in a partnership with parallel management structures and budgetary processes. This requires the IJB to be able to confidently direct NHS Tayside and Perth & Kinross Council to implement its strategy, including investment and disinvestment. Legal advice had been sought on the use of directions. There was a lack of clarity in the partnership about the rationale behind this.

As mentioned earlier in this report, the partnership did not have a comprehensive performance or progress monitoring framework for leaders or the IJB to track progress against the strategic commissioning plan. It was a recent development that the IJB audit and performance committee was to receive regular performance reports. This followed a refocus of the committee which had previously focused almost solely on audit. Prior to this, the committee received its annual report and one delayed discharge report. The first report was submitted to the committee by the OPUSC Programme Board. This was a positive development, although both IJB and OPUSC Programme Board members agreed that more work needed to be done to agree the format and content of the report for the longer term. Prior to the recent introduction of performance reports, the IJB did not have sufficient performance data

to understand and scrutinise the partnership's performance, and measure progress against its strategic priorities. This limited the IJB's ability to fulfil its role in setting strategic direction and in overseeing implementation of strategies and plans.

The IJB was at an early stage in developing its capacity to lead on strategy and direction for the partnership. It had experienced a high rate of membership turnover, with 34 voting members since its inception in 2016. The involvement of NHS Tayside members had been particularly inconsistent. The associate nurse director was temporarily filling a non-executive vacancy, but had not attended meetings. The IJB had a full quota of four elected members. Encouragingly, the voting members on the IJB were motivated and enthusiastic, and keen to fulfil their role in direction and scrutiny of the partnership.

Insufficient priority had been given to developing the IJB. The frequency and content of training for IJB members was not sufficient to enable them to fulfil their role as an autonomous decision-making board. New IJB members received a one-day induction which covered a range of complex and new topics. Bespoke training had occasionally been offered, such as finance training, to support the members to contribute to the financial plan and the financial recovery plan. This was appreciated by the members, who were positive about the overall approach of financial planning and their level of understanding. The members welcomed the visits to service areas and the comprehensive information that accompanied these. There was an appetite to do more service visits. However, there remained a lack of confidence among IJB members about the remit and scope of their role and in their knowledge of how the IJB should operate. There was a need for a comprehensive rolling programme for training to ensure the members understood all areas of performance data, service delivery and partnership performance. The partnership recognised the need to develop information and training to support IJB members, but timescales had slipped from June 2018.

There was a disconnect between the perspective of the IJB members and partnership staff in relation to the sharing of information. IJB members expressed considerable frustration that they were not being included in the review of the strategic plan at an early stage. Senior managers advised that while a draft plan had not been presented, IJB members had been fully updated on progress. Additionally, they had been engaged in its building blocks in terms of the formation of the strategic programme boards and financial planning. There was a history of poor communication and information sharing between the partnership and the IJB members. The sharing of financial information was positive and demonstrated improvement. The role of public partner and carer representatives was not being appropriately supported or valued. These issues needed to be addressed for the IJB to operate effectively.

The disconnect between the perspectives of IJB members and senior managers within the partnership was a cause for concern. IJB members need to have

ownership of the partnership's strategic commissioning plan. There was a similar disconnect between IJB members and senior managers about the IJB's creation of a clinical and care governance sub-committee resulting in ineffective communication between senior staff and IJB members on key issues.

Clinical care and professional governance

Clinical and care governance within the partnership was a key priority. Aligned rather than integrated working arrangements had resulted in a number of governance groups. This resulted in duplication and overlap. The partnership recognised this and was in the process of reviewing arrangements.

Clinical and care governance arrangements were in place for all of the partnership's activities, including community health services and social work. The partnership had a number of groups and forums that oversaw clinical and care professional governance. However, the main governance forum, chaired by the chief social work officer and associate medical director, was integrated and oversaw work considered by other forums. This group reported into an NHS pan-Tayside clinical quality forum. Within the partnership, NHS Tayside and Perth and Kinross single agency groups fed into the joint care and professional governance forum. Both NHS Tayside and Perth & Kinross Council had single agency groups feeding into the joint forum. NHS Tayside clinical governance groups had also recently been established in the three localities and there was an intention to establish a clinical governance group for mental health. The number of governance groups was time consuming and inefficient for staff who had to attend several of them. This also reflected a continuing identification with NHS Tayside and Perth & Kinross Council rather than with the partnership.

The new programme boards had been established with no clear direction on how some of the older groups fit into the structure or how the programme boards link to the clinical and care governance structure. The development of the programme boards should have created an opportunity to rationalise the number of groups.

The partnership recognised that its clinical and care governance arrangements were complex and not sufficiently integrated. Senior managers were concerned about making changes to these processes until they were clear that it was safe to do so. This was a transitional arrangement, although there was no evidence of whether the arrangements were sustainable until a more integrated approach was introduced.

The partnership was in a period of transition and was planning to develop a more streamlined and integrated model. The new model was to include an integrated care and clinical governance framework based on the Health and Social Care Standards. Although there was no clear time frame for this piece of work, it was positive and aligned with the early aspirations of the new leadership team and professional leads.

The IJB had initiated a new clinical governance committee to scrutinise clinical care and governance arrangements. It was not clear how the new committee would link to

existing clinical and care governance arrangements. There was also a lack of understanding and clarity about the role of this group and some managers expressed reservations that it would have an operational rather than a strategic focus.

4. Evaluations and areas for development

Quality indicator 1: Key performance outcomes

1.1 Improvements in partnership performance in both healthcare and social care

The partnership was performing in line with the national average when measured against a range of nationally published datasets. The partnership's performance focus had been on capacity and flow around the acute setting. Improvements in this area were evident as a result.

Nonetheless, the partnership lacked strategic leadership of performance and did not have a robust performance framework. This limited its ability to measure progress against wider strategic priorities or the aims of the strategic commissioning plan. There was no mechanism for regular scrutiny of performance in relation to service delivery across the partnership. This included the IJB audit and performance committee which had not received performance information prior to February 2019.

The partnership's performance monitoring did not build on the experiences of those receiving care or their carers. The partnership's limited use of data did not help to inform planning and commissioning decisions. Locality staff also felt hindered by a lack of performance data to identify service gaps and drive appropriate improvements.

Evaluation: Weak

Quality indicator 6: Policy development and plans to support improvement in service

6.1 Operational and strategic planning arrangements

6.3 Quality assurance, self-evaluation and improvement

6.5 Commissioning arrangements

The partnership had made progress in implementing a number of actions from its strategic commissioning plan (2016–2019) but had not maintained a balanced and effective approach to implementing all of its priorities. To some extent this reflected the impact of the capacity required to redesign inpatient mental health and learning disability inpatient services. At the same time, progress was limited by the lack of a systematic and effective approach to the development and implementation of the plan. The partnership was in the process of developing a new strategic commissioning plan. It had implemented revised strategic planning arrangements to ensure improvements from its first strategic commissioning plan (2016–2019) were achieved. It was too early to assess whether these revised arrangements would be

effective. Overall, this meant that the partnership's strengths in this area, just outweighed its weaknesses.

The partnership's first strategic commissioning plan (2016–2019) set out clear priorities. These were underpinned by a wide range of ambitious actions across the services and activities for which the partnership had responsibility. Although the partnership had made significant progress in implementing a number of actions, a balanced and effective approach to implementing all its priorities had not been maintained. Progress had been made in relation to existing operational pressures, such as delayed discharge and unscheduled care, but priorities such as workforce and complex care were progressing slowly, without a developed strategy.

The management capacity taken up by the redesign of inpatient mental health and learning disability services had a negative impact on the partnership's ability to make progress on all of its priorities. At the same time, the partnership lacked a systematic approach to monitoring and evaluating the implementation of all its plans. It had not sufficiently considered whether its plans were achievable and realistic. Plans were not underpinned by effective programme and project management or subject to regular review and re-prioritisation, taking into account the capacity available to deliver them. The partnership was developing a new strategic commissioning plan. It has implemented new arrangements to improve its development and implementation but it is too early to determine if these have been successful. Financial planning has also improved, together with collaborative working between senior management and finance.

There were effective arrangements in place for the commissioning, procurement and monitoring of services purchased from external providers. The partnership had worked hard to establish its localities. Localities had driven the development of early intervention and prevention, but clear processes to ensure alignment with strategic priorities were absent. Self-evaluation and quality assurance had not been prioritised. There was a commitment to involving external stakeholders, but this had been implemented inconsistently.

Evaluation: Adequate

Quality indicator 9: Leadership and direction that promotes partnership

9.1 Vision, values and culture across the partnership

9.2 Leadership of strategy and direction

The partnership had a clear vision and aims, underpinned by strategic themes. The partnership's vision was largely aligned with the strategic vision of partner agencies. It was widely recognised and understood by partnership staff.

Locality teams were led by effective managers who were well respected by frontline staff. However, there was a disconnect between senior managers in the wider

partnership and staff in the localities, where there was a lack of strategic direction from senior managers, and leaders were perceived as distant. Staff and managers were not confident about workforce planning intentions, despite difficulty in adequately staffing all service areas. Staff worked in a collaborative way but expressed a desire to progress to an integrated workforce, and frustration at the delay in this.

As a consequence of the aligned, rather than integrated structure, there were a number of different clinical and care governance and management groups. This contributed to a lack of clarity about the role of the groups, duplication of work, a lack of communication between groups and inefficient use of senior staff time.

The IJB was not equipped to fulfil its role. Poor communication, sharing of information and training had impacted negatively on the development of the members. The IJB was not setting the strategic direction for the partnership or fulfilling its governance role.

The new leadership team had expressed a commitment to driving integration in a positive direction, but had not yet had time to translate this commitment into action. It was too early to evaluate the impact that the new leadership team would make.

Evaluation: Weak

Evaluation summary

Quality indicator		Evaluation	Evaluation criteria
1	Performance	Weak	Excellent – outstanding, sector leading Very good – major strengths Good – important strengths with some areas for improvement Adequate – strengths just outweigh weaknesses Weak – important weaknesses Unsatisfactory – major weaknesses
6	Strategic planning	Adequate	
9	Leadership and direction	Weak	

5. Areas for development

1	The partnership should improve its approaches to performance measurement and management. A performance framework should be developed using appropriate data and information about outcomes. It should be used to benchmark and report to facilitate the identification of service gaps and to drive improvement.
2	<p>The partnership should improve its strategic planning and commissioning processes to ensure that:</p> <ul style="list-style-type: none"> • effective programme and project management supports implementation of all plans and priorities, taking into account the scale of the task, its capacity, finance and the timescale needed to achieve it • plans demonstrate SMART¹⁵ principles, and • existing strategies and planning groups are reviewed to ensure that the partnership's capacity is used effectively to deliver its strategic priorities.
3	<p>The partnership should put in place a systematic approach to monitoring and reviewing the implementation of its strategic commissioning plan and any other plans and strategies which support its implementation. This should include:</p> <ul style="list-style-type: none"> • robust prioritisation of balancing immediate pressures with longer term strategic actions which can avoid or reduce future risks • a systematic approach to reviewing and updating its strategic needs assessment • periodically considering whether plans and actions need to be re-prioritised to take account of new and emerging challenges and opportunities, and • reallocating capacity from lower priority areas where necessary, or securing additional resources.
4	<p>The partnership should ensure that it places greater priority on evaluating the impact of its plans and strategies, including:</p> <ul style="list-style-type: none"> • putting in place a systematic approach to involve stakeholders, and • effectively evaluating specific developments and initiatives to determine their impact on improving outcomes and to inform future strategy.
5	The partnership should ensure that workforce planning is maintained as a key priority in all its activities and encompasses the workforce requirements of NHS Tayside, Perth & Kinross Council and third and independent sector providers.

¹⁵ Specific, Measurable, Achievable, Realistic, Time-related

6	The partnership should build on existing good relationships with care providers and housing services to identify where there is potential to co-produce solutions to strategic challenges. This should include co-producing a market facilitation plan.
7	The partnership should review its participation, engagement and communication strategies, and monitor the impact and effectiveness of its communication and engagement activity.
8	The partnership should review its structures and processes for management, strategic planning and governance to ensure the structure is fit for purpose. The purpose and remit of each part of the structure should be clearly set out and communicated to the wider stakeholders.
9	The partnership should invest in the development and support of the IJB members. This will include improved communication, training, consultation and engagement. As well as enhanced information sharing to allow the IJB to fulfil its governance role.

6. Conclusion

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to assess the progress made by HSCPs in delivering better, more effective and person-led services through integration. In doing so, we took into account the partnership's ability to:

- improve performance in both health and social care
- develop and implement operational and strategic planning arrangements, and commissioning arrangements, and
- establish a vision, values and aims across the partnership, and the leadership of strategy and direction.

In Perth and Kinross, we found important weaknesses in some key areas, which significantly outweighed the strengths that we identified.

There had been improvement in relationships between partners and financial planning. In those performance areas where the partnership focused its attention, such as hospital discharge, a positive impact was evidenced through performance information. Localities were vibrant and staff worked closely together to provide services collaboratively.

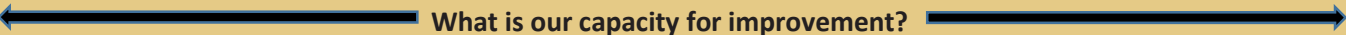
However, overall, there was a lack of leadership and strategic oversight which resulted in poor planning, direction and monitoring of services following the setup of the integration authority. Some key strategic priorities were not given sufficient attention and the partnership had not been realistic about its capacity to implement its plans. Structures and processes had not been developed or redesigned to ensure efficiency and effectiveness.

The partnership has new leaders in post who express commitment to the integration agenda and have already taken steps that reflect this commitment. This is evident in the continued building of better relationships and in improved financial planning. The partnership must sustain this as it will provide a positive foundation for improvement in the future.

It is important that the partnership progresses the identified areas for improvement to allow it to:

- build on its revised approach to strategic commissioning
- progress the transformation of its governance and planning structures
- develop its workforce planning, and
- put in place an integrated performance management structure.

Appendix 1 – Quality improvement framework

1. Key performance outcomes	4. Impact on the community	6. Policy development and plans to support improvement in service	7. Management and support of staff	9. Leadership and direction that promotes partnership
We assessed 1.1 Improvements in partnership performance in both healthcare and social care	4.1 Public confidence in community services and community engagement	We assessed 6.1 Operational and strategic planning arrangements	7.1 Recruitment and retention	We assessed 9.1 Vision, values and culture across the partnership
1.2 Improvements in the health and wellbeing and outcomes for people, carers and families	5. Delivery of key processes	6.2 Partnership development of a range of early intervention and support services	7.2 Deployment, joint working and team work	We assessed 9.2 Leadership of strategy and direction
2. Getting help at the right time	5.1 Access to support	We Assessed 6.3 Quality assurance, self-evaluation and improvement	7.3 Training, development and support	9.3 Leadership of people across the partnership
2.1 Experience of individuals and carers of improved health, wellbeing, care and support	5.2 Assessing need, planning for individuals and delivering care and support	6.4 Involving individuals who use services, carers and other stakeholders	8. Partnership working	9.4 Leadership of change and improvement
2.2 Prevention, early identification and intervention at the right time	5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks	We assessed 6.5 Commissioning arrangements	8.1 Management of resources	10. Capacity for improvement
2.3 Access to information about support options, including self-directed support	5.4 Involvement of individuals and carers in directing their own support		8.2 Information systems	10.1 Judgement based on an evaluation of performance against the quality indicators
3. Impact on staff			8.3 Partnership arrangements	
3.1 Staff motivation and support				
				

Appendix 2 – Inspection methodology

Our inspection of Perth & Kinross Health and Social Care Partnership was carried out over three phases:

Phase 1 – Planning and information gathering

The inspection team collated and analysed information requested from the partnership. The inspection team sourced other information before the inspection started. Additional information was provided during fieldwork.

Phase 2 – Staff survey and fieldwork

We issued a survey to 1,845 staff. Of those, 524 (28%) responded. We also carried out fieldwork activity over seven days, during which we interviewed a number of people who hold a range of responsibilities across the partnership. The partnership offered observation of the IJB and the audit and performance committee, which inspectors attended.

Phase 3 – Reporting

The Care Inspectorate and Healthcare Improvement Scotland jointly publish an inspection report. The report format for this inspection focuses on strategic planning and commissioning and links this to evidence gathered on current performance and the development of the integrated leadership team. Unlike previous joint reports, comment is provided on our level of confidence in respect of the partnership's ability to successfully take forward its strategic plans from intentions to changes in operational delivery.

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD –
17 DECEMBER 2019

REPORT ON: LARGE HOSPITAL SET ASIDE

REPORT BY: CHIEF FINANCE OFFICER

REPORT NO: DIJB52 - 2019

1.0 PURPOSE OF REPORT

- 1.1 The purpose of this paper is to provide the Integration Joint Board (IJB) with an overview of the Large Hospital Set Aside and sets out how this can be applied through the IJB's financial planning process.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

- 2.1 Notes the content of this report.
- 2.2 Remits the Chief Finance Officer to reflect the application of the Large Hospital Set Aside within the IJB's financial plans for 2020/21 onwards as part of the IJB's budget setting process.

3.0 FINANCIAL IMPLICATIONS

- 3.1 An effective process of collaborative working and joint commissioning between the IJB and the hospital sector through NHS Tayside will support the shift of resources from the acute sector to community based health and social care services. This forms one of the main elements of supporting the future funding of health and social care services as set out in the Scottish Government's Medium Term Health and Social Care Finance Strategy.
- 3.2 The value of the large hospital set aside calculated by NHS Tayside for Dundee IJB in 2018/19 was £17,449k.

4.0 MAIN TEXT

- 4.1 Integration of health and social care requires Integration Authorities to deliver the national outcomes for health and wellbeing via their strategic plans, which must incorporate the needs and priorities of their localities. As IJB members will be aware, the objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.
- 4.2 Integration authorities are responsible for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is a provision in the legislation surrounding the creation of IJB's and is known as the Large Hospital Set Aside.

- 4.3 Fundamental to this is a clear understanding of how “large hospital” services are being consumed and how that pattern of consumption and demand can be changed by whole system redesign. In relation to the process of understanding this consumption, as a first step it is critical that there is transparency for IJB’s and localities on how resources are being used. As a second step, there needs to be clarity about the financial impact of changes agreed through the strategic planning process which will support the release of resources which become “locked” in the acute sector to community based health and social care services. IJBs and Health Boards are required to place a value on the Large Hospital Services resources, over which IJBs will have strategic responsibility in conjunction with the Chief Operating Officer within Acute Services.
- 4.4 Since the inception of IJB’s, work has been undertaken locally and nationally to develop a better understanding of consumption of hospital based resources and what this translates to in financial terms. Most of this work to date has consisted of identifying the current “value” of the Large Hospital Resource through developing a methodology for calculation.
- 4.5 The ability to set out future commissioning plans using the Large Hospital Set Aside has been impacted on by the financial position surrounding many NHS Boards, including NHS Tayside where current and historical overspends have made it almost impossible to release acute sector budgeted resources to be reinvested back into the community. However the Scottish Government has reiterated the intent of the legislation, initially through the publication of its Medium Term Health and Social Care Financial Framework in October 2018. This framework assumes potential productive opportunities through reduced variation across A&E attendance rates, outpatient follow up rates and hospital inpatient lengths of stay and is based on improving performance to the Scottish average i.e. reducing unplanned admissions to hospital and resultant occupied bed days. This leads to an assumption that 50% of savings released from the hospital sector would be redirected to investment in primary, community and social care service provision under the direction of IJB’s through their strategic commissioning plans i.e. to shift the balance of care.
- 4.6 The Scottish Government’s financial framework sets out that based on health and social care expenditure in 2016/17, 51% of NHS Expenditure of £11.68bn in Scotland is concentrated on the hospital sector with hospital inpatient services accounting for £3.344bn of this. In the medium term, over £300m is anticipated to be saved in the hospital sector with just over £150m assumed to be reinvested in community services.
- 4.7 Recent correspondence and guidance to Health Boards and Integration Authorities regarding the development and submission of Annual Operational Plans to the Scottish Government further restates the need for Boards to demonstrate the delivery of the Medium Term Financial Framework with the delivery of effective set aside arrangements being key to delivering this commitment.

5.0 Calculating the Value of the Large Hospital Set Aside

- 5.1 The Scottish Government has determined a minimum scope for large hospital services to be strategically planned for by IJB’s. Within Tayside, some of these services have already been delegated to the IJB’s, such as Medicine for the Elderly services at Royal Victoria Hospital (RVH) therefore these have been excluded from the Tayside large hospital set aside calculation.
- Accident & Emergency
 - General Medicine
 - Geriatric Medicine (excluding RVH for Dundee, Stracathro for Angus and Perth Royal Infirmary for Perth)
 - Respiratory Medicine

The methodology for calculating the resources incorporates:-

- actual occupied bed days activity information from the Scottish Government’s Information Services Division (ISD).
- PLICS (patient level information & costing system) to determine direct costs attributed to occupied bed days.

Both of these are based on the most recent full year data i.e. the previous years information.

Large Hospitals are described for these purposes as Ninewells Hospital, Perth Royal Infirmary and Stracathro Hospital.

5.2 The Dundee 2018/19 Large Hospital Set Aside value was calculated as follows:

	2017/18 Occupied Bed Days	Emergency Department Attendances	2017/18 Direct Costs £000's
Dundee IJB			
Emergency Department	794	28,665	4,649
General Medicine	16,298		7,573
Geriatric Medicine	12,693		3,189
Respiratory Medicine	6,373		2,038
Value of Dundee IJB Total for 2018/19	36,158	28,665	17,449

5.3 The cost methodology noted above meets the Scottish Government's requirements in estimating the value of the Large Hospital Set Aside although the next step is to identify the point at which reducing the bed base and therefore cost of the acute sector would be at a such a level as to enable a reduction in indirect costs which support the acute sector (eg support services, property costs, catering, porter costs).

6.0 Reducing Occupied Bed Days and Emergency Admissions

6.1 Progress has been made by Dundee Health and Social Care Partnership since 2016 in reducing the number of unplanned occupied bed days in acute specialities as a result of a range of service redesign initiatives. An illustration of this is noted below based on the information used to calculate the value of the Large Hospital Set Aside set out in section 5.2 above. This highlights a reduction of almost 3,500 occupied bed days, primarily in Ninewells Hospital from 2016/17 to 2017/18.

	2016/17 Occupied Bed Days	Emergency Department Attendances
Dundee IJB		
Emergency Department	596	28,126
General Medicine	19,454	
Geriatric Medicine	13,377	
Respiratory Medicine	6,175	
Dundee IJB Total	39,602	28,126
2017/18 Comparison	36,158	28,665
(Reduction) / Increase	(3,444)	539

- 6.2 Given NHS Tayside's financial position, no resources have been able to be released across Tayside to date to reflect reductions in occupied bed days, with savings in the acute sector being utilised to reduce the overall NHS Tayside overspend. In 2019/20, NHS Tayside is anticipating to deliver savings of £16.8m within its operational unit which includes the acute sector. However each of the Tayside IJB's will be unable to effect significant further reductions in hospital admissions and stays without being able to invest in community based services. In line with the Scottish Government's Medium Term Financial Framework a large proportion of this needs to be released from the acute sector.
- 6.3 As part of the 2020/21 budget setting process for the IJB and NHS Tayside, the Chief Officer and Chief Finance Officer have had discussions with the Interim Director of Finance for NHS Tayside with regard to progressing the commissioning and financial framework around the Large Hospital Set Aside. This work will be progressed with the relevant parties within Angus and Perth and Kinross IJB's over the coming months with a view to ensuring the Scottish Government's stated position of releasing 50% of savings from the acute sector for investment by Integration Joint Boards.

7.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

8.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that the IJB will not be able to achieve its strategic objectives of investing in community based services and continue to shift the balance of care without a redirection of resources from the acute sector as set out within legislation.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 4 = 16 (Extreme)
Mitigating Actions (including timescales and resources)	Development of a clear, transparent and fair commissioning and financial framework around the Large Hospital Set Aside.
Residual Risk Level	Likelihood 3 x Impact 3 = 9 (High)
Planned Risk Level	Likelihood 2 x Impact 3 = 6 (Moderate)
Approval recommendation	Given the impact of the mitigating actions, the risk should be accepted.

9.0 CONSULTATION

The Chief Officer and the Clerk have been consulted on the content of this paper.

10.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 25 November 2019



REPORT TO: DUNDEE HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD –
17 DECEMBER 2019

REPORT ON: FINANCIAL MONITORING POSITION AS AT OCTOBER 2019

REPORT BY: CHIEF FINANCE OFFICER

REPORT NO: DIJB53-2019

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2019/20.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Notes the content of this report including the overall projected financial position for delegated services to the 2019/20 financial year end as at 31 October 2019 as outlined in Appendices 1, 2 and 3 of this report.
- 2.2 Notes the progress with implementation of savings initiatives as outlined in Appendix 4.
- 2.3 Notes that officers within the Health and Social Care Partnership are progressing with a number of actions required to effect a recovery plan as outlined in section 4.7.1 of this report.

3.0 FINANCIAL IMPLICATIONS

- 3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 31 October 2019 shows a net projected overspend position at the year-end of £3,123k. Officers within the Health and Social Care Partnership continue to progress a number of actions required to deliver a recovery plan.

4.0 MAIN TEXT

4.1 Background

- 4.1.1 As part of the IJB's financial governance arrangements, the Integration Scheme outlines that "The Chief Finance Officer will ensure routine financial reports are available to the Chief Officer and the Integration Joint Board on a timely basis and include, as a minimum, annual budget, full year outturn projection and commentary on material variances."
- 4.1.2 The IJB set out its final budget for delegated services at its meeting of the 25 June 2019 following receipt of confirmation of NHS Tayside's budget (DIJB31-2019). Within this report, the risks around the prescribing budget were reiterated after being formally noted in the budget report presented to a meeting of the IJB held on 29 March 2019 (Article VI of the minute refers).
- 4.1.3 The financial information presented has been provided by the finance functions of NHS Tayside and Dundee City Council as set out within the Integration Scheme.

- 4.1.4 Under the terms of the Integration Scheme, the risk sharing arrangements in relation to any residual overspends incurred by the end of the financial year will be met proportionately by the Council and NHS Tayside. Discussions will be ongoing throughout the financial year with both parties to consider the implications of this should an overspend arise. Officers within the partnership will however continue to explore areas to control expenditure and achieve the savings targets identified.

4.2 Projected Outturn Position – Key Areas

- 4.2.1 The following sets out the main areas of note from the financial information contained within Appendices 1 (Summary Position) and 2 (More Detailed Position) and provides commentary on the reasons for significant variances, actions being taken to manage these and outlines the key elements of risk which may remain.

4.3 Services Delegated from NHS Tayside

- 4.3.1 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £39k by the end of the financial year. Community based health services managed directly by Dundee Health and Social Care Partnership are projected to be underspent by approximately (£684k) and overall prescribing is projected to be underspend by (£156k). An overspend of £106k is projected in General Medical /Family Health services and an overspend of £773k as a result of the net effect of hosted services risk sharing.
- 4.3.2 Service underspends are reported within Community Based Psychiatry of Old Age (£225k), Allied Health Professionals and Community Nursing (£454k), Keep Well (£160k), Substance Misuse (£110k) and hosted services such as Psychology (£710k), Tayside Dietetics (£170k) and Sexual & Reproductive Health (£190k) mainly as a result of staff vacancies.
- 4.3.3 Service overspends are anticipated in Enhanced Community Support £610k, Intermediate Care £105k and Medicine for the Elderly £470k. These are associated with the Delayed Discharge issues highlighted at section 4.4.2 below. Community Mental Health services are also anticipated to be overspent by £230k. Additional staffing pressures have contributed to the adverse position within these services through ensuring safe staffing levels in accordance with the National Nursing and Midwifery workload tools requirements.
- 4.3.4 The Family Health Services prescribing budget currently projects an overspend of £174k based on the expenditure trends to date and predictions to the year end however this is offset by an underspend in Other Prescribing items. General Medical Services is forecasting an overspend of £131k.
- 4.3.5 Members of the IJB will also be aware that Angus and Perth and Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. More detail of the recharges from Angus and Perth and Kinross IJBs to Dundee IJB are noted in Appendix 3. This shows net overspends to the value of £698k being recharged with the net impact of hosted services to Dundee being an overspend of £773k.
- 4.3.6 As with 2018/19, the financial position of Dundee City IJB continues to be impacted upon by the significant overspend in the Mental Health Inpatient service which is hosted by Perth & Kinross IJB. Perth & Kinross IJB in collaboration with NHS Tayside and the Scottish Government have invested in project management capacity to seek to address these issues and to support the transformation of In-Patient Mental Health Services. However, the latest projection from Perth and Kinross shows Dundee's share of this overspend increased from the £588k previously reported to £688k. As instructed by the IJB at the October 2019 meeting, the Chief Finance Officer has formally written to the Chief Finance Officer of Perth & Kinross IJB to request an update on progress with implementation of the transformation programme and likely impact on the financial position for 2019/20 and beyond. At this stage no response has been received.

4.4 Services Delegated from Dundee City Council

- 4.4.1 The financial projection for services delegated from Dundee City Council to the IJB shows an anticipated overspend of £3,085k which is a deterioration from the figure of £1,857k formally presented to the IJB in October 2019, which was based on the August expenditure position to date. The Chief Finance Officer provided a verbal update to the IJB at the October meeting to advise that the position had deteriorated from the published report based on the most recent information available.
- 4.4.2 A significant financial challenge facing the IJB's delegated budget continues to be the provision of home and community based social care at a sufficient level to meet increasing demographic demand and reduce delayed discharges in hospital while balancing financial resources. At this stage of the financial year, the activity in this area is at such a level that a significant overspend is projected across a range of services. An overspend of approximately £860k is anticipated within externally purchased care at home services while expenditure on private and voluntary sector care homes is significantly higher than projected with an increased number of placements compared to the previous year's position and anticipated trajectory resulting in a further overspend of around £540k. In addition, expenditure on respite care is higher than budget by around £220k again mainly due to high levels of demand. Staff costs across services are expected to be around £1m overspent due to the non-achievement of staff savings and slippage targets, including the delay in implementing the home care review.
- 4.4.3 A range of underspends within Learning Disabilities, Substance Misuse and Mental Health functions mainly arising from staff turnover as well as slippage in the development of new services are currently projected to partly offset these budget pressure areas.

4.5 Reserves Position

- 4.5.1 The IJB's reserves position was adversely affected at the year ended 31 March 2019 as a result of a greater than anticipated overspend incurred during last financial year. The reserves position is noted below and is subject to the audit of the 2018/19 annual accounts.

	Opening Balance £000	Anticipated Commitments	Projected Net Position at Year end
Non-Earmarked Reserves	561	-	561
Earmarked Reserves – Transformation	400	(300)	100
Earmarked Reserves – Specific*	1,805	(1,805)	-
Total	2,766	(2,105)	661

*These balances mainly consist of Primary Care, Alcohol and Drug Partnership and Mental Health Action 15 Scottish Government Funds which must be spent on the purposes for which they were provided for. In addition, a balance of funding of around £300k is to be used to support the assessment at home service.

4.6 Savings and Transformation Plan

- 4.6.1 The IJB agreed a savings and transformation programme at its meeting of 29 March 2019 to the value of approximately £5,400k which was around £500k short of the required target to fully balance the budget. This shortfall is included within the projections contained within this report.
- 4.6.2 A review of progress in relation to these reviews has been made and is set out in Appendix 4 to this report. This notes that £2,808k of these agreed savings have been or are on track to be achieved with a further £2,582k regarded as either unlikely to be achieved or high risk of not being delivered. Officers from the Health and Social Care Partnership will continue to progress the outstanding savings proposals where possible to reduce the risk of non-delivery of savings. The impact of these risks are considered as part of the financial monitoring projections set out in this report.

4.7 Recovery Action

- 4.7.1 Given the level of overspend projected and continued increasing demand for services officers from the Health and Social Care Partnership are progressing a number of actions to restrict future spend and recover the overspend incurred to date. These actions are as follows:

Action:

- *Review of health and care pathways to reduce hospital stays including delayed discharge to ensure any system blockages are cleared and systems and processes are working at their optimum level.*

An action plan has been developed and is in the process of being implemented by operational services to ensure component parts of pathways can work effectively

- *Continuous scrutiny of staff vacancies and managing these effectively where safe to do so.*

All requests for approval to recruit signed off by Head of Health and Community Care Services and Chief Finance Officer with requirement to demonstrate all other alternative approaches have been explored. Patient and service user safety remains the priority.

- *Continuous review of discretionary spend across all service areas.*

Budget holders to ensure expenditure is only incurred when absolutely necessary.

- *Review of specific expenditure areas such as Learning Disability Services.*

Benchmarking exercise to be undertaken to compare cost base with other systems across other authorities in Scotland

- *Work with partners to ensure resources are maximised across the whole system supporting health and social care.*

Continued dialogue with partner agencies to ensure relevant services continue to prioritise complementary services which support the health and wellbeing of the local population. Explore joint areas of investment, for example through the agreement of the Winter Plan with NHS Tayside and the other Tayside IJBs

- *Review of progress of previously agreed savings proposals.*

As noted in Section 4.6 above and Appendix 4

- *Options around use of remaining reserves.*

The reserves position is noted at Section 4.5 above. In relation to the overspend, £300k has already been identified to support the Assessment at Home team. The balance of uncommitted reserves of £561k will need to be applied to the IJB's final outturn position at the year end should the overspend remain at its current level.

- *Restatement of eligibility criteria for access to services to critical and substantial*

As agreed at the August 2019 IJB meeting (Article VI of the minute refers)

- *Review of additional support in care packages*

Ensure any support arrangements above standard levels (eg 1:1 support in care homes) remain appropriate to meet the needs of service users

- *Review of Intermediate Care Provision*

Ensure maximum value is achieved through current contractual arrangement.

4.8 Budget Variation

- 4.8.1 Throughout the financial year, adjustments are made to the original approved budget as a result of additional funding and service transformation. These adjustments do not impact on the net projected variance position at the year-end. Changes to the delegated budget are provided below:

	Dundee City Council £000k	NHS Tayside £000k	Total £000k
Approved budget	77,047	158,879	235,926
Adjustments	82k Women's Aid 140k Apprenticeship Levy Budget 9.4k Other Minor Adjustments	496k Superannuation Adjustments / Action 15 Mental Health 788k Increase in Hospital and Community budget 2,516k Increase in General Medical Services/ Family Health services	4,031
Adjusted Budget	77,278	162,679	239,957

5.0 POLICY IMPLICATIONS

- 5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a significant risk that the IJB is unable to deliver a balanced budget over the financial year.
Risk Category	Financial
Inherent Risk Level	Likelihood 4 x Impact 5 = Risk Scoring 20 (which is Extreme Risk Level)
Mitigating Actions (including timescales and resources)	The IJB has agreed a range of efficiency savings and other interventions including the use of reserves to balance expenditure. A range of service redesign options through the Transformation Programme will offer opportunities to further control expenditure. Regular financial monitoring reports to the IJB will highlight issues raised.
Residual Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level)
Planned Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level)
Approval recommendation	While the inherent risk levels are extreme, the impact of the planned actions reduce the risk and therefore the risk should be accepted.

7.0 CONSULTATIONS

- 7.1 The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

- 8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

Date: 26 November 2019

APPENDIX 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2019/20						Oct-19
	Dundee City Council Delegated Services		NHST Dundee Delegated		Partnership Total	
	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000
Older Peoples Services	40,140	1,718	15,846	1,020	55,986	2,738
Mental Health	4,320	(94)	3,559	230	7,879	136
Learning Disability	24,451	783	1,409	40	25,860	823
Physical Disabilities	6,008	-107	0	0	6,008	(107)
Substance Misuse	1,977	(298)	2,826	-110	4,804	(408)
Community Nurse Services/AHP/Other Adult	716	-126	12,480	(454)	13,196	(580)
Hosted Services	0	0	20,166	(727)	20,166	(727)
Other Dundee Services / Support / Mgmt	-334	1,208	27,052	(440)	26,718	768
Centrally Managed Budgets	0		559	(243)	559	(243)
Total Health and Community Care Services	77,278	3,085	83,897	(684)	161,175	2,400
Prescribing (FHS)	0	0	32,233	174	32,233	174
Other FHS Prescribing	0	0	821	(330)	821	(330)
General Medical Services	0	0	26,650	131	26,650	131
FHS - Cash Limited & Non Cash Limited	0	0	19,078	(25)	19,078	(25)
Grand Total	77,278	3,085	162,679	(734)	239,957	2,350
Less: Planned Draw Down From Reserve Balances						
Net Effect of Hosted Services*			6,072	773	6,072	773
Grant Total	77,278	3,085	168,751	39	246,029	3,123
*Hosted Services - Net Impact of Risk Sharing Adjustment						

- AHP – Allied Health Professionals
- FHS – Family Health Services

APPENDIX 2

Dundee City Integration Joint Board – Health and Social Care Partnership – Finance Report October 2019

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)
	£,000	£,000	£,000	£,000	£,000	£,000
Psychiatry Of Old Age (POA) (In Patient)			4,863	-10	4,863	-10
Older People Serv. – Ecs			1,062	610	1,062	610
Older Peoples Services -Community			511	33	511	33
Medicine for the Elderly			5,274	470	5,274	470
Medical (POA)			684	0	684	0
Psychiatry Of Old Age (POA) - Community			1,972	(225)	1,972	(225)
Intermediate Care			(44)	105	(44)	105
Dundee- Supp People At Home			0	0	0	0
Medical (MFE)			1,524	38	1,524	38
Older People Services	40,140	1,718			40,140	1,718
Older Peoples Services	40,140	1,718	15,846	1,020	55,986	2,738
General Adult Psychiatry			3,559	230	3,559	230
Mental Health Services	4,320	(94)			4,320	(94)
Mental Health	4,320	(94)	3,559	230	7,879	136
Learning Disability (Dundee)	24,451	783	1,409	40	25,860	823
Learning Disability	24,451	783	1,409	40	25,860	823

		Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
		Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)
		£,000	£,000	£,000	£,000	£,000	£,000
Physical Disabilities		6,008	(107)			6,008	(107)
	Physical Disabilities	6,008	(107)	0	0	6,008	(107)
Substance Misuse		1,977	(298)	2,826	(110)	4,804	(408)
	Substance Misuse	1,977	(298)	2,826	0	4,804	(408)
A.H.P. Admin				406	(24)	406	(24)
Physiotherapy				3,807	(250)	3,807	(250)
Occupational Therapy				1,454	0	1,454	0
Nursing Services (Adult)				6,264	(50)	6,264	(50)
Community Supplies - Adult				155	(30)	155	(30)
Anticoagulation				394	(100)	394	(100)
Joint Community Loan Store				0	0	0	0
Intake/Other Adult Services		716	(126)			716	(126)
Community Nurse Services / AHP / Intake / Other Adult Services		716	(126)	12,480	(454)	13,196	(580)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)
	£,000	£,000	£,000	£,000	£,000	£,000
Palliative Care – Dundee			2,774	(40)	2,774	(40)
Palliative Care – Medical			1,180	30	1,180	30
Palliative Care – Angus			348	15	348	15
Palliative Care – Perth			1,730	190	1,730	190
Brain Injury			1,718	180	1,718	180
Dietetics (Tayside)			3,001	(170)	3,001	(170)
Sexual and Reproductive Health			2,193	(190)	2,193	(190)
Medical Advisory Service			162	(75)	162	(75)
Homeopathy			28	4	28	4
Tayside Health Arts Trust			62	0	62	0
Psychology			5,192	(710)	5,192	(710)
Psychotherapy (Tayside)			953	64	953	64
Learning Disability (Tayside AHP)			825	(25)	825	(25)
Hosted Services	0	0	20,166	(727)	20,166	(727)
Working Health Services			0	(15)	0	(15)
The Corner			416	(40)	416	(40)
Grants Voluntary Bodies Dundee			46	0	46	0
IJB Management			804	(100)	804	(100)
Partnership Funding			23,827	0	23,827	0
Urgent Care			0	0	0	0
Public Health			767	(75)	767	(75)
Keep Well			632	(160)	632	(160)
Primary Care			560	(50)	560	(50)
Support Services/Management Costs	(334)	1,208			(334)	1,208
Other Dundee Services / Support / Mgmt	(334)	1,208	27,052	(440)	26,718	768

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)	Annual Budget	Projected Over / (Under)
	£,000	£,000	£,000	£,000	£,000	£,000
Centrally Managed Budgets			559	(243)	559	(243)
Total Health and Community Care Services	77,278	3,085	83,897	(684)	161,175	2,400
Other Contractors						
Prescribing (FHS)			32,233	174	32,233	174
Other FHS Prescribing			821	(330)	821	(330)
General Medical Services			26,650	131	26,650	131
FHS - Cash Limited and Non Cash Limited			19,078	(25)	19,078	(25)
Grand Total HSCP	77,278	3,085	162,679	(734)	239,957	2,350
Hosted Recharges Out			(11,907)	75	(11,907)	75
Hosted Recharges In			17,979	698	17,979	698
Hosted Services - Net Impact of Risk Sharing Adjustment			6,072	773	6,072	773
Less: Planned Draw Down from Reserves						
Total	77,278	3,085	168,751	39	246,029	3,123

APPENDIX 3

**NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee IJB
Risk Sharing Agreement - October 2019**

Services Hosted in Angus	Annual Budget	Forecast Over (Underspend)	Dundee Allocation
Forensic Service	1,001,485	120,000	47,280
Out of Hours	7,891,045	160,000	63,040
Tayside Continence Service	1,440,352	16,000	6,304
Ang-loc Pharmacy	1,850,651	0	0
Speech Therapy (Tayside)	1,128,661	59,000	23,246
Hosted Services	13,312,194	355,000	139,870
Apprenticeship Levy	41,188	(1,803)	(710)
Superannuation Cost Pressure	13,000	0	0
Balance of Savings Target	-193,272	(193,272)	(76,149)
Grand Total Hosted Services	13,173,110	159,925	63,010
Services Hosted in Perth			
Angus Gap Inpatients	1,415,123	(10,000)	(3,940)
Dundee Gap Inpatients	6,449,209	(50,000)	(19,700)
Dundee Gap Snr Medical	3,642,248	(1,675,000)	(659,950)
P+K Gap Inpatients	4,317,013	0	0
Learning Disability (Tayside)	6,373,243	(10,000)	(3,940)
T.A.P.S.	709,919	(10,000)	(3,940)
Tayside Drug Problem Services	849,899	80,000	31,520
Prison Health Services	3,841,930	90,000	35,460
Public Dental Service	2,147,462	37,500	14,775
Podiatry (Tayside)	3,111,031	215,000	84,710
Hosted Services	32,857,077	(1,332,500)	(525,005)
Apprenticeship Levy - Others	41,700	1,900	749
Apprenticeship Levy - IPMH	76,600	100	39
Superannuation Cost Pressure - Others	67,000	0	0
Superannuation Cost Pressure - IMPH	17,000	0	0
Balance of Savings Target	(273,553)	-273,600	(107,798)
Balance of Savings Target - IPMH	(328,009)	-328,000	(129,232)
Grand Total Hosted Services	32,457,815	(1,932,100)	(761,247)
Total Hosted Services	45,630,925	(1,772,175)	(698,237)

APPENDIX 4

DUNDEE INTEGRATION JOINT BOARD					
2019/20 BUDGET - BUDGET SAVINGS LIST – UPDATE NOVEMBER 2019	2019/20 Original Savings Proposal	Projected Savings Delivered 2019/20	Projected Savings Undelivered 2019/20		
	£000	£000	£000	Nature of Saving	Reason for Projected Delay in Savings Delivery / Revised timescales
Base Budget Adjustments:					
<i>These are operational budget savings to reflect decisions already made by the IJB or through changes in service to reflect demand levels or operational requirements</i>					
Housing Support Service Changes - Resource Release	125	125	0	Resources released through change in model of provision of housing support through sheltered and very sheltered housing	n/a
General increase in income through increasing existing charges	54	54	0	Already set out within the Council's Review of Charges Exercise through the annual uprating of charges to service users	n/a
Realignment of Practical Support & Meals Service Staffing Levels to reflect reduced service demand	517	517	0	Demand for practical support and meals services continue to decrease with alternatives available from external care providers. Staff numbers in post have reduced accordingly but budget has not reduced accordingly.	n/a

Review use of voids in accommodation with support for people with a learning disability	100	0	100	Reconfigure in-house accommodation with support to ensure void levels are reduced and capacity is maximised	Delays due to legal process in transferring tenancies to other units. Some level of savings may be achieved during the latter part of 2019/20. Full saving to be achieved from April 2020
Review of transport services for day care services	50	0	50	Review of transport arrangements for service users who access building based services	Review not commenced at this stage. Reflection that this needs to be wider review of supports and should not be looked at in isolation.
Income generation for White Top Centre through offering services to neighbouring authorities	77	0	77	Maximise capacity of Whitetop Respite service through offering spare capacity to neighbouring authority areas	No current spare capacity within the service to offer to other areas due to current staffing levels impacted by recruitment difficulties
Review external provision of day care	40	17	23	Demand for traditional day services for people with a disability has reduced significantly over recent years due to an increase in the range of alternative supports available. Resources will be reviewed to ensure they are more appropriately aligned with demand levels.	Negotiation with care provider taken longer than anticipated. Full year saving to be achieved in 2020/21
Test of Change - Move from sleepovers to overnight responder services within Mental Health and Learning Disability Services (external care providers)	75	25	50	Test of change to complement existing waking night workers and replace some sleepover services where safe to do so. Working in partnership with external care providers	Care provider commissioned to implement test of change has had difficulty in recruiting. Anticipated start date now January 2020

Realign level of domestic service required for housing support / care at home services for people with a learning disability	32	32	0	An internal review of domestic services has been undertaken which assessed current levels of provision against need, including the need to encourage service user independence. This has resulted in a net reduction in the number of hours of domestic support required	n/a
Reduce External Care Home Budget	500	0	500	Due to transformational change around the way in which community based health and social care is provided locally, demand for care home placements has reduced and the budget required should reduce accordingly	Despite a trend over recent years in line with national and local policy to reduce care home placements, pressures around delayed discharge and a reduction in the number of self funded residents from January 2019 onwards has increased expenditure levels back to previous budgeted levels
Community Equipment Store Initiatives (eg new procurement arrangements)	40	40	0	Procurement arrangements already agreed by IJB in December 2018 (Report DIJB68/2018)	n/a
Implement Substance Misuse Service Investment Plan	40	0	40	The Substance Misuse Service Investment Plan was considered and approved by the IJB at its meeting of the 18th December 2018	Progress of redesign stopped pending response to Drugs Commission findings
Review of Operational Budgets	100	100	0	Reduce discretionary expenditure budgets and ensure all operational budgets are subject to tight control	n/a
Realign Meals Service contract to reflect lower levels of demand	100	73	27	Renegotiate contract with Tayside Contracts to reflect a reduced number of meals provided per year. This would be an interim arrangement prior to benefit realisation from the new Tayside Contracts Central Processing Unit to be developed by August 2020	Reduction in meals numbers purchased less than anticipated
Total Base Budget Adjustments	1,850	983	867		

Transformation Programme Financial Savings					
Review of Community Based Health and Social Care Services	1,400	300	1,100	Progress a whole system move to more locality working with integrated teams and co-located service provision. Expected to deliver reduction in duplication and increase efficiencies, reduction in demand for community services through early intervention, prevention, self directed support, technology enabled care and eligibility criteria. Changes anticipated to continue to reduce unscheduled care and delayed discharge leading to positive impact on the value of the large hospital set aside.	Redesign of Kingway Care centre beds base underway as agreed by IJB. Re-statement of eligibility criteria agreed at August IJB meeting. Progress with other programmes behind schedule.
Redesign of Homeless Services	150	0	150	Joint approach with DCC Neighbourhood Services Department to develop a Homelessness Investment plan to include investment and disinvestment of resources to build capacity, focus on early intervention and prevention of homelessness in line with the Homelessness Strategic Plan, Rapid Rehousing Plan and DHSCP Strategic & Commissioning Plan.	Progression of local homelessness strategy commissioning arrangements through partnership with DCC Neighbourhood services department and partner third sector agencies slower than anticipated
Integrated Admin Review	100	25	75	Explore opportunities arising as more systems and process are integrated with resultant reduction in duplication.	Limited opportunities in 2019/20 – pending review of community based health and social care services
Mobile Working / IT systems review	100	0	100	Explore ways of supporting a more mobile workforce through the use of technology and ensure MOSAIC client recording system working effectively.	Pilot project underway within OT services but unlikely to now deliver savings in 2019/20. Progress being made in reviewing processes within MOSAIC system however no cost efficiencies identified as yet.

Review Charging Policies to ensure equity across client groups as part of move to "Contributions Policy"	140	0	140	Development of a charging policy which ensures equity in charging, is compatible with Self Directed Support legislation and considers the impact of free personal care for under 65s and the waiving of charges for carers.	Review underway however now unlikely to deliver changes during 2019/20.
Total Transformation Programme Savings	1,890	325	1,565		
Corporate Savings					
Reduction in Funding Available to Support Change Projects	850	850	0	Former Integrated Care Fund and Delayed Discharge Fund now incorporated into mainstream budgets with successful change projects now funded	n/a
Assessment of impact of demand for new legislation (Free Personal Care for Under 65s, Carers Act demand)	800	800	0	Total additional funding for new legislation of approximately £1.2m includes elements to support projected increases in demand for services. It is anticipated that much of this demand will not materialise within the first full year therefore a non-recurring saving is anticipated, reducing year on year.	n/a
Total Corporate Savings	1,650	1,650	0		
Total Savings Proposals	5,390	2,958	2,432		



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 17 DECEMBER 2019

REPORT ON: DUNDEE DRUGS COMMISSION REPORT – RESPONDING TO DRUG USE WITH KINDNESS, COMPASSION AND HOPE

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB55-2019

1.0 PURPOSE OF REPORT

- 1.1 To inform the Integration Joint Board of the response to the recommendations presented by the Dundee Drugs Commission and present the action plan developed to support the progress for change.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Notes the contents of the Dundee Drugs Commission Report – Responding to Drug Use with Kindness, Compassion and Hope – as attached at Appendix 1.
- 2.2 Notes the specific areas for improvement for the Dundee Health and Social Care Partnership as detailed in Paragraph 4.1.5.
- 2.3 Notes the attached action plan developed by the Dundee Alcohol and Drugs Partnership to address the recommendations in response to the Dundee Drugs Commission Report as attached at Appendix 2.

3.0 FINANCIAL IMPLICATIONS

- 3.1 The response to the Dundee Drugs Commission Report will be funded from current resources available to the Dundee Community Planning Partnership, the Dundee Alcohol and Drug Partnership and the Dundee Health and Social Care Partnership. This includes additional funding from the Scottish Government to support Alcohol and Drug Partnerships.

4.0 MAIN TEXT

4.1 Background

- 4.1.1 The Dundee Alcohol & Drugs Partnership (ADP) were concerned regarding the level of deaths within the city as a result of substance use. This was further highlighted by the increasing public interest and media coverage in relation to issues associated primarily with the impact of drug misuse and the response of services in Dundee. These included public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; access to and experience of treatment and support services and the continuing rise of drug related deaths.
- 4.1.2 The Independent Drugs Commission (the Commission) was established in April 2018 by the Dundee Community Planning Partnership in order to:
- To consider the nature, extent and impact of drug misuse and drug deaths in Dundee;
 - To identify and investigate the key causes and consequences of drug misuse and drug deaths for individuals and their families along with policy and practical measures to address these;

- To seek the views and involvement of all relevant local stakeholders including individuals with lived experience;
- To assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee ADP and across community planning partners;
- To consider evidence of what has worked elsewhere, including approaches to achieve prevention and recovery;
- To prepare a report for the Dundee ADP and its partners on additional priorities for practical and achievable action to tackle and reduce substance misuse and drug deaths in the city.

4.1.3 The Commission used a range of methods to gather evidence, information and views, including the views of those with lived experience and their families. It considered evidence of what works elsewhere to respond to drug use and drugs deaths, including prevention and recovery approaches. Overall, the Commission focused on four main themes:

- Leadership and Governance
- Drugs Deaths
- Treatment & support
- Mental Health

4.1.4 The Dundee Drugs Commission Report – *Responding to Drug Use with Kindness, Compassion and Hope* was published in August 2019. The report was published in three parts and presents 16 recommendations focusing on issues relating to leadership, stigma, treatment and support, drug related deaths, the protection of children and young people and mental health. The recommendations are presented under three headings, including:

- Culture and systems;
- A holistic system model – including integrated Primary Care Provision;
- Causes and effects of drug use.

A copy of the report is attached at Appendix 1.

4.1.5 The Commission made a number of observations and recommendations relating directly to the services delivered through the Dundee Health and Social Care Partnership:

- Dundee should develop a shared care model and ensure general practice is part of the whole-system approach;
- There should be more choice in the available services, including residential rehabilitation;
- Dundee should develop a new Community Pharmacy model;
- There should be full integration of mental health and substance misuse services.
- There should be the adoption of a gendered approach to all the improvement work and ensure that the specific needs of women affected by drug use are considered and addressed.
- Integrated substance use services should be delivered as part of a whole-system approach;
- There should be improved retention in services (including ‘no unplanned discharges’) and more outreach work;
- There should be a system for same-day prescribing of opioid replacement therapies.

4.2 Response to the Dundee Drugs Commission Report

4.2.1 The Dundee Partnership accepted the report from the Commission and is committed to implementing the recommendations. Responding to the Commission’s report, Chief Officers and Elected Members expressed a commitment to progress whole-system improvements, including better leadership and better engagement with all those affected by drug use, and specific actions to bring about a culture change. There was recognition that significant improvements will take time but that every opportunity for early and quick gains will be embraced. There was also a commitment to change the governance structure of the ADP to increase scrutiny and accountability.

4.2.2 To provide an opportunity for discussion about the recommendations from the Commission and to consult on an early draft plan, a Dundee Community Forum Conference (the Forum) was held on the 23rd October 2019. 132 delegates attended the Forum, including community representatives, individuals with lived experience and family members, staff from a range of statutory and third sector services, Elected Members and members of the Commission. Presentations on the day from Commission members highlighting some key issues, including:

- The need for Dundee to address stigma and language issues;
- The increase in the availability of Gabapentin and Pregabalin;
- Links to poverty and mental health;
- The need for meaningful involvement of those with lived experience; and
- The need to develop an 'open door' access to services.

4.3 Developing a Multi-agency Action Plan for Change

4.3.1 To improve the effectiveness of the work of the ADP, Simon Little, Independent ADP Chair has conducted a governance review of the ADP. The revised governance structure of the ADP will take a leading role in developing, progressing and monitoring the actions for change. To effect the change the following has been implemented:

- Membership of the ADP has been strengthened, including additional representatives from Primary Care and Community Pharmacies;
- ADP membership will now include members with lived experience, including a carer;
- An ADP Implementation Group has been set up to replace the current Alcohol and Drug Strategic Planning Group. The implementation Group will be chaired jointly by Diane McCulloch, Head of Health and Community Care, Dundee Health and Social Care Partnership and Eric Knox, Chief Executive, Dundee Voluntary and Volunteer Action;
- Five workgroups will deliver the strategic actions and lead on the specific elements of the development and progress of the plan for change. The work-streams include the Drug Death Action Plan, Whole System of Care, Children and Families, Prevention and the Resilient Communities. The work-stream leads will be members of the Implementation Group, which in turn will report to the ADP.

4.3.2 A draft action plan was developed which set out the actions to be taken to implement the recommendations contained within the Commission report; this has now been approved by the Dundee Partnership. The actions will be managed through the five work streams and will support the implementation of the wider strategic work of the ADP. The action plan is attached at Appendix 2.

4.3.3 The Dundee Partnership will provide an overall responsibility for reviewing the progress of the plan, and other elements of the partnership will take a role in progressing the actions.

4.4 Progress to date

4.4.1 The ADP and the Dundee Partnership are committed to focus on a number of key areas, and have commenced work to meet the recommendations including:

- Improving the response to all non-fatal overdoses in Dundee to ensure contact is made within 72 hours with all known individuals that have experienced a non-fatal overdose. Multi agency work is already underway to develop, test and embed this new approach;
- Increase the assertive outreach – including a test of change through the Integrated Substance Misuse Service to follow up on people who disengage;
- Progressing with options for same-day prescribing the substance misuse services; moving to deliver services from different localities within Dundee and to increase the prescribing capacity;
- Dundee has volunteered to be an early adopter of the Scottish Government pilot to develop a joint mental health and substance misuse approach.

5.0 POLICY IMPLICATIONS

- 5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	The Drugs Commission Report set out 16 recommendations to support people who use substances and to support the reduction of the number of people who die as a result of substance use. The changes described within the report will require significant cultural change and a wholesale redesign of the models of service delivery. There is a risk that without sufficient levels of financial and other resources, the pace of change required will not be met.
Risk Category	Financial, social
Inherent Risk Level	Likelihood 4 x Impact 5 = 20
Mitigating Actions (including timescales and resources)	The implementation of the action plan developed will be closely monitored through the ADP. The strategic commissioning of future services and the redesign programme will developed in line with the commission recommendations Resources to support the change programme will be developed in line with available resources.
Residual Risk Level	Likelihood 3 x Impact 5 = 15
Planned Risk Level	Likelihood 2 x Impact 5 = 10
Approval recommendation	Approve the report.

7.0 CONSULTATIONS

- 7.1 The Chief Officer, Executive Director of Corporate Services (Dundee City Council), Interim Director of Finance of NHS Tayside and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

- 8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None.

David W Lynch
Chief Officer

DATE: 17 December 2019

Vered Hopkins
Lead Officer, Protecting People

Diane McCulloch
Head of Health and Community Care

Simon Little
Independent Chair, Dundee Alcohol and Drugs Partnership

2019

Responding to Drug Use with Kindness, Compassion and Hope

A report from the Dundee Drugs Commission

PART ONE – THE REPORT

Presented to the Dundee Partnership

**FOR FURTHER INFORMATION
PLEASE CONTACT**

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COMMISSION MEMBERS

Dr Robert Peat (Chair, Former Director of Inspection, Care Inspectorate and former Depute Chief Executive and Director of Social Work and Health with Angus Council)

Prof Alex Baldacchino (Consultant Addiction Psychiatrist, Fife)

Sharon Brand (Recovery Dundee)

Dr Andrew Fraser (Director of Public Health Science, NHS Health Scotland)

Prof Eilish Gilvarry (Consultant Addiction Psychiatrist, Newcastle)

John Goldie (Former Head of Addictions, Glasgow Addiction Service)

Cllr Kevin Keenan (Leader of the Labour Group on Dundee City Council)

Eric Knox (CEO, Volunteer Dundee)

Dave Liddell (CEO, Scottish Drugs Forum)

Jean Logan (Associate Director of Pharmacy, NHS Forth Valley)

Cllr Ken Lynn (Vice Chair, Dundee Health and Social Care Integration Joint Board)

Suzie Mertes (Superintendent, Police Scotland)

Justina Murray (CEO, Scottish Families Affected by Alcohol and Drugs)

Prof Niamh Nic Daeid (Director of the Leverhulme Research Centre for Forensic Science, University of Dundee)

John Owens (Independent Chair of Argyll & Bute ADP)

Dr Tessa Parkes (Research Director, Salvation Army Centre for Addiction Services and Research, University of Stirling)

Hazel Robertson (Head of Services for Children, Young People and Families, Perth & Kinross Council)

Jardine Simpson (CEO, Scottish Recovery Consortium) and his predecessor (**Kuladharini**)

Pat Tyrie (Family Member)

Maureen Walker (Family Member and member of the Lifeline Group)

COMMISSION FACILITATOR AND LEAD CONTACT FOR REPORT

Andy Perkins Director (Figure 8 Consultancy) – c/o The Signpost Centre, Lothian Crescent, Dundee, DD4 0HU. ✉ andyperkins@f8c.co.uk 🌐 www.f8c.co.uk

FIGURE 8 RESEARCH AND SUPPORT TEAM MEMBERS

Kevin Gardiner (Research Assistant)

Trevor McCarthy (Associate Consultant)

Jennifer Turnbull (Business Administrator and Commission Secretary – until January 2019)

COMMISSION STEERING GROUP

The Chair of the Commission (Robert Peat) and the Commission Facilitator (Andy Perkins) were assisted by a small steering group (below), who provided guidance and support. This group met on six occasions. The Commission are grateful for the advice and support they provided.

Peter Allan (Community Planning Manager,
Dundee City Council)

Vered Hopkins (Protecting People Lead Officer,
Dundee Protecting People Team)

NOTE: Simon Little was a member of the Drugs Commission until January 2019 when he resigned his position to take up the role of independent Chair for the Dundee Alcohol and Drugs Partnership.

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Reports

This Part 1 report is the main report of the Dundee Drugs Commission. There are two accompanying (Appendix) reports which contain all the supporting evidence collected over the course of the Commission in a set of 22 Appendices:

- Part 2 – Supporting Evidence – Background (contains Appendices I – IX)
- Part 3 – Supporting Evidence – Fieldwork (contains Appendices X – XXII)

Disclaimer

This report contains the views of members of the Dundee Drugs Commission who also took into account data, intelligence, evidence and views from invited participants and experts as well as over a thousand people who have responded to the Commission's calls for evidence. The members do not speak on behalf of any organisation but rather express their own conclusions following evidence from these and many other sources. The report is not intended to reflect the entire breadth of the discussions that have taken place over the last year but, instead, is a distillation of the many and varied contributions that have been made.

It is not the intention of this report to cast aspersions on any individual, but rather to help identify where systems and services are not working as they should in order to help identify realistic and workable solutions. Any identifying information about individuals has been removed to protect anonymity and confidentiality. Permission was sought from all individuals who contributed evidence to the Commission on the basis that responses would be anonymised.

For details of the Commission members (see **Appendix I** in the **Part 2 – Supporting Evidence – Background** report), as well as those who attended and contributed to the discussions (see **Appendices XI, XIII-XXII** in the **Part 3 – Supporting Evidence – Fieldwork** report) in the Supporting Evidence report.

Acknowledgments

The Commission would like to place on record its grateful thanks to all the individuals and organisations who have given evidence to the Commission – often requiring great courage to recount difficult and painful experiences.

The Commission would also like to express its thanks to the wide variety of speakers who gave up their time to prepare and present to the public meetings of the Commission. These sessions provided a wealth of valuable information and insight – without which the Commission's report would be incomplete.

Finally, the Commission would like to acknowledge the time and input from the team (Christian Cole, Emma Corrie, Harry Gray and Joyce Klu) at the Leverhulme Research Centre for Forensic Science (University of Dundee) who have produced the primary analysis of the 'deeper dive of drug-related death data' which was commissioned from ISD Scotland (see **Appendix XII** in the **Part 3** report).

1. FOREWORD – BY THE CHAIR OF THE COMMISSION



The wellbeing of Dundee is significantly affected by the use of drugs. The Dundee Partnership made a courageous decision to set up an independent Commission to consider the nature, extent and impact of drug use, and to look at drug-related deaths. We started our work in May 2018, and since then we have heard from, or spoken to, over a thousand people.

It is well known that the factors which can lead to a person becoming involved in the use of drugs are complex. It may be the result of adverse childhood experiences or other traumatic events. Drug use can have devastating consequences for individuals, families and the wider community and we have seen a growing number of drug-related deaths in Dundee and across Scotland. It is only by working in a consistent, combined and coordinated manner that the complex nature of drug use will be successfully addressed. Every life is precious and every death matters. It is with these thoughts at the forefront of our minds that we have taken forward our work.

The Dundee Partnership has clearly recognised the need to address poverty and other issues of inequality. These issues relate closely to drug use. We heard from too many people about the failings of the current system of support and care provided in Dundee. The current system is fractured. We heard heart-breaking stories from families and friends bereaved by a drug-related death. We heard many stories of the difficulty of receiving the right type of support when a person has mental health difficulties and problems relating to drug use. We met with Dr David Strang who is leading the Independent Inquiry into Mental Health Services in Tayside. Our recommendations in this area will support the work of the Independent Inquiry. We also address stigma and the importance of the use of appropriate language.

Our recommendations focus in the main on treatment and support, drug-related deaths, mental health and leadership. Without strong leadership and a determination to stick with what will be a difficult task, then the Partnership will not succeed in turning things around. Those delivering care and support in Dundee must build relationships which are based on respect and trust. These will provide a starting point for working effectively as a true and equal partnership. We believe that a shared culture is needed which values kindness, compassion and the belief in hope. This is the reason for the title of this report. With **kindness, compassion and hope**, Dundee can be a City which will lead the way in successfully responding to drug use.

The Commission has twenty members who have given their time voluntarily. I am very grateful to them for their hard work and commitment to the task. I am also grateful to the support from Andy Perkins and his colleagues at Figure 8 Consultancy. I would particularly like to thank all those who provided their thoughts and evidence to the Commission, especially those people who have lived experience of using or having used drug services and family members.

Robert Peat, Chair of the Commission (August 2019)

2. EXECUTIVE SUMMARY

Key findings

The Dundee Drugs Commission has been an intensive and rapid review of the recent history of the impact of drug use across Dundee, and the help available for people who use drugs in the city. Local Commission members have been supported by experts from across Scotland and the wider UK. To be clear, the Commission was set up in part to assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners (Objective #4). During the course of our work, we have learned about inadequacies in our local systems and services. We have frequently heard from individuals and families who feel that the system has failed them. All our recommendations are born out of the experiences of people in Dundee.

As a Commission, over the course of the last year, we have received evidence from over a thousand different people – those with lived experience of problems with drugs (current and past); family members; members of the public; clinicians and GPs; staff who work in drug treatment and support services; staff who work in wider health and social care services; senior officials within NHS Tayside, Dundee City Council and Dundee's third sector; politicians and elected members; and academics.

Some individuals and families have spoken in great detail to us about positive experiences of the help and support they've received and the strategies they have used themselves to move towards recovery from drug use. Many individuals and families shared their grief and loss over the devastation that has been caused by drug use. We have heard numerous stories of immense challenges and barriers put in front of those who require help and support, compounded by the pervasive stigma that is still attached to being a person who experiences drug problems. Staff working in services have shared both positive and enthusiastic accounts of their efforts to help those who present to services, as well as details of immense frustration and anger when things do not work as they should.

Our review of a substantial amount of evidence has taken time to distil and balance. We have been aware that when an independent Commission is set-up then you tend to have all the stories coming to the fore of how things are not working. However, we have also taken the time to seek out and listen to those who have a positive story to tell – whether one of how they've successfully made changes to their drug use by themselves (or with help from family and others) – or whether a story of how they have received the help required from local services. By so doing, we believe that we have achieved a balanced understanding of the reality of issues faced.

Our review has led us to identifying a number of key messages – all of which we have used to form the challenging set of recommendations. The key messages in our report are structured underneath the key themes of our work:

- Leadership and Governance; • Drug Deaths;
- Treatment and Support; and
- Mental Health.

Conclusions

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement, and will also require strong and dedicated leadership over many years to make Dundee a place that delivers on its belief that truly 'every death matters' and, more positively, 'every life matters'. This will require an honest and transparent acknowledgment of the failings that have taken place in the delivery of drug treatment services (in a 'no-blame' environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings.

We have scrutinised and discussed the evidence that has been received and have also looked for examples of best practice from elsewhere in order to:

1. identify immediate steps that can be taken to start improving the situation; and
2. begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Dundee Partnership to deliver. This is why a series of 'national considerations' are also offered below. We sincerely hope that these will be responded to by the Scottish Government and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will

require a renewed determination to work much more effectively across local, regional and national structures to deliver them. Our insight of best practice from countries such as Canada, Iceland and Portugal would, similarly, require changes in national policy and legislation and systems/practices in order to allow Dundee to implement fully the changes that are required.

The political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated. The time is now right to hand back the evidence and findings of our work to our elected leaders and ask them to set the standard for the leadership and accountability that is going to be required in Dundee (and beyond) to turn around the national emergency that is epitomised by the severe rates of drug-related deaths across Scotland.

Local Recommendations

The following are our set of **sixteen (16)** 'headline' recommendations that we believe are within the abilities of the Dundee Partnership to progress. Our Part 1 Report provides full detail of what will be required to see each recommendation fulfilled.

The recommendations are grouped under the following three headings:

- A. Culture and systems;
- B. A holistic system model - including integrated Primary Care provision; and
- C. Causes and effects of drug use.

A. CULTURE AND SYSTEMS

This first suite of recommendations **(1-6)** is focused around the need for cultural change across drug treatment services, related disciplines and communities of Dundee, and changes in local systems that will help facilitate such cultural change.

Recommendation 1: The Dundee Partnership must do all that is necessary to achieve the required standard of leadership – the test of which will be that agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families.

Recommendation 2: Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner.

Recommendation 3: Language matters. People who experience problems with drugs, and their friends and families, are part of our communities – let's make them feel like that.

Recommendation 4: Level the 'playing field' to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision. The balance between current centralised statutory and other provision needs to be changed.

Recommendation 5: Meaningful involvement of people who experience problems with drugs, their families and advocates.

Recommendation 6: Learning from the things that have gone wrong – attention to continuous improvement to benefit others who are vulnerable.

B. A HOLISTIC 'SYSTEM' MODEL – INCLUDING INTEGRATED PRIMARY CARE PROVISION

The second suite of recommendations **(7-13)** is concerned with the provision of drug treatment and support services in Dundee. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose.

Recommendation 7: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to people in Dundee.

Recommendation 8: The provision of services currently offered by ISMS should be delivered through the development of a new 'whole system' model of care. This should be structured via a joint and equal partnership with both primary care and the third sector, with the key purpose of utilising the unique strengths of all partners.

Recommendation 9: Reframe all substance use services to prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base including, but not limited to: improved retention through having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.

Recommendation 10: Involvement of primary care and shared care models.

Recommendation 11: Review and refresh the community pharmacy model for OST engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use substances. Look to establish a new Community Pharmacy model with additional support.

Recommendation 12: Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.

Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems.

C. CAUSES AND EFFECTS OF DRUG USE

The third suite of recommendations (14-16) is concerned with a wider understanding of the causes and effects of drug use in order to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups in Dundee.

Recommendation 14: Address the root causes of drug problems.

Recommendation 15: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.

Recommendation 16: Attend to the intergenerational nature of substance use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents. Explore the creation of family support workers in the third sector that can provide support ahead of families reaching crisis point and requiring social work intervention.

National Considerations

In considering how to achieve the significant improvements that are required in Dundee, there are a number of areas that are outside of Dundee's powers to change – resting either with Scottish Government or the UK Government. For Dundee to succeed in its ambitions to effectively tackle the challenges it faces, the Commission needs to highlight the following matters for national consideration:

1. The Commission would ask Scottish Government to consider equal regulation of the whole substance use services/treatment sector.
2. The Commission would ask the Scottish Government to consider how it can change the funding systems in Scotland to allow ADPs to control the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of ADPs to ensure they can function as fully independent commissioning bodies.
3. The Commission welcomes the Scottish Government declaring the drug deaths crisis as a public health emergency. In Scotland, at present, it is unclear whether such a declaration will unlock any new powers or resources. International examples exist that can be learned from, for example in British Columbia, Canada in response to a provincial emergency. The Commission welcomes the moves by the Minister for Public Health and Sport to set up a National Task Force to advise on what further changes, in practice or in law, could be made in Scotland.
4. The Commission is aware of the current inquiry into problem drug use in Scotland being run by the Scottish Affairs Committee and would support the calls for petitioning the UK government to have increased devolved powers to allow for a full 'Scottish' review of drug laws to be conducted and action taken as a result. In the short-term the Commission would ask the Scottish Government to consider how they can make the most of the powers that they already have (including policy) – such as police and enforcement practice.
5. The Commission would ask the Scottish Government to consider convening a National Learning Set for Drug Death Review Groups (including standardisation of processes).
6. The Commission would ask the Scottish Government to consider how 'real time' data (without extensive delays in getting these data into the public domain) can be achieved in order to enhance the ability to respond both locally and nationally.

7. The Commission would ask the Scottish Government to consider allocating appropriate resources to national toxicology testing to enable more effective and quicker reporting.
8. The Commission would ask the Scottish Government to consider developing a plan of work to address the findings in the 2018 Scottish Government report on women and drug-related deaths.

Objectives of the Commission

The Commission was provided with a draft set of objectives from the Dundee Partnership, and refined them slightly to the following:

The Dundee Drugs Commission will:

1. Consider the context, nature, extent and impact of drug use and drug-related deaths in Dundee.
2. Identify and investigate the key causes and consequences of drug use and drug-related deaths for individuals and their families along with policy and practical measures to address these.
3. Seek the views and involvement of all relevant local stakeholders including individuals with lived experience of accessing substance use services, partner organisations providing support and/or treatment, and public-sector service managers and frontline service providers.
4. Assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners as relevant.
5. Consider evidence of what has worked elsewhere to combat drug use and drug-related deaths including approaches to achieve prevention and recovery.
6. Prepare a report for the Dundee ADP and its partners including Dundee City Council, NHS Tayside and the Health and Social Care Partnership with evidence-based recommendations on priorities for practical and achievable action to tackle and reduce drug use and drug-related deaths in the city. Recommendations should also be offered at national and global levels as well as local.

National context

Without doubt, Scotland is currently experiencing a crisis in relation to the rapidly increasing numbers of drug-related deaths.

Recent publication of the number of drug-related deaths in Scotland in 2018 by the National Records for Scotland show a 27% increase from the previous year (rising from 934 to an all-time high of 1,187). Between 2008-2018, the number of drug-related deaths has more than doubled (107% increase from 574 in 2008 to 1,187 in 2018). Over this period a combined total of **7,605** people have died in Scotland from a drug-related death, **404** of whom have been in Dundee.

Scotland's figures imply a drug-related death rate that is nearly three times that of the UK as a whole. It is also higher than that reported for any other EU country. Scotland's reported drug-related death rate is now higher (218 per million of the population) than the one reported for the USA (217 per million of the population), which has previously been considered to be the highest rate in the world.

Local context

Members of the Dundee Alcohol and Drug Partnership [DADP] have been aware of increasing public interest and media coverage in relation to a range of issues associated primarily with the impact of drug use and the response of services in Dundee. These include public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; patients' access to and experience of, treatment services; the reported rise in drug-related deaths in Dundee to the highest (population) rate of drug-related deaths in Scotland; and debate regarding the potential effectiveness of safe consumption spaces.

The DADP was asked to establish a panel based on the model used by the first Dundee Fairness Commission. Members of the DADP subsequently endorsed this proposal and asked officers to make arrangements for an independent Dundee Drugs Commission incorporating the strengths and good practice

of the Fairness Commission including research, community engagement, user perspective, a partnership approach and a focus on practical recommendations for action.

Dundee recorded 66 drug-related deaths during 2018 (up from 57 in 2017 and 38 in 2016). Between 2014-2018 Dundee City averages the highest rate of drug-related deaths per 1,000 population of all council areas in Scotland (0.31 deaths per 1,000 population). Of note, Glasgow City is not dissimilar.

Its rate of drug-related deaths per 1,000 population is 0.30.

To more fully understand the context of drug-related deaths in Dundee, the Commission met with and heard evidence from experts at ISD (**Dr Lesley Graham**, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team; and **Lee Barnsdale**, Principal Information Analyst [Drugs], ISD) in order to try and identify and understand whether Dundee has any specific conditions or factors that are influencing the high rates of drug-related deaths. As a result of these meetings, the Commission requested that a 'deeper dive' of drug-related death data be undertaken by ISD in order to compare Dundee against the Rest of Scotland in respect of a range of criteria (discussed and agreed by the Commission and ISD).

In discussions with ISD, who completed the 'deeper dive', the areas that are worthy of consideration and further exploration are:

- Proportionally (when compared to the Rest of Scotland), in Dundee there are:
 - more deaths in the 25-34 age group; ○ fewer suicides¹; ○ more individuals who live in areas within SIMD 1; ○ more people in treatment (prescription) at time of death; ○ more people on methadone at time of death; ○ more deaths where the individual had been diagnosed with Hepatitis C; and ○ more people diagnosed with a mental illness.
- Higher proportions of DRDs in Dundee with gabapentinoids; etizolam and diazepam implicated in death.

The indication that Dundee has proportionately more drug-related deaths amongst those who live in areas within SIMD 1 (noted above) is of particular interest to the Commission given the work of the Dundee Fairness Commission that has been progressed in the City over the last few years.

Guiding principle of the Commission

The people of Dundee have been and remain our first priority. When systems and services fail it is the people that they were designed to help (and their loved ones and communities) who are disadvantaged. This is the guiding principle that has informed all of our recommendations. This principle should continue to guide all future decision making and action in seeking to help people and communities who are affected by drug use in Dundee.

It's now time for action

As a Commission we are fully aware that we have provided a significant challenge for the Dundee Partnership in terms of the volume of action and work that will be required to implement our recommendations – which are framed over a five year period. Our hope is that all disciplines and

services (including the DADP) quickly (within three months) prioritise the time necessary to reflect upon the findings and recommendations laid out in this report, and provide a detailed response and action plan to the Dundee Partnership to describe the part they can all play in helping to tackle this set of significant challenges.

There are some quick wins to be had in learning from the mistakes of the past to uncover the solutions for the future.

There is a deep passion amongst the people of Dundee to assertively respond to the serious challenges faced. As Commission members we are fully prepared to continue in a supporting role to help ensure Dundee can implement the changes we have sought to describe and understand. We would therefore want to support the Dundee Partnership and the DADP as a 'critical friend' as they look to take the lead on

¹ Care and attention needs to be taken with this as there is difficulty in determining whether a death is suicide or an unintentional overdose – i.e. not all cases of suicide are listed as such on the death certificate.

implementation. Having challenged the Dundee Partnership to pick up the baton and run with an ambitious programme of change, it would be negligent of the Commission to deliver its report and walk away. As an independent Commission we are prepared to support the DADP as it begins a new journey and to reconvene and collaboratively review progress within the next 12 months.

The values of **kindness, compassion and hope** will underpin and guide the support that the Commission is able to provide. In return, we challenge the Dundee Partnership to having 'a year of kindness and compassion' to get things moving in the right direction and reignite the hope that things can and will change.

3. LANGUAGE, TERMINOLOGY AND GLOSSARY

Language

The world of drug treatment is full of jargon and abbreviations. We have made a conscious effort to reduce the volume of jargon in this report and to write using the principles of 'Plain English'.² We have also included a section in our findings and recommendations regarding the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who experiences problems with drugs.

At our first meeting, we held a detailed discussion regarding the original title for the Commission (i.e. 'Dundee Drug Misuse Commission'). Commissioners experienced the most difficulty with the term 'misuse' in the title. It was agreed that terminology such as 'misuse' or 'abuse' is stigmatising and should not be used, in line with guidance from the Global Commission on Drug Policy³. We had the sense that the current conversation and priority in the drug treatment field is now about whole populations and wellbeing (i.e. a continuum of users and non-users). We therefore agreed to remove the term 'misuse' from the title and agreed on 'Dundee Drugs Commission'.

In considering the role that language has in reflecting and framing critical conversations, we also considered other terms within the wider discourse that warrant some reflections due to their prior use. Perhaps the most obvious and commonly used of these is 'service user', a narrow term applied to those who use or have used treatment services, rather than being a person-centred term to describe a whole population of people (whether in treatment or not) who have chosen (for whatever reason) to use drugs (whether legal or illegal). We have favoured the use of the term 'individual' (who uses services) or 'a person who experiences problems with drugs'. This is a direct approach to help:

- counter the stigma of possible labelling;
- reflect the ambiguities of boundaries and identities; and
- adopt a more inclusive and person-centred position.

We have welcomed the extensive interest of local and national media in the work of our Commission and have noted and appreciated a changing use of reporting language over the course of the last year. For example, at the outset of the Commission the phrase 'shooting galleries' was commonly used in reports, which has been replaced by more accurate and respectful terms such as 'Drug Consumption Rooms' or 'Safer Injection Sites'.

We recommend that great care and attention is given by all relevant stakeholders and groups to developing language that is truly person-centred and aimed at reducing stigma rather than perpetuating it. We recommend that services in Dundee select titles to align with language that avoids stigmatisation. Several helpful resources are already available to aid this task. We would

² Available at: <http://www.plainenglish.co.uk/files/howto.pdf>

³ Available at: http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

particularly recommend that the online leaflet 'Language Matters', developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia⁴, is promoted at all opportunities across Dundee (see **Figures 3.1 and 3.2** below):

Figure 1: Language Matters', developed by the Network of Alcohol and other Drugs Agencies²

<div> <div>Language matters</div> <p>Language is powerful—especially when discussing alcohol and other drugs and the people who use them. Stigmatising language reinforces negative stereotypes. "Person-centred" language focuses on the person, not their substance use.</p> </div>	
When working with people who use alcohol and other drugs...	
👍 try this	👎 instead of this
substance use, non-prescribed use	abuse misuse problem use non-compliant use
person who uses/injects drugs	drug user/abuser
person with a dependence on...	addict junkie druggie alcoholic
person experiencing drug dependence	suffering from addiction has a drug habit
person who has stopped using drugs	clean sober drug-free
person with lived experience of drug dependence	ex-addict former addict used to be a...
person disagrees	lacks insight in denial resistant unmotivated
treatment has not been effective/chooses not to	not engaged non-compliant
person's needs are not being met	drug seeking manipulative splitting
currently using drugs	using again fallen off the wagon had a setback
no longer using drugs	stayed clean maintained recovery
positive/negative urine drug screen	dirty/clean urine
used/unused syringe	dirty/clean needle dirties
pharmacotherapy is treatment	replacing one drug for another
<p>Adapted from Language Matters from the National Council for Behavioural Health, United States (2015) and Matua Raki, New Zealand (2016).</p> <div>   </div>	

Figure 2: Language Matters', developed by the Network of Alcohol and other Drugs Agencies²

⁴ Available at: <http://nadaweb.azurewebsites.net/resources/language-matters/>

Person-centred language in non government AOD services

About this resource

Person-centred language focuses on the person, not their substance use. It is a simple and effective way of showing you respect a person's agency, dignity and worth.

This resource has been developed for people working in non government alcohol and other drugs (AOD) services. It has been developed in consultation with people who use drugs.

The purpose of this resource is to provide workers with guidelines on how to use language to empower clients and reinforce a person-centred approach.

Why have we developed this resource?

Our attitudes towards AOD use and how we respond rests on the concepts and language we use.

Words like 'addict', 'clean' and 'dirty' reinforce negative stereotypes and encourage judgement, blaming and shaming.

Fear of stigma and being labelled as a 'drug user' can and does prevent people from accessing treatment and support. Use of such language also contributes to poorer treatment outcomes.

Being mindful about the words we use is not about being politically correct. Language is powerful and it is the power of language which makes it an important practice tool; a tool to empower clients and fight stigma.

What this resource is not

This resource is not an exhaustive list of 'dos' and 'don'ts'. Language is complex. What is considered 'person-centred' will depend on the individual and the context. Terms, like 'recovery' for example, might be stigmatising for some, while others may prefer such terminology. There is no one-size-fits-all approach. What is important is that we are respectful and person-centred in our approach.



To learn more, visit the International Network of People who Use Drugs website: www.inpud.net.

Better practice guidelines

When working with people who use drugs:

- Don't define a person by their substance use or diagnosis —emphasise the person first. For example, say 'person who injects drugs' instead of 'injecting drug user' or 'person living with hepatitis C' instead of 'they're infected with hep C.'
- Don't impose your language on others. Where appropriate ask the person what language they prefer and respect their wishes.
- Choose terms that are strengths-based and empowering. Avoid terms like 'non-compliant'; use terms like 'chooses not to' or 'decided against' which affirm a person's agency, choice, and preferences.
- Be mindful of the implications of your language. Avoid terms like 'clean' and 'dirty' when talking about urine drug screen results. Consider also the implications of referring to opioid pharmacotherapies as 'substitution' or 'replacement' treatment.
- Avoid expressions like 'has a drug habit' or 'suffering from addiction' which can disempower a person by trivialising or sensationalising their AOD use.
- Use language that is accessible. Don't speak above a person's level of understanding or assume that a person is not capable of understanding. Avoid slang and medical jargon which can be misinterpreted or cause confusion when used incorrectly.
- Don't make assumptions about a person's identity—be inclusive. For example, ask about a person's preferred gender pronouns or, if you are unsure, use gender neutral terms like 'their', 'they' or 'them'. Better still, avoid unnecessary references to gender altogether by using the person's name.
- Be aware of the context of the language being used. Some terms are ok when used by members of a specific community as a means of claiming identity; the same terms can be stigmatising when used by people outside that community.
- The community of people who use drugs, like all communities, can suffer from lateral discrimination. Be careful not to take on the biases of others. Your language should respect a diversity of experience and empower the person who is looking to you for help.
- Remember, we don't just use words to communicate. Use non-verbal cues, like eye contact, tone of voice and body language to demonstrate you respect the dignity and worth of all people.

References

International Network of People who Use Drugs (2011). Statement and Position paper on Language, Identity, Inclusivity and Discrimination.
International Network of People who Use Drugs (2015). Drug User Peace Initiative: Stigmatising People Who Use Drugs.
Matua Raki (2016). Language Matters.
Mental Health Coordinating Council (2015). Language of Mental Health Recovery.

Terminology

When quoting individuals or citing literature sources we will use the terms they have chosen for accuracy of representation. Direct quotes will be clearly identified within speech marks. Where the Commission has paraphrased and summarised its analysis into a particular phrase, this will be identified using italics and should not be misconstrued as a direct quote from an individual.

Glossary

To aid anyone reading this report, we have included the Glossary below to identify any abbreviations used within the report. We have written the full term in the report for the first time each abbreviation is used.

Table 3.1: Glossary of terms used in the report

Abbreviation, Acronym or meaning Key word	Definition and meaning	
DADP	Dundee Alcohol and Drug Partnership	Alcohol and Drugs Partnerships are multi-agency strategic groups tasked by the Scottish Government with tackling alcohol and drug issues through partnership working.
DCR	Drug Consumption Rooms	Drug consumption rooms are professionally supervised healthcare facilities where drug users can consume drugs in safer conditions. They seek to attract hard-to-reach populations of users, especially marginalised groups and those who use on the streets or in other risky and unhygienic conditions. Also known as: Supervised/Safe Injection Sites/Facilities, Drug/Safe Consumption Facilities/Spaces or Medically Supervised Injection Centres.
DRD or DD	Drug-related death or Drug death	<p>‘Drug-related death’ is the definition used in the national statistics reporting and is a death where the underlying cause is: drug abuse or drug dependence; or drug poisoning (intentional or accidental) that involves any substance controlled under the Misuse of Drugs Act 1971.</p> <p>A ‘drug death’, reported locally, is specifically a death directly resulting from the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances.</p>
HAT	Heroin Assisted Treatment	Heroin-assisted treatment refers to the prescribing of synthetic, injectable heroin to those who are dependent on opiates, who do not benefit from or cannot tolerate treatment with one of the established drugs used in
		opiate replacement therapy like methadone or buprenorphine.

HSCP	Health and Social Care Partnership	Health and Social Care Partnerships, (HSCPs) are the organisations formed as part of the integration of services provided by Health Boards and Councils in Scotland. Each partnership is jointly run by the NHS and local authority. There are 32 HSCPs across Scotland.
IJB	Integration Joint Board	The Public Bodies (Joint Working) (Scotland) Act 2014 (the 'Act') required Local Authorities and Health Boards to jointly prepare an Integration Scheme, which sets out how Health and Social Care Integration is to be planned, delivered and monitored within their local area. A separate legal body called the 'Integration Joint Board' is the main decision-making body. It leads on and has devolved responsibility for the planning and monitoring of community health and social care services.
ISMS	Integrated Substance Misuse Services (Dundee)	Formerly known as Tayside Substance Misuse Services [TSMS] or the Drug Problem Centre [DPC])
ORT or OST	Opioid Replacement Therapy(ies) or Opioid Substitution Therapy(ies)	Opioid replacement therapy or Opioid Substitution Therapy involves replacing an opioid, such as heroin, with a longer acting but less euphoric opioid. Medicines commonly prescribed for ORT are methadone or buprenorphine.

4. WHAT WE WERE ASKED TO DO

Background

Members of the Dundee Alcohol and Drug Partnership [DADP] have been aware of increasing public interest and media coverage in relation to a range of issues associated primarily with the impact of drug use and the response of services in Dundee. These include public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; patients' access to and experience of, treatment services; the reported rise in drug-related deaths in Dundee to the highest (population) rate of drug-related deaths in Scotland; and debate regarding the potential effectiveness of safe consumption spaces.

The DADP was asked to establish a panel based on the model used by the first Dundee Fairness Commission⁵. Members of the DADP subsequently endorsed this proposal and asked officers to make arrangements for an independent Dundee Drugs Commission ['the Commission'] incorporating the strengths and good practice of the Fairness Commission including research, community engagement, user perspective, a partnership approach and a focus on practical recommendations for action.

In March 2018, Figure 8 Consultancy [hereinafter referred to as 'Figure 8'] was commissioned to setup and facilitate a Dundee Drugs Commission.

The Dundee Partnership announced that the Commission would be commencing at a launch event at the end of March 2018. Between March – May 2018, Figure 8 recruited twenty members to the Commission, including members with lived experience of substance use and family members affected by a loved one's use of substances. The Commission met for the first time in May 2018 followed by a further eleven formal meetings up until July 2019. Six of these meetings contained an open, public evidence session where members of the public and local media were invited 'into the room' to observe proceedings (full details of these public evidence sessions and details of the evidence speakers is provided in **Appendix XIII** in the **Part 3** report).

Objectives of the Commission

The Commission was provided with a draft set of objectives from the Dundee Partnership, and refined them slightly to the following:

The Dundee Drugs Commission will:

1. Consider the context, nature, extent and impact of drug use and drug-related deaths in Dundee.
 2. Identify and investigate the key causes and consequences of drug use and drug-related deaths for individuals and their families along with policy and practical measures to address these.
-
3. Seek the views and involvement of all relevant local stakeholders including individuals with lived experience of accessing substance use services, partner organisations providing support and/or treatment, and public-sector service managers and frontline service providers.
 4. Assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners as relevant.
 5. Consider evidence of what has worked elsewhere to combat drug use and drug-related including approaches to achieve prevention and recovery.
 6. Prepare a report for the Dundee ADP and its partners including Dundee City Council, NHS Tayside and the Health and Social Care Partnership with evidence-based recommendations on priorities for practical and achievable action to tackle and reduce drug use and drug-related in the city.
Recommendations should also be offered at national and global levels as well as local.

⁵ Full details on the work of the Dundee Fairness Commission can be found at:

<http://www.dundeepartnership.co.uk/content/dundeefairness-commission>

5. WHAT WE HAVE DONE

A wide variety of quantitative (data and statistics) and qualitative (expressed views) activities have been used to capture as broad and balanced a set of evidence as possible over the last year. In total, we have grouped these activities into eighteen different categories of evidence, as detailed below.

No. Evidence source		Notes
1	Initial Call for Evidence	An initial call for evidence was distributed through various networks across Dundee during May 2018. The call for evidence consisted of three key questions, focused on understanding how the work of professionals across Dundee in supporting those who have problematic drug use can make a positive difference to their outcomes. In total 39 responses were received. Full analysis is provided in Appendix XI in the Part 3 report.
2	Deeper Dive of Drug Death Data	Following discussions with and a presentation to the Commission by Lesley Graham (Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team) and Lee Barnsdale (Principal Information Analyst [Drugs], ISD) a formal request was made to ISD for provision of a 'Deeper Dive' of Drug-related Death data to compare a set of key parameters between Dundee and the rest of Scotland. The aim was to identify if there are any factors of relevance to Dundee in relation to DRDs, compared to other areas of Scotland. A summary of this Deeper Dive is included in Chapter VI and a full analysis at Appendix XII in the Part 3 report.
3	Public Evidence Sessions	Over the course of the last year, the Drugs Commission has held six public evidence sessions where a range of experts were invited to either present to the Commission or discuss certain topics as part of a panel-based question and answer session with the Commission. Full details of evidence speakers are provided at Appendix XIII in the Part 3 report. Copies of presentations can be seen at: http://www.figure8consultancy.co.uk/latestnews/dundee-drugs-commission/
4	Service user / family focus groups	Seven focus groups, with a total of 60 participants, were conducted by Figure 8 Consultancy with a range

		of groups with people experiencing drug problems and family/carer support groups across Dundee between June – August 2018. Full details are provided in Appendix XIV in the Part 3 report.
5	Service visits	A range of visits to third sector service in Dundee were undertaken by groups of Commission members on 14 th November 2018. In total, six services were visited, with an opportunity for Commission members to meet with staff and service users or family members. Full details are provided in Appendix XV in the Part 3 report.
6	Evidence submissions from the Integrated Substance Misuse Service	<p>Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place regarding the Integrated Substance Misuse Service (ISMS) in Dundee. The Commission requested detailed information from ISMS on the services it provides, and ISMS have submitted some detailed documents to the Commission as part of its evidence submissions, with the key documents being:</p> <ol style="list-style-type: none"> 1. Provision of a 'factsheet' from ISMS 2. Written response from ISMS to questions posed by the Commission 3. Written submission to the Drug Commission's Final Call for Evidence 4. Analysis of the Deeper Dive of DRD Data commissioned from ISD (Dundee v's Rest of Scotland) 5. Clinical Guidelines 6. Service Redesign Plans 7. Performance and Governance 8. Carers 9. Guidelines for Medical Treatments for Substance Misuse (ISMS) <p>Full details are provided in Appendix XVI in the Part 3 report.</p>
7	Staff focus groups (ISMS)	Three focus groups were conducted with a total of 16 staff at ISMS during March 2019. Full details are provided in Appendix XVII in the Part 3 report.

8	Key stakeholder meetings and interviews	A whole range of key stakeholder meetings and interviews with professionals took place over the course of the year, on a whole range of themes. Although it has not been possible to write all of these
		up for the purposes of this report, the discussions that have taken place have consistently helped to shape the findings of the Commission's work. A list of meetings conducted is included in Appendix XVIII in the Part 3 report.
9	Service user, family and members of the public – meetings and correspondence	<p>Invitations were extended through the Commission's Calls for Evidence and by word of mouth through services and via meetings for individuals with lived experience and family members to speak directly to the Commission (via discussions with Andy Perkins and or Robert Peat). This has been added as an extra layer of informal evidence gathering to the initial planned methods of the Commission.</p> <p>Over 30 individuals and family members have come forward over the last year to speak of their experiences of the treatment and support that is available in Dundee and to discuss the changes they would like to see to improve the situation in Dundee. Full details are provided in Appendix XIX in the Part 3 report.</p>
10	Drug-Related Deaths survey	<p>The purpose of the survey was two-fold: to gather a rich strand of qualitative evidence of what the problem is in terms of exploring the high rates of drug-related deaths in Dundee, and to gain insight on what can be done about reducing these deaths; and to engage a wider audience in the work of the Dundee Drugs Commission. The survey was distributed online and via hardcopy through various networks and was open during July - September 2018. The survey consisted of demographic questions and one key open-ended question:</p> <p><i>'What has to be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths?'</i></p> <p>In total, 927 responses to the question were analysed. Full analysis is provided in Appendix XX in the Part 3 report.</p>

11	Commission Sub-Groups	Following analysis of its Initial Call for Evidence and other early evidence gathering activities, the Commission considered the main themes that it needed to prioritise in timeframe allocated (one year). There were four consistent themes that were identified, over and above any others: Drug-Related Deaths; Leadership; Mental Health; and Treatment.
		The Commission set-up four sub-groups to explore and report upon these core themes. Further details of each sub-group's composition and work is provided in Appendix XXI in the Part 3 report.
12	Final Call for Evidence	A final call for evidence was distributed online and via hardcopy through various networks across during March-April 2019. There were 112 responses to the survey, although most only completed demographic information. There was a total of 39 respondents who provided answers to the key questions posed – a mixture of individual and corporate responses. Full analysis is provided in Appendix XXII in the Part 3 report.
13	Literature and evidence review and bibliography	Throughout the course of the Commission we have identified relevant reports, documents, articles, policies, strategies, etc. The Figure 8 team have selected and reviewed the most relevant of these to its work and have written these up in summary form for consideration by Commission members. These 76 documents have provided a whole library of evidence that are directly linked to our report recommendations. A wider set of evidence sources (n=181) have been considered throughout the Commission process and are included as a full Bibliography. Full details are provided in Appendix III in the Part 2 report.

14	Rapid review of literature in relation to Low Threshold Methadone prescribing	One of the foremost gaps identified by the Commission in the provision of drug treatment services in Dundee is that of Low Threshold Methadone Maintenance Treatment (MMT). With this in mind, a rapid review of key literature in relation to Low Threshold MMT has been conducted to provide the supporting evidence for recommending a swift move to developing such service provision in Dundee. This rapid review of literature is detailed in Appendix IV in the Part 2 report.
15	International research evidence case studies (Canada, Iceland, Portugal)	The Commission were asked to consider evidence of what has worked elsewhere to combat drug use and drug-related deaths including approaches to achieve prevention and recovery. After due consideration, the Commission requested that Figure 8 look at evidence from Canada (in relation to Harm Reduction approaches), Iceland (in terms of a prevention approach for young people), and Portugal (in terms
		of their approach to decriminalisation). Full details are provided in Appendix V in the Part 2 report.
16	Related Conferences – materials	Across the lifespan of the Drugs Commission, members of the Commission and the Figure 8 support team have attended a number of conferences in Scotland that have had significant relevance to the issues that have been considered by the Commission. A summary of the conferences attended is provided below. The conference materials obtained have been included in our full review of evidence. Full details are provided in Appendix VI in the Part 2 report.

17	Rapid inequalities review (Dundee)	<p>Problem drug use has strong links to poverty and deprivation, with individuals from deprived areas more likely to have experienced psychological trauma and mental health issues, which can result in the use of high-risk drugs to escape psychological stress and trauma. That is not to say, however, that deprivation causes addiction, given the links between poverty and drug misuse are multifaceted. Recent local data suggest that 73% of individuals who died as a result of the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug-related deaths, with more than half of drug-related deaths occurring in areas of greatest socioeconomic deprivation. Full details of this review are provided in Appendix VII in the Part 2 report.</p>
18	Scottish Affairs Committee Inquiry into Problem Drug Use in Scotland – summary of relevant written submissions	<p>The Scottish Affairs Select Committee has been receiving evidence as part of its inquiry into the use and misuse of drugs in Scotland and is due to report in the autumn (2019). All responses to the Scottish Affairs Select Committee have timely relevance to the Dundee Drugs Commission. A rapid review of submissions responding to the questions ‘What are the unique drivers of drugs abuse in Scotland?’, ‘How is drugs misuse in Scotland different from the rest of the UK?’ and ‘recommendations’ has highlighted themes of significant relevance, which are presented in Appendix VIII in the Part 2 report.</p>

What we haven’t done – the limitations

Despite extensive efforts to fully cover all the objectives of the Commission, there are some areas that have not received as much or enough attention as others. The Commission decided at a very early stage to focus its attention on the key themes that arose from the Initial Call for Evidence (Leadership, Drug Deaths, Treatment and Mental Health) in order to ensure that a thorough review of these elements was possible in the timeframe and resources available to the Commission. In doing so, we would like to identify a number of areas which have been beyond the realistic scope of the Commission, but which we feel will require further (detailed) attention down the line so that the Dundee Partnership can have a full, whole-systems review and approach at its disposal.

The key areas that we haven’t been able to give as much attention to as we would ideally have liked to are:

1. The impact of drug use upon children and young people affected by their own use or that of family members/significant others.

We have attempted to provide some evidence within our report on these matters and have conducted some key interviews along the way, as well as utilising the expertise of our Commission members – which have informed our recommendations. However, this area deserves and needs a far greater review than we have been able to conduct and we would welcome moves from the Dundee Partnership

to prioritise this area in the next phase of its development work. Examples of areas that require further attention are:

2. The role of substance use services in Child Protection case conferences and review of resourcing and capacity to ensure this matter is always given utmost priority. See **Recommendation 16** in Chapter 8 for further details.
3. At the very end stage of our evidence gathering, the development of the PAUSE programme⁶ in Dundee was brought to our attention. It was a surprise that this initiative had not been brought to our attention from the outset of the Commission. Due to the late submission of evidence around this service, the Commission has not been able to give due consideration to this initiative. However, some Commission members have expressed concern over the setting up of this project in Dundee and would suggest that wider consultation is required about this initiative.
4. The impact of childhood sexual abuse for those who have used drugs to help cope with the trauma experienced in their early years. Detailed evidence was provided to the Commission in written evidence submissions. Again, we have not had the resources or time to give this matter the necessary and full consideration it deserves and would welcome this being prioritised as a matter for detailed review.
5. The role of criminal justice services and matters of availability of drugs across Dundee and law enforcement of drugs.

⁶ "The purpose of Pause is to prevent the damaging consequences of thousands more children being taken into care each year. Pause works with women who have experienced – or are at risk of – repeated pregnancies that result in children needing to be removed from their care." [PAUSE Dundee, Updated Scoping Report, April 2018].

Although this is an area that has been (in the main) beyond the realistic remit of the Drugs Commission a wide range of evidence has been presented and obtained in relation to the role of criminal justice for those who use drugs. Good evidence has been provided to the Commission which details the helpful and strong role that criminal justice services across Dundee play, with many reports of good working practices noted. As part of our evidence gathering members of the Drugs Commission visited HMP Perth and spoke to the Governor as well as several prisoners from Dundee and prison staff. The recurring key theme was of the challenges posed to accessing good quality treatment pre- and post-release. It was noted that if you are arrested towards the end of a week and held in custody over the weekend, then you face one of two scenarios. On the one hand, if you go to court on the following Monday and are released from police custody, then you are likely to be suspended from your methadone prescription due to having missed your prescription pick-up for a number of days since your arrest; whereas, on the other hand, if you are remanded into custody by the court then your methadone prescription will be continued upon arrival at HMP Perth. One prisoner explained that he had experienced this and that he was "praying" when he went into court on the Monday after his arrest that he would be remanded into custody so that his methadone would continue and not be stopped.⁶

In relation to availability and enforcement issues this has proved to be beyond the ability of the Commission to give due attention to at this stage. However, one of our Commissioners (Suzie Mertes, Superintendent, Police Scotland) has helpfully provided a precis of current approaches to availability and enforcement in Dundee (see **Appendix IX** in the **Part 2** report). It must be noted though that the Commission has not had the time to review this area.

⁶ The Commission has been advised by ISMS that 'Current practice is that if prior notice is given to the pharmacy/ISMS that someone was dispensed over the weekend prior to release, then dispensing is continued uninterrupted.'

6. CONTEXT

National context

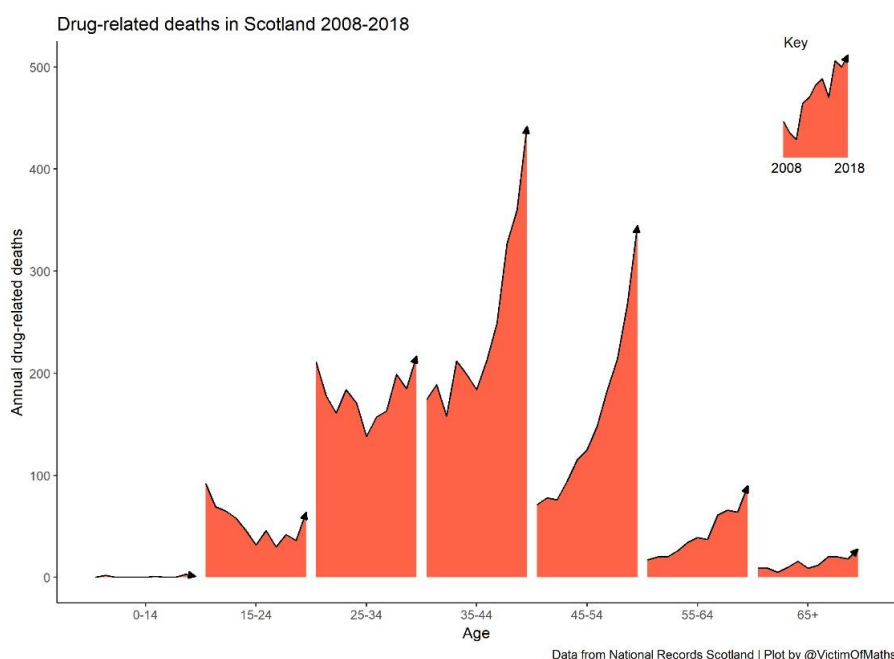
Without doubt, Scotland is currently experiencing a crisis in relation to the rapidly increasing numbers of drug-related deaths.

Recent publication of the number of drug-related deaths in Scotland in 2018 by the National Records for Scotland⁷ show a 27% increase from the previous year (rising from 934 to an all-time high of 1,187).

Between 2008-2018, the number of drug-related deaths has more than doubled (107% increase from 574 in 2008 to 1,187 in 2018). Over this period a combined total of **7,605** people have died in Scotland from a drug-related death, **404** of whom have been in Dundee.

The loss of life, particularly amongst those aged 35-55 years, is such that drug-related deaths are affecting overall life expectancy trends for Scotland⁸.

Figure 6.1: Drug-related Deaths in Scotland – 2008-2018 (by age)⁹



The majority (905, 76%) of deaths in 2018 were of those aged 35 years and older – so called ‘older drug users’. There were 282 deaths among people under 35 years of age during 2018 (up 26% from 224 in 2017).

As in previous years, most drug-related deaths were among men (860, 72%). However, comparing annual averages for 2004-2008 with 2014-2018, the percentage increase in the number of drug-related deaths was greater among women (212%) than men (75%).

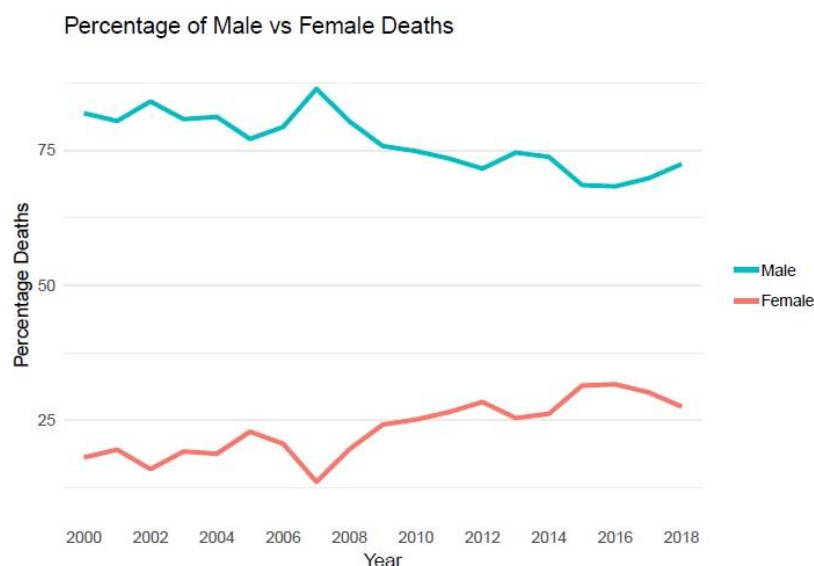
Figure 6.2: Male v Female deaths – by percentage¹⁰

⁷ <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2018>

⁸ <https://www.scotpho.org.uk/population-dynamics/recent-mortality-trends/>

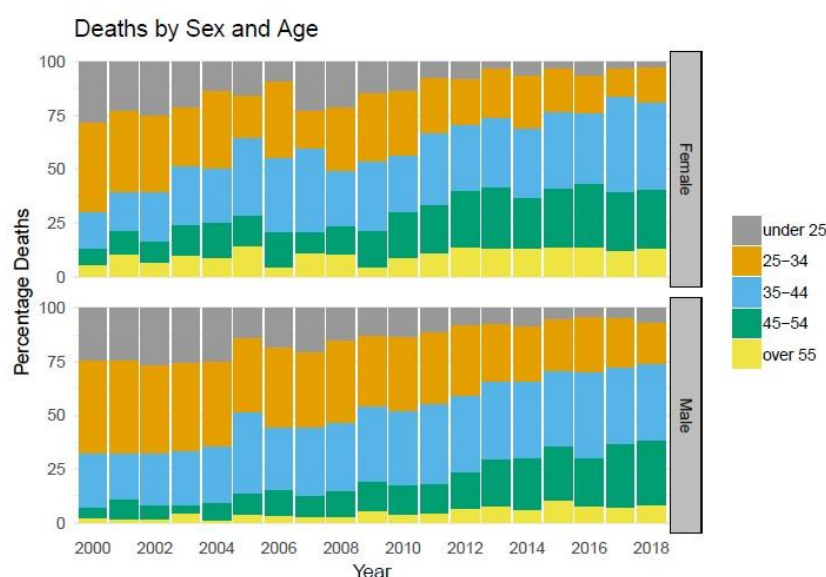
⁹ Thanks to Colin Angus, Senior Research Fellow, Sheffield Alcohol Research Group, University of Sheffield for permission to use this graph.

¹⁰ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.



Males are mostly affected by drug-related deaths, but females are increasing.

Figure 6.3: Deaths – by sex and age¹¹



In 2000 deaths were largely in the under 35s. In 2018 they are dominated by the 35 and over. Particularly in females.

Opioids (e.g. heroin/morphine, methadone) have continued to be implicated in most (86%) drugrelated deaths, whilst the implication of street benzodiazepines (57% in 2018), gabapentinoids (31%) and cocaine (23%) in drug-related deaths has increased over time.

Figure 6.4: Drugs implicated in death – Opioids and Benzodiazepines¹²

¹¹ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

¹² Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph. ¹⁴

Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

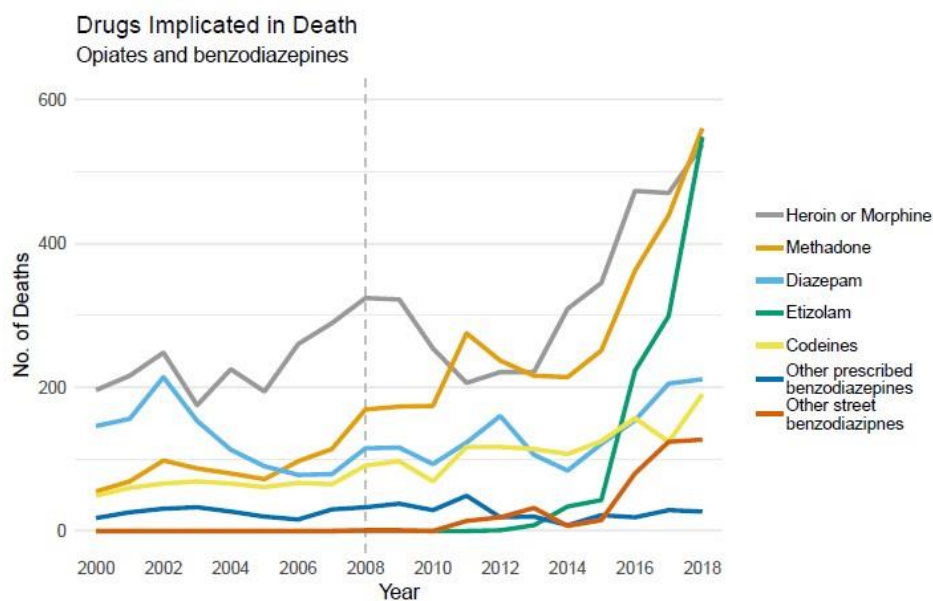
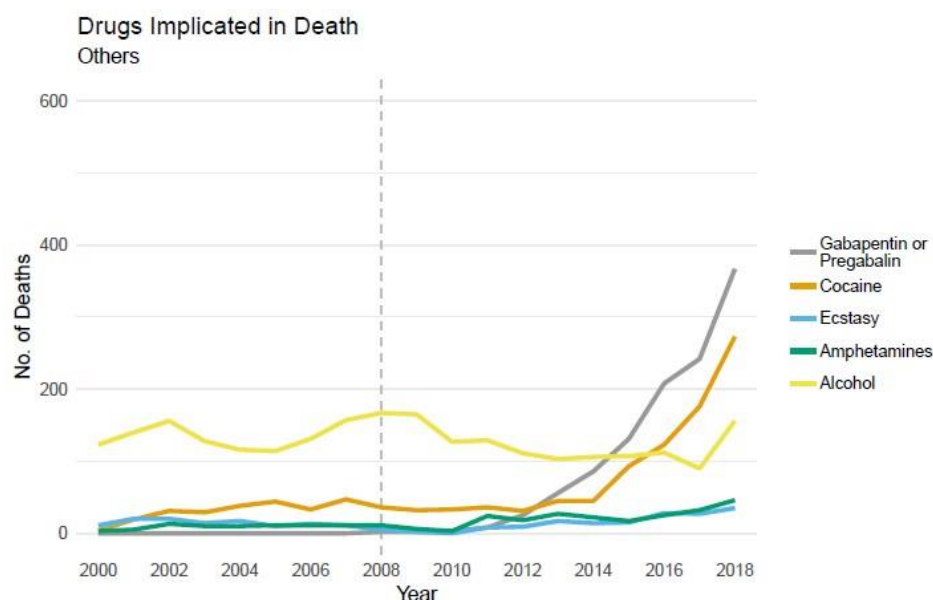


Figure 6.5: Drugs implicated in death – Others¹⁴



NB: data prior to 2008 uses a different definition than the data from 2008. See notes in table 3.

Scotland's figures imply a drug-related death rate that is nearly three times that of the UK as a whole. It is also higher than that reported for any other EU country.¹³

Figure 6.6: Number of drug-related deaths (per million population) – by EU countries

¹³ However, countries differ in how deaths are recorded and coded, and there may be under-reporting in some cases. See <https://www.gov.scot/news/1-187-drug-deaths-in-2018-up-27-percent-in-a-year/> ¹⁶ <https://www.bbc.co.uk/news/uk-scotland-48938509>

European drug deaths per capita

Aged 15-64, cases per million population



Scotland's reported drug-related death rate is now higher (218 per million of the population) than the one reported for the USA (217 per million of the population)¹⁶, which has previously been considered to be the highest rate in the world.

The Scottish Government has recognised that the country is facing a public health emergency over the rise of drug-related deaths and the Minister for Public Health and Sport (Joe Fitzpatrick, MSP) is arranging a high-level summit in Glasgow to discuss the crisis. The Minister has also announced that a new national taskforce is to be set-up to help tackle the crisis.

"A new taskforce to tackle the rising number of drug deaths in Scotland is to be chaired by Professor Catriona Matheson from the University of Stirling. The taskforce will examine the main causes of drug deaths, promote action to improve the health outcomes for people who use drugs, and advise on further changes in practice, or in the law, which could help save lives. It will collate and publish good practice about what has worked in other parts of the UK and internationally, and work with partners to spread and sustain good practice in Scotland.

The group will also examine whether the Misuse of Drugs Act 1971 affects the provision of a

strengthened and consistent public health approach to drug use, recognising that this is reserved to the UK Parliament and that any changes will require their agreement, or for responsibility to be devolved to Scotland. The review will specifically consider what impact the Act has on proposals to provide public health harm reduction services, such as medically supervised drug consumption rooms."¹⁴

Local context

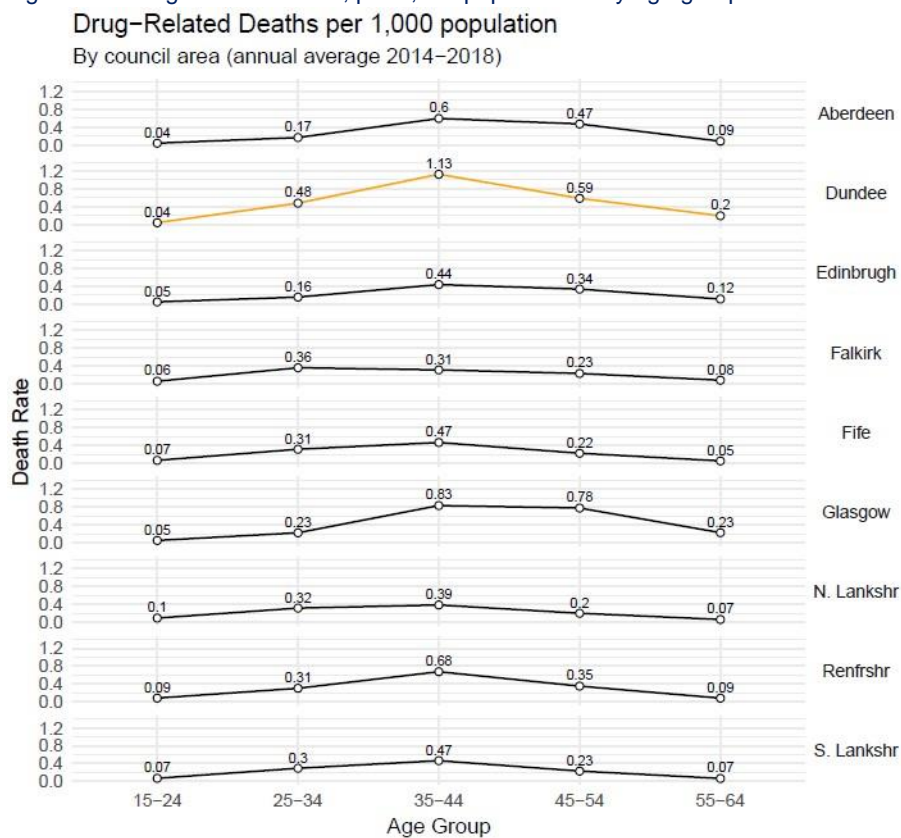
Dundee recorded 66 drug-related deaths during 2018 (up from 57 in 2017 and 38 in 2016). Between 2014-2018 Dundee City averages the highest rate of drug-related deaths per 1,000 population of all council areas in Scotland (0.31 deaths per 1,000 population). Of note, Glasgow City is not dissimilar.

Its rate of drug-related deaths per 1,000 population is 0.30.

Initial analysis of the national (2018) dataset highlights some aspects about the nature of drug-related deaths in Dundee.

Firstly, proportionately there are noticeably more deaths in the 25-34 and 35-44 year old age groups than for other areas of Scotland, as shown in the graph below:

¹⁴ <https://www.gov.scot/news/chair-of-new-drug-deaths-taskforce-appointed/>

Figure 6.7: Drug-related Deaths, per 1,000 population – by age group¹⁵

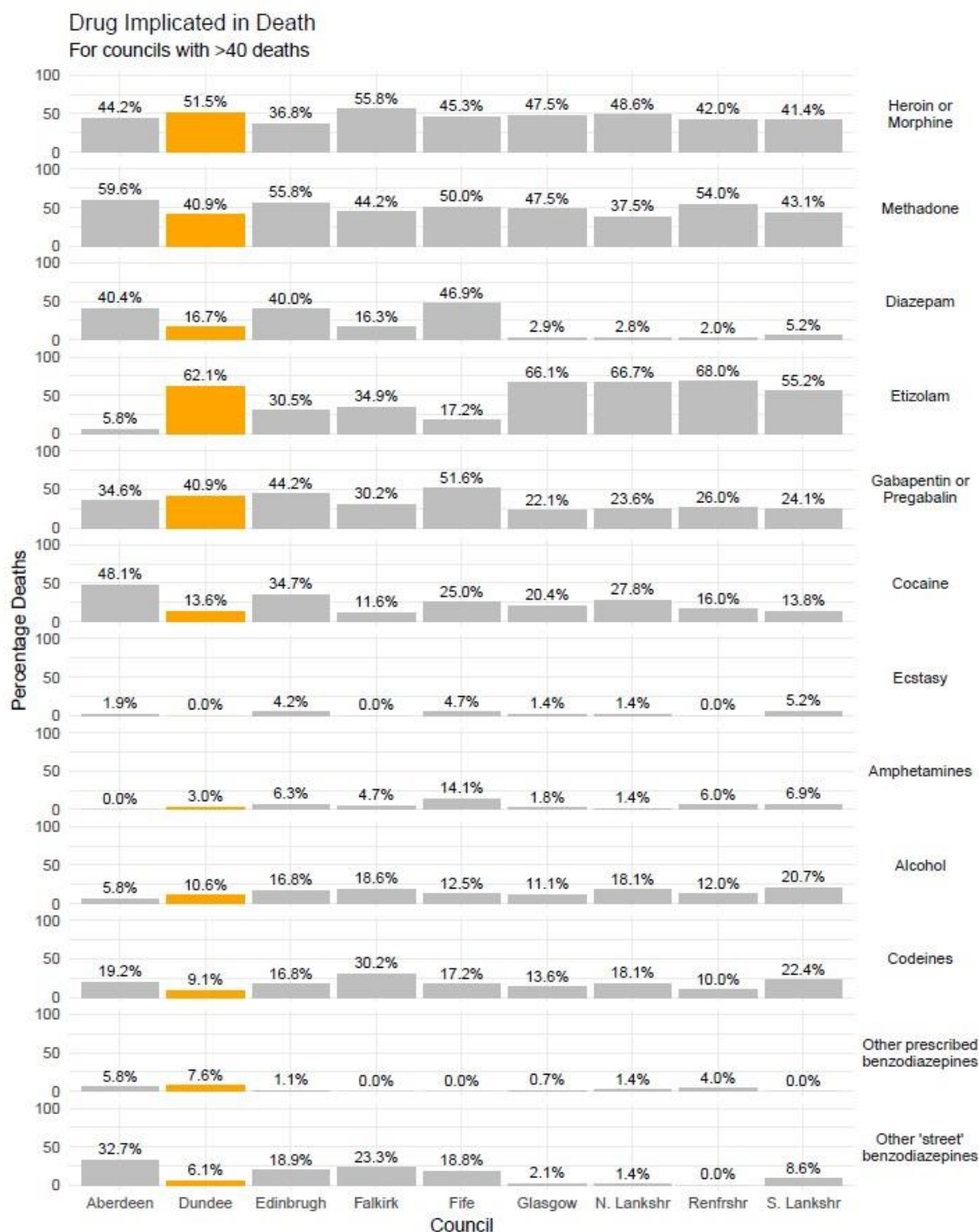
It is also important to note regional comparisons of drug-related deaths, by drugs implicated in deaths (for all council areas with more than 40 DRDs in 2018), as shown in the figure below:

Figure 6.8: Regional comparisons of DRDs – by drugs implicated in deaths¹⁶

¹⁵ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

¹⁶ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

Regional Comparisons



To more fully understand the context of drug-related deaths in Dundee, the Commission met with and heard evidence from experts at ISD (**Dr Lesley Graham**, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team; and **Lee Barnsdale**, Principal Information Analyst [Drugs], ISD) in order to try and identify and understand whether Dundee has any specific conditions or factors that are influencing the high rates of drug-related deaths. As a result of these meetings, the Commission requested that a 'deeper dive' of drug-related death data be undertaken by ISD in order to compare Dundee against the Rest of Scotland in respect of a range of criteria (discussed and agreed by the Commission and ISD).

The dataset provided by ISD was submitted to the DADP on 27th May 2019 and then forwarded to the Dundee Drugs Commission. A team of statisticians and data scientists from the Leverhulme Research Centre for Forensic Science, at the University of Dundee, agreed to conduct a rapid, independent review of the data to perform an observational analysis and prepare data visualisations. Their report is provided in **Appendix XII** in the **Part 3** report. Although the numbers for Dundee over the timeframe 2009-2016 are small in some cases, and although the Commission has had very little time to analyse in depth the findings, the Commission believes that the 'deeper dive' has highlighted important information, especially the comparisons with the rest of Scotland, that has not been available previously to help inform planning around drug-related deaths. The Commission believes that there are potential alternative explanations within the data to current thinking, and that the data will need to be interrogated further and triangulated with other qualitative evidence sources to be able to fully understand what is happening in Dundee (when compared to the rest of Scotland). The Commission has not had the time or resource to do this fully and would therefore like to suggest that the 'deeper dive' of data is repeated in due course (with inclusion of 2017-18 data) and included within a full independent health needs assessment (see **Recommendation 12** in **Chapter 8**). This will enable exploration of all possible alternative explanations to ensure credibility and accuracy of findings and conclusions.¹⁷ The Commission remains of the view that strong inferences cannot be made because of the low numbers in some of the data fields and that the data must be viewed with that caveat – and would require further testing by repeating the 'deeper dive' over several years. In discussions with ISD, who completed the 'deeper dive', the areas that are worthy of consideration and further exploration are:

- Proportionally (when compared to the Rest of Scotland), in Dundee there are:
 - more deaths in the 25-34 age group; ○ fewer suicides¹⁸;
 - more individuals who live in areas within SIMD 1¹⁹;
-
- more people in treatment (prescription) at time of death; ○ more people on methadone at time of death;
 - more deaths where the individual had been diagnosed with Hepatitis C; and ○ more people diagnosed with a mental illness.
- Higher proportions of DRDs in Dundee with gabapentinoids; etizolam²⁰ and diazepam implicated in death.

The indication that Dundee has proportionately more drug-related deaths amongst those who live in areas within SIMD 1 (noted above) is of particular interest to the Commission given the work of the Dundee Fairness Commission²¹ that has been progressed in the City over the last few years.

The Commission has conducted a Rapid Inequalities Review (see **Appendix VII** in the **Part 2** report) as part of its evidence gathering, which suggests, through available recent local data, that 73% of individuals who died as a direct consequence of drug use in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug deaths, with more than half of drug deaths occurring in areas of greatest socioeconomic deprivation.²²

¹⁷ The Commission has noted that ISMS, in its evidence submissions (see **Appendix XVI** in the **Part 3** report) has undertaken work to understand operational data within the context of the 'deeper-dive'. This work needs to be further developed.

¹⁸ Care and attention needs to be taken with this as there is difficulty in determining whether a death is suicide or an unintentional overdose – i.e. not all cases of suicide are listed as such on the death certificate.

¹⁹ The Scottish Index of Multiple Deprivation (SIMD) measures across seven domains: current income, employment, health, education, skills and training, housing, geographic access and crime. These seven domains are calculated and weighted for 6,976 small areas, called

²⁰ Etizolam was the most common substance found in drug-related deaths (41 deaths) in Dundee City in 2018, more so than methadone (27) or heroin/morphine (34). The role of Etizolam in drug-related deaths should be a top priority for the Tayside Drug Deaths Review Group to investigate. The proposed independent Health Needs Assessment (see **Recommendation 12**) should have an explicit objective to understand the increasing use of Etizolam and other new and emerging non-opioid substances.

²¹ <https://www.dundeefightingforfairness.co.uk/>

²² Tayside Drug Death Review Group. 2018. *Drug Deaths in Tayside, Scotland, 2017*. Available at:

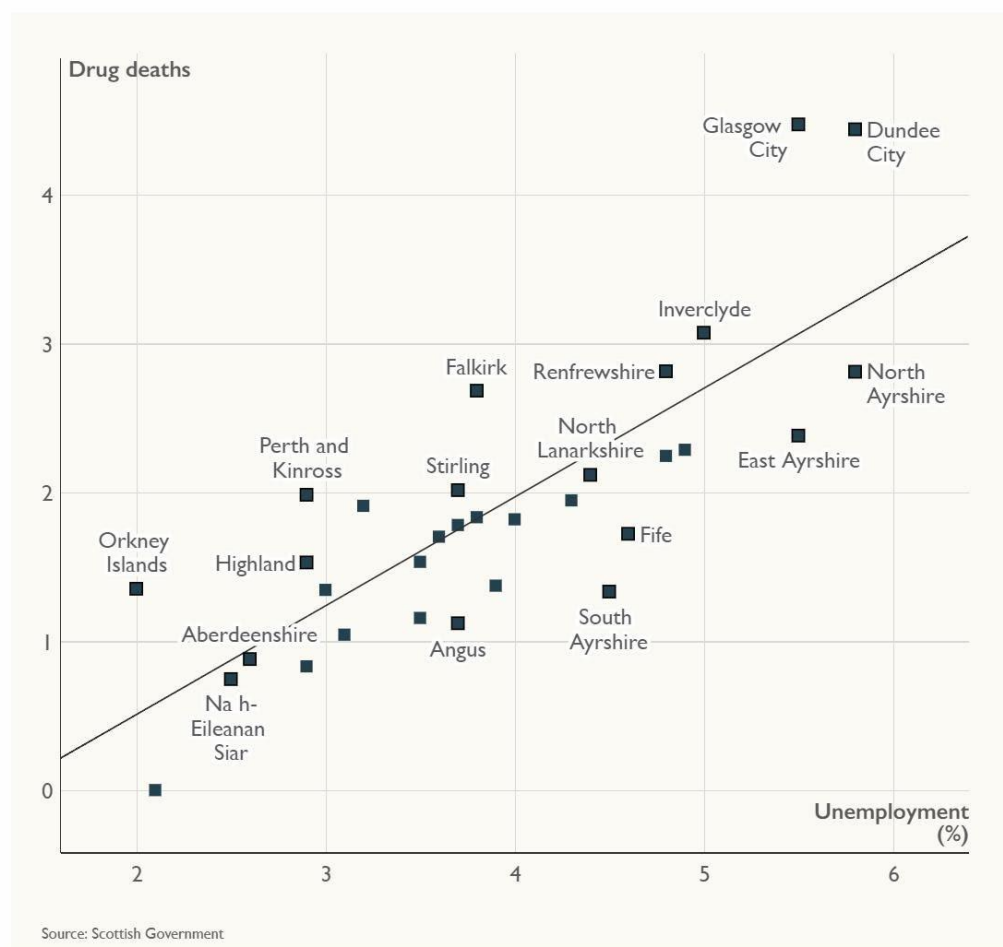
The link to deprivation also appears stronger in Dundee when the 'employment status' of those who have died from a drug-related death is considered, as indicated in the table below. Dundee City can be seen to have the highest (population) rate of unemployment amongst those who have died from a drug-related death of all local authority areas in Scotland – as well as the highest (population) rate of drug-related deaths. Understanding, in greater detail, the links between drug-related deaths and poverty will be critical for the Dundee Partnership to develop robust responses and solutions.

'data zones', with roughly equal population. The SIMD provides a relative measure of deprivation which means that the main output from SIMD - the SIMD ranks - can be used to compare data zones by providing a relative ranking from most deprived (rank 1) to least deprived (rank 6,976).

Figure 6.9: Drug deaths and unemployment in Scotland – by population rates

Drug deaths and unemployment in Scotland

Drug deaths per 10,000 people and the percentage of unemployed working age adults



7. WHAT WE HAVE HEARD

The Dundee Drugs Commission has been an intensive and rapid review of the recent history of the impact of drug use across Dundee, and the help available for people who use drugs in the city. Local Commission members have been supported by experts from across Scotland and the wider UK. To be clear, the Commission was set up in part to assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners (Objective #4). During the course of our work, we have learned about inadequacies in our local systems and services. We have frequently heard from individuals and families who feel that the system has failed them. All our recommendations are born out of the experiences of people in Dundee.

The changes proposed in these recommendations are based on four key sources of information:

1. People in Dundee including people who experience problems with drugs, their families, friends and our wider community;
2. Professionals who work in Dundee;
3. Experts from across Scotland; and
4. International research evidence and best practice guidance.

In total, eighteen (18) different evidence sources were used across the above four groups (which are detailed in **Chapter 5** of this report as well as **Appendix II** in the **Part 2** report and **Appendix X** in the **Part 3** report).

Guiding principle of the Commission

The people of Dundee have been and remain our first priority. When systems and services fail it is the people that they were designed to help (and their loved ones and communities) who are disadvantaged. This is the guiding principle that has informed all of our recommendations. This principle should continue to guide all future decision making and action in seeking to help people and communities who are affected by drug use in Dundee.

Limitations of the Commission

It is important to recognise that, within the time and resource constraints facing the Commission, we do not claim to have conducted a comprehensive review of all the research and evidence on responses to drug problems, nor have we been able to spend as much time as we would have liked talking to those who experience problems with drugs and their families, service providers, or residents of Dundee.

Notwithstanding these limitations, the Commission has facilitated and witnessed many significant and far reaching discussions concerning the nature and extent of the challenges faced and, most importantly, on what can be done to rapidly improve the situation. We have reached consensus on a number of recommendations that we believe could make a material difference to dealing more effectively with drug use related problems across Dundee and, ultimately, result in reductions in the high number of drug-related deaths in the city. Some of our recommendations are aimed at local partners and leadership and some are aimed at national leadership.

Key Messages

As a Commission, over the course of the last year, we have received evidence from over a thousand different people – those with lived experience of problems with drugs (current and past); family members; members of the public; clinicians and GPs; staff who work in drug treatment and support services; staff who work in wider health and social care services; senior officials within NHS Tayside, Dundee City Council and Dundee's third sector; politicians and elected members; and academics.

Some individuals and families have spoken in great detail to us about positive experiences of the help and support they've received and the strategies they have used themselves to move towards recovery from drug use. Many individuals and families shared their grief and loss over the devastation that has been caused by drug use. We have heard numerous stories of immense challenges and barriers put in front of those who require help and support, compounded by the pervasive stigma that is still attached to being a person who experiences drug problems. Staff working in services have shared both positive and enthusiastic accounts of

their efforts to help those who present to services, as well as details of immense frustration and anger when things do not work as they should.

Our review of a substantial amount of evidence has taken time to distil and balance. We have been aware that when an independent Commission is set-up then you tend to have all the stories coming to the fore of how things are not working. However, we have also taken the time to seek out and listen to those who have a positive story to tell – whether one of how they've successfully made changes to their drug use by themselves (or with help from family and others) – or whether a story of how they have received the help required from local services. By so doing, we believe that we have achieved a balanced understanding of the reality of issues faced.

Our review has led us to detailing a number of key messages – all of which we have used to form the challenging set of recommendations (later in this chapter). The key messages are structured underneath the key themes of our work (Leadership and Drug Deaths; Treatment and Support; and Mental Health). **To be clear, the phrases below that are set in *italics* are the words of the Commission rather than direct quotes from individuals.** However, we have paraphrased in order to summarise the consistent and strong messages that we have heard.

Leadership and Drug Deaths

In terms of investigating the role of leadership in the drugs field in Dundee, we have taken evidence from a range of sources, with particular focus on the roles of the DADP, Chief Officers Group (COG), the Dundee Partnership, the Dundee Health and Social Care Partnership, and the Dundee IJB.

The evidence we have received has led us to conclude that leadership in Dundee (related to the drugs problem) has been disjointed, inconsistent and ineffective. We have evidenced this by: (1) an inability and/or lack of accountability mechanisms to follow through on improvement plans and promises; and (2) a lack of ambition ('whatever it takes') in some areas to act to prevent harms and drug-related deaths. Within the initial portion of evidence gathered we identified a clear lack of leadership from DADP members and a lack of 'holding the DADP to account' by the Chief Officers Group (COG), the Dundee Partnership, and the Dundee IJB. Our findings and outputs from further investigations conclude that there has been a lack of leadership across all services to facilitate the changes required to effectively reduce the risk of drugs deaths in Dundee. The governance framework that has been in place has been disconnected and therefore not able to effectively monitor and implement change.

Governance

Overall, the DADP has been lacking a clear governance structure and it is not clear what its current relationship is to the Community Planning Structure or the Health and Social Care Partnership (HSCP). There has also been a lack of clarity around the role and influence of the HSCP Strategic Planning Group (SPG). The DADP has not known its place and therefore has become ineffectual to strategically lead, direct and influence service provision across the city. The SPG is a sub-group of the DADP. It would appear that the group has too many members to be an effective tasking group. The feeling of many of the members is that the SPG provides an information function only. It does not feel like a transparent and inclusive process. There is a power imbalance between the statutory and voluntary sectors where the agenda and control of commissioning and funding is dominated by the statutory sector, which we discuss in further detail below. The Community Planning Partnership has a clear responsibility to ensure the DADP functions and actively addresses the increasing number of drug-related deaths in Dundee. There is little evidence to demonstrate how they have shown leadership in this area.

Leadership

There appears to have been a lack of leadership and direction from the members of the DADP over a number of years. This has resulted in several key pieces of work not being satisfactorily acted upon. The commissioned Prevention Strategy and the Care Inspectorate self-assessment are two examples of this. We are therefore led to question whether there has been a resistance in Dundee to introduce best practice from elsewhere.

The ability of the DADP to provide effective leadership may have been affected by reduced capacity of the DADP support staff over the last two years – for example, the DADP Lead Officer now has other responsibilities as well as the ADP remit, and the previous ADP Support Officer position has not been filled.

Performance Management

There have been no systematic performance management processes across all services funded by the DADP. There is no outcomes framework for the DADP, despite previous reports recommending priority action to rectify this. The commissioned voluntary sector organisations have their performance monitored by the HSCP Contracts Monitoring Group, but performance is not considered through any DADP Committee. The DADP, for many years, has not had any consistent approach to establish how services are performing.²³ Dundee, like all other areas of Scotland, has not been helped in this regard by the substantial delays to the roll-out of the DAISy (Drug and Alcohol Information System).²⁴

There is no overall scrutiny of funding against performance.

There are no Service Level Agreements (SLA's) with NHS Tayside, the Health and Social Partnership, or Dundee City Council, for services delivered by them. In practice, this means there is no accountability to the DADP for performance against any outcome's framework.

There was a pilot of a common assessment tool previously, but this was never progressed by the DADP.

The Scottish Government's Recovery Outcomes Web (ROW) was seen as good practice but has not been adopted uniformly across services.

There is no evidence of a structured process for positively drawing on the insights of people with lived experience to shape and reform service going forward.

Cultural Change

The culture of service delivery in Dundee is inflexible and based on a treatment model. There is little evidence of a joined-up Recovery Orientated System of Care (ROSC). To achieve this will require clear leadership to achieve a combined shift and focus across all service delivery.

The feedback we have received from most of those individuals using statutory services is that they attend with an expectation that they may face a stigmatising attitude. Action will need to be taken to ensure that this situation changes (see **Recommendation 2**).

A cultural change leadership programme is required across all services. However, this is particularly relevant across statutory services – particularly those hosted by NHS Tayside and the Dundee HSCP.

Funding structures

Fundamentally, the 'playing field' in drugs services in Dundee is not 'level' because the majority of funding for drug treatment is held by the NHS and managed by the Integration Joint Board [IJB]. This leaves a situation where one partner commissions and contract manages its third sector partners.

This makes it difficult for the third sector to engage equally and results in concerns about '*biting the hand that feeds them*' by speaking honestly.

The unequal power and control in the drug treatment system, the majority of which is held by the NHS, has led to a breakdown of relationships between statutory ISMS and the third sector – to the point where third sector services have chosen not to speak honestly in meetings for fear that their services will be decommissioned. Some staff members (from a mix of services) have chosen to provide their evidence to the Commission anonymously due to concerns about job security. This breakdown of trust between ISMS and its third sector partners is one of the most worrying findings of the Commission and will require urgent attention. This leaves us with a strong sense of a 'them and us' scenario.

The DADP only has direct control of about one third of the total drug and alcohol budget, of which almost four-fifths is spent on Treatment and Support, with a further 10% spent on Prevention and Recovery activities, and the remaining 10% spent on 'dealing with the consequences of problem drug and alcohol use in the ADP locality'.

Analysis of recent DADP annual returns to Scottish Government identify approximate proportions of the overall budget being allocated to: (1) Treatment and Support Services; (2) Prevention; and (3) Recovery – as identified in the Table below:

²³ The Commission has noted recent developments by the DADP. Information is now being provided to the DADP from all contracted services through the use of a 'balanced scorecard'. This has been in place since the start of 2019.

²⁴ <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drug-Alcohol-Information-System/>

Figure 7.1: Total drug and alcohol spend – Dundee City

% of overall expenditure spent on Treatment, Prevention and Recovery			
	TREATMENT	PREVENTION	RECOVERY
2017-18	79.83%	7.76%	2.73%
2016-17	79.00%	7.24%	4.41%

Treatment and support

This is the area which has dominated the time of our Commission for evidence gathering. When we began our inquiry, our primary objective was to review the impact of drug use across Dundee. However, the reality of our evidence gathering has been dominated by people wanting to talk about the main specialist treatment service, the Integrated Substance Misuse Services (ISMS), in Dundee, and the problems they have faced with access, engagement and lack of choice. Indeed, the service has a very high level of unplanned discharge.²⁵

The system, driven by a national direction to get individuals into ‘specialist treatment’, focuses on ‘funnelling’ individuals into the prescribing service, rather than having a prevention-based philosophy (which would be aimed at avoiding the need for individuals getting to a place where they

require specialist treatment in the first place), and therefore leaving the specialist service to work with those who really do require specialist input. Our review has led us to a clear feeling of ‘*all roads lead to ISMS*’.

The reports we have heard at the Commission are dominated by accounts of how the service treats so many people that they struggle to deal with the people with the most complex circumstances (the people that they should fundamentally be dealing with); and at times not working with them until they have managed their drug use to a certain degree. It is a scenario where specialist treatment almost becomes the only option in Dundee for those who use drugs and who desire help.

Many of the stories we have heard were of people struggling to access Opioid Substitution Therapy (OST) and then struggling with the rigidity of the programme (with numerous reports that if you do not meet the established service criteria (see Treatment Agreement, **Section 2 of Appendix XVI** in the **Part 3** report - **question 4**) or expectations at any one point of the system, no matter how small, then that apparent failure is used as a reason to put somebody back to the start of the process for receiving treatment).

Some individuals currently using the service reported how the service requires individuals to complete a drug diary prior to initiation of treatment, and at all intervals where there may be a change in prescription. Drug diaries are not an accurate reflection of an individual’s use of drugs or their motivation to change and should not be used to either demonstrate motivation, or to delay access to treatment.

Additionally, some service users report the need to do multiple drug tests prior to commencing treatment and perceive that these are often used to delay (or even deny) access to treatment, rather than being used as a tool to support treatment.

Ultimately, there needs to be greater flexibility and choice for individuals.

The conclusion we have drawn from the evidence is that the ‘system’ in Dundee is currently heavily focused on a bureaucratic, centralised model, narrowly delivering OST at the expense of delivering a more joined-up integrated system of care which involves a range of stakeholders. Despite the narrow focus on OST, we believe it is not being delivered in line with contemporary evidence-based practice. There are all too often long waits for treatment and high drop-out rates. We consider that this requires urgent and immediate attention. There is a lack of swift access to treatment, followed by unnecessary barriers that then delay OST starting and, in many cases, then high risks of being suspended from treatment for not complying with a regime that appears to be too rigid.

The Commission has heard multiple accounts of challenges at all levels of the system in Dundee – in relation to access, retention, quality of care and the safety of those using services. Our recommendations will prioritise and focus attention on taking a whole systems approach to dealing with these challenges.

Our overarching observation is that there is limited choice in the current system of care and support. A new member of the Community Health Team in Dundee reported, as part of her induction, going around the

²⁵ ISMS report 452 unplanned discharges in the last 12 months – see **Appendix XVI** in the **Part 3** report for further details.

[named area] of the city to find out what community organisations and groups exist. She reported counting at least ninety different groups in the one area of the city. This reinforces the point that drug treatment services in Dundee are operating over-capacity and in silos, often detached from the wealth of support opportunities available to people across Dundee. The development of a 'Recovery Road Map' by the Parish Nursing Team at The Steeple has been a significant step forward in helping services to take an outward-looking approach, to counter the historic inward-looking approach.

Let us be clear that, although there are significant problems within the current system, there are also some real positives. There are passionate, skilled and experienced professionals (in all services) who are often working over-capacity but who are constantly battling the 'system' to be able to do their jobs to the best of their ability. We have, however, heard many reports from staff that they are often 'unable to see the wood for the trees' because of the high numbers of individuals they are having to work with, and because of the systems that require a whole range of procedures to be followed – some of which are perceived as being unnecessary and risk-averse.

We have also heard numerous stories of how, for some people, once they are in ISMS, it is very difficult to come out the other end and leave the service. For others, often some of the most vulnerable individuals, their experience is that they struggle to comply with the perceived rigid regime and therefore opt out of treatment altogether (or never present). The service reports 452 unplanned discharges over the last 12 months which is a significant proportion of those on prescribed OST in Dundee. The service also reports very few planned discharges (22 in the last 12 months), and has informed the Commission that, 'There is no service to discharge people to who are stable on OST.' This is where GPs and Community Pharmacists need to be an active part of the system and solution. GPs have been disengaged from prescribing over many years in Dundee, a situation which requires urgent attention. At one of our public evidence sessions we heard from three Edinburgh-based GPs who reported that out of the 4,000+ individuals on prescribed OST in Edinburgh, around 3,000 are prescribed within Primary Care across the city. Pharmacist prescribers are supporting GP practices to provide OST in other areas of Scotland. In Dundee, there are only two GP practices currently prescribing OST. Therefore, the vast majority of individuals have to be seen by ISMS. ISMS staff reported a significant element of their client group as being stable enough that their care should be transferred back to Primary Care, but unfortunately this is not currently a widely available option.

We experienced significant and unnecessary delays in accessing the data and detailed information required to fully consider the role and performance of statutory treatment services and arranging opportunities to speak to service staff and users. In contrast, the access we have had from all other services in Dundee could rightly be described as providing 'unfettered access'. The time needed to address the significance of statutory treatment services in Dundee therefore limited the capacity of the Commission to consider a wider set of issues (for example, the impact on children and families, prison liberations, availability/enforcement), all of which are vital parts of the bigger picture.

As of September 2018, ISMS stated an aim to get patients on prescription within 10-14 days, although evidence presented to the Commission suggests that this has not been routinely achieved. The expert evidence heard by the Commission confirms that this target is too slow. The Commission heard from two GPs in Edinburgh who are moving toward 'same-day' prescribing in certain cases where people experiencing problems with drugs are at particularly high risk of a range of harms. This has left us with the view that the system is too slow and insufficiently responsive.

Drug treatment is viewed by many in Dundee as a 'specialism'. This allows disciplines, such as mental health services, to be distant or not fully engaged with those who are currently using illicit substances by asserting that the drug problem needs to be tackled before other help can be offered²⁶. Additionally, this 'specialism' view allows ISMS to take the position that they are the only ones skilled to deal with people who experience problems with drugs and is a possible reason why there are so few planned discharges from the service.

This will require some sort of normalisation – i.e. there should be '*no wrong door*' for people who need help to get the help they need, no matter which service they present at. There are also some parallels to the advent of 'Getting It Right For Every Child' in Scotland, in that a mandating of '*it's everyone's responsibility*' may be required nationally to deal with the massive challenges of stigma faced by those who use drugs.

We have reflected on the range of widely held and polarised views that we have heard over the course of the last year and it is clear that certain deep seated perceptions have been built up over time that exacerbate the tensions and feelings of professionals, people who need help with drug problems and affected families alike. Staff at ISMS have had little access to allow them to feed in their views directly to the Commission. This has led to the perception that the Commission is a threat to the service, rather than an opportunity to engage with a process to improve the situation in Dundee for the benefit of everyone.

²⁶ In relation to those with co-occurring drug use and mental health problems, this is contrary to widely accepted contemporary evidence which outlines the need for both conditions to be worked with 'simultaneously'.

The overwhelming perception of almost everyone else that has provided evidence to the Commission is that the service is risk averse and that the system is sometimes punitive. This has led to an ingrained view that there is little point in speaking up and a loss of hope that things can change.

Neither of these perceptions represent the truth of the matter as we have found it to be, although they do shine a light on the state of the sector and the challenges that lie ahead. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose rather than any one particular service.

The reality is that the situation is not all bad. There are success stories, there is passion, there is belief that people and the system can change. It is time for all parties to take a step back and seek to find common ground to engage in a new and constructive conversation. It is time for leaders (at all levels of the system) to lead by example. This will need to be done on a 'no-blame, solution focused' basis.

Everyone in the drug treatment system in Dundee will need to work hard and commit to changing these unhelpful perceptions in order to see the improvements that are desperately needed – starting with a reduction in the barriers to quick and effective treatment.

Mental Health

The most common and consistent message we heard across all our evidence gathering was of '*a lack of mental health support for those who experience problems with drugs.*' This message was usually expressed as either: a reluctance of statutory drug treatment services to work with mental health problems (i.e. where those presenting to substance use services are told '*we only deal with drug problems, not mental health*')²⁷; or the perceived refusal of mental health services to work with individuals unless they deal with their drug use first.

During the course of our evidence gathering, we also received approaches from the Dundee 'Fighting for Fairness' Commission (Mental Health Working Group) who, during 2018, collected and analysed 39 survey responses (out of a total of 122) where respondents reported that at some point they had struggled with their mental health; and Dundee Service User Network who conducted a series of ten Focus Groups during 2018 with one hundred individuals as part of the evidence gathering for the Independent Inquiry into Mental Health Services in Tayside²⁸. Both of these pieces of work highlighted significant issues in Dundee (and Tayside) for those who experience problems with drugs, in relation to access and support for mental health problems. Through our discussions with both the Fairness Commission and the Independent Inquiry, it became clear that their data sources and those of the Drugs Commission were identifying the same key issues.

The Dundee 'Fighting for Fairness' Commission, in its most recent report (November 2018)²⁹, recommended that: 'The Dundee Drug Commission and the Dundee Alcohol & Drug Partnership [should] utilise the Fairness Commission's mental health research findings to ensure that people with substance misuse issues are offered and can access appropriate mental health support.'

We are fully supportive of this recommendation and have fully considered the evidence provided by the Fairness Commission (as well as that provided by the Dundee Service User Network) in developing our key recommendation around this issue (see **Recommendation 13**).

Further, we have discussed our findings with the Chair of the Independent Inquiry and expect the Independent Inquiry (in its forthcoming report) to make 'whole system' recommendations to support the development of services for those with co-occurring drug and mental health issues in addition to our own recommendations. Our emphasis would be to focus on developing services in line with the two key principles

²⁷ Numerous reports were made to the Commission in this regard. This contrasts with the evidence provided to the Commission by ISMS which indicates established policies and procedures for working simultaneously with drug and mental health problems.

²⁸ <https://independentinquiry.org/>

²⁹ Available at: https://docs.wixstatic.com/ugd/725539_993c625815b74e2182517772df578fdd.pdf

identified by Public Health England in its 'Better care for people with cooccurring mental health and alcohol/drug use conditions' report (2017)³⁰:

-
- '1. Everyone's job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
 2. No wrong door. Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.'

³⁰ Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for Commissioners and Service Providers. London. Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Cooccurring_mental_health_and_alcohol_drug_use_conditions.pdf

8. OUR RECOMMENDATIONS

As an independent Commission, in collating and analysing the vast amount of evidence that has been gathered over the last year, we have taken our time to reflect upon, and attempt to balance, the wide variety of views presented. In doing so, we have met physically as a whole Commission on eleven (11) occasions over the last year, with a further substantial layer of sub-group meetings around our four key themes, and additional telephone calls and email exchanges, in order to develop the following set of recommendations and considerations.

The recommendations are aimed at the Dundee Partnership which was courageous enough to open up the issue of drug use in Dundee to independent (and highly public) scrutiny. From the outset we unanimously agreed that we needed to respond to the request of the Dundee Partnership with a commitment to formulate a set of bold and brave recommendations.

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement, and will also require strong and dedicated leadership over many years to make Dundee a place that delivers on its belief that truly 'every death matters' and, more positively, 'every life matters'. This will require an honest and transparent acknowledgment of the failings that have taken place in the delivery of drug treatment services (in a 'no-blame' environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings.

We have scrutinised and discussed the evidence that has been received and have also looked for examples of best practice from elsewhere in order to:

3. identify immediate steps that can be taken to start improving the situation; and
4. begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Dundee Partnership to deliver. This is why a series of 'national considerations' are also offered below. We sincerely hope that these will be responded to by the Scottish Government and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will require a renewed determination to work much more effectively across local, regional and national structures to deliver them. Our insight of best practice from countries such as Canada, Iceland and Portugal would, similarly, require changes in national policy and legislation and systems/practices in order to allow Dundee to implement fully the changes that are required.

The political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated. The time is now right to hand back the evidence and findings of our work to our elected leaders and ask them to set the standard for the leadership and accountability that is going to be required in Dundee (and beyond) to turn around the national emergency that is epitomised by the severe rates of drug-related deaths across Scotland.

Local Recommendations

The following are our set of **sixteen (16)** recommendations that we believe are within the abilities of the Dundee Partnership to progress. They detail three parallel areas of required work:

1. **Immediate action in the next 12 months** to address the challenges in the current system and to draw a line in the sand to enable all parties to effectively work together in the future.
2. **Transition planning and arrangements over the next 3 years** to allow time for longer-term plans to be designed, approved and resources allocated.
3. **Creation and implementation of a long-term vision over the next 5 years** for a high-quality and person-centred treatment and care system in Dundee, where drug-related deaths are eradicated³¹.

The Commission has referenced these timescales within some of the recommendations below. Where timescales aren't indicated within the recommendations, we would expect the Dundee Partnership to identify appropriate timescales when prioritising and developing their action plan in accordance with the above framework.

The recommendations are grouped under the following three headings:

³¹ The Commission acknowledges that this will not be possible in isolation from wider national and UK changes – due to poverty and drugs supply/criminalisation issues etc. that keep existing harms in place.

- D. Culture and systems;
- E. A holistic system model - including integrated Primary Care provision; and
- F. Causes and effects of drug use.

A. CULTURE AND SYSTEMS

This first suite of recommendations (1-6) is focused around the need for cultural change across drug treatment services, related disciplines and communities of Dundee, and changes in local systems that will help facilitate such cultural change.

Recommendation 1: The Dundee Partnership must do all that is necessary to achieve the required standard of leadership – the test of which will be that agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families.

Leadership, accountability and governance should be addressed first as an immediate priority as this will take the greatest effort and change to improve. Drug deaths are not inevitable and are absolutely preventable. This is a message that needs to be driven home from the top of all public organisations in Dundee.

Leadership needs to mean taking clear responsibility for the problem and putting in place a dynamic, responsive, cohesive plan to address the harms created by substance use, as well as a transparent

framework of accountability for the action that is required to reduce drug-related deaths in Dundee. A 'whole system' approach needs to be taken, inclusive of people who use (and have used) drugs, family members and local community responses.

Leadership needs to be strong and distributed, along with themes of accountability, which should be mutual at times of trouble. The Chief Officers are accountable, but they must work in an environment that places clear roles and responsibilities on them. Political leadership is important, and so is listening leadership – and there was plenty that the Commission heard that shows that leaders haven't been connected with people who experience problems with drugs and affected families.

'Civic' leadership is required here, including: political leadership (which is connected with local and national (Scottish, UK) elected leaders, who are in a position to take action); and Chief Officer leadership (which is mutually accountable, strongly bonded and clear about the key priorities and the action that is required).

The Commission welcomes the appointment of an independent Chair for the DADP which increases our confidence that significant and swift change is possible.

In order to fully implement this recommendation, the Commission considers that the following elements of action need to be initiated as a matter of urgency:

- Restructure the membership of the DADP:
 - The DADP should operate as an impartial and effective commissioning and strategic leadership body. [For the avoidance of all doubt, this means that no individual with current drug service provision responsibility should be a core member of the DADP.]
 - The Finance and Performance DADP Sub-Group (or any future equivalent group) should be chaired by an independent person who has no service delivery/operational responsibility.
 - There must be senior representation from GPs³² and Community Pharmacy.
 - A service providers group should be set up with regular attendance being a requirement from all drug service providers to report into the DADP on a regular basis. A rotation system for the Chair of the group should be adopted to ensure equality of participation amongst all members. The Chair should be invited to provide written and verbal updates to the main DADP meetings (as a standing item).
 - The correct level of representation needs to be achieved (in terms of both seniority and commitment to regular attendance and participation) to enable strategic accountability and

³² So long as any GP representative does not have any commissioning or funding conflict of interest.

avoid any 'conflicts of interest' for individual members. Attendance at meetings should be monitored and publicly reported.

- The DADP needs a formal Constitution as a matter of urgency, with clear lines of accountability. The Community Planning Partnership should oversee implementation of the new DADP and structure. A new governance structure needs to demonstrate and deliver

(within 12 months) mutual and visible accountability. This provides a unique opportunity going forward to pilot a new model for ADPs across Scotland, that all face a similar challenge.

- Given the increased public health focus of the new national Drug and Alcohol Strategy³³, NHS Tayside's Public Health department must take a leading role in supporting and guiding the DADP in its future planning and commissioning. An essential component of this has to be an increased attention to prevention; the starting point of which must be that DADP formally approves and implements the recommendations of the previous prevention research and strategy development it commissioned in 2016-2017.
- A comprehensive performance management and monitoring structure (with key quality indicators) should be in place for all service provision for substance use services.
- A detailed transformational change programme requires to be established to change the culture within treatment services. This needs to be underpinned by the Scottish Human Rights Commission's PANEL principles³⁴ (Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality). The cultural problems we have seen in our evidence have to be changed by dynamic changes at the very top of all organisations in Dundee that have responsibilities that intersect with drugs and drugs harms. Specialist treatment services must be ambitious on behalf of the people they work with. Consistent and comprehensive evidence has been heard which details specialist services that can be experienced as having low expectations of, and lack of respect for, the people they were set up to help.
- Clinical governance is seen as a barrier to undertaking transformational change, rather than a facilitator. This requires clear leadership from NHS Tayside to ensure that change can be managed with a 'can do' attitude and 'no-blame' culture, but which ensures evidence-based practice (which has patients' needs and safety at the heart). The Commission recommends that NHS Tayside develops a clinical governance transformation plan for substance use and mental health, based on the values and substance of 'realistic medicine'³⁵, as well as inclusion of a full Equality Impact Assessment (EQIA)³⁶ related to all change and transition plans.

³³ Scottish Government (2018). Rights, Respect and Recovery: alcohol and drug treatment strategy. Available at:

<https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/rights-respectrecovery/documents/00543437-pdf/00543437-pdf/govscot%3Adocument/00543437.pdf?forceDownload=true>

³⁴ Scottish Human Rights Commission 'PANEL principles' [Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality]. Available at: http://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf

³⁵ Scottish Government (2017). Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016. Available at: <https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/>

³⁶ "An Equality Impact Assessment (EQIA) involves assessing the impact of new or revised policies, practices or services against the requirements of the public sector equality duty. The duty requires all Scottish public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. It covers people in respect of all aspects of equality (age, disability, sex, race, religion or belief, sexual orientation, gender reassignment and pregnancy and maternity). It helps to ensure the needs of people are taken into account during the development and implementation of a new policy or service or when a change is made to a current policy or service." Available at: <https://www2.gov.scot/Topics/People/Equality/Equalities/EqualFramework/EvidencePSED/EQIA>

Recommendation 2: Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner.

Stigma comes in all shapes and guises. The Commission has heard countless stories and experiences where those affected by drug use and their families have been stigmatised in the forms of labelling, stereotyping, social rejection and exclusion, as well as the internalisation of negative attitudes in the form of shame by the person/family being discredited. Stigma can also be keenly felt when using services with poor quality physical environments, such as buildings that are not fit for purpose. In particular, the Commission has heard many detailed views about the main building used for drug treatment service provision (Constitution House) from those who use and have used the service. The Commission concurs that this building is not fit-for-purpose (in either design or physical fabric), as it is neither welcoming nor respectful of those who need to attend for their appointments. A review of all premises used for drug treatment services should be conducted as a matter of priority. The review should have the key aim of finding creative solutions to developing more appropriate accommodation and spaces in Dundee, where negativity towards people who use drugs and stigma is challenged and addressed, so that individuals attending feel safe and respected. The review should be conducted in full partnership with those who use services to fully understand their experiences and ideas of how the right type of space and environment can aid treatment. We would hope that this could contribute towards improved and increased engagement of people in need, and, ideally also retention in services.

The Dundee Partnership should consider comprehensive methods for proactively challenging stigma in Dundee. Various strategies and initiatives have been highlighted in the Literature and Evidence Review (see **Appendix III** in the **Part 2** report) which should be considered for developing in Dundee. The principles of the 'Inclusive Cities' concept and project³⁷ are of particular interest in this regard.

The Commission is also aware of the current Recovery Friendly Dundee project (coordinated by the Community Health Team), which is aimed at challenging and reducing stigma across the local communities of Dundee. The Commission welcomes this approach and suggests that the Dundee Partnership fully support and expand this initiative. This is something that will require a long-term commitment and an encouragement of as many groups, organisations, services and individuals to sign-up to the 'Recovery Friendly Dundee' pledge.³⁸

Beyond the pervasive nature of the stigma that people who experience drug problems and their families face on a daily basis in their lives and communities, the Commission has also heard regular

reports that individuals have had to face responses that do not meet best practice from the services that are supposed to be helping. This evidence must be taken seriously by all services, with commitments made to act upon such reports and provide assurances that such attitudes will not be tolerated. The Commission would like to see the values of kindness, compassion and hope take centre stage in improving the experiences of people who experience problems with drugs and their families in Dundee. Services should be tasked by the DADP with developing a plan (within 3 months) for combating stigma and discrimination based on these core values. Each plan should be developed from the bottom-up and be conducted in equal partnership with those who use each service. Evidence of 'how' the plan is produced in such a partnership should be included in the submission to the DADP. Each plan should have an in-built mechanism for review – which should focus on 'lessons learned' and 'progress made'. Service providers should share their plans with each other to encourage joint learning and encourage working together.

³⁷ <https://www.inclusivecities.info/>

³⁸ Recovery Friendly Dundee Pledge - Your pledge is a commitment to the Recovery Friendly Dundee ethos as follows: 'We believe that people should be treated with respect and dignity and that Dundee should be a city where everyone feels valued, respected and supported rather than defined by their health condition or life circumstances. Dundee should be a safe and supportive city and the efforts of people in recovery should be recognised and encouraged.' Your commitment may include: Attending an awareness session; Treating everyone with dignity and respect; Providing people with access to information and support; Challenging negative attitudes and language that stigmatises people in recovery; Building your awareness of what is available to support people in your area. More information can be sought from: Recovery Friendly Dundee, c/o Community Health Team – Room 21 Mitchell Street Centre – Mitchell Street Centre, Dundee, DD2 2LJ. robin.falconer@dundeecity.gov.uk / 01382 435854

Recommendation 3: Language matters. People who experience problems with drugs, and their friends and families, are part of our communities – let’s make them feel like that.

The Global Commission on Drugs Policy’s 2017 report is clear that the language used to talk about substance use creates a myriad of additional harms. We recommend that the words ‘addict’, ‘abuse’, ‘junkie’, ‘misuse’, ‘dirty’ and ‘clean’ are not used, and that Dundee creates an accessible guide to appropriate language use for the city based on the Global Drugs Commission report and other resources, such as the excellent ‘Language Matters’ leaflet developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia³⁹. We recommend that the local media are invited to be part of these guidelines and principles and sign up to a protocol regarding changing their language and presentation of the problem to a health and harms focused reporting where drugs use is ‘everyone’s problem’. This has been a key element of the overdose prevention response in other jurisdictions such as British Columbia. There is international evidence that this helps to reduce stigma, shame and fear. The Commission would like to note and express its thanks to the local media in Dundee who have attended the open Commission meetings and in many cases reported accurately and compassionately on what journalists heard in these meetings.

Language used to talk about drugs, drugs deaths and harms, and people whose lives are directly impacted by drugs, both in and out of formal public services, needs to change to be compassionate and non-stigmatising.

The Commission has noted the name of the main treatment service in Dundee as being the ‘Integrated Substance Misuse Service’ and would recommend that a consultation exercise is conducted to create a new identity for the service without the word ‘misuse’ in the title. Interestingly, a significant proportion of those providing evidence do not know of the service, or still refer to the service, as the Drug Problem Centre (DPC), despite that name being changed many years ago. This suggested consultation could help provide a significant opportunity and starting point for a service, which is perceived by many to be a fundamental part of the issues for which the Commission has

been set-up to respond to. The opportunity is to wholeheartedly focus on creating the culture, system and relationships that it will need to be able to learn from errors rather than be threatened by them. The consultation should (organisationally) be bottom-up in nature rather than yet another venture which is imposed top-down by management. The new identity should provide an opportunity for the service to acknowledge previous failings and to detail a new vision for the years to come. More details of the roadmap for this are provided in the Recommendations below.

Recommendation 4: Level the ‘playing field’ to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision. The balance between current centralised statutory and other provision needs to be changed.

DADP needs to create the right conditions to allow all partners to speak openly and honestly about how a level playing field should be created. A report should be presented to the Dundee Partnership within six months to enable action to be taken. The report should be focused on how the ‘17 elements of Recovery-Oriented Systems of Care and Services’⁴⁰ should be embedded and evolved in a future system design. We suggest that a ‘no-blame, solution-focused’ approach is taken from now on, when consultation and future planning is taken forward.

Consideration should be given to making the necessary moves towards a singular joined-up commissioning plan over the next five years, not just for current ADP spend, but for the entire provision of drug and alcohol spend so that future planning can allow for the combined funds to be spent more holistically. This will be essential in order to tackle some of the evident inequalities that currently exist in service provision and reach. Any joint commissioning plan should not be based on maintaining existing provision but rather on a preferred new landscape – some of which we have proposed within this report, but which we also envisage would come from a new approach to leadership and vision setting. However, this is a situation that the Dundee Partnership cannot change by itself but will need to escalate to Scottish Government to find a solution. This will be discussed under ‘national considerations’ later in this chapter. In the short-term, the Dundee Partnership needs to ensure the DADP has the delegated authority to set the tone of funding conversations with immediate effect.

To achieve equal accountability for all services, the new DADP group (as defined in **Recommendation 1**) needs to ensure that all services have a robust service level agreement in place. This should be achieved within 12 months with Service Level Agreements to run through for a further 2-3 years. This should be

³⁹ Available at: <http://nadaweb.azurewebsites.net/resources/language-matters/>

⁴⁰ https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf (page 2)

considered a 'transition' period to allow current contracts to continue until a new 'system model' (as discussed in the Recommendations below) has been designed and instigated. Each Service Level Agreement should require routine and proportionate independent evaluation to be undertaken.

Recommendation 5: Meaningful involvement of people who experience problems with drugs, their families and advocates.

Peer-led, advocacy and mutual aid groups, as well as Recovery Communities, must be resourced effectively to build capacity for people who use services and peers to become partners in care. They must also be valued as equal partners. This is one of the most effective ways to address power imbalances that create service-led rather than people- or beneficiary-led care. Resources should be redirected into rebalancing the sector to support more community-based provision. This will increase choice and enable all those who require services and support to exercise their rights.

Support is required to foster and nurture the evolving recovery community in Dundee and to appreciate that different approaches exist (i.e. independent recovery groups as well as serviceled/supported recovery groups). The Scottish Recovery Consortium is well placed to offer advice and support in this regard. The Dundee recovery community (as a whole) has a vital role to play in ensuring that the changes recommended in this report are implemented. They could be a tremendous asset to support positive change but will undoubtedly be the loudest critic if required changes are not forthcoming. The power of lived experience needs to be fully harnessed to drive improvement across the city.

The DADP must prioritise and resource capacity building over the next three years for a range of advocacy provision in Dundee for those who use substances. This was highlighted consistently in the Commission's evidence gathering as one of the biggest gaps in provision, and one of the areas of greatest concern for families and other professionals currently supporting those with drug issues.

The Commission is aware of, and welcomes, the discussions between the Scottish Recovery Consortium and REACH Advocacy (Lanarkshire) with the DADP to explore their plans for Lived Experience Representative Councils and to train Recovery Advocacy Workers as part of a National Recovery Advocacy Network. This should be prioritised by the DADP to complement and add capacity alongside other advocacy approaches and the well-developed peer research approaches that have been developed in Dundee. Peer research surveys should be used at regular intervals over the coming years to help assess whether local services change their practices in line with the recommendations.

Peer researchers, Advocacy Workers and Recovery Communities need to be engaged to help coproduce measures of success for the new system model that will be discussed below. Additionally, these groups need to be fully involved in ensuring a robust response to complaints.

While we return to the issue of gender-sensitive approaches below, we would like to highlight that involvement of women who experience problems with drugs in the design and delivery of services and policies should be specifically considered, recognising that wider efforts to involve people who experience problems have not always succeeded in reaching women, and that women who use drugs have a diversity of preferences and needs.⁴¹

In terms of the experience of family members, the evidence that the Commission gathered illustrated a predominant experience that they had of being **judged and stigmatised**, which is covered in our wider recommendation around stigma and discrimination. Evidence was gathered in our process that indicated that families are largely being excluded by statutory treatment services (they are more included by third sector services) which runs counter-to the commitment in the national drug and alcohol strategy, 'Rights, Respect, Recovery', that states that families have the right to be involved in treatment and care as appropriate. The Commission recommends that:

- All commissioned services undertake family inclusive practice training within twelve months. Our understanding is that this is part of the Scottish Government's emerging workforce development framework.

⁴¹ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

- All commissioned services adopt and follow good practice standards for family inclusive practice which includes pro-actively seeking consent to involve the individual's supporter in their care, and seeking consent on an ongoing basis if it is refused at first appointment, as well as explaining the treatment/care process to family members, and encouraging family members to share information with the service, even if information cannot be shared back the way. Scottish Families Affected by Alcohol and Drugs is a national organisation that is able and willing to support services to do this at no cost.

Evidence received showed that there is a lack of dedicated and visible **family support** for families in their own right, in particular of one to one support, structured group support, and advocacy. The existing family support groups in Dundee are well established but we believe that they would benefit from wider assistance with publicity, including treatment and care services routinely sharing information on available support with families, and pro-actively encouraging engagement.

- The DADP should work with the existing groups on an expansion and publicity plan. Scottish Families Affected by Alcohol and Drugs would be happy to assist with this at no cost.
- We would also encourage all groups to use evidence-based, solution-focused programmes such as CRAFT, SMART Family and Friends or 5-Step, to ensure that families are given tools and techniques to manage their situation and improve their self-care.

It is important to acknowledge that most people who are experiencing problems with drugs are not accessing formal treatment, so promotion and engagement methods must also reach to other places families are engaging, such as primary care services, workplaces and carers centres etc.

Recommendation 6: Learning from the things that have gone wrong – attention to continuous improvement to benefit others who are vulnerable.

Progress and success are only possible when mistakes are confronted rather than reframing the evidence to avoid having to change deeply held beliefs. Too many people have lost their lives to drug use in Dundee and the leaders in Dundee must now act swiftly to learn the necessary lessons and take significant action to turn this situation around. Total drug deaths in Scotland significantly exceeded 1,000 for the first time in 2018. If 1,000 people or more died each year in Scotland from another preventable and avoidable cause, then there would undoubtedly be a national outcry.

The Dundee Partnership needs to develop, and be recognised for, having a progressive attitude and approach, in order to tackle the immense challenges that it faces in this area. By so doing the Commission firmly believe that the Dundee Partnership (in time) will be able to demonstrate progress, inspire creative solutions, and help nurture resilience amongst the groups of people that the Commission has had the privilege of listening to over the last year (whether it be those who face the reality of life affected by drug use or the many professionals across Dundee who seek to support and help those who are affected). It will also then set the standard for the type of leadership that is required by the organisations we have encountered who have historically worked in silos and who have demonstrated defensiveness rather than an active willingness to move forward together.

Additionally, improved and timely use of intelligence needs to be prioritised in Dundee by utilising a 'lessons learned' approach. Intelligence, learning and subsequent recommendations need to be integrated into DADP and Dundee IJB action plans as a matter of urgency (as well as all other Community Planning Partners). The Commission requested a 'deeper dive' of drug death data (Dundee vs the rest of Scotland) from Information Services Division (ISD) Scotland to aid understanding of underlying causes of, and reasons for, the high levels of drug-related deaths in Dundee. When the data is integrated with the interviews and submissions to the Commission from those with lived experience and families, a clearer picture emerges of the lessons that need to be learned. The Commission recommends that this thorough Dundee versus rest of Scotland analysis of the complexity of circumstances of people who have died is conducted on an annual basis to help NHS Tayside's Public Health department with further developing its understanding of the profile of drug deaths in Dundee. The DADP needs to take a lead in identifying the lessons that can be learned from the data, putting swift actions in place, with timely reviews and holding all parties to account for actions they are responsible for. Transparent and prompt reporting is required from the DADP with a focus on what action has been taken as a direct consequence of the annual drug death report.

The Dundee Partnership should instigate a review of local Drug Death Review processes (as well as non-fatal overdoses and near misses), to take account of other models of enhanced death reviews e.g. Ruby Reviews for Child Deaths. All services (secondary care, primary care, police, social care etc.) have a duty to reflect on the support, care and/or treatment they each have provided to an individual who has died of a drug death and the purpose of a drug death review group should be to identify common areas of process that can

be improved, emerging trends, have an oversight as to how well services work together in providing care, and be there to present the evidence and advocate for change going forward (in collaboration with the DADP). These reviews should also support the broader Dundee service provider group with learning and change, as well as aiding integrated practice.

B. A HOLISTIC 'SYSTEM' MODEL – INCLUDING INTEGRATED PRIMARY CARE PROVISION

The second suite of recommendations (7-13) is concerned with the provision of drug treatment and support services in Dundee. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose. The Commission believes it is a system that is characterised by siloed working of services, a breakdown of trust and relationships between statutory and third sector services, and an overly risk-averse prescribing service. The current system is dominated by a five-year transformation plan for ISMS which has been imposed upon the sector with the expectation that everyone outside of ISMS needs to work to support the new ISMS model. The Commission considers it to be a 'service-led' plan, rather than being a joined-up 'whole system model' developed in collaboration with all partners and those with lived experience.

The Commission's recommendations are focused on outlining the roadmap that is urgently required to re-envision and establish a high-quality and person-centred treatment system in Dundee, where the first and foremost aim to keep people alive, and where all possible efforts ('whatever is required') are made to achieve this. Indeed, the recently published Tayside Drug Death Review Group's Annual Report for 2018⁴² states: *"Drug deaths in Tayside continue to rise. A drug death occurs as the result of a non-intentional overdose of illicit (or illicitly obtained controlled) substances and therefore **should be avoidable**. Yet we are still seeing increasing numbers of drug deaths occurring, with each one a tragedy affecting families, friends and communities."* The drug deaths being experienced in Dundee are preventable and the view of the Commission is that a whole system prioritisation should be put in place to turn this tide around. As a starting point, the DADP needs to resurrect and refresh the ten-year 'Prevention and Recovery' Strategy (2017-2027) which it commissioned yet never implemented. The Strategy was titled 'Stop People Starting and Supporting People to Recover', ambitions which would serve Dundee well in moving forward.

Recommendation 7: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to people in Dundee.

As discussed earlier, one of the strongest messages that the Commission has heard repeatedly over the last year is a frustration with the lack of choice and options for treatment for people who use drugs. The widely held perception amongst those who use services is that it is 'methadone (opioid substitution treatment) or nothing.' Although the reality is not as blunt as this, it is important to recognise that this is how the treatment system is perceived by many of the people who are closest to it. Whilst it is acknowledged that pharmacological treatments including methadone are a vital part of the system response, the perception, and sometimes reality, of the predominance of methadone prescribing in Dundee seems to take place at the expense of a system that should have a broad spectrum of options for the wide range of people who require help. The following recommendation proposes a complete change of course and, in so doing, it will enable a whole system review to take place, at the heart of which needs to be a plan to increase choice of treatment options.

There needs to be greater flexibility and choice for individuals. This includes choice in prescribing options beyond just methadone. Buprenorphine could be used more widely, including the new slow release preparation. Heroin Assisted Treatment (HAT) should also be considered.

Repeated calls have been made to the Commission for Dundee to either get its own substance use rehabilitation unit, or for provision to be made for those who require a longer-term, intensive, structured period of treatment to be able to get access to an existing rehabilitation unit outside of Dundee. Dundee has historically only invested a small proportion of existing resources to fund such placements, compared to most

⁴² NHS Tayside. *Drug deaths in Tayside 2018 annual report*. Available at: https://www.nhstayside.scot.nhs.uk/News/Article/index.htm?article=PROD_322284

other areas of Scotland and the UK. It has been clear that those who are calling for such a unit in Dundee see it as a vital part of the solution to Dundee's problems. However, when listening in depth to the calls for such a service, what becomes evident is the intense frustration that there is so little choice for those who want and need help. There are great examples around the UK of traditional rehabilitation models, as well as new and innovative variations (based around Recovery Communities). Interestingly, in their recent submission of written evidence to the Scottish Affairs Committee Problem Drug Use in Scotland inquiry⁴³, the DADP has noted 'improved access to residential rehabilitation' as one lesson that Scotland could learn from other countries. The Commission recommends that Dundee consider the approach in Fife where there is a dedicated budget held by the third sector, with people being appropriately prepared to access Residential Rehabilitation and then picked-up upon discharge. The Fife service is based within the Fife Intensive Rehabilitation and Substance Misuse Team (FIRST)⁴⁴.

The Commission believes that the Dundee Partnership should invest in an options appraisal of both community and residential rehabilitation models, as well as a review of evidence-based responses for people who do not use opiate drugs, to inform decisions regarding what might be suitable developments to meet needs in Dundee. This options appraisal needs to be considered alongside the Commission's recommendation for a full independent Health Needs Assessment for people experiencing drug problems (see **Recommendation 12**).

Recommendation 8: The provision of services currently offered by ISMS should be delivered through the development of a new 'whole system' model of care. This should be structured via a joint and equal partnership with both primary care and the third sector, with the key purpose of utilising the unique strengths of all partners.

These services should be born out of, and embedded within, a new whole system of care and treatment for drug use. The vision for a new 'system' model needs to be formed by fully embracing the lessons that have to be learned, and by harnessing the incredible and tangible passion and determination of the wide range of stakeholders who have provided evidence to the Commission,

and who have demanded (rightly so) that things have to change quickly for the good. The vision should aim to be nothing less than a high-quality and person-centred example of care and treatment.

This will not happen overnight and the Dundee Partnership needs to take care and pay significant attention to providing immediate and long overdue support to a service that is over capacity and struggling to provide even the basic level of treatment that is required in a timely manner.

There is now an important and timeous opportunity for the Dundee Partnership to work with the Scottish Government, and other relevant national bodies, to address the findings of the Commission and shape future services that reflect the principles contained within the new national strategy 'Rights, Respect and Recovery'. Since moving to the HSCP the Commission has noted that ISMS have highlighted issues relating to capacity and skills mix. The Commission has been advised that this has resulted in an increase in nursing and social work staffing levels, the introduction of the direct access clinic, an increase in clinical psychology and a programme to increase the number of prescribers. This has been reported through a range of forums and recorded through risk systems.

Despite the above, the Commission is extremely disappointed that a robust effort from all responsible partners has not been evidenced, when the challenges that the service has faced over a considerable time are well known and documented. Lessons need to be learned and humility needs to be shown by asking for help. Success can only happen when past mistakes are confronted with honesty and sincerity.

At the same time, the Dundee Partnership needs to start transition planning for a period of the next three years whilst the new 'whole system' of care is designed, agreed, and resources restructured to allow it to come to fruition. The transition period should be framed around the development of clear and proportionate Service Level Agreements (as outlined in **Recommendation 4**). The Service Level Agreements should be configured to run through to a realistic and agreed timepoint where the new system model can be instigated – likely to be somewhere between three-five years from now. All Service Level Agreements should require all

⁴³ Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairscommittee/problem-drug-use-in-scotland/written/99493.pdf>

⁴⁴ <https://www.firstforfife.co.uk/residential-rehabilitation>

partners to work closely with the primary aim of reducing and removing the current barriers to quick and responsive treatment. The Service Level Agreements should be explicit about the evidence-based elements that allow high quality treatment to be a highly protective factor against the potential for drug-related deaths. The vision for a high-quality and person-centred treatment and care system in Dundee needs to start once the DADP has been restructured (as per **Recommendation 1**) to be an independent commissioning group, so that they can take the lead in facilitating discussions and the forming of the new vision. The starting point for discussions should be the agreement of a set of clear principles to allow creativity, inspiration, enthusiasm and determination to be expressed and owned by all. The principles, as a minimum, should include (but not be limited to):

- agreement to a no-blame and solution-focused culture;
- agreement to confront past mistakes with a progressive attitude;
- agreement to take a bottom-up approach to discussions, consultations and decision-making; and
- agreement to include all relevant parties.

Although the Commission does not want to be prescriptive about what the new model should look like, it would like the Dundee Partnership to consider the following elements for inclusion within a new system model:

- Be directly commissioned and monitored by the DADP as an independent commissioning body (as previously described);
- Be an equal partnership of statutory, third sector and primary care, including a lead partner and support partners;
- Include an OST service of a combination of addiction psychiatry, physicians, sessional GPs and non-medical (nurse and pharmacist) prescribers that can adapt to the breadth of needs, and integrated with the third sector;
- Include integrated mental health support and psychological interventions, and meaningful engagement with Children's Services, where this is appropriate (see **Recommendation 13**);
- Be adaptive to urgent needs and specific vulnerable groups such as: those who are homeless; those with high physical care needs; and those who are most at risk of drug-related death;
- Deliver via a locality hub model, to ensure community-based delivery and enable co-location of services.

The new model should be informed by exploring the very best contemporary models for working with people experiencing problems with drugs. As a minimum, the new service must include options (as a matter of urgency) for low threshold prescribing,^{45,46} as well as low intensity provision,⁴⁷ which will allow the specialist services to work with the more vulnerable population in an integrated fashion (intensive, complex needs and crisis provision).

The Commission would like to highlight a very useful document on ways to deliver trauma-informed, low threshold Opiate Replacement Therapy (ORT) services in Scotland. This was brought to the attention of the Commission after the session with three Lothian based GPs and developed by Dr Joe Tay⁴⁸. We believe this document is worthy of full consideration for the new system model, as well as the holistic drop-in service that runs in Midlothian.⁴⁹

⁴⁵ Low Threshold Prescribing is based around (1) fast access to treatment, usually within 1-2 days, with little or no expectation for abstinence, and (2) retention in treatment with no possibility of suspension from treatment.

⁴⁶ Strike, C. et al (2013). *What is low threshold methadone maintenance treatment?* The International journal on drug policy 24(6) DOI: 10.1016/j.drugpo.2013.05.005

⁴⁷ Low intensity provision aims to stabilise the patient and settle them back with primary care/GP as soon as possible, with no push to stop.

⁴⁸ The document shared with the Commission by Dr Joe Tay is concerned with the development of trauma-informed, low threshold Opiate Replacement Therapy (ORT) services using principles of safety; transparency and trustworthiness; choice; and collaboration, respect and empowerment. Crucial is the removal of any barriers to limit or delay access to ORT, In addition it welcomes open referrals and self-referrals and minimises intake assessments.

⁴⁹ Details can be provided by the Commission.

Finally, it is important to note that the remit of the Commission has been to look at drugs only, and not alcohol. The main statutory treatment service (ISMS), like many others, is a combined drug and

alcohol service, therefore the Commission would like to acknowledge that the changes being proposed for this service must ensure that alcohol treatment provision is not downgraded or adversely affected as a result. The following commentary was provided to the Commission by a senior clinician in NHS Tayside:

'ISMS, as well as having responsibility for drug addiction, are also supposed to provide services for alcohol. Currently this provision is sub-optimal. Any recommendations the Commission makes will have impacts on alcohol services...Services [need] to ensure they consider the impact on alcohol services of any responses that they propose to the Commission's report. The anecdotal feedback from patients is that there is only one type of service for all patients with addictions, and if you are not on heroin then they are not interested in you. Clearly this is not high-grade evidence, but it is a substantial change in the patient feedback from the days when there was a specific alcohol service.'

Recommendation 9: Reframe all substance use services to prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base including, but not limited to: improved retention through having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.

The Commission acknowledges that a vision for a high-quality and person-centred treatment and support system in Dundee will take time and considerable courage and efforts to come to fruition. In the short-term it is therefore critical that efforts are focused on reframing current substance use services so that they can come out of their silos and repair the trust that has broken down between them. This will require strong and distributed leadership, with a clear focus on the evidence base that will help improve services and which will result in fewer drug-related deaths (as a primary and key measure).

The evidence base is clear that engaging and retaining individuals in opioid substitution treatment (OST) should be a 'protective' factor. Attention therefore needs to be placed squarely upon prioritising and improving access, retention, quality of care, and the safety of those using services. Quick access and strong retention should be for all: those returning from prison, those who dropout of service, those who are discharged from hospital and new attenders. Independent (expert) external support needs to be provided (via a 'mutual aid' request to Scottish Government) to develop an action plan around these high-priority areas. The Commission recommends the development of regional support for prescribers (medics and non-medics) to support and create a governance structure. The Commission believes that such a support framework will help to sustain different types of interventions and enable people to have a broader competency framework. The Commission recommends that all efforts are focused immediately on speeding up access to treatment and removing any barriers to quick access. The stated goal of ISMS to get people on Opioid Substitution Therapy within 10 days from first contact is welcomed as a step in the right direction. However, from the reports heard since this target was implemented in September 2018, the Commission is left with little confidence that this goal is currently being met (see **Section 2 of Appendix XVI** in the **Part 3** report – question 13, which indicates that the time to start treatment is 'currently sitting at three weeks'). In the short-term all efforts need to be focused on meeting this target as a minimum requirement, and the service needs to report monthly to the DADP on progress and compliance with this target. Beyond this, the service needs to prioritise much quicker access. The aspiration should be a service which can deliver same day OST. However, we are not persuaded that the existing service model will deliver this and that is why we are calling for a complete reconfiguration of the service with different models of delivery including those in the voluntary sector and primary care.

There must be a broad menu of evidence-based services, supports and interventions to reflect the range of needs of people who experience problems with drugs. Priority focus should be on following contemporary evidence-based practice around optimising OST, and a clear ambition set for offering low threshold (same-day) prescribing treatment when needed by the person seeking help. There should be a spectrum of drug treatment and support interventions, from prescribing and harmreduction through to inpatient detoxification and residential rehabilitation when need is clearly assessed. It is also vital to ensure access to a range of psychological and social interventions within the new system model, including welfare support, housing and mental health support. Attention should also be paid to providing nurse-led hospital liaison services for people who experience problems with drugs in the same way as Alcohol Liaison nurses are provided in NHS Tayside.

The Commission is aware of and welcomes the recent funding received to pilot an assertive outreach nursing service (based in the third sector but co-ordinated as a partnership approach) to focus on preventing and responding to non-fatal overdoses. This is a small-scale, time-limited initiative, but is exactly the type of

response where current resources need to be expanded. Assertive outreach needs to be positioned as a fundamental ingredient of both the transition plans and the longer-term system redesign.

Recommendation 10: Involvement of primary care and shared care models.

It is the view of the Commission that local General Practitioners are a severely under-utilised resource in the provision of services to people who experience problems with drugs in Dundee. The Commission therefore strongly suggest that the Dundee Partnership prioritise immediate discussions with local GPs regarding how they might be much more actively involved in supporting the delivery of high quality services to people who experience problems with drugs in Dundee, especially with regard to taking a prescribing role in OST. The Commission firmly believes that meaningful and wider involvement of primary care, and specifically GPs, would support and enhance the other recommendations that are made in this report. Crucially, where done well, involvement of primary care and GPs can expand reach and access to people who can be supported almost entirely in primary care because their needs can be met there without substantive involvement of more specialised services. GPs (and primary care based nonmedical prescribers) can also take on shared care arrangements with specialist services if there are local arrangements in place. This can help specialist services to discharge people into safe and supportive care and prevent the bottle necks that we have seen develop in Dundee where specialist services have nowhere to discharge their clients to. While we are also very keen to see primary carebased non-medical prescribing supported we do believe that the very low numbers of involved GPs is itself a problem that needs to be specifically addressed. This should be done in addition to providing support more generally for wider primary care involvement in the care of people who experience problems with drugs, such as non-medical prescribing professionals.

The Commission does understand that there are substantial challenges within primary care/general practice more generally, nationally and locally, in terms of shortages of staff, succession planning, and concerns about working in an area where practitioners can lack confidence and sometimes willingness to work with this client group. However, there are many areas of Scotland where shared care arrangements are working very well notwithstanding having similar generic challenges. There are initiatives that can be developed locally to provide good training and support that practitioners need to practice safely and confidently. There is also a need for national training such as the Royal College training on addictions that used to be supported by the Scottish Government.

There is therefore the need to create immediate open and participatory discussions with local GPs on how to develop the right terms and conditions to support their increased involvement. The Commission would suggest that NHS Lothian is a good model for Dundee to explore because of the long-term nature, and extent, of primary care involvement in OST and shared care arrangements. The Commission would also note the work done in Forth Valley to develop a GP Prescribing Service (GPPS) which has been operating for 14 years as a partnership model of holistic care between people who experience problems with drugs, GP, third sector recovery worker and community pharmacy⁵³. Another recent and complementary model is also worth noting. In Greater Glasgow and Clyde there are steps being taken to employ Medical Officers in Alcohol and Drug Recovery Services. They state: *'Medical Officers, many from a GP background, are part of a medical and prescribing workforce that includes psychiatrists and independent prescribers. They deliver a wide range of interventions to problem drug and alcohol users with the aim of improving health and social outcomes. These include assessment and review of their health needs, substitute prescribing, detoxification and relapse prevention prescribing, providing testing and treatment for Hepatitis C and HIV. Medical Officers are based in integrated community teams, carry a caseload, work closely with specialist services and GPs and are professionally accountable to senior clinicians. They assess and review individuals with drug and/or alcohol dependency.'*

In terms of meeting the very complex needs of people who experience problems with drugs, who may not be able to be well managed/supported in primary care settings by GPs (or primary care

⁵³ Forth Valley GP Guide to Managing Substance Misuse (2016) sets out the criteria for GPPS below;

- Opiate dependency where there is no problematic alcohol or polysubstance use.
- Stable accommodation
- Willingness to work towards recovery, reduction and a drug-free lifestyle.
- Good general health, (caution with significant co-morbidities).
- Good mental health, (caution with significant co-morbidities).
- Commitment to attending GP and regular key-worker sessions, and working towards positive outcomes.

based non-medical prescribers), the salaried health board employed Medical Officer model would also be one that Dundee could actively explore.⁵⁰

Recommendation 11: Review and refresh the community pharmacy model for OST engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use substances. Look to establish a new Community Pharmacy model with additional support.

An increased role for Community Pharmacy in Dundee should be welcomed and developed as part of a comprehensive solution to the challenges currently faced. A new model for Dundee should include the following elements:

1. Explore and test the use of Pharmacist Independent Prescribers to support Recovery Oriented Systems of Care in selected pharmacies.
2. Invest in the training of community pharmacy teams by developing a programme of protected learning accessible to all staff to support the delivery of pharmacy services within a Recovery Oriented System of Care across NHS Tayside. This programme of protected learning should:
3. Address stigma and attitudes;
4. Provide pharmacist prescribers with opportunities for work shadowing and support from designated medical practitioners to improve communication and appreciation of workflow;
5. Help the wider integrated workforce to understand the role of Community Pharmacists.
6. Support communication systems between treatment services and Community Pharmacists to become two-way, easy, fast and secure to support recovery and safety.
7. Develop weekend contacts and ensure advice is available consistently across Dundee.
8. To prevent a repetition of the practice frequently reported to the Commission where people have had to travel significant distances to access methadone prescriptions, the prescribing services should seek to find person centred and recovery focussed solutions through collaborative working.

Recommendation 12: Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.

Although the Commission has not had sufficient time to consider in detail a wider set of evidencebased supports and services in respect of their applicability and appropriateness for Dundee, a number of such supports and services have been consistently referred to, and requested by, those submitting evidence to the Commission.

With this in mind, the Commission strongly recommends that an independent comprehensive health needs assessment for people who experience problems with drugs is conducted, along similar lines to the 'Taking Away the Chaos' Health Needs Assessment conducted in Glasgow in 2016⁵¹ (utilising a tripartite health needs assessment framework, comprising epidemiological, comparative, and corporate approaches). The Glasgow Needs Assessment report details a comprehensive view and suggested approach to implementing evidence-based supports and services such as Safer Injecting Facilities (SIFs) and Heroin Assisted Treatment (HAT) as a response to the high numbers of individuals injecting drugs in public places. The process of engagement used throughout the needs assessment proved to be equally as important as the final report in that it allowed all stakeholder groups to participate in a detailed discussion and debate of the

⁵⁰ https://gallery.mailchimp.com/c4876cb152fa1983ef265ad1b/files/b6b5d4d4-b3cb-41e4-acc5b848c7ee3186/SP_Flyer_Final_Version_002_.pdf?mc_cid=c0251cef58&mc_eid=ce9fba1d08

⁵¹ Tweed, E. and Rodgers, M. 2016. *Taking away the chaos: a health needs assessment for people who inject drugs in public places in Glasgow, Scotland*. Available at: https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf

evidence around such interventions. This work has proved to be the catalyst for the steps that the Glasgow Health and Social Care Partnership has taken towards successful implementation of a broader range of interventions, including the garnering of essential political support.

A long-term plan should be developed to establish, on the basis of this independent health needs assessment, evidence-based services such as SIFs (Overdose Prevention sites, Drug Consumption Rooms [DCRs]) and HAT in Dundee, with enough spaces to accommodate all who require these additional services. The Commission has noted that, in its recent submission of written evidence to the Scottish Affairs Committee Problem Drug Use in Scotland inquiry⁵², the DADP named 'Supervised drug consumption facilities' as one lesson that Scotland could learn from other countries. Additionally, the Commission requested Dundee-specific evidence from the national Needle Exchange Surveillance Initiative (NESI)⁵³ in relation to Drug Consumption Rooms (DCRs). As part of the annual NESI survey a question is asked of people who inject drugs (PWID) as to whether they would be willing to use a DCR if one was made available. The results for those who completed the survey from Dundee are shown in the table below:

Table 8.1: Proportion of PWID in Dundee willing to use a DCR, 2017-18

	Willing to use a DCR if one was made available		
	Yes (%)	No (%)	Total
All people who inject drugs (PWID)	110 (70)	47 (30)	157 (100)
Current PWID (reported injecting in the last 6 months)	91 (86)	15 (14)	106 (100)

Data source: Needle Exchange Surveillance Initiative (NESI)⁵⁴

An assessment of the needs for drug checking and testing services should also be included within the independent health needs assessment.

As mentioned previously in this report, the Commission recommends that this needs assessment should include in its scope further detailed analysis of the 'deeper-dive' of data that has been undertaken. Further, the Commission recommends that the 'deeper-dive' is repeated (with inclusion of 2017-18 data).

In the short-term, the Dundee Partnership should work proactively with the Scottish Government and UK government to remove barriers to evidence-based services that have demonstrated their positive impact on harms and overdoses.

⁵² Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairscommittee/problem-drug-use-in-scotland/written/99493.pdf>

⁵³ The aim of the Needle Exchange Surveillance Initiative (NESI) is to measure and monitor the prevalence of the Hepatitis C virus (HCV) and injecting risk behaviours among people who inject drugs (PWID) in Scotland.

⁵⁴ Many thanks to Dr Andrew McAuley (NESI Study Manager) and colleagues for extracting this Dundee-specific data for the purposes of the Dundee Drugs Commission.

In the longer-term, the above action will help to ensure implementation of missing yet essential evidence-based supports and services. By so doing, unnecessary additional harms for people who experience problems with drugs, and their children and families, will be prevented.

Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and the majority of people with substance use problems also have mental health problems.

A worrying number of those giving evidence to the Commission have expressed the view that when people with co-occurring mental health and drug use problems present themselves at either mental health or substance use services in Dundee, that one issue should be dealt with first. Apparently, this erroneous view is still current among a range of professionals across Dundee. The evidence has been clear for many years (and has recently been re-iterated in the 2016 NICE guidance⁵⁵) that mental health and substance use issues should be addressed concurrently.

Substance use and mental health services need to be commissioned to deliver evidence-based interventions that are aligned with relevant guidance (e.g. NICE). It should not be acceptable that any professional express views that are contrary to the evidence⁵⁶. This is a contract management issue. There may also be implications for continuing professional development, supervision and training. People living with mental ill health and those with substance use problems experience stigma, prejudice and discrimination. These experiences can be mitigated by addictions services that are actively engaging with, and sensitive to, mental health issues and by mental health services that are active and competent in addressing addictions. There are no wholly integrated statutory services that respond to the needs of people with mental health and substance use challenges in Scotland. The existing model of integration in Dundee (which is reported as often being based on having a file open in two services), as well as services, are not delivering for people, their families or the city. There is therefore an urgent need for radical rethinking of service models. High quality integrated models are suggested⁵⁷ as the best way forward and the Commission therefore recommends that advice, guidance and support are sought from the Glasgow Integration Joint Board and the Glasgow Health and Social Care Partnership who have made successful strides forward in commissioning integrated services (across homelessness and substance use services, as referenced earlier in the report). There are now good UK and international examples of integrated services from other jurisdictions (Public Health England have recently highlighted examples of good practice, and other examples are noted in Australia, Canada and the USA) which should be considered as part of an options appraisal exercise. These could provide the basis of new integrated models of care for Dundee to adopt (including Crisis Care), once the Tayside Mental Health Services Independent Inquiry has delivered its final report. The Dundee Partnership should approach Scottish Government with a view to commissioning Scotland's first fully integrated mental health and substance use service.

An opportunity also exists for the Dundee Partnership to work with researchers and practitioners from Australia and Canada to develop a standardised but flexible process for the sustained uptake of integrated care in mental health and drug and alcohol services. Further details will be provided to the Dundee Partnership.

In summary, the Commission view the urgent task of the Dundee Integration Joint Board and the Dundee Health and Social Care Partnership in this regard to be: (1) state clearly the things that need to change; (2)

⁵⁵ National Institute for Health and Care Excellence (NICE), (2016), *Co-existing severe mental illness and substance misuse: Community Health and Social Care Services*, (2016), Available at: <https://www.nice.org.uk/guidance/cg120>

⁵⁶ It was reported to the Commission from a range of sources (and across sectors) that there is a widespread view within mental health services that substance use issues should be dealt with separately. This is sometimes articulated as substance use should be dealt with before mental health issues (i.e. sequential treatment). This is contrary to national guidance (2016, 2002) and defies the principle that individuals should be able to choose their own 'door' into services (i.e. 'no wrong door' principle).

⁵⁷ Public Health England (2017). *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for Commissioners and Service Providers*. London. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Cooccurring_mental_health_and_alcohol_drug_use_conditions.pdf

conduct an immediate options appraisal on what models could work in Dundee; (3) act swiftly to commission a new model and phase out elements of old service models that do not work, protecting care for vulnerable people and their families meantime and with an Equalities

Impact Assessment conducted throughout to ensure that potential negative outcomes for particular groups are considered and addressed in advance; and (4) involve people and families and services in the change process whilst actively developing feedback loops.

As noted in a letter from the Dundee Suicide Prevention Partnership, the risks for those with intersecting mental health and substance use (including alcohol) problems are heightened considerably. This has also been highlighted in the Tayside Multi-Agency Suicide Review Group Annual Report 2017. The Commission is very supportive of the intention to work in partnership with the DADP to prevent suicide in Dundee.

SMART actions need to be agreed and implemented with a clear procedure produced for how they will be measured. Integrated services need to be a core part of such partnership working.

Additionally, the Commission recommends that the Dundee Partnership explores the potential future roll-out of the Distress Brief Intervention (DBI) Programme⁵⁸ as part of an integrated substance use and mental health service model in Dundee. The DBI programme is currently being piloted in four sites across Scotland. The initial results of the DBI pilot sites appear positive with an extension of the programme having already been granted to cover 16-17 year old's across the four pilot sites.

C. CAUSES AND EFFECTS OF DRUG USE

The third suite of recommendations (14-16) is concerned with a wider understanding of the causes and effects of drug use in order to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups in Dundee.

Recommendation 14: Address the root causes of drug problems.

The root causes of drugs use are poverty, trauma, violence, neglect in childhood and adulthood, incarceration and criminalisation, stigma towards people who experience problems with drugs, drug and health policies that exclude rather than include, and lack of access to effective and high-quality treatment and support⁵⁹.

Studies are increasingly identifying the importance of early life experiences to people's health throughout the life course. Individuals who have adverse childhood experiences (ACEs), during childhood or adolescence, tend to have more physical and mental health problems as adults than do those who do not have ACEs, and ultimately greater premature mortality.⁶⁰ ACEs include harms that

affect children directly (e.g. abuse and neglect) and indirectly through their living environments (e.g. parental conflict, substance use, or mental illness).

The Commission has heard detailed accounts of second, third and even fourth generation substance users in Dundee – all of whom have devastating stories which highlight the root causes of substance problems being about the issues above rather than the substances themselves. Drugs should not be looked at in isolation of the reasons why people can use them to the point of becoming dependent upon them. Most drug use does not lead to problems or dependence.

⁵⁸ <https://www.dbi.scot/>

⁵⁹ See recent relevant submissions to the Scottish Affairs Committee's Inquiry into the Use and Misuse of Drugs in Scotland, including NHS Health Scotland/NHS National Services Scotland joint response. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairs-committee/problem-drug-use-inscotland/written/100340.html>

⁶⁰ Bellis MA, Hughes K, Leckenby N, Hardcastle KA, Perkins C, Lowey H. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. *J Public Health* 2015; 37: 445–54.

The Commission would like to stress the importance of enhancing the provision of employability, education, training, and volunteering opportunities, to address the boredom, social isolation, and lack of opportunities many encounter when attempting to reduce or cease drug use.⁶¹

Given the high prevalence of drug deaths occurring for those who live in areas of higher deprivation, it is imperative that the work of the Dundee Fairness Commission is joined-up and considered when putting action plans together to tackle the recommendations in this report.

Recommendation 15: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.

The Commission recommends that the Dundee Partnership specifically considers the particular needs of women in Dundee who experience problems with drugs. Recent work undertaken in Scotland⁶² on women and drugs related deaths suggests that women might need different approaches or types of services to address their specific needs and associated potential risks and harms. Tweed et al. (2018) state that, on the evidence gathered by their scoping review, women who use drugs are likely to be particularly affected by the adverse impacts of welfare reform and public sector austerity measures and that such changes “may interact with other risk factors such as abusive or coercive relationships, commercial sex work, experiences of trauma, mental health issues, and changes in drug treatment services” (page 4). Stakeholders consulted in their review highlighted that recent changes to drug treatment services in Scotland, as well as in the wider health and social care landscape, may have particularly affected women. They state: “*Cuts in funding were felt to have resulted in the withdrawal of services, reduced provision, reductions in staffing levels and skill-mix, lack of continuity in relationships, and changes in ethos*” (page 4). Other review informants highlighted the potential role of poor drug treatment practices and insufficient throughcare support for women in the criminal justice system. These are areas that clearly resonate with the evidence that the Commission has gathered over the past year. Drawing on the scoping report’s practice and policy recommendations,

the Commission recommends that the Dundee Partnership recognises: the commonalities between men and women who use drugs as well as the differences; the diversity of experiences within genders; and the intersections between gender and other axes of inequality, such as deprivation (please see the quantitative analysis that shows the high numbers of people dying in Dundee from the poorest communities – see **Appendix XII** in the **Part 3** report). Our view is therefore that the Partnership should take cognisance of this far-reaching report that explores both women’s potential particular risks and the gender-sensitive recommendations for policy and practice therein. Some of Tweed et al’s (2018) recommendations have been highlighted below.

- Adopt gender mainstreaming approaches - this refers to a systematic and meaningful consideration of the implications for both women and men when developing, implementing, and evaluating changes in policy and practice, with a view to promoting gender equality.
- Prioritise the development of trauma and violence-informed, and psychologically-informed, approaches and services which recognise and respond to previous experiences of adversity and their ongoing influence on people’s circumstances and engagement with treatment.
- Provide enhanced support at specific times of vulnerability, such as bereavements and loss of child custody.
- Provide additional assistance for individuals with benefits, housing, and legal issues, to help mitigate challenging financial and social circumstances - particularly those associated with welfare reform. These might usefully be delivered through integration or co-location with drug treatment services and

⁶¹ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

⁶² Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

in other healthcare settings (see Edinburgh Access Practice as an example of this working well in Scotland).

- Explore the feasibility, evidence base, and preferences for gender-concordant workers and female-specific support and recovery groups.

Recommendation 16: Attend to the intergenerational nature of substance use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents. Explore the creation of family support workers in the third sector that can provide support ahead of families reaching crisis point and requiring social work intervention.

For decades, the intractable problems faced by generations of those using drugs, have been impossible for traditional services to resolve. Dundee's children deserve better and they (and their parents) need a future filled with hope and aspiration. There is now a desperate need for radical change, and it feels that, both locally and nationally, there is the impetus to deliver.

This does not necessarily mean removing children from their birth family, which can place children and parents at additional risk of harms, but this may result in supporting parents and kinship networks in a wide variety of ways, including the provision of high quality treatment services and helping to support compassionate communities, with interventions and support for children and young people in their own right. Services in Dundee need to take a greater pro-active role in engagement with these issues and challenges. One of the findings of the Commission, as mentioned earlier in the report, is the lack of engagement of ISMS in attending Child Protection Case Conferences where children are deemed to be at greatest risk, and to Core Group Meetings in Dundee when plans are established to ensure the safety and protection of the child. This has to change with immediate effect and should become a mandatory requirement that the service attends the maximum number of case conferences as possible, or for the exception where attendance is not possible, a detailed report should be submitted.

Records indicate that from January 2018 until 15th May 2019 (16.5 months) there were 380 case conferences (both initial and review) for 290 children in Dundee; 134 of whom were affected by substance use (83 drugs, 18 alcohol and 33 both). ISMS staff attended just one of these conferences and provided a report to a further three conferences overall providing recorded input for four children.⁶³

The Commission recommends that options for bereavement counselling and support for children, young people and families affected by a drug death in Dundee are made available as soon as practicably possible. The Dundee Partnership must require more services to address substance use from a 'whole family perspective'.⁶⁴ There is little merit in supporting a child independently, or to try to address an adult's use of substances as a sole focus, when we know they are a parent. Neither of these exist in isolation and there are many complex wider family issues which make sense to be considered simultaneously.

Services in Dundee appear to have been developed in 'silos' with limited reference to other key partners who can offer support, advice and assistance. The whole 'Getting It Right For Every Child'⁶⁹ (GIRFEC) approach is universally understood for children and young people in Scotland and this can be applied equally to adults but, for some reason, when an adult has a drug problem it is most frequently the 'risks' posed for any children that become the sole focus. This can be enhanced by improved engagement between those providing statutory and third sector drug services with those in Children's Services and directly with families and communities.

Greater awareness of the impact of adverse childhood experiences (ACEs), improved traumainformed practice, and the building of resilience and self-esteem for the whole family, should be the ambition for Dundee and would lead to much better outcomes for all. However, this is not a 'cheap' option and would need a genuinely well-resourced responsive service, potentially with 24/7 availability and the commitment of a range of flexible and creative practitioners who are invested in the family's functioning. The Commission would like to challenge the Dundee Partnership to consider this recommendation in detail as this would require a 'transformational approach' and would require

⁶³ The Commission has welcomed a submission from ISMS which highlights attendance at Child Protection Case Conferences as a risk, with mitigating actions put in place.

⁶⁴ Whole family approaches are currently being practised through the third sector (in some cases funded by the DADP). ⁶⁹

Available at: <https://www.gov.scot/policies/girfec/>

a far more detailed scoping report than the Commission has had time to produce in this regard. As Tweed et al (2018) have noted:

“Child- and family-sensitive treatment services, and support for family relationships: Such approaches would recognise the importance of family relationships and parenting to recovery and harm reduction, and might include options which make childcare arrangements easier (for instance through suitable timing and location of appointments, including home visits), residential treatment services which support family integration, and support for parenting and re-establishing family relationships. One such approach cited by stakeholders as an example of best practice was a residential facility permitting women to live with their children whilst undergoing rehabilitation: however, this facility is now closed, apparently due to funding issues. Another example is a recently initiated home detox programme run by Barnardo’s in Fife.”

The Commission would like to see the establishment of a multi-disciplinary service built around the family. This would include:

- clinical psychology to address long-term trauma and distress, speech and language therapy to promote cognition, as so many of our drug users cannot ‘process’ information in the way they are required to in order to benefit from the services that can currently be provided;
- social work and social care services to enhance family dynamics to help repair family relationships and to promote community engagement;
- housing support to help families move to appropriate accommodation (away from high risk) and the associated development of welfare/budget management skills;
- community learning opportunities to encourage education, training and employment and the aspiration of families to do more than simply ‘recover’ to support other users; and
- wider, reparative, family support to help rebuild relationships and enhance community-based support.

The Dundee Partnership needs to nurture a vision for increasing expectations of what is possible and a focus on removing the barriers to allow children and young people to see that people can correct the choices they make and it need not define who they are for the rest of their lives.

National Considerations

In considering how to achieve the significant improvements that are required in Dundee, there are a number of areas that are outside of Dundee’s powers to change – resting either with Scottish Government or the UK Government. For Dundee to succeed in its ambitions to effectively tackle the challenges it faces, the Commission needs to highlight the following matters for national consideration:

1. Inspection of all substance use services. Unlike England where all substance use services are subject to regular inspections from the Care Quality Commission (which is the independent regulator of all health and social care services in England), only certain categories of substance use services are inspected by regulatory bodies in Scotland. This only adds to the unequal ‘playing field’ as discussed in Recommendation 4. **The Commission would ask Scottish Government to consider equal regulation of the whole substance use services/treatment sector.**
2. Funding of substance use services. Unlike England, ADPs across Scotland only have direct control of a minority of funds for drug treatment. For example, in Dundee, the DADP only has direct control of approximately one third of the total drug and alcohol spend⁶⁵, with the NHS retaining control of the majority two thirds with decisions taken by the Dundee IJB. The Commission believes this maintains an unhealthy balance and explains why ADPs have largely been ineffective across Scotland in making a decisive shift towards prevention (as outlined by the Christie Commission). They are unable to redistribute funding in the manner needed to fulfil the Christie mandate. **The Commission would therefore ask the Scottish Government to consider how it can change the funding systems in Scotland to allow ADPs to**

⁶⁵ See Table 7.1 in Chapter 7 ‘Key Messages’ earlier in report.

control the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of ADPs to ensure they can function as fully independent commissioning bodies.

3. Public Health Emergency. Given the rapidly increasing number of drug-related deaths across Scotland, and the seriousness of the issues the Commission has reported on in Dundee (which are similar to other areas of Scotland), **the Commission welcomes the Scottish Government declaring the drug deaths crisis as a public health emergency.** In Scotland, at present, it is unclear whether such a declaration will unlock any new powers or resources. International examples exist that can be learned from, for example in British Columbia, Canada in response to a provincial emergency. The Commission welcomes the moves by the Minister for Public Health and Sport to set up a National Task Force to advise on what further changes, in practice or in law, could be made in Scotland.
4. Decriminalisation. As part of its work over the last year, the Commission has looked at several different approaches from other countries. The Commission was highly impressed with the decriminalisation approach of Portugal over many years now (which also focused on better treatment, employability and housing, as well as welfare improvement), and the improved outcomes it is experiencing (see **Appendix V** in the **Part 2** report). **The Commission is aware of the current inquiry into problem drug use in Scotland being run by the Scottish Affairs Committee and would support the calls for petitioning the UK government to have increased devolved powers to allow for a full ‘Scottish’ review of drug laws to be conducted and action taken as a result. In the short-term the Commission would ask the Scottish Government to consider how they can make the most of the powers that they already have (including policy) – such as police and enforcement practice.**
5. Drug Death Review processes - learning. There is currently no standardisation of local drug death review processes or systems for shared learning across different Health Board areas. There is a group whereby data co-ordinators can meet and discuss processes related to data assimilation and recording, but there is no co-ordination of Chairs/strategic leads in this area, which provides little opportunity to learn from one another. **The Commission would therefore ask the Scottish Government to consider convening a National Learning Set for Drug Death Review Groups (including standardisation of processes).**
6. Drug Death Review processes – speed. Enhanced surveillance and utilisation of overdose data to inform practice and policy is required. **The Commission would ask the Scottish Government to consider how ‘real time’ data (without extensive delays in getting these data into the public domain) can be achieved in order to enhance the ability to respond both locally and nationally.** Current data processes have lags of between 12-18 months. The British Columbia Drug Overdose and Alert Partnership (DOAP) model provides an excellent example for proactive multi-sectoral action related to harms from substance use, including overdose.⁶⁶
7. Toxicology. Reporting of toxicology findings on post-mortems are too slow (currently ~8 to 10 weeks). **The Commission would ask the Scottish Government to consider allocating appropriate resources to national toxicology testing to enable more effective and quicker reporting.**
8. **The Commission would ask the Scottish Government to consider developing a plan of work to address the findings in the 2018 Scottish Government report on women and drug-**

⁶⁶ <http://www.bccdc.ca/resource-gallery/Documents/Opioid%20Overdose%20Response%20Strategy.pdf> Website info: <http://towardtheheart.com>

related deaths.⁶⁷ Many of the areas identified in this far-reaching report address issues that have resonated in the Dundee Commission's work over the past year and we suggest that the policy and practice recommendations therein offer the potential for much needed "cross-sectoral collaboration and policy synergy – for instance, with mental health, social security, justice, community cohesion, housing and homelessness, and the equalities agenda more broadly" (Tweed et al, 2018). One of the recommendations from this work that relates centrally to the Dundee experience is the need for a more co-ordinated and holistic approach across substance use treatment, mental health, physical health, and social support (including housing, employment, legal and financial advice). This approach has been recommended by recent reports from the Scottish Drugs Forum, the European Monitoring Centre for Drugs and Drug Addiction, and Public Health England. Elements of this approach might range from workforce training,

multidisciplinary meetings, and robust referral pathways to a holistic approach to treatment eligibility and thresholds and greater integration of services. Integration of trauma- and violence-informed, and psychologically-informed, approaches must be led at a national level - as well as actively supporting and promoting cross-sectoral collaboration across substance use, homelessness, justice, mental health, education, and children's services. Protecting and, where possible, enhancing funding for drug treatment services – particularly harm reduction – and mental health care will be required. Strengthening efforts will also be needed to mitigate the adverse impacts of welfare reform, especially among those who may experience disproportionate harms, as well as ensuring sufficient attention to the intersection between gender, substance use, mental health, and other inequalities in the design of Scotland's new social security system.

It's now time for action

As a Commission we are fully aware that we have provided a significant challenge for the Dundee Partnership in terms of the volume of action and work that will be required to implement our recommendations – which are framed over a five year period. Our hope is that all disciplines and services (including the DADP) quickly (within three months) prioritise the time necessary to reflect upon the findings and recommendations laid out in this report, and provide a detailed response and action plan to the Dundee Partnership to describe the part they can all play in helping to tackle this set of significant challenges. There are some quick wins to be had in learning from the mistakes of the past to uncover the solutions for the future. For example, we were struck by the high-quality evidence provided to the Commission by Professor John Dillon (Professor of Hepatology & Gastroenterology, School of Medicine, University of Dundee, and Ninewells Hospital and Medical School) about the major successes in Dundee of efforts to eradicate Hepatitis C. This has been achieved in large part by a simple reframing of how services engage with those who require help – to offer a more welcoming, humane and respectful approach. The irony is that the Hepatitis C population (who are benefitting from the new approaches) include members of the drug using population that have experienced (and report) a very different type of specialist provision for their drug use issues.

Another high-quality example was provided to the Commission by Ann Eriksen (Head of Strategic Planning, Executive Lead - Sexual Health & BBV, NHS Tayside). Dundee once had the title of 'Teenage Pregnancy Capital of Europe'. No more though. Dundee has successfully changed its approach over the last decade to ensure better outcomes. It is time to apply these approaches to the issues of drug use so that Dundee is able to shed the label of 'Drug Death Capital of Europe' once and for all, and ensure that Dundee is a city where every life and death matters.

There is a deep passion amongst the people of Dundee to assertively respond to the serious challenges faced. As Commission members we are fully prepared to continue in a supporting role to help ensure Dundee can implement the changes we have sought to describe and understand. We would therefore want to support the Dundee Partnership and the DADP as a 'critical friend' as they look to take the lead on implementation. Having challenged the Dundee Partnership to pick up the baton and run with an ambitious programme of change, it would be negligent of the Commission to deliver its report and walk away. As an independent Commission we are prepared to support the DADP as it begins a new journey and to reconvene and collaboratively review progress within the next 12 months.

⁶⁷ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

The values of **kindness, compassion and hope** will underpin and guide the support that the Commission is able to provide. In return, we challenge the Dundee Partnership to having 'a year of kindness and compassion' to get things moving in the right direction and reignite the hope that things can and will change.

9. OUR REFLECTIONS

Reflections of members of the Dundee Drugs Commission

Full details of Commissioners can be found in **Appendix I** in the **Part 2** report and at:

<http://www.figure8consultancy.co.uk/wp-content/uploads/2018/11/DDMC-Commission-Members->

[biographies.pdf](#)

Alex Baldacchino, Professor in Medicine, Psychiatry and Addictions at the St Andrews University

“It is never easy to ask the right questions as you might find yourself involved in finding the wrong answer. My time with the Commission was fruitful and productive in trying to tease out what is actually happening in Dundee, whilst identifying the core elements that will allow ALL individuals who are asking for support to get the best available support in a timely manner. Polarisation and segmentation of ideas and persuasion is never a useful tool to conduct the piece of work that the Commission were tasked to do. It certainly allowed Dundee stakeholders to focus their minds and energy to support the Commission in producing suggested action points. Some very uncomfortable messages, but necessary to read and act on.”

Sharon Brand, Co-Founder, Recovery Dundee

“My biggest hope is that the Commission’s report is received in the spirit that it is given. It is every individual’s responsibility in the City to reflect upon the serious issues presented in this report and to play their part in implementing the changes that are needed. The time for action is now.”

Andrew Fraser, Director of Public Health Science, NHS Health Scotland

“Being part of the Dundee Drugs Commission offered me a clear view of the pain and raw sense of not being heard when disasters strike and persist in families, and services that are under strain can’t or don’t work together to piece together a system of support that benefits users, on their terms. Businesses such as illegal drugs suppliers that prey on people who are dependent on drugs are not around the table, discussing their contribution to the rising numbers of younger people losing their lives. But communities can and must come together with the organisations that can help, from all sectors in a much more joined up way, focussing on the needs of people, putting aside differences. Policy-makers, leaders and professionals need to remain accountable to the people they serve, through the quality of their work and their relationships, caring about and learning from the consequences when failures occur.”

Eilish Gilvarry, Consultant Psychiatrist in Addictions, Newcastle Addictions Service and Professor of Addiction Psychiatry, University of Newcastle upon Tyne

“The composition of the Commission demonstrated broad skills and experience of all aspects of drugs: policy, treatment, prevention, experience, families, criminal justice systems and health. This was a setting then for seeking evidence and challenge, and the commission heard from multiple related areas (e.g. primary care, statistics on deaths, liver specialists) in presentations, in focus groups, in written material and oral advice. The most striking learning point for me was the involvement of families. To hear their stories, their difficulties, their problems as they perceived them with services, what they wished to happen was so forceful and reflective. Reviewing statistics, evidence, etc was important but they demanded action and change with such passion and compassion that our recommendations must demand that change too. Drug-related deaths are not just statistics but those who die belong to families, have families and all are so effected by their deaths.”

John Goldie, former Head of Addiction Services (South Glasgow), Glasgow Addiction Service

“I very much welcomed the invitation to join the Dundee Drugs Commission and did so with the hope that I could share some of my experiences of a career spent trying to improve the provision for those affected by substance use. In the past 12 months I have experienced highs and lows from humbling life shares from those and their families having been through and in the midst of chaotic drug use to

extraordinary stories of recovery and inspiring insights into committed staff and volunteers, but also exasperation at what seems to be a professional dislocation from the reality of the crisis within Dundee. The treatment and care services had already undertaken a full review of its provision prior to the start of the Commission and this appeared at times to be seen as their rationale not to engage fully, although this did improve towards the end. The recommendations of their review are central to change in Dundee but the past evidence is that treatment and care services cannot be left alone to ensure all changes are fully implemented, it is my ask that the Commission requires a revisit in 12 months to ensure that improvements are in place to ensure Dundee has a service provision that all Dundonians need and deserve.”

Cllr Kevin Keenan, Leader of the Labour Group, Dundee City Council

“The Dundee Drugs Commission has been an eyeopening experience for me and quite humbling to have heard evidence from many families who have been affected. Individuals have shared some extremely personal experiences and they have done this in the hope that the Drugs Commission and its recommendations will be taken forward in order to make a difference to people’s lives in Dundee. I have also gained a considerable insight into the various problems that exist and the potential solutions, many of which will come without a great deal of cost. Treating people with respect and doing everything we can to help sort out what sometimes are chaotic lifestyles will make a real difference. There are a number of organisations that need to modify how their services are delivered, working with others taking a multi-agency approach to support and treat those individuals affected.”

Eric Knox, Chief Executive Officer, Volunteer Dundee

“I have been moved by the evidence that the commission has heard from the people who have lost loved ones and who use services. Individuals have the right to receive support and treatment from our services and we must ensure that no one is turned away. I am committed to ensuring that to commission’s findings a fully implement across Dundee in the years to come.”

Dave Liddell, Chief Executive Officer, Scottish Drugs Forum

“The Dundee Drugs Commission has allowed me, and fellow members of the Commission, important insights into the lives of people who are suffering greatly. They are not being provided with the care and support they have a right to expect in a civilised society. The Commission’s findings must not be just be another report but be a springboard for real change; firstly, enabling people to stay alive and secondly, being provided with the help and support they need to live full lives. It remains shocking that we continue to maintain a system that can treat people so inhumanely and seemingly without care and that we see so many tragic outcomes. What is incredible is that the key specialist service has changed so little over a very long period of time despite several reviews taking place. This sadly highlights the lack of leadership and compassion which has allowed the status quo to persist. Staff in all services need to be supported to work through change because radical change must be delivered to services in Dundee now if we are to keep people alive and ensure they have opportunities to flourish.”

Jean Logan, Associate Director of Pharmacy, Community Services, NHS Forth Valley

“It has been a real privilege to be part of the Dundee Drug Commission. As a healthcare professional it has been extremely hard to hear the stories of people seeking help who have been failed. Stigma is clearly still evident, and we all need to listen carefully to feedback, both good and bad. There is an opportunity for services to create a cohesive and compassionate environment working collaboratively with people affected by drugs to help them realise their full potential. It was a bold move by the Dundee Partnership to commission this work and I hope they will now be bold and brave in taking action.”

Suzie Mertes, Superintendent (Partnerships and Performance, D Division), Police Scotland

“Having spent 25 years in policing in Tayside and have seen at first-hand the trauma caused by drug-related deaths, and know only too well the harm and damage that drugs can do to individuals, their friends and families, and to our communities. However, even with that experience, it would be fair to say that prior to joining the Commission I didn't fully understand all of the causes, interconnections and circumstances that made Dundee particularly, but I suspect not uniquely in Scotland, vulnerable to such high rates of harmful substance use. The Commission has thrown a light onto those connections. Every person who has died in Dundee as a result of harmful substance use was a person with potential and the recommendations allow us, as a community, to now work better together to save lives.”

Justina Murray, Chief Executive Officer, Scottish Families Affected by Alcohol and Drugs

“This is the first time I have been a member of a Commission and I thought I knew what to expect (lots of meetings, reading, visits). This bit turned out to be true, but what I was not expecting was the (at times overwhelming) power, volume and consistency of the personal testimony that people have shared with the Commission. In my role, I meet a lot of families and others involved in the world of drugs and alcohol. I have heard many stories which are moving and upsetting, and which motivate everyone in Scottish Families to campaign for better support and involvement of families and their loved ones. However, the evidence from Dundee has come thick and fast with no holds barred, and people have shone a powerful light on a broken system which is full of injustice, judgement and complacency. I feel a massive responsibility to all of the people who have shared their stories with us to ensure that their words do effect unprecedented change and improvement across the city.”

Niamh Nic Daeid, Director, Leverhulme Research Centre for Forensic Science, University of Dundee

“It has been a privilege to be asked to be a Commissioner on the Dundee Drugs Commission. Our work has been greatly enhanced by the quality and probing nature of the questions the Commission has asked and the honesty and frankness of the answers we received. The evidence and experience provided to us from agencies in Dundee, elsewhere in Scotland and further afield has been most welcome and informative. The lived experience has been hugely impactful and has greatly enriched the statistical evidence with which we have been provided bringing the challenges into life beyond the sometimes coldness of numbers. This combination of experience and statistical fact allowed us to both frame our findings and to make evidenced based recommendations. We need now to move forward in partnership with each other, all sections of the community working together, to address positively the challenges which have been highlighted.”

Hazel Robertson, Head of Services for Children, Young People and Families, Perth & Kinross Council

“The Dundee Drug Commission has offered a unique opportunity to examine local need and scrutinise existing service provision through a ‘forensic lens’. This has enabled members to test the appetite for change and explore innovative solutions which may genuinely benefit the city’s residents. To achieve the momentous change required, Dundee requires truly audacious leadership. Change is tough and the road may be long and bumpy but there is a degree of enthusiasm to be more creative and to try to ensure existing services become more nimble and able to respond, much more quickly, to changing need. Drug users in Dundee have made their views clear, they need greater access to opportunities to support the changes being proposed and robust, high quality and responsive services that are ‘barrier free’. The Drugs Commission has, in part, fulfilled its role, but there needs to be assurance that proposed changes will be implemented and that progress will be monitored. There must continue to be clear expectations on all those with responsibility to ensure the improved provision of services.”

Jardine Simpson, CEO, Scottish Recovery Consortium

“Joining the Dundee Drugs Commission in October of 2018 I was struck by the City of Dundee’s challenges being an extreme example of what is happening (or not happening) across Scotland. Dundee needs confident and competent leadership to reduce Drugs Related Death and improve treatment and support responses. Leadership and staff of all services must learn to communicate better amongst themselves and authentically include the people presenting to them for support in this process. All staff in Dundee are Duty Bearers – they have a responsibility to respect, care for and work with, patients and service users who themselves are Rights Bearers; Rights Bearers who are entitled to improved quality in the treatment they receive and accountability throughout their engagement with Public and third sector services.”

Pat Tyrrie, Family Member

“Notwithstanding my own ‘lived experience’ of the impact of addiction on family life I have become more informed of the struggles for people with addiction, the gaps in services and the effect on families. I have a sense that public understanding on the daily struggles for people with an addiction is changing. There appears to be a more compassionate view for those who are essentially our sons and daughters, brothers and sisters, mothers and fathers. I am also more informed of the success of other countries e.g. Iceland where prevention work has had a positive outcome in reducing the use of drugs and alcohol by young people. I sincerely hope the findings of the Commission will be acted upon to prevent drug deaths, provide appropriate mental and drug addiction health services and develop links with young people to work towards stopping drug and alcohol use in the first place.”

Maureen Walker, Family Member

“Having personal experience of living alongside someone who has a problem with drugs, and how it affects not only the user but also family members, I was very interested in the Drugs Commission. I was invited to take part, and I felt it would be very worthwhile to do so. To be part of what after all is very important. It is encouraging to see so many professionals work so hard to put together recommendations that may help to make changes that will have more success than in the past. Drug users are real people. Stigma is still a real problem, but drug users are still human beings that for some reason have taken the wrong path in life. Many are crying out for help. The Commission is putting forward recommendations, not criticism, and hopefully will be looked on as positive, not negative. The past didn't work, so if we all work together now, there is hope.”

Dundee Partnership: Action Plan for Change

RESPONDING TO THE REPORT OF THE INDEPENDENT DRUGS COMMISSION

This plan has been developed on behalf of the Dundee Partnership and as such it reflects a broad partnership approach for working with vulnerable individuals and families affected by substance use. Existing structures, including the Protecting People approach, will be key to the implementation of this plan.

We recognise that in the past when planning and structuring services, we have tended to consider substance use in isolation of the underlying issues that cause it, with not enough consideration to other vulnerability issues, including mental health, adverse childhood experiences (ACE) and gender-based violence.

This plan contains a focus on specific substance use issues: including prescribing practices, access to and maintaining engagement with specialist services, rapid response to non-fatal overdoses, tackling stigma and being informed by lived experience. In addition, the plan also incorporates efforts to tackle trauma and mental health (including ACE), working with vulnerable women and children (affected by a whole range of other issues, including substance use), linking to sexual health, and resilience and prevention work within schools focusing on health and wellbeing. Moreover, elements of this plan have been linked to on-going transformation processes, including the Transforming Public Protection process (and specifically the Leadership improvements being progressed through this programme).

The implementation of this plan is the responsibility of the entire Community Planning system, with the ADP taking a lead on monitoring / scrutinising progress and escalating any areas that are not being progressed at the required pace to the Chief Officers Group and onwards to the Dundee Partnership.

Following an initial period of action to address some of the most urgent issues identified by the Drug Commission report, such as establishing the Non-Fatal Overdoses test of change, this action plan has been developed in collaboration with a wide range of stakeholders. It represents our current assessment of the actions required to address the findings of the Drugs Commission, however the plan will be an evolving document. We are committed to the implementation of the actions contained within the plan but know that there will be a need to recognise quickly where any actions are not progressing as we have anticipated or are not having the predicted impact and to adapt our approach accordingly.

The timescales identified within this plan are ambitious and will require collective prioritisation across all Community Planning partners. They represent our best assessment of likely timescales for completion of actions at this point in

the development of the plan. Chief Officers from across the Community Planning Partnership are committed to supporting the workforce to deliver against these timescales.

This plan will be supported by a separate performance management framework that will support the ADP, and other relevant Community Planning groups, to not only track the completion of actions but to evaluate their impact on the wellbeing of individuals, families and communities. Each action within the plan will also be supported by a more detailed delivery plan that identifies key milestones for implementation with associated timescales and identifies appropriate measures of impact. These detailed action plans are currently being developed by the lead officer, supported by the working groups they are chairing.

Although this plan has a focus on Dundee it does not exist in isolation. There is an expectation that the lead officers and working groups identified within it will take an approach that is evidence based, cognisant of best practice across Scotland and beyond, and supports innovation. There will also be a need to consider in further detail how the work in Dundee links to and is supported by work at a national level including the work of the National Task Force.

DUNDEE PARTNERSHIP: ACTION PLAN FOR CHANGE AND IMPROVEMENT, WORKING DOCUMENT DECEMBER 2019

Key Priority		Relevant Commission Recomm.	Responsible for Actions Planning	Specific Actions – for completion by workgroups	Lead Role/ Group	Target for completion	Outcomes / Indicators of success
1	Tackling the immediate risk factors for drug deaths	9	Drug Death Action Plan workgroup (DDAP), supported by work of the TDDRG and Tayside Overdose Prevention Group	Lead the implementation, evaluation and subsequent sustainable delivery of the Non-Fatal Overdose Pathway, including: <ul style="list-style-type: none"> - Design, run and evaluate the Test of Change; - Support the securing of resources to implement findings from the ToC; - Utilise learning from the ToC to review organisations' approach to non-fatal overdose and develop a partnership brief intervention model and associated staff training. 	Chair of the DDAP workgroup/ Lead Pharmacist	May 2020	All NFODs in Dundee are responded to within 72 hours.
				Commission the design and delivery of a behaviour change intervention to prevent further overdose using a health psychology model	Sexual Health & BBV MCN / ADP	Summer 2021	There is a defined early trends monitoring system in place, which provides an initial response within 72 hours.
				Establishing and evaluate an Early Trends Monitoring system to co-ordinate and support the delivery of proactive and reactive harm reduction messages of emerging drug death trends	Public Health Consultant/ Chief Inspector Communities/ Tayside OD prevention group/DDAP group	December 2020	Relevant and proportionate information is shared to keep individuals safe.
				Explore the development of a Risk-Assessment tool for multi-agency use to guide the response to supporting people affected by drug use.	Chair of DDAP Workgroup	March 2020	There is optimal cover of the Take-Home Naloxone programme to keep individuals safe.
							Reduction in the number of overdoses.

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Key Priority		Relevant Commission Recomm.	Responsible for Actions Planning	Specific Actions – for completion by workgroups	Lead Role/ Group	Target for completion	Outcomes / Indicators of success
				Extend the Take-Home Naloxone Programme to provide optimal coverage and ensure front-line staff, individuals / families and friends are able to access the training to ensure participation in the programme.	Naloxone Lead (Access Directorate NHS Tayside)/ H&SCP	By April 2020	
2	Urgently increase the capacity and capability of specialist services to support access, quality and safety.	9	Whole System of Care workgroup/ H&SCP/ ASP Committee/ Mental Health SPG	<p>Evaluate direct access clinic model to determine future capacity requirements and options in line with the development of a pathway</p> <ul style="list-style-type: none"> Agree the business case for bridging resources to increase capacity of treatment services to manage current and predicted levels of demand for treatment and ensure a response case management model of support; Work with partners to identify a different name to ISMS Review and test options for same day prescribing; Implement models to support quick access to treatment options. <p>Increase the level of non-medical prescribing through recruitment and training opportunities</p>	<p>Whole System of Care workgroup</p> <p>ADP</p> <p>H&SCP/ Consultant Psychiatrist</p> <p>H&SCP Head of Service</p>	<p>June 2020</p> <p>End January 2020</p> <p>March 2020</p> <p>January 2022</p>	<p>There is an increase in the number of people (in line with estimated prevalence) accessing support and treatment.</p> <p>The option of same day prescribing is available to all the individuals assessed to benefit from it.</p> <p>There is a reduction in the waiting times for access to OST and improve retention of people in treatment.</p> <p>There is improved progression of individuals through support and recovery pathways.</p>

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3	Improve retention in treatment and recovery services	9	Whole System of Care workgroup (under discussion)	<ul style="list-style-type: none"> Pilot assertive outreach model within ISMS to support those at risk withdrawing from support Pilot assertive outreach models within the community delivered by third sector services 	H&SCP Head of Service	June 2020	The number of people discharged from services in an unplanned way is reduced to a minimum.
			H&SCP	Embed a range of service provision (statutory and third sector services) in key sites across Dundee with the aim of supporting people to continue to expand substance misuse services providing support within various community locations across Dundee	Whole System of Care workgroup	June 2020	There is an increase in treatment and support options available to individuals and uptake of these options.
				<ul style="list-style-type: none"> Expand the Housing First Model, including additional support for vulnerable women. As part of the review of temporary accommodation consider the need for women-only accommodation options. 	Whole System of Care workgroup	June 2020	Individuals are better supported to maintain engagement and progress with their recovery.
				<ul style="list-style-type: none"> Progress the on-going development of a Peer-Support Framework and support the implementation of the Framework; Develop a whole-system Advocacy Framework and commission supports for the Framework 	Whole System of Care workgroup	October 2020	
				Work in partnership with the Harm Reduction Nursing Team to develop referral pathways and shared care models	Whole System of Care workgroup / SHBBV MCN	June 2021	
				Develop a commissioning framework to support access to residential rehabilitation options	Whole System of Care workgroup	April 2020	
			Tayside/Fife Throughcare	In partnership review and update the Tayside “Pathways” for people leaving prison custody to ensure there is a clear	Chair of the Throughcare Network	September 2020	People leaving prison custody with an identified need have a recovery service access point in the community

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Key Priority		Relevant Commission Recomm.	Responsible for Actions Planning	Specific Actions – for completion by workgroups	Lead Role/ Group	Target for completion	Outcomes / Indicators of success
			Network Group	route to access community based recovery services for those who have an identified need	reporting through the ADP		
4	Implement a revised person centred, seamless, sustainable and comprehensive model of care	7,8,10,11,13	Whole System of Care workgroup/ HSCP	Map and development and co-produce an agree pathway for people who use substances which supports a recovery model, built on integrated service delivery based within local communities, that provides access to a range of treatment and support options	Whole System of Care workgroup	December 2020	Individuals and families in Dundee affected by substance use have easy access to services within their localities.
				Redesign service pathways, functions and delivery models in line with agreed pathway and commission services to implement the model	Whole System of Care workgroup	December 2020	There is access to high quality shared care model for people experiencing mental health issues who use substances.
				Agree a model of shared care within general practice <ul style="list-style-type: none"> - Test out model of shared care within the three 2c practices - Evaluate and consider how the model can be delivered within communities and/or near where people live 	H&SCP Head of Service	December 2020	Dundee has in place a whole-system model of care, including statutory and 3 rd sector organisations and based on a locality model (including the 3 community hubs).
				Improve access to Mental Health Services <ul style="list-style-type: none"> - Review and develop protocols for referral and access to service - In line with decision of Scottish Government funding decisions, review options to develop service which have an integrated response for 	Whole System of Care workgroup	June 2020	

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				people with mental health issues who use substances			
				Implement the recommendations from the Independent Evaluation of the 3 Community Hubs	Whole System of Care workgroup/ Resilient Communities	December 2020	
		Conduct a comprehensive Independent Needs Assessment	NHS Tayside Public Health Directorate	Consult and agree on an initial HNA scoping document	Director of NHS Tayside Public Health	End December 2019	Robust and up to date information is available to direct planning, improvement and commissioning decisions.
				<ul style="list-style-type: none"> Agree collaborative commissioning model with national colleagues for timely delivery of a HNA for consideration by the Partnership. This proposal will contain timescales and resource requirements including consideration of how to undertake qualitative elements of the HNA Undertake qualitative work to understand why people are disengaging from care. 	Director of NHS Tayside Public Health	End January 2020	
5	Win the trust and confidence of all stakeholders through effective Leadership, Governance and Accountability	1,4,6	ADP / Chief Officers Steering Group	<ul style="list-style-type: none"> Implement and support the new Governance of the ADP; ensuring explicit lines of accountability and actions are clear and measurable; and Complete and implement the revision of structural arrangements for the governance of Multi-Agency Public Protection strategic groups and ensure the ADP transitions effectively into the new PP governance arrangements 	ADP Chair / ADP H&SCP Senior Manager, Strategy & Performance/ COG	February 2020 April 2020	Effective governance arrangements are in place to lead on and progress efforts to protect vulnerable individuals and families in Dundee.

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				<ul style="list-style-type: none">Revise the role of the Independent Chairs to establish a shared expectation of their contribution to leadership, governance and accountability;Establish a strategic risk register for the COG to guide focus of work and to support accountability arrangements for the Protecting People structure; andImplement a Risk Assessment framework specifically focused on the ADP	H&SCP Senior Manager, Strategy & Performance/ COG ADP Implementation Group	March 2020	Chief and Senior Officers are aware of and respond to risks in a joint-approach. The ADP has robust and up to date information to inform its decisions.
				Negotiate and implement an initial Key Performance Indicators (KPI) framework that provides up-to-date insight into the performance of all key services in both the statutory and third sector.	ADP Implementation Group	March 2020	Leaders in Dundee are supported to make informed decisions and exercise robust scrutiny.
				Work to enhance the knowledge, understanding and engagement of all Elected Members around the underlying causes of substance misuse issues.	Protecting People Team	December 2020	
				With support from Scottish Government, adopt the <i>Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs</i> (focus specifically on section 10 of the Framework)	Dundee ADP/ Scottish Government	April 2020	
				Participation in Scottish Trauma Informed Leaders Training and proposed pilot activity	See details in Priority 9 below.		
6	Ensure the meaningful involvement & engagement of people who experience	5	Resilient Communities workgroup	The actions within Key Priority 6 will be informed by the work on Trauma-Informed Leadership pilot, specifically the lived experience element (see Key Priority 9 below)			Increase in recruited volunteers. People with lived experience are actively participating in all
				Expand the recruitment of volunteers to support recovery and tackle stigma within communities, incorporating a volunteer training programme	Chief Executive DVVA/ Lead Officer to the	December 2020	

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	problems with drugs, families and carers and those that advocate for them				Peer Recovery Network		aspects of the implementation of this plan.
				Establish a Lived Experience Quality group to ensure that involvement of people with lived experience is embedded effectively and meaningfully across the ADP structure and the wider delivery of support.	Chief Executive DVVA / Peer Support Co-ordinator/ ADP Implementation Group and all Workgroups	March 2020	The work of all ADP Workgroups is informed by and engages with individuals with lived experience.
				Support the delivery of two development sessions, each year to bring together people who use supports, families and service providers to share information and test out progress.	ADP Implementation Group	December 2020 and annually	
7	Confront and address stigma and strengthen mutual and community support	2,3	Resilient Communities workgroup / Fairness Commission	Further develop and expand delivery of awareness workshops to local community groups and services within every locality to raise awareness of how stigma impacts on individuals’ health and wellbeing.	Community Health Team; DVVA	December 2020	Individuals and family affected by substance use are treated in a professional and respectful manner.
				Promote and increase uptake of the Recovery Friendly Dundee pledge across organisations, businesses and community groups	Community Health Team	December 2019	There is a city-wide support for recovery and a reduction in stigma from local communities.
				Implement a <i>Language Matters</i> campaign to challenge use of stigmatising language.	Senior Health Promotion Officer/ DVVA/ Community Planning Manager/ Fairness Commission	June 2020	Individuals in recovery are active and contribute to their communities.

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Key Priority		Relevant Commission Recomm.	Responsible for Actions Planning	Specific Actions – for completion by workgroups	Lead Role/ Group	Target for completion	Outcomes / Indicators of success
				Promote the range of community groups and opportunities which contribute towards positive health and wellbeing and wider Local Community Planning Partnership priorities, supporting involvement of local communities, including people with lived experience of substance use.	Communities Officers via LCPPs/ DVVA	By October 2020	
				Work in partnership with the Sexual Health and BBV Managed Care Network to reduce stigma associated with Hepatitis and HIV	Resilient Communities workgroup / SHBBV MCN	December 2020	
8	Keep children safe from substance use and its consequences	16	Children and Families Workgroup/ Child Protection Committee/ C&Fs service	Three new non-medical prescribing trainee nurses will be placed within Children & Families Teams (one at the East locality, one at the West and one with the Intake Team). Support the 3 nurses to complete their NMP qualification	Service Manager (Acting) C&Fs Service/ Service Manager ISMS	January 2020 January 2021	Parents who are affected by substance use receive fast access to treatment and are supported to maintain engagement.
				Progress work with 3 rd sector organisations (including Aberlour, children 1 st and TCA) to establish and agree their role in delivering Tier 2 support to families (and ensure the children are supported) earlier on and throughout the recovery process.	Service Manager (Acting) C&Fs Service/ Service Manager ISMS/ 3 rd sector	April 2020	Children & families are safer and better supported.
				Hold 4 joint development sessions for front-line staff within ISMS, C&Fs Teams and key 3 rd sector organisations to progress and facilitate the interface and joint working between C&Fs and Adult services, and encourage a focus on the whole family.	Service Manager (Acting) C&Fs Service/ Service Manager ISMS/ Senior Advisor Learning and OD Development	December 2020	There is a whole-family multi-agency model of care in place to ensure vulnerable children at significant risk are safe. There is active participation from the substance use workforce in child care and protection processes.

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Key Priority	Relevant Commission Recomm.	Responsible for Actions Planning	Specific Actions – for completion by workgroups	Lead Role/ Group	Target for completion	Outcomes / Indicators of success
			ISMS will work closely in partnership with the Children & Families Service to identify a process which will support the increased attendance of staff at CP conferences and the provision of relevant information to support the decision-making at conferences	H&SCP Head of Service/ Service Manager (Acting) C&Fs Service/ Service Manager ISMS	December 2020	There is improved recognition, awareness and response within substance use services to women, children and young people experiencing gender-based violence.
			Increased meaningful contribution at CP conferences, through attendance of staff and other appropriate mechanisms, to address significant risk currently noted on Datix Risk Register.	H&SCP Head of Service/ Service Managers ISMS/ PP Lead Officer Child Protection	February 2020	
			Develop a continuum of services (following on from the New Beginning Service) for vulnerable women (those with multiple and complex needs), and broaden the range of gendered services that provide intensive and tailored programmes to address their needs	Gendered Services Group	April 2020	
			We will continue embedding the Safe and Together and MARAC approaches in Dundee with a specific focus on embedding this approach within substance use services.	Lead Officer VAW/ Service Manager (Acting) C&Fs Service/ H&SCP Head of Service	December 2020	
			Through the Transforming Public Protection work: <ul style="list-style-type: none"> strengthen and evaluate the focus on chronologies and risk assessment and roll out to all practice teams; Revise early screening arrangements for people of all ages to facilitate whole family approaches to risk assessment and risk-management. 	Protecting People Lead Officers H&SCP Head of Service / C&F Head of Service	December 2020	

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9	Implement trauma informed approaches, targeting those at increased risk of substance use / and death	13	Protecting People Team/L&OD team, local Transforming Psychological Trauma Implementation Coordinator (TPTIC)	The Trauma Training steering group will complete a needs assessment for frontline workers (in line with the National Trauma Training Framework and Plan), including: <ul style="list-style-type: none">• a mapping of the workforce• an assessment of their training needs in relation to trauma-informed work; and• Identifying the key gaps and priorities for training. <p>This will link to the NHS Tayside Trauma Training Strategy currently being implemented with a strong focus on trauma training.</p>	Lead Officer VAW/ TPTIC Consultant Clinical Psychologist L&OD Manager	March 2020	Key workforce groups are trauma informed Our leaders and organisations are trauma informed. Services are delivered through trauma informed environments and practice
				Trauma training at levels 1, 2 and 3 will be delivered by the TPTIC in conjunction with L&OD team and the local level 3 trainer. A review of the Protecting People training framework will incorporate trauma training at all levels.	As above	March 2021	
				Trauma-Informed Leadership – Dundee has been invited to apply for funding from the Scottish Government/NHS Education Scotland to pilot a trauma informed leadership test of change in Dundee, building on the TPP Leadership strand. This includes utilising Trauma Lived-Experience of the workforce.	As above	March 2021 (dependent on outcome of funding bid)	
10	Tackle the root causes of substance use	12,14	Prevention Workgroup	The work on prevention will be informed by the Comprehensive Health Needs Assessment that will take place during 2020	As in Key Priority 4 above	As in Key Priority 4 above	Robust information and up to date is available to inform the development of prevention interventions. There is a streamlined, coherent and co-
				Undertake a Prevention Scoping Exercise to establish the activities currently taking place at environment, community and individual levels (targeting issues including sexual health and gendered-based issues, mental health and	Prevention Subgroup (PP Team & H&SCP)	December 2020	

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			trauma, and substance use) with the aim of developing a consistent, coherent and joint approach in Dundee, and identifying gaps	Contracts to organise)		ordinated approach to prevention in Dundee, focused on the root causes of substance use.
			Work with the Children & Families Service (Education) to support the implementation of the Dundee Substance Misuse Curriculum Framework in schools and relevant community settings.	Public Health Naloxone Lead/ Senior Health Promotion Officer	April 2020	Prevention intervention in Dundee are in line with evidence of good and effective practice.
			Development of a Recovery Friendly Pledge for schools	Education Support Officer Health & Wellbeing/ Community Health Team Lead	December 2020	Best use is made of prevention material and key prevention messages that are developed nationally.
			Support greater engagement with Emotional Health and Wellbeing for children and young people – A toolkit for all staff.	Health and Wellbeing Strategy and Action Group/ Sarah Anderson	June 2020	
			Continued development of Mentors in Violence Prevention programme.	Education Support Officer Health & Wellbeing	To be identified	
			Development of Community Mental Health and Wellbeing model.	Children Services Manager	March 2021	
			Introduction of access to Counselling in schools – aged ten years and up.			

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				Organise one annual meeting for a multi-agency Dundee-wide (this be a Tayside Forum) Prevention Forum to review progress, discuss evidence and agree priorities.	Prevention workgroup	November 2020	
				Support and learn from the Youth in Iceland Model research project currently taking place in Dundee.	Senior Health Promotion Officer/ Chief Inspector Communities	September 2020	
				Promote the National Count 14 Prevention Campaign in Dundee and ensure the campaign’s messages around safe and responsible consumption of alcohol are widespread.	Senior Health Promotion Officer	September 2020	
				Link to the local implementation of the new partnership between Scottish Association of Mental Health and Sportscotland to support mental health in young people.	Education Support Officer Health & Wellbeing/ Active-Schools manager	March 2020	
11	Ensure Gendered Approaches are considered in all activities and accommodated in design and delivery of services	15	All ADP workgroups/ VAW Partnership’s Gendered Services Working Group (GSWG)	The Dundee Violence Against Women Partnership (VAWP) will ensure information about existing women’s services, including the services on offer and how to access them, is widely available and continuously updated.	Gender Services Working Group	March 2020	Communities/ individuals and service providers are well informed about available support for women, children and young people experiencing gender-based violence. All services and supports to vulnerable individuals
				The learning & recommendations from the research project (conducted by Dundee University/ funded by the Challenge Fund) on the specific needs of vulnerable women will be implemented across all the Protecting People services.	PP Lead Officer VAW/ CEO Women’s Aid	June 2020	
				Specific training on appropriate Gendered-Responses will be develop and delivered to all mainstream services.	VAWP Training Consortium/	December 2020	

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					L&OD service/ Dundee Uni		are gendered-informed and appropriate.
				The learning & recommendations from the project (conducted by SHBBV MCN) on the needs of vulnerable women in relation to sexual and reproductive health will be implemented across all the Protecting People services.	Lead Officer VAW / Health Psychologist - SHBBV MCN	December 2021	Children & Families affected by gender-based violence and substance use are safe
				Lead on the development of pathways for women with complex needs including substance misuse. Identify and implement ways to streamline and integrate to make better use of available resources, and seek to attract additional resources to develop collaborative responses.	Gendered Services Group (VAWP)	December 2020	Vulnerable women can have easy access to and maintain engagement with services
12	Ensure clear and consistent communications are delivered through a partnership approach.	All	Protecting People Cross-Cutting Communications Subgroup	Implement a strategic Protecting People (PP) Cross-Cutting Communications strategy (workforce and public) to deliver communication messages around all PP areas, including substance use.	DCC Service Manager, Communications	April 2020	Coherent, up-to-date and accurate shared messages are communicated.
				Develop a coherent multi-agency/multi-service communication protocol to ensure all planned and reactive communication messages follow due process and all individuals are clear about their role.	DCC Service Manager, Communications	February 2020	Communities and the workforce are well informed of agreed plans and approaches.
				Establish a framework to ensure the communications messages are fully informed and up to date at all times, reflecting progress across the Partnership action plan.	ADP/ DCC Service Manager, Communications	May 2020	

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - ATTENDANCES - JANUARY 2019 TO DECEMBER 2019

Organisation	Member	Meeting Dates January 2019 to December 2019						
		26/2	29/3	23/4	25/6	27/8	29/10	17/12
Dundee City Council (Elected Member)	Cllr Ken Lynn	√	√	√	√	√	√	
Dundee City Council (Elected Member)	Cllr Roisin Smith	√	√	√	√	√	√	
Dundee City Council (Elected Member)	Bailie Helen Wright	√	√	√	√	√	√	
NHS Tayside (Non Executive Member)	Trudy McLeay	√	√	√	√	√	√	
NHS Tayside (Non Executive Member)	Jenny Alexander	A	√	A	√	√	A	
NHS Tayside (Non Executive Member)	Dr Norman Pratt	√	√					
NHS Tayside (Non Executive Member)	Professor Nic Beech			A	A	√	√	
Dundee City Council (Chief Social Work Officer)	Jane Martin	√	√	√	√			
Dundee City Council (Chief Social Work Officer)	Diane McCulloch					√	√	
Chief Officer	David W Lynch	√	√	√	√	√	√	
Chief Finance Officer	Dave Berry	√	√	√	√	√	√	
NHS Tayside (Registered Medical Practitioner (whose name is included in the list of primary medical performers))	Dr Frank Weber	A	A	A	A	A	A	
NHS Tayside (Registered Nurse)	Sarah Dickie	√	√	A	√			
NHS Tayside (Registered Nurse)	Kathryn Brechin					√	√	
NHS Tayside (Registered Medical Practitioner (not providing primary medical services))	Dr Cesar Rodriguez	√	√					
NHS Tayside (Registered Medical Practitioner (not providing primary medical services))	Dr James Cotton			A	√	√	A	
Trade Union Representative	Jim McFarlane	√	A	√	√	√	√	
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	√	√	√	√	√	A	
Voluntary Sector Representative	Christine Lowden	√	√	√	√	√		
Voluntary Sector Representative	Eric Knox						√	
Service User Representative	Linda Gray	√	√	√	√	√	√	
Carer Representative	Martyn Sloan	√	√	√	A	A	√	
NHS Tayside (Director of Public Health)	Dr Drew Walker	√	A	√	√	√	√	

- ✓ Attended
 A Submitted Apologies
 A/S Submitted Apologies and was Substituted
 No Longer a Member and has been replaced / Was not a Member at the Time

