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

City Chambers
DUNDEE
DD1 3BY

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

23rd August, 2021

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I refer to the agenda of business issued in relation to the meeting of the above Integration Joint Board which is to be held remotely on Wednesday, 25th August 2021 at 10.00 am and now enclose the undernoted report which should be read as a replacement for the version issued.

Yours faithfully

VICKY IRONS

Chief Officer

11 ANGUS AND DUNDEE STROKE REHABILITATION PATHWAY REVISION - Page 1

(Report No DIJB44-2021 by Chief Officer, copy attached).

ITEM No …11…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **ANGUS AND DUNDEE STROKE REHABILITATION PATHWAY REVIEW**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB44-2021**

1.0 PURPOSE OF REPORT

1.1 To report on the outcomes of the review of hyperacute and acute stroke care pathway as part of the Angus and Dundee Health and Social Care Partnerships respective redesign programmes.

2.0 RECOMMENDATIONS

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

2.1 Note the work to date to progress the development of stroke rehabilitation pathway review.

2.2 Support and approve the preferred model of care.

2.3 Request a detailed implementation plan is brought back to Dundee Integration Joint Board.

2.4 Remit the Chief Officer to issue Direction to NHS Tayside as indicated at section 13.1 of the report

3.0 FINANCIAL IMPLICATIONS

3.1 Whilst finance was not part of the option assessment scoring criteria as described in 5.2, subsequent financial due diligence has been undertaken against each of the short listed options. The revenue cost of the preferred option 1 is c£3.7m and will release c£0.4m revenue resource. This option does not require any capital investment as the existing accommodation has sufficient space to support a 30 bed unit. The revenue cost of option 2 is c£3.9m and will release c£0.2m revenue resource. The increase in cost reflects the additional medical workforce required to provide safe patient care along with additional running costs associated with a new unit. In addition there will be c£11m capital investment required for a new unit. Lastly the revenue cost of option 3 is c £3.8m and will release c£0.3m revenue resource. The increase in cost from option 1 reflects the additional running costs associated with a new unit. Furthermore there is an additional c£11m capital investment required for a new unit.

3.2 It should be noted any request for capital funding requires to abide by the Capital approvals process and in the case for Options 2 and 3 the Scottish Capital Investment Manual (SCIM) guidance would require to be followed with delegated authority from the Capital Investment Group (CIG) at Scottish Government.

3.3 In summary the outcome from the financial assessment demonstrates the preferred option 1 as the most economically viable option and will result in an annual total net reduction of c£0.4m across both partnerships. This reduction can only be delivered through collaborative working with Angus HSCP and is interdependent on both IJBs supporting the preferred model.

4.0 MAIN TEXT

4.1 Hyperacute and acute stroke care pathways in Tayside were reviewed and reorganised in 2019 and are delivering improved acute care for people who have had a stroke, including delivery of thrombolysis ('clot busting') and thrombectomy ('clot removal').

There is now a need to review the stroke rehabilitation pathways to make sure that people who have had a stroke receive modern, evidence based and high quality rehabilitation in order to maximise their chance of making the best recovery possible.

4.2 There is strong research evidence to show that stroke survivors with mild-to-moderate disability benefit from receiving specialist stroke rehabilitation at home or in a community outpatient setting. This can reduce the length of stay in hospital and improve long-term functional outcomes for patient with mild-to-moderate stroke.

4.3 This review focuses on how stroke rehabilitation is provided to people who have traditionally received their stroke rehabilitation in an in-patient facility in either the Stracathro or Royal Victoria Hospital (RVH) Stroke Rehabilitation Units (for people aged 65 years and over) or in the Tayside Centre for Brain Injury Rehabilitation Unit (specialist in under 65 stroke rehabilitation.

4.4 The aim of this review is to ensure we deliver person-centred specialist stroke rehabilitation and ongoing support provided by our specialist clinical staff supported by third sector partners rather than a service centred approach, providing the ability to reinvest specialist stroke services in the community. Within the new pathway it is proposed this care will be delivered at home where clinically possible.

4.5 A multi professional group was formed to review the current rehabilitation pathway and consider options for an improved community stroke rehabilitation pathway that would be offered to residents of Dundee and Angus admitted to Ninewells following an acute stroke. Representatives from staff side, Tayside Stroke Managed Clinical Network and the Stroke Association also formed part of the group.

The group considered the following stroke rehabilitation components to determine the pathway options:

- National stroke rehabilitation guidelines
- Evidence-based practice
- Patient and carer feedback
- Staff feedback
- Third sector partners

4.6 A progressive stroke rehabilitation framework was also developed which incorporated best practice rehabilitation care to ensure best outcomes for patients receiving stroke rehabilitation care. Patient and staff feedback obtained through various engagement and feedback sessions was also an important consideration.

The most important factors identified throughout the review were:

- Workforce availability
- Length of hospital stay
- Community-based stroke rehabilitation at an appropriate intensity and beginning soon after discharge from hospital
- Specialist stroke rehabilitation staff across the rehabilitation journey including the community setting
- Access to the appropriate care and support for patients and carers across the pathway.

Stroke rehabilitation services must be resilient, equitable and sustainable for the future.

5.0 CURRENT POSITION

5.1 It is not possible to provide specialist inpatient stroke rehabilitation within two separate units and provide the level of home-based specialist rehabilitation that clinical standards recommend. As a result there are a number of people currently receiving inpatient stroke rehabilitation who could be receiving this support at home if the resources were realigned

An options appraisal was undertaken by members of the multi professional project group, with six options identified. Members of the group were invited to independently review and score each option before a collective discussion.

5.2 Scoring was based on the following criteria:

- **Person centred care:** Services are personalised with a programme of care that is aligned to person's needs and choices, provided at home when clinically safe and appropriate.
- **Quality and quantity of rehabilitation**: Provision of evidence based, specialist stroke care at an intensity appropriate to the person's needs, in keeping with recommended levels of rehabilitation, focussing on the best possible outcomes and recovery with smooth transitions of care across the whole patient journey.
- **Workforce**: Right professional with the right skills at the right time in the right place. Availability of a flexible workforce with specialist stroke skills and training.
- **Safety**: Care is delivered in a safe and effective way within an appropriate environment where risks are assessed and managed safely.
- **Accessibility**: People recovering from stroke, and their carers will have access to a care pathway, information and support they need to live a fulfilled life. This will be delivered in a flexible and person centred manner supported by third sector partners.
- **Environment:** The environment is suitable to accommodate specialist stroke rehabilitation considering estates and buildings and is sustainable for the future (5years +).

5.3 The long list of options considered were:

1. RVH and Stracathro stroke rehabilitation with limited home based rehabilitation (status quo)
2. Home based rehabilitation with inpatient rehabilitation in RVH
3. Home based rehabilitation with inpatient rehabilitation in Stracathro
4. Home based rehabilitation with inpatient rehabilitation in Ninewells Hospital
5. Home based rehabilitation with inpatient rehabilitation (non-stroke specialist) in community hospitals
6. Home based rehabilitation with no inpatient rehabilitation.

Following the scoring process a short list of options was agreed and are detailed below:-

1. Home based rehabilitation with inpatient rehabilitation in Royal Victoria hospital
2. Home based rehabilitation with inpatient rehabilitation in Stracathro
3. Home based rehabilitation with inpatient rehabilitation in Ninewells Hospital.

Thereafter the multiprofessional group considered the options, taking into consideration the feedback from service users, carers and staff and the following preferred option was agreed upon:

- Home based rehabilitation with inpatient rehabilitation in Royal Victoria Hospital.

Based on all the information available it was agreed that RVH presents the best opportunity to provide the inpatient element required for stroke rehabilitation and the ability to reinvest in community based services. This is because RVH:

- already has a suitable environment to support the required number of beds without the need to significantly invest in other sites.

- is in close proximity to the acute stroke ward based in Ninewells Hospital which improves safety in the event of a patient's deteriorating medical condition. The close proximity to Ninewells also allows the specialist teams to work flexibly across acute and rehabilitation in response to fluctuating demand. This will also improve staff knowledge of the whole stroke pathway.

6.0 QUALITY/ PATIENT CARE

6.1 Providing non acute specialist stroke rehabilitation services on one site will ensure we can deliver safe, effective, high quality person-centred care. This will also ensure adequately staffed clinical teams which can offer specialist inpatient rehabilitation services over 7 days to enhance optimal recovery and earlier discharge from hospital. One unit will also mean that people who have a stroke, irrespective of age, will have equitable access to high quality stroke rehabilitation.

7.0 WORKFORCE

7.1 Current roles will be required to be reviewed and adapted to deliver a new model of care, however the benefits of having one in–patient stroke rehabilitation unit are:-

- the ability to staff it more efficiently and flexibly and develop expertise, which will create a more skilled unit.
- improve access to specialist stroke education, training and support.
- create a service which is attractive to newly graduated practitioners and potentially improve recruitment and retention of all staff.

It is important that adequate time is taken to plan and make any changes suitably, with minimum disruption to staff and patients. Further discussions will take place with health and social care staff, Third Sector partners and people with lived experience of stroke to prepare a detailed implementation plan following approval of the proposed new model of stroke rehabilitation.

The professional and personal experience and ideas our staff and stroke survivors will continue to be invaluable in shaping how services will be delivered. A number of suggestions have already been given by a variety of people and we are keen to get further ideas to help improve rehabilitation and support for stroke survivors and their families.

8.0 COMMUNICATIONS AND ENGAGEMENT

8.1 The Tayside Stroke Managed Clinical Network has already undertaken a considerable amount of work to engage with people with lived experience of stroke and with staff, in order to identify improvements to the stroke rehabilitation pathway. Feedback has identified priorities from patients, carers and staff. Examples of engagement include:

- Stroke Voices Group met with patients and carers to understand their rehabilitation experiences and preferences. A 'Working Together' Group has been set up to work in partnership with Third Sector partners, charities and patient groups including Stroke Association, Chest Heart and Stroke Scotland, Headway and Carers Centres.
- Participation in the national 'Programme for Government' review of Stroke rehabilitation
- Three engagement sessions were held for staff and 120 staff completed a staff stroke care survey.

Patients and carers told us that it was important to have timely access to appropriate rehabilitation to support their needs throughout their recovery and enable them to live their best life possible after their stroke. This was endorsed by staff.

8.2 As part of our responsibility regarding involvement and engagement, it was important that feedback was sought from people with lived experience of stoke, staff and members of the public about our proposal to redesign the Dundee and Angus stroke rehabilitation pathway. A range of engagement opportunities took place from 26 July – 12 August. These included:

- Public Engagement Events via MS Teams
- Joint Angus and Dundee IJB Event via MS Teams
- Staff Engagement Events via MS Teams
- Angus and Dundee HSCP Strategic Planning Groups

A press release was prepared and various social media and website postings invited people to become involved and provide feedback by joining one of the sessions and/or to complete a survey monkey questionnaire. Staff were also invited to complete a separate questionnaire. A frequently asked questions document has been produced based on questions received from staff, people with lived experience of stroke and members of the public. This is an evolving document. Further questions and answers will be added during the ongoing staff and public engagement activities.

8.3 In addition to the above the pathway review has been discussed and supported by the following forums/meetings:

- Frailty Strategic Planning Group (Dundee HSCP)
- NHS Tayside Operational Leadership Group
- Angus Clinical Partnership Group with representatives from GP Cluster Leads
- The Stroke Association in Scotland have been involved throughout this piece of work and involved in the development and appraisal of options. They also provided a statement of support for the proposed stroke rehabilitation pathway and highlighted the importance of the voice of lived experience as being vital in informing the delivery of services.

8.4 **Public Survey**

105 people responded to the public survey monkey

- 75% of those who responded shared where they lived with
  - o49% from the North East Locality,
  - o27% from the North West,
  - o7% from the South East Locality
  - o4% from the South West Locality.
  - oThe remainder of respondents were from Dundee or neighbouring areas.
- 55% respondents had lived experience of stroke.
  - o62%thought that early supported discharge would have a positive impact for someone with mild to moderate stroke.

38 staff responded to a survey

- 13 Allied Health Professionals
- 8 GPs
- 4 Hospital Doctors
- 13 Other professional

The main area of concern, from members of the public and staff, about all specialist inpatient stroke rehabilitation being provided in RVH, was around the perception of withdrawing in – patient services from Angus and the distance to travel, especially if people lived in more remote areas of Angus however were supportive of rehabilitation being provided at home.

9.0 PROPOSALS

9.1 It is proposed that the preferred option to develop home rehabilitation with one in patient facility at Royal Victoria Hospital is supported and approved by Dundee IJB.

9.2 Dundee and Angus HSCP will continue to work together to develop a fully costed implementation plan for the provision of home based rehabilitation with inpatient rehabilitation in Royal Victoria Hospital.

9.3 Further discussions will take place with health and social care staff, Third Sector partners and people with lived experience of stroke to prepare a detailed implementation plan. It will be important that we build upon our strong foundation of multidisciplinary team working, eliminating barriers to effective integrated working and develop pathways of care which improve patient outcomes.

10.0 EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment is required and is included in Appendix 1.

11.0 RISK ASSESSMENT

11.1 This is a mandatory field and an explanation must be provided which covers the fields below. Please fill in and copy this table for each individual risk identified.

Risk 1 Description	Workforce
Risk Category	High
Inherent Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Mitigating Actions (including timescales and resources)	There are existing workforce issues across the 2 sites, being mitigated by a pooling of available staff resource across both Angus and Dundee partnerships, as well as realignment of existing staff resource to maximise skills
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	Given the level of risk inherent in the existing structure, this is manageable

Risk 2 Description	Governance
Risk Category	low
Inherent Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Mitigating Actions (including timescales and resources)	Extensive negotiations and consultations with both staff and the public have taken place in preparation
Residual Risk Level	Likelihood 1 x Impact 2 = Risk Scoring 2
Planned Risk Level	Likelihood 1x Impact 1 = Risk Scoring 1
Approval recommendation	All mitigation has been progressed in preparation, therefore risk level is now regarded as low

12.0 CONSULTATIONS

12.1 The Chief (Finance) Officer and the Clerk were consulted in the preparation of this report.

13.0 DIRECTIONS

13.1 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: NHS Tayside	
	1. No Direction Required	
	2. Dundee City Council	
	3. NHS Tayside	X
	4. Dundee City Council and NHS Tayside	

14.0 BACKGROUND PAPERS

14.1 NONE

Vicky Irons
Chief Officer

DATE: 9th August 2021

DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

1	Reference	DIJB44-2021
2	Date Direction issued by Integration Joint Board	25 August 2021
3	Date from which direction takes effect	25 August 2021
4	Direction to:	NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Stroke Rehabilitation
7	Full text of direction	Dundee Integration Joint Board directs NHS Tayside to remodel the stroke rehabilitation pathway for Dundee and Angus patients in line with the agreed model of service detailed within this report
8	Budget allocated by Integration Joint Board to carry out direction	£3.7m
9	Performance monitoring arrangements	Through regular financial monitoring reports to Dundee Integration Joint Board.
10	Date direction will be reviewed	25 August 2022

Integrated Impact Assessment Report.

Committee Report No: DIJB44-2021

Document Title: Proposed redesign of Dundee and Angus Stroke Rehabilitation Pathway

Document Type: Policy

New/Existing: new

Period Covered: 29/05/2020 - 29/05/2023

Document Description:
IJB Paper

Intended Outcome:
Approval to proceed with proposed redesign of stroke pathway

How will the proposal be monitored?:
By lead officers through strategic redesign process

Author Responsible:

Name: Lynne Morman

Title: Associate Locality Manager

Department: Health and Social Care Partnership

E-Mail: lynne.morman@dundeecity.gov.uk

Telephone: 01382 660111

Address: Ninewells Hospital Dundee DD1 9SY

Director Responsible:

Name: Vicky Irons

Title: Chief Officer

Department: Health and Social Care Partnership

E-Mail: vicky.irons@dundeecity.gov.uk

Telephone: 01382 436310

Address: Dudhope Castle

A. Equality and Diversity Impacts:

Age:	positive
Disability:	positive
Gender Reassignment:	no impact
Marriage and Civil Partnership:	no impact
Pregnancy and Maternity:	no impact
Race/Ethnicity:	no impact
Religion or Belief:	no impact
Sex:	no impact
Sexual Orientation:	no impact

Equality and diversity Implications:

Positive impact in providing equitable service across Dundee and Angus for all age groups

Proposed Mitigating Actions:

n/a

Is the proposal subject to a full EQIA? : No

B. Fairness and Poverty Impacts:

Geography	
Strathmartine (Ardler, St Mary's and Kirkton):	no impact
Lochee(Lochee/Beechwood, Charleston and Menzieshill):	no impact
Coldside(Hilltown, Fairmuir and Coldside):	no impact
Maryfield(Stobswell and City Centre):	no impact
North East(Whitfield, Fintry and Mill O' Mains):	no impact
East End(Mid Craigie, Linlathen and Douglas):	
. **The Ferry:**	no impact
West End: no impact	
Household Group	
Lone Parent Families:	no impact
Greater Number of children and/or Young Children: no impact	
Pensioners - Single/Couple:	no impact
Single female households with children:	no impact
Unskilled workers or unemployed:	no impact
Serious and enduring mental health problems:	no impact
Homeless:	no impact
Drug and/or alcohol problems:	no impact
Offenders and Ex-offenders:	no impact
Looked after children and care leavers:	no impact
Carers:	no impact

Significant Impact	
Employment:	no impact
Education and Skills:	no impact
Benefit Advice/Income Maximisation:	no impact
Childcare:	no impact
Affordability and Accessibility of services:	no impact
Fairness and Poverty Implications:	
Positive impact	
Proposed Mitigating Actions:	
n/a	

C. Environmental Impacts

Climate Change

Mitigating greenhouse gases:

Adapting to the effects of climate change:

Resource Use	
Energy efficiency and consumption:	no impact
Prevention, reduction, re-use, recovery or recycling waste:	no impact
Sustainable Procurement:	no impact
Transport	
Accessible transport provision:	no impact
Sustainable modes of transport:	no impact
Natural Environment	
Air, land and water quality:	no impact
Biodiversity:	no impact
Open and green spaces:	no impact
Built Environment	
Built Heritage:	no impact
Housing:	no impact
Is the proposal subject to Strategic Environmental Assessment no	
No further action is required as it does not qualify as a Plan, Programme or Strategy as defined by the Environment Assessment (Scotland) Act 2005.	
Proposed Mitigating Actions:	
n/a	
Environmental Implications:	
n/a	

D. Corporate Risk Impacts

Corporate Risk Implications:
The risk implications associated with the subject matter of this report are 'business as normal' risks. The subject matter is routine and has happened many times before without significant loss. There is comfort that the risks inherent within the activity are either transferred to another party, shared equally and fairly between the Council and another party or are negligible.

Corporate Risk Mitigating Actions:
Risks shared equally between Angus and Dundee HSCPs, and constitute service improvement.

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

City Chambers
DUNDEE
DD1 3BY

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

(See Distribution List attached)

17th August, 2021

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 remotely on Wednesday, 25th August 2021 at 10.00 am.

Members of the Press or Public wishing to join the meeting should contact Committee Services on telephone (01382) 434228 or by email at committee.services@dundeecity.gov.uk by 12 noon on Monday, 23rd August, 2021.

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. Proxy Members are allowed.

Yours faithfully

VICKY IRONS

Chief Officer

A G E N D A

1 APOLOGIES/SUBSTITUTIONS

2 DECLARATION 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 23rd June, 2021 is submitted for approval, copy attached).

4 SUICIDE PREVENTION STRATEGIC UPDATE - Page 9

(Report No DIJB37-2021 by Chief Officer, copy attached).

5 CARERS INVESTMENT PLAN UPDATE - Page 19

(Report No DIJB38-2021 by Chief Finance Officer, copy attached).

6 REVISION OF DUNDEE HEALTH AND SOCIAL CARE INTEGRATION SCHEME (DIJB39-2021)

In December 2020 the Integration Joint Board was informed that NHS Tayside and Dundee City Council had completed the statutory review of the Dundee Health and Social Care Integration Scheme (required by section 44 of the Public Bodies (Joint Working) Scotland Act 2014) and had agreed that a revised scheme should be prepared (Article X of the minute of the meeting of the Dundee Integration Joint Board held on 15 December 2020 refers). The report provided to the IJB at that time set out the intended approach to the preparation of a revised scheme and committed to providing an update on progress no later than 31st March, 2021.

The work to progress the production of a revised scheme has progressed more slowly than had originally been intended. In part this was due to the second wave of the pandemic at the beginning of 2021. However, additional time was also taken to clarify, through the Tayside joint-Chief Executives Group, the scale and scope of the revision work in order that this could be progressed through a joint approach across all Tayside partners (corporate bodies and IJBs).

At the current time the following key areas of progress have been achieved:

- A Principal Officer from Angus Health and Social Care Partnership has been seconded to project manage the revision process.

- An Integration Project Group has been established with representation from each Council, NHS Tayside and each Health and Social Care Partnership across Tayside and has been meeting regularly since April 2021. The Chief Finance Officer and Service Manager, Strategy and Performance are representing the Dundee Health and Social Care Partnership on this group.

- A Project Initiation Document (PID) has been agreed through the Tayside joint-Chief Executives Group following consultation with IJB Chief Officers. This sets out how partners will work together to revise the schemes across Tayside including the aims of the project, drivers for change, project scope, roles and responsibilities of stakeholders, outline timescales, project reporting and risks to project delivery.

- The Principal Officer has undertaken a review of integration schemes in place across Scotland, with particular attention to the small number of schemes that have recently been revised following the completion of the statutory review in other Partnerships.

- The Principal Officer has begun the process of compiling discussion documents to support stakeholder engagement in the re-drafting of scheme text for sections of the scheme identified as priorities for revision through the Tayside joint-Chief Executive Group.

The Principal Officer leading the project will work with the Chief Finance Officer and Service Manager, Strategy and Performance to provide quarterly updates to IJB members through appropriate local reporting and communication routes (including further formal reports to the IJB where this is required at key points in the revision process). The target for full project completion, including submission to the Scottish Government for parliamentary approval of the revised scheme, remains March 2022.

The Integration Joint Board is asked to note the updated position.

7 DUNDEE PRIMARY CARE IMPROVEMENT PLAN UPDATE - Page 29

(Report No DIJB40-2021 by Chief Officer, copy attached).

8 MENTAL HEALTH AND WELLBEING STRATEGIC UPDATE - Page 57

(Report No DIJB41-2021 by Chief Officer, copy attached).

9 FINANCIAL MONITORING POSITION AS AT JUNE 2021 - Page 63

(Report No DIJB42-2021 by Chief Finance Officer, copy attached).

10 ALCOHOL AND DRUG PARTNERSHIP SELF- ASSESSMENT FINDINGS - Page 79

(Report No DIJB43-2021 by Chief Officer, copy attached).

11 ANGUS AND DUNDEE STROKE REHABILITATION PATHWAY REVISION - Page 173

(Report No DIJB44-2021 by Chief Officer, copy attached)

12 A NATIONAL CARE SERVICE FOR SCOTLAND-CONSULTATION (DIJB45-2021)

The Independent Review of Adult Social Care recommended the creation of a National Care Service, with Scottish Ministers being accountable for adult social care support. The First Minister set out a commitment to start formal consultation for the new National Care Service in the first 100 days of the Parliament with a view to introducing legislation in the first year of the Parliament. However, the Scottish Government's ambition is to go beyond that. This consultation therefore seeks views on creating a comprehensive community health and social care service that supports people of all ages. It is focused on exploring the suggestions for significant cultural and system change that will need to be supported by primary legislation, new law, and to ensure the governance and accountability across the system to deliver successfully for people.

The Scottish Government are proposing that the National Care Service will define the strategic direction and quality standards for community health and social care in Scotland. It will have local delivery boards which work with the NHS, local authorities, and the third and independent sectors to plan, commission and deliver the support and services that the people of Scotland require.

The proposals will also take forward recommendations of the Independent Review of Adult Social Care around:

- ensuring that care is person-centred and human rights based
- providing greater recognition and support for unpaid carers
- improving conditions for the workforce
- commissioning for public good, and
- more effective approaches to scrutiny and improvement of social care services.

The consultation is divided into the following themes:

- Improving care for people
- The scope of the National Care Service
- Community Health and Social Care Boards
- Commissioning of services
- Regulation
- Fair work and valuing the workforce

The Consultation will run from 9th August, 2021 until 18th October, 2021 and can be accessed here: A National Care Service for Scotland - Scottish Government - Citizen Space (consult.gov.scot).

Organisations are asked to promote the consultation widely within local networks and to support people with lived and living experience to engage with the consultation in a meaningful way.

13 MEETINGS OF THE INTEGRATION JOINT BOARD 2021 – ATTENDANCES - Page 187

(A copy of the Attendance Return DIJB46-2021 for meetings of the Integration Joint Board held to date over 2021 is attached for information and record purposes).

14 DATE OF NEXT MEETING

Wednesday 27th October, 2021 – 10.00am (Being held remotely).

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

Role	Recipient
VOTING MEMBERS	
Elected Member (Chair)	Councillor Ken Lynn
Non Executive Member (Vice Chair)	Trudy McLeay
Elected Member	Councillor Lynne Short
Elected Member	Bailie Helen Wright
Non Executive Member	Anne Buchanan
Non Executive Member	Donald McPherson
NON VOTING MEMBERS	
Chief Social Work Officer	Diane McCulloch
Chief Officer	Vicky Irons
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	Wendy Reid
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 Emma Fletcher
PROXY MEMBERS	
Proxy Member (NHS Appointment for Voting Member)	Dr Norman Pratt
Proxy Member (NHS Appointment for Voting Member)	Jenny Alexander
Proxy Member (DCC Appointment for Voting Members)	Depute Lord Provost Bill Campbell
Proxy Member (DCC Appointment for Voting Members)	Councillor Steven Rome
Proxy Member (DCC Appointment for Voting Member)	Councillor Margaret Richardson

(b) CONTACTS – FOR INFORMATION ONLY

Organisation	Recipient
NHS Tayside (Chief Executive)	Grant Archibald
NHS Tayside (Director of Finance)	Stuart Lyall
Dundee City Council (Chief Executive)	Greg Colgan
Dundee City Council (Executive Director of Corporate Services)	Robert Emmott
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Legal Manager)	Kenny McKaig
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty

Dundee City Council (Members' Support)	Sharron Wright
Dundee Health and Social Care Partnership (Secretary to Chief Officer and Chief Finance Officer)	Pauline Harris
Dundee Health and Social Care Partnership	Christine Jones
Dundee Health and Social Care Partnership	Kathryn Sharp
Dundee City Council (Communications rep)	Steven Bell
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Gillian Robertson
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Audit Manager)	Anne Marie Machan

Dundee Health & Social Care Partnership

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held remotely on 23rd June, 2021.

Present:-

Members	**Role**
Ken LYNN *(Chairperson)*	Nominated by Dundee City Council (Elected Member)
Trudy McLEAY *(Vice Chairperson)*	Nominated by Health Board (Non-Executive Member)
Lynne SHORT	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Donald McPHERSON	Nominated by Health Board (Non-Executive Member)
Anne BUCHANAN	Nominated by Health Board (Non-Executive Member)
Vicky IRONS	Chief Officer
Dave BERRY	Chief Finance Officer
Diane McCULLOCH	Chief Social Work Officer
Wendy REID	Registered Nurse
James COTTON	Registered medical practioner(not providing primary medical services)
Raymond MARSHALL	Staff Partnership Representative
Jim McFARLANE	Trade Union Representative
Linda GRAY	Service User Representative

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

Jenny HILL	Head of Health and Community Care
Kathryn SHARP	Strategy and Performance Service Manager
Tony GASKIN	Chief Internal Auditor
Anne Marie MACHAN	Audit Scotland Representative

Ken LYNN, Chairperson, in the Chair.

Prior to commencement of the business the Chief Officer took the opportunity to appraise the Integration Joint Board of the current position in relation to the ongoing health emergency and operational management of this which was noted.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:-

Members	**Role**
Martyn SLOAN	Person providing unpaid care in the area of the local authority
Emma FLETCHER	Director of Public Health

II DECLARATION OF INTEREST

There were no declarations of interest.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Integration Joint Board held on 21st April, 2021 was submitted and approved.

Following questions and answers the Integration Joint Board further agreed to note, that, in relation to Article II of the minute, the advice of the Chief Finance Officer in reply to Donald McPherson that the Partnership would now look to hold the development session on Risk Management in late August 2021.

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

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

Reference was made to Article III(a) of the minute of meeting of this Integration Joint Board held on 30th October, 2018, wherein it was noted that Jenny Alexander had been nominated by NHS Tayside to serve as a Voting Member on the Integration Joint Board.

It was reported that, at the meeting of the NHS Tayside Board held on 29th April, 2021, it was agreed that Anne Buchanan be nominated to be a member of the Integration Joint Board as replacement for Jenny Alexander in the capacity of Voting Member.

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

(b) MEMBERSHIP – NHS TAYSIDE APPOINTMENT – PROXY MEMBER

It was reported that, at the meeting of NHS Tayside Board held on 29th March, 2021, it was agreed that Jenny Alexander be appointed as a Proxy Member for the NHS Voting Members on the Integration Joint Board.

The Integration Joint Board agreed to note the position and that Jenny Alexander may attend as a Proxy Member for the NHS Tayside Voting Members on the Integration Joint Board.

V PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF PREVIOUS MEETING OF 26TH MAY, 2021

The minute of the previous meeting of the Performance and Audit Committee held on 26th May, 2021 was submitted and noted for information and record purposes.

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

Following questions and answers the Integration Joint Board further agreed:-

(i) to note, in relation to Article III of the minute, that the Chief Finance Officer advised that discussion had taken place with the Clerk on the establishment of an Action Tracker as an accompaniment to the minutes and this would be provided from the meeting in August 2021.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB36-2021 by Trudy McLeay, 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.

VI PREPARATION OF THE INTEGRATION JOINT BOARDS ANNUAL PERFORMANCE REPORT 2020/2021

There was submitted Agenda Note No DIJB27-2021 reporting that Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 stated that Integration Authorities must prepare an annual performance report for each reporting year. A performance report was described as a report which set out an assessment of performance by each Integration Authority in planning and carrying out its integration functions. The Public Bodies (Content of Performance Reports) (Scotland) Regulations 2014 set out the prescribed content of an annual report prepared by an Integration Authority in terms of Section 42 of the Act. There was a requirement for each Integration Authority to publish their annual performance report within four months of the end of the reporting year. The fifth annual report of the Dundee Health and Social Care Partnership (for 2020/2021) was therefore due for publication by 31st July 2021.

Since 2017 the Partnership had published a summary version of the annual performance report by 31st July following consultation with all Integration Joint Board members and formal approval of the content and format by the Chairperson, Vice-Chairperson and Clerk of the Integration Joint Board, Chief Officer, Chief Finance Officer and the Head of Service - Health and Community Care. The summary version had been developed to meet the requirements of the regulations, including information regarding progress against the National Health and Wellbeing Outcomes and information at Partnership and locality level in relation to financial planning and performance, best value and scrutiny / inspection. The Scottish Government had previously indicated that this approach was acceptable, as had the Clerk.

The Integration Joint Board agreed:-

(i) to note that, consistent with the approach agreed by the Integration Joint Board at its meeting held on 25th August, 2020 (Article VIII of the minute refers), it was not intended to utilise the provisions of the Coronavirus (Scotland) Act 2020 Schedule 6, Part 3 to delay publication of the annual performance report until a date after 31st July, 2021 but prior to 30th November, 2021; and

(ii) to note that, to support transparency and public scrutiny, a summary version would be published on or before the statutory deadline (31st July, 2021), with a full version submitted to the Integration Joint Board no later than 27th October, 2021 for approval and subsequent publication.

VII LEADERSHIP OF PUBLIC PROTECTION ARRANGEMENTS

There was submitted Report No DIJB28-2021 by the Chief Officer updating the Integration Joint Board regarding arrangements for leadership of the strategic public protection agenda by the Chief Officers (Public Protection) Strategic Group, including key developments over the last six months and future strategic ambitions.

The Integration Joint Board agreed:-

(i) to note the role of the Chief Officers (Public Protection) Strategic Group in providing leadership for the protection of children and adults at risk as outlined in section 4.2 of the report;

(ii) to note the work undertaken by the Chief Officers (Public Protection) Strategic Group over the last six months to enhance arrangements for public protection, including the response to the second wave of the COVID-19 pandemic as outlined in sections 4.3 and 4.5 of the report; and

(iii) to note the priorities for the Chief Officers (Public Protection) Strategic Group for the next six months as outlined in section 4.6 of the report.

Following questions and answers the Integration Joint Board further agreed:-

(iv) to note that training on Trauma Informed Leadership was being held as indicated by Anne Buchanan, and her request that this be extended to the membership of the Integration Joint Board;

(v) to note, following observation from Bailie Helen Wright in relation to rise in homelessness as outlined in the report, that the Strategy and Performance Service Manager would contact Housing and Communities Service Manager for further information on background to this and provide the membership with analysis of this;

(vi) to note, following enquiry from Trudy McLeay in relation to some Public Protection Bodies having Independent Chairs and not others such as Suicide Prevention and Humanitarianism, that the Chief Social Work Officer would provide information on Governance Arrangements in her next report to the Integration Joint Board on Suicide Prevention;

(vii) to note, following enquiry from Councillor Lynne Short in relation to current work being undertaken on Trauma and the impact on older people in the community that the Strategy and Performance Service Manager advised that studies were being done and that she would look to collate information from the Trauma Steering Group for possible update to the Integration Joint Board; and

(viii) to note the advice of the Chief Officer that the effect of trauma was being examined at a national level and the recognition that, separate to the impact on staff, there was an impact across the whole population, including older people and children making transition from school.

VIII STRATEGIC AND COMMISSIONING PLAN – COVID IMPACT AND STRATEGIC REVIEW

There was submitted Report No DIJB29-2021 by the Chief Officer updating the Integration Joint Board regarding progress made by the Strategic Planning Advisory Group to assess the impact of the second wave of the COVID-19 pandemic on the delivery of priorities and actions within the Strategic and Commissioning Plan 2019/2020 and considerations in relation to the timescale and approach to the statutory review of the Plan.

The Integration Joint Board agreed:-

(i) to note the contents of the report, including ongoing work led by the Strategic Planning Advisory Group, to assess the impact of the second wave of the COVID-19 pandemic on the delivery of the current strategic and commissioning plan and of a range of factors on the planned approach and timeline for the statutory review of the plan as outlined in section 4.6 of the report; and

(ii) to instruct the Chief Officer, on behalf of the Strategic Planning Advisory Group, to make detailed recommendations to the Integration Joint Board regarding the approach and timeline for completion of the statutory review of the strategic and commissioning plan no later than 27th October, 2021.

Following questions and answers the Integration Joint Board further agreed:-

(iii) to note, following enquiry from the Staff Partnership Representative on the Living Wage and the compliance of providers in this respect, the explanation from the Chief Finance Officer in relation to current tender process for commissioning work and that this included the provision of information on Fair Work practices and terms and conditions of employment of any prospective provider, and that the Strategy and Performance Services Manager would arrange for a companion document on this to be provided alongside the next report on Strategic Commissioning in October 2021;

(iv) to note, following the concerns of Trudy McLeay and Donald McPherson that, in terms of Care in the Community Provision, they had become aware that some providers only provided payment to staff for time spent in the persons home and not travel to those homes which would be undertaken in their own time, the assurance given by the Head of Health and Community Care that the Partnership would be looking at this in terms of Fair Work in future and that she would further arrange for a report to be submitted to the next meeting of the Integration Joint Board on this in consultation with the Staff Partnership Representative and the Trade Union Representative;

(v) to note the observation of Trudy McLeay that Care Workers should have advancement possibilities available to them in their work and that as, indicated by Bailie Helen Wright, the importance Care Workers had to their vulnerable clients; and

(vi) to note, as advised by Councillor Lynne Short, that there was currently a campaign in Dundee called “Make Dundee a Living Place” and that the Partnership may wish to get in touch with the Steering Group behind the Campaign;

IX DUNDEE INTEGRATION JOINT BOARD 2021/2022 BUDGET

Reference was made to Article IV of the minute of meeting of this Integration Joint Board held on 26th March 2021 wherein the 2021/2022 Delegated Budget was approved. There was submitted Agenda Note No DIJB30-2021 reporting that at the time the budget was set, there were two areas where further funding confirmation was required which resulted in the following recommendations being agreed to, namely:

- to instruct the Chief Finance Officer to report back to the Integration Joint Board following receipt of formal notification from Tayside NHS Board of the budget offer with associated recommendations including any implications of the finalisation of hosted services budgets and the Large Hospital Set Aside on the Integration Joint Boards net budget position and associated savings.

- to Instruct the Chief Finance Officer to report back to the Integration Joint Board on the implications to the Integration Joint Board's budget should the additional funding received by the Integration Joint Board to implement the national living wage policy vary from the anticipated cost.

NHS Tayside Board met to agree it’s Strategic Financial Plan 2021/2022 on 29th April 2021 and the Chief Finance Officer had received confirmation that the previous indicative uplift figures to the NHS delegated budget had been approved and were therefore regarded as final figures with the exception of a figure for the Large Hospital Set Aside which was yet to be determined. Therefore no amendment was required to the Integration Joint Board’s delegated budget at this stage.

The Scottish Government had now confirmed Dundee’s share of additional funding provided to meet in full the cost of implementing the living wage for all adult social care workers, including the national policy direction to increase the value of all eligible contractual arrangements by 2.2% in 2021/2022. This additional funding recognised a shortfall in the original national allocation of funding for implementation of the policy which the Integration Joint Board was offsetting through its savings plan in addition to an increased commitment of the policy through the national 2.2% contractual uplift. This had resulted in additional funding not budgeted for within the original Integration Joint Board’s Budget proposal of £906k, offset by an additional cost of the policy of £290k. This left net additional funding of £616k.

The Integration Joint Board agreed that the additional funding was utilised to reduce the Integration Joint Board’s required 2021/2022 savings programme as follows to ease financial pressure on services during the year and to support the remobilisation of services:-

Reduce Anticipated Staff Turnover Saving from £700k to £350k (reduction of £350k)
Reduce Discretionary Spend Saving from £300k to £175k (reduction of £125k)
Reduce Meals Service Saving from £93k to £52k (reduction of £41k)

Reduce Delayed Utilisation of Reinvestment Funding from £500k to £400k (reduction of £100k)
Total Reduced Savings: £616k.

X FINANCIAL MONITORING POSITION AS AT 31ST MARCH, 2021

There was submitted Report No DIJB31-2021 by the Chief Finance Officer providing an update of the year end financial monitoring position for delegated health and social care services for 2020/2021, including an overview of the costs and financial risks associated with Dundee Health and Social Care Partnership's response to the COVID-19 crisis.

The Integration Joint Board agreed:-

(i) to note the content of the report including the overall actual financial position for delegated services to the 2020/2021 financial year end as at 31st March, 2021, as outlined in Appendices 1, 2, 3 and 4 of the report;

(ii) to note the costs associated with Dundee Health and Social Care Partnership's response to the COVID-19 crisis as set out in section 4.5 of the report; and

(iii) to note the year end reserves position as set out in section 4.6 of the report.

Following questions and answers the Integration Joint Board further agreed:-

(iv) to note the request by Donald McPherson for information on Dundee City Council Older Peoples Services to be provided in the report to assist understanding and that the Chief Finance Officer would arrange for the report for submission to the August meeting to be more detailed so as to provide greater clarity and explanation in relation to figures mentioned;

(v) to note, following enquiry from Bailie Helen Wright in relation to prescribing, the explanation of the Chief Finance Officer in relation to the underspend and that prescribing costs were managed on a national basis and the propriety of the prescribing process in place in the interests of patient safety and that, in addition, he would take up Bailie Wright's question in relation to use of bubble pack medicines and the effect any change of a particular drug contained would have on the continued use of that pack with relevant officers and get back to her directly on the matter;

(vi) to note the observation of the Staff Partnership Representative in relation to savings in the Learning and Disability Service and his request for assurance that people were getting the service they required, and the explanation of the Chief Social Work Officer that this saving was more to do with the recruitment of staff and that she would provide him with more detail on this outwith the meeting; and

(vii) to note the view of Trudy McLeay that there could be more of a focus made on social prescribing to support the population.

XI UNAUDITED ANNUAL ACCOUNTS 2020/2021

There was submitted Report No DIJB32-2021 by the Chief Finance Officer presenting the Integration Joint Board's Unaudited Annual Statement of Accounts 2020/21.

The Integration Joint Board agreed:-

(i) to approve the content of the Unaudited Final Accounts Funding Variations as outlined in Appendix 1 of the report;

(ii) to approve the Draft Dundee Integration Joint Board Annual Corporate Governance Statement as outlined in Appendix 2 of the report;

(iii) to note the Integration Joint Board's Unaudited Annual Statement of Accounts 2020/21 as outlined in Appendix 3 of the report; and

(iv) to instruct the Chief Finance Officer to submit the Unaudited Accounts to the Integration Joint Board's external auditors (Audit Scotland) by the 30th June, 2021 to enable the audit process to commence.

Following questions and answers the Integration Joint Board further agreed:-

(v) to note the observation of Anne Buchanan that Dundee had the highest proportion of adults with learning disabilities in Scotland and the explanation, provided by Trudy McLeay, that her understanding was that this was recognition of the standard of support provided and people moving in to the area to take up that support;

(vi) to note, as advised by Trudy McLeay, that the vacancy on the Integration Joint Board for a Registered General Medical Practitioner whose name was on the list of primary medical performers may be filled in July 2021;

(vii) to note, as indicated by Trudy McLeay, the importance of attendance at meetings of the Integration Joint Board by medical professionals and, in particular, their contribution to decisions as the country was moving from the lockdown period and that the Chairperson, Councillor Ken Lynn would contact NHS Tayside with a view to securing more regular attendance at meetings;

(viii) to note, as indicated by the Service User Representative, that separate to her membership of the Integration Joint Board that she had been invited to attend a meeting of the Dental Executives Group in Dundee; and

(ix) to note, as indicated by the Chief Finance Officer that Page 71 of the report would be amended to reflect that Martyn Sloan who served on the Integration Joint Board as the "Person proving unpaid care in the area of the local authority" was not a representative from Dundee Carers Centre.

XII ANNUAL INTERNAL AUDIT REPORT 2020/2021

There was submitted Report No DIJB33-2021 by the Chief Finance Officer advising of the outcome of the Chief Internal Auditor's Report on the Integration Joint Board's internal control framework for the financial year 2020/2021.

The Integration Joint Board agreed:-

(i) to note the content and findings of the Annual Internal Audit Report 2020/2021 as outlined in Appendix 1 of the report; and

(ii) to instruct the Chief Finance Officer to incorporate the recommendations of the Annual Internal Audit Report into the Integration Joint Board's Governance Action Plan, presented to and monitored by the Performance and Audit Committee.

Following questions and answers the Integration Joint Board agreed:-

(iii) to note, following enquiry from Bailie Helen Wright the explanation of the Chief Internal Auditor as to what was meant by "weaknesses"; and

(iv) to note the observation of Donald McPherson for the opportunity for a common approach to deal with matters and any other areas along the same approach as that undertaken for Risk Management across a Tayside perspective.

XIII STANDING ORDERS – AMENDMENT

There was submitted Agenda Note No DIJB35-2021 reporting that as meetings of the Integration Joint Board and the Performance and Audit Committee were now being held at 10.00 am, it was recommended that the Integration Joint Board agreed that the Clerk be remitted to make amendment to the Standing Orders accordingly and that Section 15.1 relative to Procedure for Motions and Amendments be amended to reflect that all motions and amendments should be submitted in writing to the Clerk to the Integration Joint Board on or before 12 noon on the day before the meeting.

The Integration Joint Board agreed that the Standing Orders be amended as indicated.

XIV MEETINGS OF THE INTEGRATION JOINT BOARD 2021 – ATTENDANCES

There was submitted a copy of the attendance return Report No DIJB34-2021 for meetings of the Integration Joint Board held to date over 2021.

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

XV DATE OF NEXT MEETING

The Integration Joint Board agreed to note that the next meeting of the Integration Joint Board would be held remotely on Wednesday 25th August, 2021 at 10.00 am.

Ken LYNN, Chairperson.

ITEM No …4……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **SUICIDE PREVENTION STRATEGIC UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB37-2021**

1.0 PURPOSE OF REPORT

1.1 To provide the IJB with an overview of strategic suicide prevention arrangements in Dundee and collaborative developments across Tayside.

2.0 RECOMMENDATIONS

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

2.1 Note the content of this report.

2.2 Remits to the Chief Officer to submit a report to a future IJB meeting regarding the outcomes of the suicide prevention stakeholder event planned for November 2021 (section 4.3.4).

2.3 Remits to the Chief Officer to submit the draft Dundee Suicide Prevention Strategic and Commissioning Plan for approval once this has been refreshed (section 4.3.5).

2.4 Remits to the Chief Officer to submit the draft Tayside Suicide Prevention Action Plan 2021-2024 for approval once this has been finalised (section 4.3.5).

2.5 Note the publication of the toolkit to support the development of local area Suicide Prevention Action Plans (Appendix 1).

3.0 FINANCIAL IMPLICATIONS

3.1 There are no specific financial implications related to this report. Suicide Prevention developments will continue to be progressed within the available financial resources of Dundee Health and Social Care Partnership.

4.0 MAIN TEXT

4.1 Dundee Suicide Incidence, Prevalence and Trends

4.1.1 There were 833 probable suicides in Scotland in 2019, compared with 784 in 2018. This is the highest annual total since 2011. Men accounted for nearly three quarters (74%) of probable suicides, a similar proportion to every year since the late 1980s. Nearly a third of all probable suicides were of people aged between 45 and 59. The 44-49 age group has the highest probable suicide rate of any age grouping. This represents a shift in age profile; in the late 1990s the largest proportions were for people in their late 20s and early 30s.

4.1.2 Tayside has a rate of probable suicides of 15.8 per 100,000 of population. This is higher than the National average (13.6 per 100,000) and, in real terms means that around 70 lives are lost to suicide each year. Within Tayside, Dundee City has a rate of around 21.4 per 100,000 with Perth and Kinross and Angus at 14.6 and 10.3 per 100,000 respectively. There is a strong association between deprivation and suicide. Evident for both male and female probable suicides, people living in the most deprived decile have rates three times the size of those living in the least deprived decile.

4.1.3 One quarter of people who die by suicide had contact with mental health services in the year prior to their death. However, nearly one in two had contact with unscheduled care services and people who died by suicide were significantly more likely to have contact with an unscheduled care service than the general population over a similar time period. It is particularly notable that people who died by suicide were six times more likely than the general population to have contact with Scottish Ambulance Service.

4.1.4 Research indicates that death by suicide cannot be reliably predicted. Whilst emergent use of artificial intelligence or "machine learning" shows promise - with several research groups indicating that heuristics may be able to predict who is going to attempt or die by suicide with 90% accuracy – they cannot determine when; meaning they continue to be of very limited use. What is agreed, is that suicide is likely to be caused by a set of complex and interacting factors. "Risk factors" are characteristics of a person or their environment than seem to increase the likelihood that they will die by suicide. Risk factors include, for example: having made previous suicide attempts; misuse of alcohol and/or substances; having major mental health problems, particularly mood problems; and chronic disease and disability.

4.2 **National Suicide Prevention Strategy**

4.2.1 The national strategy for suicide prevention is set out within Scotland's Suicide Prevention Action Plan: Every Life Matters, Scottish Government 2018-2020 (available on the Scottish Government webpages at https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/). The national strategy envisages a Scotland where suicide is preventable, where help and support is available to anyone contemplating suicide or impacted by it and where suicide prevention is everyone's business.

4.2.2 Every Life Matters is structured around five strategic themes:

- People at risk of suicide feel able to ask for help, and have access to skilled staff and well-coordinated support.
- People affected by suicide are not alone.
- Suicide is no longer stigmatised.
- We provide better support to those bereaved by suicide.
- Through learning and improvement, we minimise the risk of suicide by delivering better services and building stronger, more connected communities.

4.2.3 Alongside these five strategic aims, the strategy identifies 12 actions for delivery through collaborative work between the Scottish Government, National Suicide Prevention Leadership Group and a range of other national, regional and local stakeholders.

4.2.4 A review of "Every Life Matters" was undertaken to establish progress against the Action Plan between 2018 and 2020 and was published in February 2021, "Every Life Matters: the first two years", Scottish Government (available on Scottish Government webpages at https://www.gov.scot/publications/review-scotlands-suicide-prevention-action-plan-2018-2020/pages/2/). The review also aimed to draw out lessons from the implementation process to date, including taking account of the ongoing implications of the COVID-19 pandemic.

4.2.5 The review concluded that there has been clear progress towards implementation of the national action plan, however full implementation has not yet been achieved and the pandemic has necessitated the pausing and reprioritisation of some actions. It also found very strong evidence of engagement, collaboration and partnership working (including with local suicide prevention leads, statutory and third sector partners, the general public and people with lived experience and with the wider workforce beyond those working in mental health services) and the positive impact that this has had on building momentum for change and contributing to a social movement around suicide prevention. Lessons learned in the implementation process to date included: the need to identify a sustainable model to maintain the involvement and commitment of people with lived experience over an extended implementation period; the need for well-resourced and skilled programme infrastructure to support speedy implementation of actions; the absence of high quality evidence of effectiveness in some areas of work on which to base proposals for change and improvement; and, the need for an outcomes framework to clarify the intended impact of each action and support work to track progress of implementation.

4.2.6 Earlier this year, the Convention of Scottish Local Authorities (COSLA) and the National Suicide Prevention Leadership Group (NSPLG) launched a new toolkit to support all 32 local authorities in Scotland to develop a tailored action plan to prevent suicide (see Appendix 1). This toolkit will inform local work to revise local suicide prevention strategy, action plans and activities as described in sections 4.3 and 4.4 of this report.

4.3 **Local Suicide Prevention Planning and Response**

4.3.1 Governance of suicide prevention activity in Dundee has been through the Chief Officers Group within a Protecting People framework. This reflects the fact that suicide prevention is a multi-agency responsibility and recognises the lived experience of people at risk of suicide, who frequently also have a range of other experiences of public protection issues including childhood abuse, drug and alcohol use and violence against women. The Chief Officers Group is currently actively reviewing the multi-agency governance and strategic structure for protecting people and this will include considering how suicide prevention work is best supported for both adults and for children and young people in the future. Within this review attention is being given to the interface between the protecting people governance and strategic structure and the Dundee Community Planning Partnership, with the ambition to strengthen this interface and ensure that all community planning partners take active responsibility for their contribution to responding to protecting people issues, including suicide prevention.

4.3.2 A Strategic Partnership Planning Group for Suicide Prevention has been in place over recent years in Dundee. A draft Suicide Prevention Strategic Plan was developed during 2018/ 2019. The Planning Group decided in early 2020 that the Plan required further consideration and co-production, alongside the development of an accompanying commissioning plan.

4.3.3 A multi-agency Tayside Suicide Prevention Network was established in January 2021. The aim of the Network is to improve leadership, co-ordination and efficiency of suicide prevention activity and to ensure best use of overall resources. The Network will assume responsibility for activity that requires a Tayside wide collaboration and governance/ oversight of activity will sit with each local Suicide Prevention Partnership Planning Group.

4.3.4 A stakeholder event focussing on suicide prevention is planned for November. To date, there has been periodic engagement and involvement of third sector organisations, carers and people with lived experience in suicide prevention work in Dundee. Third sector engagement is facilitated by a range of city-wide networks and forums which enable voluntary and community organisations to connect with strategic planning. Moving forward this approach will be strengthened using the November event as a focus for building an approach that enables more consistent engagement for all stakeholders. Strengthening connections between protecting people and community planning will also bring decision-making closer to local communities and make it easier for local people to participate in suicide prevention work within the city.

4.3.5 It is envisaged that the learning gained from the stakeholder event will enable a final refresh of Dundee's draft Suicide Prevention Strategic and Commissioning Plan and that the Strategic Partnership Planning Group will reconvene to make any necessary changes/ additions prior to submission to the IJB for approval.

4.3.6 Collaborative suicide prevention activity across Tayside is a priority action within" Living Life Well", Tayside's Mental Health and Wellbeing Strategy, February 2021. Progress will also therefore be reported regularly to Tayside Mental Health and Wellbeing Strategic Board. An early draft of a Tayside Suicide Prevention Action Plan has been produced and will be further adapted following the event planned for November. Once complete, the draft will require to be submitted to each IJB in Tayside for approval.

4.3.7 Providing a parity of response to people experiencing emotional distress (to those experiencing acute mental health challenges) is a key area for development. Distress Brief Interventions (DBI) will be operational by Autumn and the establishment of a Community Wellbeing Centre (CWC) which will be open 24/7 with access to accommodation with support by early 2022.

4.3.8 Pending the finalisation of the draft Suicide Prevention Strategic Plan, Dundee has continued to deliver on it's Suicide Prevention Strategic Outcome Plan (2019 -2022). The focus has continued on the three main priorities identified within the Outcome Plan;

Wellbeing, Connection and Resilience

- Information, and support is available and accessible to people most at risk of suicide.
- Social inclusion, wellbeing and resilience are promoted to reduce stigma associated with crisis, suicide and social isolation.

Upstream Prevention: At Risk Groups and Communities

- Improving outcomes for people at high risk of suicide through focused interventions and influencing whole systems change.
- Promoting long term solutions to build capacity to develop sustainable approaches to change.

People Bereaved or Affected by Suicide

- People bereaved or affected by suicide will receive effective support.

4.3.9 During 2020 new national messages and promotional material complimented local activity. A COVID focused Radio and social media campaign "Don't hide your feelings behind a mask" was led by Dundee in February 2021. Suicide prevention material was made available at all community hubs, and latterly vaccination centres. Although suicide prevention week 2020 was limited by COVID restrictions a local press and social media pack was developed and widely distributed.

4.3.10 In terms of bereavement by suicide, both staff and communities affected now receive a targeted response. Locations of concern work has continued with a local focus on Tay Bridge and the Rail Transport network. Links with the Frailty Strategic Planning Group (SPG) are in place and the Frailty strategic plan has actions to promote improved outcomes for individuals who are retired and have long term condition.

4.3.11 Training throughout the COVID period shifted primarily to online activity. This is now moving forward with a Suicide Intervention and Prevention / Safety Plan training programme being developed with Tayside partners for September 2021.

4.4 **Arrangements for Review of Suicide Deaths**

4.4.1 The Tayside Multi-agency Suicide Review Group has been systematically considering the circumstances surrounding suicide deaths since the start of 2016 and is the only group of its kind in Scotland. It is jointly funded by NHS Tayside and the Health and Social Care Partnerships across Tayside. The group reviews all completed suicides in Tayside to determine common demographic, social, health, service use and other factors that have contributed to each suicide. This information is used to determine recurring themes which can be used to develop priorities for local suicide prevention activity. An annual report is published by the group each year. Review activity has continued to take place through the pandemic period.

4.4.2 Tayside is performing well in achieving the local recommendations from the national Suicide Prevention Leadership Group that relate to timely and accessible data about suicides and multi-agency reviews of deaths. However, this group also made recommendations relating to the development of a new model of care for people bereaved by suicide; this has not yet been fully progressed within Dundee however options for further development continue to be explored.

4.4.3 In addition to the work of the Tayside Multi-agency Suicide Review Group, where individuals known to mental health services die by suicide, a comprehensive review of the care, treatment and support offered is undertaken from a learning perspective. In addition to recommendations arising from individual cases, thematic analysis is used to determine where targeted systems changes could be made in order to strengthen services going forward.

4.4.4 National and local intelligence are used meaningfully to drive strategic change. For example, paragraph 4.1.3 above outlines that people who die by suicide are more likely to have contact with Scottish Ambulance Service than the general population, with very few of these people in contact with mental health services. The Partnership has joined with Scottish Ambulance Service to establish a Paramedic Mental Health Response Vehicle which will be staffed by both a paramedic and a mental health nurse. This will respond to 999 calls triaged as being mental health in nature for the periods of time (6pm to 2 am) shown elsewhere in the country to be the peak times for such contacts and will endeavour to provide immediate care and direct people towards appropriate community-based resources for those assessed as being in emotional distress and mental health care for those assessed as requiring more specialist care and treatment.

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 and implementation of the revised Suicide Prevention Strategic Plan, to support a reduction in suicide deaths, does not progress in line with the proposed actions and timescales outlined in this report.
Risk Category	Governance, operational
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Mitigating Actions (including timescales and resources)	Planned programme of activities in September has been designed to utilise virtual approaches and therefore minimise potential for delays and disruption due to pandemic context. Draft strategic plan is in an advanced stage. Operational work continues aligned to existing outcomes plan and emerging, urgent priorities.
Residual Risk Level	Likelihood 2 x Impact 4 = Risk Scoring 8

Planned Risk Level	Likelihood 2 x Impact 4 = Risk Scoring 8
Approval recommendation	This risk should be accepted.

7.0 CONSULTATIONS

7.1 The Chief (Finance) 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	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None.

Vicky Irons
Chief Officer

DATE: 19 July 2021

Arlene Mitchell, Locality Manager
Linda Graham, Clinical Lead for Mental Health and Learning Disabilities
Andrew Beckett, Lead Officer Protecting People

Local Area Suicide Prevention Action Plans

Scottish Guidance

Navigation Tool

COSLA

National Suicide Prevention Leadership Group

Navigation Tool

As a local area we are at the start of our suicide prevention action plan development and we want to understand more about where this work fits in with the national context – Document 1

As a local area we are keen to understand the key messages about suicide – Document 1

As a local area we are interested in gaining an understanding of why we need a local action plan for our suicide prevention work – Document 1

As a local area we are keen to understand a structure for governance and monitoring which will support the development and implementation of local action plans – Document 2

As a local area we would like to know how to engage stakeholders in this work – Document 2

As a local area we recognise the importance of co-producing action plans with those who have lived experience of suicide and bereavement to suicide and want to ensure we do this effectively – Document 2

As a local area we appreciate the value of data and intelligence and are looking for the most relevant resources to support us in this – link to document 3

As a local area we are keen to gain an understanding of the needs in our local area – Document 3

As a local area we want to gain an understanding about suicide and its prevention by using the most up to date information available – Document 3

As a local area we would like to understand what activities might have the greatest impact in addressing the needs identified in our area – Document 3

As a local area we realise the importance of monitoring the implementation of our action plan and would like information about this – Document 4

As a local area we know that building the evidence of what works is important and want to know more about evaluating the work we do – Document 4

ITEM No …5……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **CARERS INVESTMENT PLAN UPDATE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB38-2021**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Integration Joint Board in relation to work undertaken by the Carer's Partnership following report (DIJB16 – 2021 – Article VIII of the minute of 21st April 2021 refers), to seek approval of the updated Carers (Scotland) Act Investment Plan 2021-2022 and to note the anticipated allocations for 2022-2023.

2.0 RECOMMENDATIONS

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

2.1 Notes the work undertaken by the Carer's Partnership to develop investment plans described below

2.2 Approves the Carers (Scotland) 2016 Act Investment Plan 2021-2022 set out in Appendix 1 which includes anticipated allocations for 2022-2023.

2.3 Accepts the risk level described in 6.0 below

2.4 Remits the Chief Officer to issue the directions set out in section 8 below

3.0 FINANCIAL IMPLICATIONS

3.1 Funding of £28.5 million for the implementation of the Carers (Scotland) Act 2016 has been provided nationally as part of local government finance settlement 2021/2022. This is additional to funding provided by the Scottish Government in previous years. The total budget for Dundee for 2021-2022 is £1,242,000 which has been planned for as part of the IJB's 2021-2022 budget. Of this total amount £373,369 has previously been approved by the IJB to be mainstreamed (as set out in Appendix 1). The Carers Investment Plan sets out plans for further allocation of £687,560 in 2021-2022. A total of £181,071 remains to be allocated by the IJB for 2021-22.

3.2 Appendix 1 also sets out the anticipated investment plan for 2022-23. Currently it is anticipated that £1,260,924 will be available to be allocated. This does not take into account any future increase in allocation from Scottish Government. Of this amount £378,037 has previously been approved by the IJB (assuming a 1.25% increase on 2021-2022 levels). The investment plan identifies new anticipated allocations of £1,261,306.

4.0 MAIN TEXT

4.1 Funding referred to in 3.1 above is provided to support the Local Authority to fulfil its duties in relation to implementation of The Carers Act (Scotland) 2016. The Act is designed to support carers' health and wellbeing and help make caring more sustainable. Measures include:

- a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria.

- a specific adult carer support plan (ACSP) and young carer statement (YCS) to identify carers' needs and personal outcomes (separate funding is available to address the majority of needs of Young Carers).
- a requirement for local authorities to have an information and advice service for carers which provides information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights.
- a requirement for the responsible local authority to consider whether that support should be provided in the form of a break from caring and the desirability of breaks from caring provided on a planned basis.

4.2 As set out to the IJB in DIJB16-2021, following engagement with Carers in Dundee the following Workstreams were established:

1. Mental Health and Wellbeing
2. Outcomes and Workforce
3. Adult Carer Support Plans
4. Information and Communication
5. Carers Personalisation
6. Finance and Employability
7. Engagement and Involvement

4.3 Workstream co-leads were identified and were tasked with working collaboratively to develop proposals for investment which would meet the recommendations within the engagement report and help to take forward outstanding actions within the Carers Action Plan. The involvement of Carers in this process was facilitated by Dundee Carer's Centre, but was limited by availability of carers to be involved within the timescales.

4.4 Where Partnership members (or other relevant parties) were aware of work which should be taken forward but which did not fit within the workstreams they were encouraged to also submit their proposals.

4.5 Workstreams met (often on a weekly basis) and connected together where there were overlaps for example workforce development and information and communication. The attached investment plan is the result of that intensive work.

4.6 A template for funding proposals was sent to workstreams leads for completion. In addition workstream leads were asked to submit

- Clear narrative describing any workstream proposals which require further work
- Clear narrative describing any areas which have been identified for inclusion within the ongoing workplan of the Carers Partnership
- Any other information which will be of interest to the Carers Partnership.

4.7 These submissions were considered at a meeting of workstreams leads on 23rd June 2021 and final submissions received by 7th July 2021. The final proposals were approved at a meeting of the Carers Partnership on 14th July 2021. Although presented as separate funding proposals on the investment plan, these pieces of work will, where appropriate, be taken forward together.

4.8 This innovative and collaborative means of developing the Investment Plan is to be evaluated by the Carers Partnership to help inform future development work.

4.9 All allocations will be made ensuring compliance with current procurement legislation.

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	A number of achievements to date have been supported by Scottish Government Carers (Scotland) Act implementation funding. This funding is not guaranteed in future years which potentially jeopardises existing activity and development.
Risk Category	Financial, Political
Inherent Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (High Risk)
Mitigating Actions (including timescales and resources)	• Refreshed Carers Strategy will identify priorities and resource requirements for the period of the strategy.
Residual Risk Level	Likelihood 3 x Impact 2 = Risk Scoring 6 (Moderate)
Planned Risk Level	Likelihood 3 x Impact 2 = Risk Scoring 6 (Moderate)
Approval recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

7.0 CONSULTATIONS

7.1 The Chief (Finance) Officer and the Clerk were consulted in the preparation of this report. This report has been developed by the Carer's Partnership, which has broad representation from statutory and voluntary bodies, and from Carers. The workstreams have extended this involvement across NHS Tayside, Dundee City Council and wider third sector.

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	X

9.0 BACKGROUND PAPERS

9.1 None

Dave Berry
Chief Finance Officer

DATE: 22 July 2021

DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

1	Reference	DIJB38-2021
2	Date Direction issued by Integration Joint Board	25 August 2021
3	Date from which direction takes effect	25 August 2021
4	Direction to:	Dundee City Council and NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	Yes –supersedes direction DIJB28-2019
6	Functions covered by direction	Services for carers in terms of the Carers (Scotland) Act 2016 Investment Plan.
7	Full text of direction	Dundee City Council is directed to enter in to contractual arrangements with all relevant service providers and make provision for services to be provided directly by the council as identified in the Carers (Scotland) Act Investment Plan for the delivery of those services required for the implementation of the Act. NHS Tayside is directed to make provision for services to be provided directly as identified in the Carers (Scotland) Act Investment Plan.
8	Budget allocated by Integration Joint Board to carry out direction	2021-2022 Dundee City Council – £985,929 2021-2022 NHS Tayside – £75,000

9	Performance monitoring arrangements	Through the financial monitoring and workforce planning review arrangements to Dundee Integration Joint Board.
10	Date direction will be reviewed	31st March 2022

Proposed Carers Investment Plan 2021-22

Year 2021/22 Projected Spend	Year 2022/23 Anticipated spend	Service to be Delivered & Organisation	Comments
113,327	114,744	Caring Places - Dundee Carers Centre	Formerly funded via ICF - Agreed in Report DIJB28-2019 - Carers Investment Plan 2019/20 Article XIV of minute of 25th June 2019 refers
32,323	32,727	Carers (Scotland) Act Implementation Officer - Dundee Carers Centre	Formerly funded via ICF - agreed in Report DIJB28-2019 - Carers Investment Plan 2019/20 Article XIV of minute of 25th June 2019 refers
125,341	126,908	Caring Places - Dundee Carers Centre	Formerly Agreed in Report DIJB16 – 2021 (Article VIII of Minute of 21st April 2021 refers)
11,343	11,485	Volunteer Co-ordinator -Dundee Carers Centre	Formerly Agreed in Report DIJB16 - 2021 (Article VIII of Minute of 21st April 2021 refers)
50,625	51,258	Strategic Support - Strategy & Performance - DHSCP	Formerly Agreed in Report DIJB16 - 2021 (Article VIII of Minute of 21st April 2021 refers)
40,410	40,915	Learning and Development - Dundee Carers Centre	Formerly Agreed in Report DIJB16 - 2021 (Article VIII of Minute of 21st April 2021 refers)
373,369	**378,037**	**Total of already mainstreamed Projects**	
868,631	**1,260,964**	**Funding available to be allocated at start 21/22**	

Year 2021/22	Year 22/23		
	Provisional Earmarks	**Proposed 21/22 (& 22/23) project spend**	**Comment/rationale**
14,000	*23,500*	Increase capacity and signposting of Listening Service - NHST	Increase availability of low level mental health and wellbeing interventions for carers
25,000	*49,586*	Increase capacity and remove financial barriers to carers counselling - Dundee Carers Centre	Increase availability of low level mental health and wellbeing interventions for carers
18,000	*58,000*	Bereavement Service – DHSCP (NHST)[(i)]	Continued provision of bereavement support to carers bereaved during COVID period and beyond
43,000	*79,835*	Young Carers Health Check - NHST	Improve health of Young Carers
13,769	*23,858*	Central Support re HSCP information - DHSCP(DCC)	To provide additional support re service information available to carers and the people they care for.
11,200	*23,500*	Carers Charter Implementation - Dundee Carers Centre	Promote the uptake of the Charter by employers. Enhance carer identification and carer support in the workplace
30,000	*30,000*	Awareness raising campaign - Dundee Carers Centre	12-month campaign including TV advert, increase carer identification and knowledge of supports available and promote Short Breaks & Self-directed support
6,845	*13,690*	Drop in support by Lead Scotland re IT - DCC	Increase the number of carers able to access information and support online
70,000	*250,000*	Adults Carer Support Planning Team [(ii)]	Increase uptake of ACSP and supports, thus improving carer outcomes, to improve carer identification and to embed practice and principles across the HSCP, enhancing carer experience
43,000	*128,000*	Streamline assessment process for replacement care to enable a short break - Dundee Carers Centre/DHSCP	Increase carer outcomes through accessing a break including wellbeing and being able to manage their caring role.
35,000	*75,400*	Self Directed Support (SDS) posts	Support SDS development enhance carer outcomes. Reduce barriers to access SDS and increase uptake.
40,862	*180,759*	Participatory Budgeting - Dundee Carers Centre [(iii)]	Carers and communities have a direct say over how money is spent to improve carer outcomes in their locality
36,884	*75,178*	Involvement & Engagement Team - Dundee Carers Centre	Strengthen the support and opportunities for carer participation in the decisions that impact on their lives, services, and communities.
300,000	*250,000*	Increase in respite provision	Increase provision of respite provision (non chargeable) for carers
687,560	***1,261,306***	**Total of new proposed allocations**	
181,071	**-342**	**Remaining funding available to be allocated**	
1,242,000	**1,639,000**	**Total Proposed Budget**	

(i) **This relates to 2 posts which sit within the hosted Palliative Care Service in Dundee. One post is funded on a fixed term basis from NHS Tayside endowments and comes to an end in December 2021; the other post is funded through endowments while the current postholder remains in post. Should the post holder leave the post the funding will cease. This proposal seeks to secure ongoing funding for both posts. As these posts are Tayside wide we will enter discussions with Perth and Kinross and Angus HSCP re potential for contribution towards ongoing costs. There is no intention to set any precedent re funding of any hosted services.**

(ii) **This is a priority for development but needs further work to confirm costs – estimated costs included at this stage which may be reviewed within the overall budget**

(iii) **This will support Dundee Partnership efforts to give communities a stronger influence on how resources are spent in localities. We will work closely with colleagues in Neighbourhood services to ensure that this adds value to existing work**

ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **DUNDEE PRIMARY CARE IMPROVEMENT PLAN UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB40-2021**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide an update on the implementation of the Dundee Primary Care Improvement Plan for 2020/21 and seek approval for the implementation of the Dundee Primary Care Improvement Plan for 2021/22.

2.0 RECOMMENDATIONS

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

2.1 Notes the progress to implement the Dundee Primary Care Improvement Plan 2020/21 in the third year of delivery (attached as Appendix 1) and the key achievements as described in section 4.3.3.

2.2 Approves the proposed actions for Dundee Health & Social Care Partnership for 2021/22 as described in Appendix 1 and notes the proposed allocation of funding as detailed in Section 3.

2.3 Notes that aspects of the Plan will not be fully implemented by March 2022, and that practices will receive transitionary payments after that time point for services they are still delivering as outlined in section 4.

2.4 Instructs the Chief Officer to issue directions to NHS Tayside to implement the specific actions relevant to them in Appendix 1.

2.5 Notes the previous agreement to delegate the monitoring of the Dundee allocation of the Primary Care Improvement Fund as noted in Section 3.6.

2.6 Instructs the Chief Officer to provide a further report on progress made in the fourth year of delivering the Dundee Primary Care Improvement Plan to a future IJB.

3.0 FINANCIAL IMPLICATIONS

3.1 Funding for delivery of the Dundee Primary Care Improvement Plan (the Dundee Plan) for 2020/21 was agreed by the Integrated Joint Board in 2020 (Article XIII of the minute of meeting of 25th August 2020 and report no DIJB36-2020 refers). There has been significant increase in delivery and spend in year 3 (2020/21), however this was still lower than planned, in part due to the impact of the pandemic, and part workforce and premises issues. The actual spend is detailed in Table 1 below.

Table 1 2020/21 spend against allocation

	Approved PCIF Allocation	Actual Funding / Expenditure
	£'000	£'000
Scottish Government Allocation*	***3,419***	**3,413**
Plus B/F underspend	***1,288***	**1,288**
Forecast Expenditure -		
Vaccine Transformation Programme (VTP)	*166*	171
Pharmacotherapy	825	494
Community Treatment and Care Service (CT&CS)	761	772
Urgent Care	579	241
First Contact Physio / Musculoskeletal	288	255
Mental Health	270	157
Link Workers	202	192
Other	154	247
Total	**3,244**	**2,529**
(Over)/Underspend	***1,463***	**2,173**

*After receipt of locally agreed inter-IJB reallocation of funding from Angus IJB and Perth & Kinross IJB

3.2 The development of the Dundee Plan and the associated financial plans for 2021/22, and the recurring cost of this plan, are summarised in Table 2 below. These figures continue to be refined as learning is gained from the tests of change that are taking place and the models being developed. Table 2 details the proposed allocation for 2021/22 and full year cost of the current plan, along with a comparison of figures prepared in January 2020 to highlight estimated full scale implementation. (The latter figures noted as optimum implementation have not yet been revised but may require to be updated as learning over the past 18 months will have an impact on this.) The 2021/22 costs include non-recurring elements which are either one off projects to support this work or maybe required longer term for which other funding will need to be identified, such as through redesign of current services. There is a recurring shortfall in funding of £210k, which is an underlying risk in the longer term that needs to be addressed albeit carried forward reserves can potentially meet this cost for c 4-5 years, if not utilised for other aspects of delivery. The issue of potential funding shortfalls in fully implementing the plan is not unique to Dundee and has been raised with Scottish Government nationally for future funding considerations. There is a further underlying risk regarding pay uplifts from 2022-2023 onwards which will increase the costs year on year above the levels shown below.

Table 2 Proposed 2021/22 Financial Plan

	2021/22	Full Year Cost (Recurring)	*Optimum Implementation*
	£'000	£'000	*£'000*
Scottish Government Allocation *	**4,716**	**4,716**	***4,716***
Forecast Expenditure -			
Vaccine Transformation Programme	378	378	*488*
Pharmacotherapy	829	1,061	*2,047*
Community Treatment & Care Service	1,078	1,578	*1,354*
Urgent Care	781	937	*1,828*
First Contact Physio / Musculoskeletal	450	482	*535*
Mental Health	280	280	*535*
Link Workers	210	210	*290*
Total Recurring	**4,006**	**4,926**	***7,077***
Additional Non-Recurring			
Additional First Contact Physio / Musculoskeletal	121		
Digitilisation of paper GP Records	350		
Other**	154	154	194
Total Non-Recurring	**625**	**154**	**194**
Total Projected Annual Spend	**4,631**	**5,080**	***7,271***
In year (Over)/Underspend - recurring only	**710**	**(210)**	***(2,361)***

In Year (Over)/Underspend	**85**	**(365)**	***(2,555)***

*After receipt of locally agreed inter-IJB reallocation of funding from Angus IJB and Perth & Kinross IJB
** Expenditure levels being reviewed and alternative sources of funding being sought

3.3 The formal Scottish Government Allocation letter has been received. There is a small decrease in funding to Dundee due to changes in National Resource Allocation Committee (NRAC) allocations.

3.4 At this stage plans remain fluid as the ongoing impact of the pandemic, including the current wave, is still unclear. Many of the teams were asked to prioritise and support other areas of work during the last 18 months and may be asked to do so again. The risk of this is much lower than it was previously. As a result, the financial implications continue to evolve as project plans develop.

3.5 Recruitment of sufficient staff at the appropriate skill-mix continues to be a significant risk, and this has been a major contributing factor in slippage to date.

3.6 The financial management of the Primary Care Improvement Plan is delegated to the Chief Officer, Chief Finance Officer and Clinical Director, as agreed previously, with the monitoring of this budget overseen by the Dundee Primary Care Improvement Group. The Local Medical Committee remain core to this process and have to agree all plans, including finance.

3.7 There was a significantly increased cost to support GP recruitment and retention. There were a number of factors for this, including a higher than anticipated number of GPs in the career start pathway. This funding was agreed retrospectively, but is not feasible longer term, so other sources of funding are being sought.

3.8 Brought forward underspends from previous years totalling £2,173k are held in Earmarked IJB reserves and continue to be available for the Primary Care Improvement Plan purposes. These underspends will be reviewed and spend planned in conjunction with the Local Medical Committee to ensure they are used consistent with the Primary Care Improvement Plan, and reflecting that this is non-recurring funds. This process will be managed by the Primary Care Improvement Group.

3.9 The financial implications of reimbursing practices after April 2022 for areas of the plan which have not been fully implemented are not yet known.

4.0 MAIN TEXT

4.1 Context

4.1.1 The IJB has previously considered papers setting out the context and challenges within primary care (report DIJB51–2017, article IX of the minute of the meeting held on the 19th December 2017 refers) and the implications of the General Medical Services (GMS) contract and related memorandum of understanding (report DIJB9-2018, article IX of the meeting held on the 27th February 2018 refers) and subsequently the plans for years 1-3. The Primary Care Improvements Plans consists of a Tayside wide Primary Care Improvement Plan (the Tayside Plan) which sets out the high level regional and local improvements. This Tayside Plan is expressed locally at a Dundee level through the detailed Dundee Primary Care Improvement Plan (the Dundee Plan). These plans have previously been discussed and agreed with the most recent plan for 2020/21 being on the 25th August 2020 (report DIJB36-2020, article XIII of the minute of the meeting held on 25th August 2020 refers).

4.1.2 This paper details the progress against the actions set out in year 3 of the Dundee Plan, associated expenditure, and details the proposed actions and spend for year 4 (2021/22). The Tayside Plan, incorporating the Dundee Plan, was approved by each Integration Authority, the Local Medical Committee (LMC) and NHS Board. The Tayside Primary Care Improvement Plan and the Dundee Plan for each of years 1 to 3 were previously approved. This report updates these plans and sets out the priorities for implementation in year 4.

4.1.3 The following are the nationally agreed priorities for the primary care improvement plans which must be delivered between 2018 -2021:

- The Vaccination Transformation Programme (VTP)
- Pharmacotherapy Services (PCT)
- Community Treatment and Care Services
- Urgent Care (now due 2023)
- Additional professional roles - such as musculoskeletal focused physiotherapy services and mental health
- Community Link Workers (referred to as social prescribers).

4.1.4 The Scottish Government and British Medical Association released guidance in December 2020 which reinforced their commitment to delivery of the 2018 GMS contract, but noted that the timeframe had been reviewed with delivery deferred to 2022, other than for urgent care which is deferred to 2023.The policy position is noted in table 3 below. The following table describes the revised programme.

Table 3

Priority Area	**Policy Position**
Vaccinations	Those vaccinations included in the Additional Serviced Schedule, such as childhood vaccinations and immunisations and travel immunisations to be removed from GMS Contract regulations by 1st October 2021. Where GPs remain involved in the delivery of some vaccinations on 2022-23 this will be covered by a nationally negotiated Transitionary Service arrangement
Pharmacotherapy	NHS Boards are responsible for providing a level One Pharmacotherapy service to all practices for 2022-23, with a nationally negotiated Transitionary Service arrangement in place where this is not achieved.
Community Treatment and Care Services	A Community Treatment and Care Service must be provided by the Board by 2022-23 with a nationally negotiated Transitionary Service arrangement in place where this is not achieved.
Urgent Care	Legislation will be amended so that NHS Boards are responsible for providing an Urgent Care service to practices for 2023-24 with recognition this must fit with wider urgent care redesign work regionally and nationally.
Additional Professional Roles	Further work will be undertaken to articulate the 'end point' for the additional professional roles by the end of 2021.

A number of these service developments are at risk of not being fully implemented by the revised deadline of March 2022.

4.2 Dundee Governance

4.2.1 The Dundee Primary Care Improvement Group (DPCIG) was established in 2018 with a remit to develop the Dundee Plan and take responsibility for implementation going forward. The Tayside General Medical Services Contract Implementation and Advisory Group supports work at a regional level, ensuring sharing of practice and coordination, particularly of the regional aspects of the contract delivery. This group feeds into the Tayside Primary Care Board. There are also a number of regional and local sub groups which lead the development of the service areas. Given the breadth of the range of services that sits within this overall context this is broad ranging and a number of these have much wider links.

4.2.2 The financial management of the Primary Care Improvement Plan is delegated to the Chief Officer, Chief Finance Officer and Clinical Director. The DPCIG has responsibility for the distribution and monitoring of the use of the Dundee allocation of the Primary Care Improvement Fund. Planning is in conjunction with the GP Sub Advisory Committee, and funding is approved by the Local Medical Committee.

4.2.3 Reporting to the Scottish Government continues every 6 months for both financial governance and more detailed progress of delivery.

4.3 Progress

4.3.1 Overall there has been significant progress in year 3 with most of the 7 work streams, however some work streams, such as urgent care, have reduced and are unlikely to regain the previous workforce for some foreseeable time.

4.3.2 In line with others services Scottish Government guidance on consultations has meant that many of the services have moved from face to face, often to phone, unless there was an urgent need for face to face. The increased use of phone, and to a lesser extent video, technology has been positive for many people accessing services, but not universally, and for some patients has been a significant barrier. This is not unique to Primary Care Improvement. Patient feedback is important and some services have been able to assess this change and have used that to inform plans for remobilisation and longer term delivery of the service. The change has also impacted on staff satisfaction with their roles, and it has added to the challenges teams have faced over this very difficult period.

4.3.3 The progress against all the key areas is outlined in Appendix 1. Key achievements include:

- Aspects of the Vaccination Transformation Programme have continued, especially for children and young people. The extended adult flu programme in 2020/21 was delivered jointly with NHS Tayside, Dundee HSCP with all practices supporting the delivery. In addition to the 24 practice teams delivery there were 3 sites used by HSCP staff in Kings Cross, Royal Victoria Hospital and McKinnon Centre (Broughty Ferry). The centralised team also vaccinated staff and residents in nursing homes, with support for the care home staff, while the adult community nursing team vaccinated those in residential care homes. This work has also informed the huge scale of the Covid Vaccination Programme and a similar methodology had been used, albeit with a mass vaccination centre in the Caird Hall.
- The First Contact Physiotherapy (FCP) team who assess for musculoskeletal issues expanded to all clusters last year, and recruited to all previously planned posts. However increased demand is currently exceeding capacity and impacting on service delivery. (Noting that not all Musculoskeletal (MSK) presentations will move from general practitioners even longer term because of frequency and complexity.) The FCP team sits within the wider Musculoskeletal team, which was deployed for much of the last 18 months, with an impact on that aspect of the service ie those patients who require a physio intervention. Elements of the phone and video consultations used during covid will be retained, but as an option rather than for the majority of consultations.
- The Pharmacy Locality Team provided a lot of support to practices, and wider teams, as they coped with the demands of the pandemic. The service was maintained and additional roles were undertaken, but there was limited expansion of PCT because of this, and recruitment issues.
- The Care and Treatment Team have rolled out wound care and some phlebotomy. In the early phase of the pandemic they supported patients who were shielding by undertaking bloods, and other care, in people's homes, to minimise risks. This was a significant, but very positive, impact. The lack of clinical space continues to create access issues for people, although there are now 9 sites across Dundee. Some planned areas have not yet started due to other demands and premises issues.
- The Integrated Care Home Team continued to assess patients in care homes rather than a GP, for some practices and some care homes. There has been both recruitment and staff leaving so that there has been an overall loss of capacity. The trainee advanced paramedics were withdrawn by Scottish Ambulance Service at the start of the pandemic

to support demand within the core service and they have not returned and seem unlikely to do so in the foreseeable future.

- The Patient Assessment and Liaison for Mental Health Service (PALMS), led by the psychology team, is seeing patients who present with mental health and wellbeing issues in some practices, with an increased skill mix being tested and using telephone for most consultations. There have been a number of workforce challenges which has led to a review of the delivery model.
- The Social Prescribing Link Workers have been able to support all practices, albeit in a different way, with the impact of Covid, rather than the 14 practices they supported before. They are testing a new support role in the team, and looking at different criteria. It was anticipated that in the autumn there would be a large increase in referrals as restrictions eased but this has not materialised, despite the known impact of Covid on people's health and wellbeing, including social circumstances such as finance and housing.

4.3.4 Workforce recruitment, retention and development has impacted on some services more than others. Currently for example the pharmacy team have managed to recruit to most vacant posts, but turnover remains relatively high. Creating jobs which retain staff is key going forward. For new staff developing their role and relationships in virtual teams has been challenging. A small number of staff have moved to care and treatment services under a TUPE process. An external recruitment microsite has been developed with a commercial company, and to support across Tayside. The impact of this is not yet known, but roles across primary care are promoted.

4.3.5 Suitable clinical space has continued to impact on service delivery. Any capacity in practices has now been utilised either because the requirements of the practice have changed with the need for a "Covid" assessment room, or because of social distancing. A small amount of clinical space has become available and is now used, particularly for care and treatment services. A number of small projects were identified to upgrade or create space in practices, but this had limited progress due to a lack of technical resource in NHS Tayside. Patients can access the site that is most convenient to them, which may be near where they live rather than their practice. This has been positive for many people. However where people live close to their practice and there is no alternative site for health use with capacity, the geographical aspects of access have not been maintained with the changing service.

4.3.6 The constraints of physical buildings for a number of services will impact on the pace of development over the next year. There is also considerable interest from other teams, particularly in secondary care, of using care and treatment services to deliver aspects of care locally for people. There is broad support for this intention but there is currently not space, or resource, to progress this significant shift in workload from secondary care and specialist teams. It would require budget transfer to allow this to progress . Plans to develop further health and care centres as part of any new developments is key to this. A review of the current general practice buildings, and how they fit into a longer term primary care premises strategy needs developed to inform future investment.

4.4 Plans for 2021/2022

4.4.1 Work stream leads have been developing their plans and this is reflected in Appendix 1 in the detailed plans. However the recent increase/wave 3 of people with Covid has impacted on the ability to progress some of these plans. This may continue to be the case for some time.

4.4.2 Plans in Dundee are evolving and are outlined in Appendix 1, with the current estimate of costs. Key aspects of this include:

- The transfer of vaccinations, including travel, have been impacted by covid and the covid vaccine in particular. The Joint Committee on Vaccination and Immunisation (JCVI) have released guidance for planning purposes which suggests that a likely covid booster will be given at the same time as flu vaccination to a very similar cohort, noting that the guidance on flu vaccinations has been broadened for 2021/22. The cohort for flu and covid which was not part of the original scope of Vaccine Transformation Programme (VTP) will be funded from other sources not the PCI funds. It is anticipated regional planning will progress this, building on the blended model of general practice delivery and a centralised

team. Travel vaccines also need to be transferred by autumn from practices. A model has not been agreed for this but it is anticipated demand will be low initially.

- Expansion of the team to consolidate delivery for those elements already moved, including wound care, and some monitoring, including bloods. Ear care pathway to be tested from July. Lack of space is a key issue for expansion of this service.
- For pharmacotherapy consolidate new posts and develop the teams who have had significant change. If suitable premises develop a cluster model, and progress pharmacy assistant role.
- Expand the delivery of the care home team of advanced practitioners more broadly and review the wider urgent care team, recognising the role of other teams.
- First Contact Physiotherapy Service will recruit further staff and reassess if capacity and demand are in line before further decisions are made.
- The Link Worker team will develop the new support worker role in the team, and continue to consider skill mix going forward. Given the impact of Covid it is anticipated demand will increase for this team.
- The PALMS service will review the roles in the team and how to work in a cluster model. There is unlikely to be full roll out by March 2022 given the current position.

4.4.3 As noted above in section 4.1.3 services should be in place by March 2022, or March 2023 for urgent care. Further information is awaited from the Scottish Government in relation to the revised Memorandum of Understanding (MOU2) (which was received early August) to clarify expectation and the financial impact of practices being funded if service not fully transferred. Three services have been prioritised in the MOU2, vaccination transformation programme, pharmacotherapy and care and treatment services. Other workstreams should progress and be developed where there is funding available to do so.

4.4.4 The developments within information systems for PCI teams have been positively received and provide an opportunity for wider teams to ensure care delivered remains part of the core patient record. Other teams who link with practices are keen to use this system, but this needs managed. The planned GP IT reprovisioning which will progress over the next 2 years, and may result in a new IT system, offers opportunities for this to be more integrated.

4.4.5 Ongoing review and feedback from patients using the developing services has and continues to influence how services develop. There have been a number of challenges because of the limited access to suitable premises for some people, while others have benefited from access more quickly with improved pathways of care. There has been limited communication around the evolving nature of the primary care team because of the variability of the services across practices. However most practices and patients are now supported by most of the services and we are awaiting finalised communications materials that can be shared widely to increase awareness of the public to the specialist services now available.

4.5 Next Steps

4.5.1 The Primary Care Improvement Group will continue to support and monitor the development of the programme and its impact. Plans will be progressed on the assumption that there will not be a significant impact of Covid, beyond what is already known, and this will be revised if required. Actions will be progressed as outlined to implement the plan, noting that for a number of key areas the target of March will not be achieved.

5.0 POLICY IMPLICATIONS

5.1 This report has not been screened for any policy implications in respect of Integrated Impact Assessment. More detailed assessments will be part of each service development, noting this is a national policy.

6.0 RISK ASSESSMENT

6.1 Risks 1 – 3 were identified in 2018 and remain current with risk 4 added in 2020 and risk 5 in 2021. There has been some change in risk and mitigating actions. More detailed operational risks will be identified and managed within each service in more detail and managed by the Dundee Primary Care Improvement Group. More detailed risks and issues are noted in appendix 1.

Risk 1 Description	There is a significant risk that Dundee may not recruit or develop the workforce to deliver all of the commitments in this plan given the scale and breadth of the plan. This applies across a number of professions, including pharmacy, nursing (advanced nurse practitioners) and mental health practitioners This will directly impact on the delivery of services described.
Risk Category	Workforce, operational
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme
Mitigating Actions (including timescales and resources)	All services are planning with this risk at the forefront and looking to maximise skill mix as much as possible to reduce this. Longer term national work to provide increased undergraduate training will support this but not within the timescales of the year plan. NHS Tayside Advanced Care Academy will also help support development of urgent care practitioners. The most significant risk currently is with the PALMS teams and advanced practitioners with key risks to both areas of not meeting deadlines.
Residual Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16 - Extreme
Planned Risk Level	Likelihood (3) x Impact (4) = Risk Scoring 12 - High
Approval recommendation	The level of risk is deemed to be acceptable given the mitigating actions being put in place

Risk 2 Description	There is a risk that we will have inadequate infrastructure to support the delivery of the Plan, both in terms of IT infrastructure and systems, and buildings/premises. This risk remains but the premises risk is now greater than the IT risk as a number of aspects of the IT issues have been resolved. The risk re lack of suitable premises is increasing as teams develop towards planned capacity, and with the impact of covid for distancing and cleaning.
Risk Category	Technological, Environmental, Financial
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme
Mitigating Actions (including timescales and resources)	The test of change for IT infrastructure has been positive and will be rolled out at scale. This reduces the risk for IT and data. Covid has impacted on the roll out of the new systems to some teams, with a linked impact to developing services effectively. There is an ongoing, and increasing, pressure for space to deliver services from. It is anticipated that some planned minor works with capital allocated by NHS Tayside which did not progress in 2019 will progress in 2021. However the impact of Covid and requirements to both reduce footfall and ensure safe environments for staff and patients mean that there is less space which can be accessed than previously. There are ongoing concerns raised by patients who are currently having to travel further than previously due to lack of local access in some areas.

	This risk includes the risk of not indentifying suitable premises required for the flu (and covid) vaccination programmes.
Residual Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20– Extreme
Planned Risk Level	Likelihood (3) x Impact (3) = Risk Scoring 9 - High
Approval recommendation	The level of risk is deemed to be acceptable given the mitigating actions being put in place

Risk 3 Description	There is a risk that the finance allocated via the primary care improvement fund will not adequately meet all the costs to implement the plan, and that resource will have to be identified from other sources, or services will need to be smaller than anticipated. The impact of Covid has reduced the risk for 21/22 as a number of developments have been delayed, but the longer term risk remains the same. The risk levels are unchanged since the last report. However there is a related risk linked to underspends also now noted below.
Risk Category	Financial
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme
Mitigating Actions (including timescales and resources)	Other sources of funding will be identified as opportunities arise. Finance is a key component of planning and ensuring the most cost effective models are progressed. Where models with variation in costs are tested in different parts of Tayside there will be a judgement made as to cost effectiveness of these models prior to roll out.
Residual Risk Level	Likelihood (4) x Impact (4) = Risk Scoring 16 - Extreme
Planned Risk Level	Likelihood (3) x Impact (4) = Risk Scoring 12 - High
Approval recommendation	The level of risk is deemed to be acceptable given the mitigating actions being put in place

Risk 4 Description	The current Covid-19 pandemic has delayed aspects of implementation of the PCI plan locally and increased further the risk of the commitments in the MOU not being achieved by March 2022 (March 23 for urgent care) as planned.
Risk Category	Operational, Political
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring -20 -Extreme
Mitigating Actions (including timescales and resources)	There are limited actions that can be taken at this time point to reduce this risk given the uncertainty of the future occurrence of the coronavirus and the ongoing competing demands for both clinical and managerial capacity. .
Residual Risk Level	Likelihood (5) x Impact (4) = Risk Scoring -20 - Extreme
Planned Risk Level	Likelihood (3) x Impact (4) = Risk Scoring 12 - High
Approval recommendation	The level of risk is deemed to be acceptable given the mitigating actions being put in place

Risk 5 Description	Delays with implementation mean there is a financial underspend which is increasing due to further delays with recruitment and in some cases finding appropriate space. There are a number of reasons for this, including covid. This also means that transitionary payment to practices will be required next year and no budget has been identified for this. It is unclear at this time if underspends can be utilised for this purpose.
Risk Category	Operational, Political
Inherent Risk Level	Likelihood (5) x Impact (4) = Risk Scoring -20 -Extreme
Mitigating Actions (including timescales and resources)	.Increasing numbers of staff who can be recruited beyond the recurring budget on a short term basis will allow expansion of teams to support the wider primary care team and capacity. Longer term funding shifts will be required to sustain this longer term. Underspends may be used to support practices who are still delivering services until moved. Options for use of any underspends which fit with the ethos of the contract will be progressed.
Residual Risk Level	Likelihood (5) x Impact (4) = Risk Scoring -20 - Extreme
Planned Risk Level	Likelihood (3) x Impact (4) = Risk Scoring 12 - High
Approval recommendation	The level of risk is deemed to be acceptable given the mitigating actions being put in place

7.0 CONSULTATIONS

7.1 The Clinical Director, Chief Finance Officer, Head of Service, Health and Community Care and the Clerk were consulted in the preparation of this report. The Dundee Primary Care Improvement Group has developed the paper at appendix 1.

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.

Vicky Irons
Chief Officer

DATE: 12 August 2021

Shona Hyman
Senior Manager
Service Development & Primary Care
Dundee HSCP

David Shaw
Clinical Director
Dundee HSCP

Dundee Health & Social Care Partnership

DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

1	Reference	DIJB40-2021
2	Date Direction issued by Integration Joint Board	25 August 2021
3	Date from which direction takes effect	25 August 2021
4	Direction to:	NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	Yes – DIJB45-2018 and DIJB33-2019 and DIJB36-2020
6	Functions covered by direction	Specific actions relevant to NHS Tayside in the Tayside Primary Care Improvement Plan and Dundee action plan.
7	Full text of direction	Dundee IJB directs NHS Tayside to implement, with immediate effect, the specific actions relevant to them in the Tayside Primary Care Improvement Plan as outlined in the Dundee Action Plan (Appendix 1).
8	Budget allocated by Integration Joint Board to carry out direction	The provision of premises and the implementation of IT systems by NHS Tayside as required by this Direction are not specifically funded from the IJB/PCI budget.
9	Performance monitoring arrangements	Performance will be reviewed on a regular basis, (currently 2 monthly,) by the DPCIG
10	Date direction will be reviewed	March 2022 (or earlier if required).

APPENDIX 1

Dundee Primary Care Improvement Plan 2021-22

Commitment	Actions Delivered 20-21 (to July 21)	Comment	Lead Officer	20-21 Spend (£k)	Actions to be Delivered 21-22	21-22 spend – Estimated (£k)	Risks/ Issues
1. Vaccination Transformation Programme (regional approach)	**Actions completed** A joint approach to flu delivery was taken with NHS Tayside, HSCPs and practices all supporting this. The flu programme in Dundee was delivered by all practices and across 3 NHS sites. New staff cohorts were included in this. Uptake of flu was higher than in previous years. There was significant learning for this which informed the covid vaccine programme. **Actions partially completed** **Actions outstanding** No progress with other adult vaccines or travel advice and immunisation. (As noted in plan for 20/21)	Limited progress in this area as the pandemic and covid vaccination impacted on staff being able to focus on this.	Daniel Chandler, Consultant in Public Health Medicine	£171k	Detailed action not yet agreed due to the evolving picture with the covid vaccine. However it is anticipated that a blended model with practice team and central teams will deliver both flu and any further covid vaccines. The flu cohort for 21/22 has been expanded further, for both patients (adults and children) and staff groups The wider cohort group will not be funded via PCIF. Once advice re any national element to travel service and immunisations is known a local model will be developed to support this. This is due to commence in the autumn so concerns re timescales for recruiting and training staff. Anticipated travel will be low.	378k	It is anticipated that covid and flu vaccine programmes will become more integrated but this is not clear, nor is the model going forward given the size of workforce for a part of year Community pharmacy is one option being explored for travel vaccines

2. Pharmacotherapy Services (regional approach)	**Actions completed** Processing of IDLs, outpatient and non medication requests, medicine shortages, review of specials, compliance reviews in own homes, formulary compliance/prescribing indicators, and support for medicine safety recalls are delivered to all practices, (but not for all of the workload). Acute prescribing requests, pharmaceutical queries and non clinical medication reviews are also being undertaken in some practices.. Career start post developed and being tested. Test of recruitment of newly qualified pharmacists completed and will be further rolled out. **Actions partially completed** Pharmacy First continues to be well promoted but not yet data to assess if increased use. Increase in pharmacists prescribers in community, pharmacy who support common clinical conditions, but still small numbers and minimal impact. Some increase in serial prescriptions. **Actions outstanding** Pharmacotherapy assistant post not yet started Hub model started in Angus but not yet in Dundee. Angus learning will be built on.	Some elements of this section (level 1 PCT) are being delivered by practices as this allows the pharmacy locality team to focus on other tasks that have a bigger impact on GP workload Small number of practices in one cluster have some areas not fully delivered due to localised issues. Premises suitable for this is a constraining factor and now impacting on further development	Elaine Thomson, Locality Team Leader/ Jill Nowell, Associate Director of Pharmacy – Primary Care & Medicines Governance	£494k	Develop further work in conjunction with practices, recognising that current recruitment projections means that not all of PCT will be delivered by March 22. Additional activity may vary between practices to reflect priorities in the practice. Continue to recruit staff as able, with a degree of flexibility in the overall budget, and noting that there are already a high number of pharmacy technicians in the Dundee team. Evaluate the career start programme and assess its ability to expand. Further develop, and support implementation of, education and training frameworks for all staff. Test and develop a hub model in Dundee, based on Angus learning. If the hub progresses develop a pharmacy assistant role.	829k	The pandemic has had a significant impact on demands for the locality pharmacy team, who have worked very flexibly to support in a range of ways, both within practices, linking to community pharmacy and also supporting secondary care. Changes to the way secondary care worked has resulted in a significant increase in out-patient's communications and issues with discharge communications that has put additional pressure on the pharmacy team. Space is an issue both within practice and for a hub model. Time to train and develop newly recruited staff is required. This will limit further roll out in the short term but needs to be built into workforce plans with an agreement that it is an integral part of PTS. In order to sustain service delivery and aid staff retention.

3. Musculoskeletal (MSK) Services First Contact Physio	**Actions completed** All staff recruited as per FCP/PCIP plan for 20/21. FCP now in place for GP practices across all 4 clusters. Monthly reports generated via the Vision 360 federated appointment system demonstrate a very high utilisation of FCP appointments; c95% In response to Covid, local factors and Scottish Government guidance, the FCP service adapted its model to deliver a current virtual first approach via telephone and Near Me consultations. Patients are invited for in-person appointments as required. Vision Anywhere roll out has been successful for FCP practitioners, enabling them to write directly into the GP record. Patient feedback on virtual first model collected via Survey Monkey. **Actions partially completed** Covid has delayed the full evaluation of the impact of FCP on other areas of the MSK pathway. It is anticipated that a level of MSK resource will be released to support FCP expansion in the future. However, MSK waiting lists have increased during Covid (due to deployment	Consultations have been delivered by phone or video during the pandemic in line with guidance, unless face to face essential. This will shift back. Demand has exceeded capacity over the last few months. This had led to delays and/or a higher use of GP time. There is still no mechanism to record to EMIS directly.	Matthew Perrott, Integrated Manager (Occupational Therapy & Physiotherapy – Outpatients)	£255k	Review impact of FCP on other parts of the MSK pathway / service. Complete data collection to assess impact of FCP on GP appointments. Establish accurate data on demand for FCP service across all Dundee GP practices. Use data to inform capacity required. Work with practices to improve appropriate use of FCP service and develop role as part of an extended primary care MDT. Continue to work with e-health colleagues to develop Vision Anywhere FCP templates and outcome reports, as well as developments in RMS referrals / electronic prescribing. Qualitative patient experience survey (by questionnaire & interviews) to evaluate and influence development. This was delayed during Covid.	450k	Lack of capacity to meet demand from GP practices. Providing a service which can replicate the accessibility of general practice for acute presentations will be challenging 5 days/week, 52 weeks/year Lack of identified permanent space, particularly within cluster 2 locality, specifically Broughty Ferry. Patients can access virtual service but will have to travel to other parts of the city for in person appointments if no space found. The evolving role of practice reception staff as care navigators is key to effective utilisation of the FCP service. Assess how best to utilise technology used during Covid to support a range of ways of offering appointments.

	of AHP staff to support inpatient Covid activity) and some time is required to re-establish the expected demand/capacity.						
4. Mental Health Services	**Actions completed** PALMS has **r**ecruited additional Band 6 CMHN posts (Action 15 monies) working in two practices, demonstrating increased skill mix and appropriate competencies to support further roll out of PALMS. There are 7 GP practices with full access to PALMS and 4 practices with partial access to PALMS. Updated training has been delivered to practice admin staff to increase skills and confidence in determining the best clinician for patients' presenting needs. Listening Service maintained in all practices (with Action 15 monies) except in one practice with no space. 1 year report for practices with established PALMS resource is complete and 6 month report completed for further practices. **Actions partially completed** A small test of change, with anticipated duration of 6 months, has commenced in 1 practice. This offers 'light touch' brief intervention for up to 4 sessions	There are therefore 13 practices with no support yet.	Helen Nicholson-Langley, Consultant Clinical Psychologist	£157k	Transition to a hub and spoke model of delivery is anticipated by March 2022. Increasing the skill mix to include a greater proportion of Band 6 CMHN resource, with Band 8a oversight for each Cluster is also anticipated. Establish a sustainable model of delivery with sufficient workforce. To work with other Mental Health & Wellbeing (MH&W) practitioners and services to establish low intensity group based interventions at community/practice level to increase access, and speed of access to appropriate interventions. To work with other MH&W practitioners/services to influence and develop pathways of care for people presenting with MH difficulties in primary care – the right person to the right service at the right time.	280k	Recruitment of mental health staff, across professions remains a significant challenge. PALMS development must be integrated with wider MH&W strategic work in Tayside. Physical space in Practices remains a practical constraint however remote working has been successful. There are anticipated challenges relating to admin and IT systems should PALMS move to the hub & spoke model. It is recognised that banding or grading of staff is not necessarily reflective of competence and confidence to practice safely in PALMS. Any proposed changes to the structure of PALMS must consider

	with a PALMS practitioner to investigate whether this reduces onward referral for formal psychological therapy. This is anticipated to offer further valuable information about the model which can best meet the needs before extending PALMS to the remaining practices in all 4 clusters. Some previously provided sessions have been withdrawn from 2 clusters temporarily due to workforce challenges. Some Practices are therefore receiving reduced sessions until we can recruit appropriately. **Actions outstanding** A HUB model has not been tested nor established but is proposed for later this year to help increase flexibility and adopt a more sustainable model of delivery.						carefully how all staff will be supported. Given current staffing challenges the PALMS service will not be in all practices by March 2022
5. Link Workers / Social Prescribing	**Actions completed** The link workers now provide a service to all GP practices in the city fulfilling this commitment in the Primary Care Improvement Plan. (Noting lower demand during the last year.) **Actions partially completed**	A move to telephone/ online support has enabled the link workers to extend their support to an additional 9 practices. A band 6 vacancy has arisen and the likelihood is that this post will	Sheila Allan, Community Health Inequalities Manager	£192k	Introduce greater skill mix. Work with practice staff to develop appropriate triage system and support signposting/ referral. Develop and enhance current promotions across new and existing practices. Work with E-health to formulate new systems for the link worker	210k	A decrease in referral numbers has assisted the team to extend coverage to additional practices. Capacity may become an issue if numbers increase significantly. Care is required to ensure that staff at different bands are assigned to appropriate patients in

	Work is ongoing to introduce a skill mix in the team which over time will enable patients to be supported at different levels of need more efficiently. **Actions outstanding** Support for wider practice teams to signpost patients to services directly has stalled due to the Covid situation. The link worker team has plans in place to pick this work up with practice staff when guidelines/ restrictions allow.	be filled by a band 4 support worker. The team has a resource pack and training session in place ready to use once practices are ready to explore their referring/ signposting potential.	Sheila Allan Sheila Allan		team and finalise a move to Vision Anywhere. Work with the Scottish Government and PHS on the next phase of the national core data set. Participate in the development and implementation of the new national Community Link Worker Network		terms of interventions required, needs and complexity. Needs to be managed carefully to ensure that patients who need to see link workers benefit from the service, and similarly, those who do not require that level of support are signposted directly. In addition, there may be other pressures on practice staff and this work might be deprioritised.
6. Urgent Care	**Actions completed** Nurse Consultant appointed Roll out of Care Home Urgent Care to 11 practices **Actions partially completed** Review of Urgent Care (Home visiting) model following withdrawal of SAS staff **Actions outstanding** Implementation of new Urgent Care (Home visiting) model		Allison Fannin, Integrated Manager (Urgent Care)	£241k	Care Home Roll out to continue as planned, aiming to support all care homes by April 21 (assuming successful recruitment) New model aligned with Cluster focussed urgent care teams to be partially implemented All practices to have access to either care home or home visit urgent care teams. Recruit further Advanced practitioners from a range of professional backgrounds. Continue to assess pathways and skill mix to ensure people	Recruit additional 6 ACPs 781k	There is limited availability of specialist paramedics, ANP's, or a nurse consultant, who can undertake this work. These may need to be developed as trainee roles initially which will delay implementation to the degree planned. There is significant demand for roles at advanced practice level in a range of settings, including practices, out of hours and core ambulance service. NHST does not have a well-developed

					are seen by the person with the right skills. Continue to work with e-health to develop information systems that support managing the increasing workload in a way which supports urgent care team delivery. Review if current training for advanced practice is appropriate for the developing service, and link across Tayside to progress this if not.		infrastructure to support the development of advanced practitioners in the numbers required to support PCIP, across workstreams. However urgent care is the area most reliant on this. Work to develop a framework for advanced practitioners (AP's) has been delayed due to COVID
7. Care and Treatment Services	**Actions completed** • Phlebotomy service city wide but not all of phlebotomy is able to transfer – nor planned to in current funding. • Community Leg ulcer service city wide • Wound care rolled out city wide • Providing some injections. • Providing some chronic disease monitoring **Actions partially completed** Ear care service planning in place, Test of change in cluster 1 for ear care starting July 21	The team provided significant support during the start of the pandemic by seeing patients at home for phlebotomy who were shielding, was a significant workload for a number of months. Although these services have been transferred to care and treatments services they are available in a smaller number of locations with	Cath Cook, Community Care and Treatment Service Team Leader	£772k	Scoping/evaluation of services to be prioritised by GP practices i.e. ear care service or additional phlebotomy to ensure services delivered are reflective of GMS contract and beneficial to patients and General Practice Recruitment of additional staff to undertake services agreed Work with colleagues in property team to identify space which is suitable, and secure funding to upgrade this where required.	1,078k	Securing additional suitable accommodation is a key risk. Ongoing staff absence as a result of COVID-19 and T&T (assumption that full vaccine roll out will minimise this) Potential delays in recruitment There are significant requests from secondary care for phlebotomy, and other care delivery, in community to be part of care and treatment services. There is no staff capacity for this

	Actions outstanding CC&TS phlebotomy services under review to integrate secondary care phlebotomy	limited local access. Lack of premises is currently hampering expansion of some services. Single pathway and additional resource required for all phlebotomy services to be integrated					currently and no space to develop this. The wider system should review its requirements and feed this into longer term plans.
8. Premises, Infrastructure and IT Systems	**Actions completed** **Actions partially completed** Near me had increased in practices in the early phase of the covid pandemic but this has reduced over time. **Actions outstanding** No progress in any scoping of space in practices and potential for minor works or premises development to increase space, due to lack of capacity across teams. A Primary Care Premises Strategy has not progressed and will be carried forward into 21/22. Vision Anywhere has been used to support the covid vaccination programme and this has limited the ability of the team to develop	No actions have been fully completed as the manager who led on premises work retired and was not replaced by the property team, and the senior manager for Primary care was redeployed to support the covid assessment centre and then flu and covid vaccinations.			Work with practices to identify if there is underutilised space which could be used for clinical service delivery with small investment of resources. This will inform any decisions re further SG investment at a local level for premises. Review longer term plans and develop a Dundee Primary Care Plan for premises. Work with colleagues in NHS Tayside property teams, and PC Department, re a range of actions which will inform premises planning, including surveys which are being completed for practices. Work with colleagues in e-health to roll out Vision Anywhere (VA), and test new functionality which is expected over the coming months,	40k	Premises reprised for primary care will be part of the wider HSCP property strategy.

	the ongoing areas for PCI work. This will be progressed in 21/22.				including reporting for clinical outcomes. Where there are gaps in what VA can deliver work with colleagues to identify how these can be managed. Work with colleagues in NHS Tayside, Dundee City Council and the 3rd sector to develop a plan for future development of primary care sites, including general practice and health and community care centres, based on the premises survey to be undertaken, and building on the Dundee H&SCP Property Strategy, once completed. Work with clusters to consider boundaries for general practice to ensure all areas of the city have adequate access to general practice and care and treatment services, recognising that teams are increasingly geographically based Build on the shift seen with Near me and other technologies, (including medilink) during covid to promote technology as an option for care delivery across practices. Work with the third sector to support access to devices to allow Near Me for those who would be digitally excluded normally.		Practice boundaries and how practices and clusters link to and communicate with a range of teams is important as wider teams are formed.

					Work with colleagues in Angus to assess the impact of Flo for BP management and how links to other technologies and software programmes which can support this area of care.		
9. Workforce Planning and Development	**Actions completed** Work was completed to review practice based nurses/HCA's who could be TUPEd to care and treatment services. This impacted on a small number of staff. A microsite was developed to support recruitment and has been up and running for some time now. It is being reviewed and refined as learning is gained on its impact. There is a Tayside programme around recruitment and retention of GP's. This has a range of interventions including retaining staff at the end of their career, and recruiting new GPs once qualified via a career start programme. The latter was more successful than anticipated and so there was an increased cost. This is no longer funded nationally and so cost this year met within PCI funding. **Actions partially completed** **Actions outstanding**			6k 241k	Develop a shared culture where the focus is on teams who can support people with their health and care, and which communicates effectively in a range of ways, adapted to the range of settings that the primary care team will work from. Work with colleagues leading on developing advanced nurse practitioner roles to ensure we have a clear pathway for ANP training and role development in the context of PCI. Work with organisational development colleagues to consider how to create cohesive teams, focussed on the person at the centre of a pathway, which also recognises the pivotal role of the GP as a leader. Work with colleagues to look creatively at new roles which will be seen to attract staff to this area, as they are innovative and attractive.	114k	Recurring funding for recruitment and retention of GP's, including carer start, needs identified.

	Most actions were not completed due to the impact of covid and have been carried forward to 21/22.				Consider in any training and development programmes if a wider range of training experience will help recruit and retain staff locally.		
10. Sustainability / scalability	**Actions completed** None **Actions partially completed** A range of evaluation work that had been planned was unable to be undertaken because of the significant impact of covid on delivery. **Actions outstanding** All actions outstanding				Review evidence base for models and the impact they are having as we gain that information to assess if they are effective and efficient. Consider roll out across all clusters and if the service being provided can be fully implemented at scale. Identify other sources of funding which may be able to support the shift of some of the work within PCI, recognising that money can not be transferred from practices		A national PCI leads group has recently been set up by Scottish Government which will share learning and consider issues. This should give opportunities to learn from elsewhere in a way that has not been possible until now.
11. Practice Staff Development	**Actions completed** **Actions partially completed** Although the PASC work was put on hold nationally some of the workflow and care navigation was used as part of how practices looked at their processes during covid. **Actions outstanding**	The increased use of initial triage by a range of staff in the practice has changed initial contact with the practice. Some of this is likely to be longer term change.			Review progress with care navigation and workflow as practices start to remobilise services. Review the impact of changes in service delivery particularly on those in the nursing team, and ensure opportunities to develop roles in the practice team are optimised.		
12. Evaluation	**Actions completed** Formal evaluation was not feasible during the last year due to demands on both delivery				Undertake audits, both within services and with support from the LIST team, or via VA		

	teams and those in a more formal evaluation role. However ongoing review of feedback, including complaints, has influenced how services have developed over the year, where possible. **Actions partially completed** **Actions outstanding** More formal review and evaluation is outstanding and actions have been carried forward.				reporting when it is available, to assess the impact of changes. Work with colleagues across Tayside to share learning and knowledge as that develops, and use this learning to influence change. Undertake qualitative evaluation as well as quantitative to provide more in-depth feedback on both patients and staff perceptions of changes. All workstreams to have a clear evaluation plan in place with timescales for this.		
13. Communication and Engagement	**Actions outstanding** None of the actions from 20/21 are complete and most are ongoing, with limited progress. These have therefore been carried forward.				Teams will share across PCI and with practices methods of effective engagement. Comms team will work with PCI teams to agree key messages and branding to be used to increase public awareness. Develop information on NHST public website with colleagues across Tayside, linking to social media where appropriate. Use this information on practice websites as well. Work with a range of groups to engage and consult with the public going forward around		

					service delivery, where there are options around delivery. Share examples of how service change has had a positive impact on people who have received support. All teams will create patients stories, considering if video can be used as part of this. Use learning from the PASC care navigation work, and learning from across all workstream, to ensure a coordinated approach to this change and how communicated.		

ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **MENTAL HEALTH AND WELLBEING STRATEGIC UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB41-2021**

1.0 PURPOSE OF REPORT

1.1 To brief the Integration Joint Board about local and Tayside strategic mental health and wellbeing developments.

2.0 RECOMMENDATIONS

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

2.1 Note the contents of this Report.

2.2 Remits to the Chief Officer to present a report outlining the outcome of the review of Dundee Mental Health and Wellbeing Strategic Plan in October 2021.

2.3 Approves a funding contribution of £180k per annum from delegated mental health funding as Dundee's contribution towards implementing Distress Brief Intervention as set out in section 4.13 of this report.

3.0 FINANCIAL IMPLICATIONS

3.1 The costs associated with the developments outlined in this report will be funded through a combination of a reconfiguration of existing budgets held by the IJB and other partners and through accessing additional funding where appropriate. The Finance teams across NHS Tayside and IJBs are working with Mental Health operational leads to develop high level strategic financial plans for MH services. These plans will be expected to provide a high level description of current financial resources in the system, describe current commitments and to map out further potential investment priorities identified to deliver the MH Strategy. The plans would be expected to describe any shift of resources within the system. They will also note financial deficits in the system and highlight the need to address as part of the MH strategy.

3.2 As detailed in section 4.13 of this report, a 2 year contract to deliver Distress Brief Intervention has been put out to tender to the value of approximately £1,100k. A commitment from Scottish Government to provide £200k financial support during the first 2 years has been received, with the remaining cost of £900k being apportioned between the 3 IJB's. The Dundee share of cost is anticipated to be around £180k per annum.

4.0 MAIN TEXT

4.1 Dundee Mental Health and Wellbeing Strategic Plan 2019-2024 (the Strategic Plan) was approved by the IJB at its meeting of 27 August 2019.

4.2 A progress report in relation to the Strategic Plan was noted by the IJB at its meeting of 23 June 2020.

4.3 Dundee Mental Health and Wellbeing Strategic and Commissioning Group (MHWSCG) is in the process of reviewing progress against the priorities set out within the Plan and considering whether the Strategic Plan requires to be refreshed in light of learning gained regarding the impact of the COVID-19 pandemic on citizens of Dundee.

4.4 In summer 2020, three surveys explored experiences over the early months of the pandemic including use of services. The total sample was 1535: Fairness Commission 452; Engage Dundee 892; Food Insecurity Network 192. Common themes related to the challenges of being locked down, mental health impacts, reduced access to services, social isolation and financial/job insecurity. For many, the issues were interconnected and for some the pandemic exacerbated what were already difficult life circumstances. Inequalities emerged for particular age groups, the unemployed and those on welfare benefits, the long term sick and disabled, carers and people who lived alone. The findings have been shared with a wide range of partners to raise awareness of the impact of the pandemic particularly for those who are most disenfranchised and find it hardest to be heard.

4.5 In reviewing its current plan, the MHWSCG identified additional actions for development to ensure it addressed issues arising from the evidence above. These were: improved linkages with other strategic plans; assessment of action to address the mental health impacts raised across relevant partnerships; identification of gaps; inclusion of action for vulnerable groups including gendered approached and other targeted activity; strengthening work in communities; and consideration of workforce development. A working group, led by a member of the MHWSCG will ensure that these areas are incorporated within the refreshed Strategic Plan.

4.6 Report DIJB22-2021 “Mental Health Crisis Support in Dundee” was noted by the IJB on 21 April 2021 and it was remitted to the Chief Officer to present a progress report to the IJB in October 2021.

4.7 Since April 2021 there has been progress made towards the development of a Community Wellbeing Centre (CWC). The CWC, which will be “always open” (that is, operating 24/7) will provide an immediate, compassionate response to anyone who considers themselves to be in need of immediate support regardless of whether that need is arising from an acute deterioration in a recognised mental health problem or from high levels of emotional distress arising from problematic life events and circumstances.

4.8 Development of services for people experiencing emotional distress is a key priority. The immediate, compassionate response within the CWC will be followed by assistance to access community based resources and, importantly, access to Distress Brief interventions (see 4.13 below).

4.9 Those people identified as requiring immediate assessment, care or treatment for an acute deterioration in a mental health problem will be supported to access specialist mental health services. This will ensure that everyone requiring specialist mental health support has easy and immediate access to it. It is envisaged that the CWCs will be able to support people whilst the clinical assessment process is ongoing and, importantly, if specialist mental health care and treatment is not required, people will already be in the correct place to access the supports available for people experiencing distress. It is hoped that this seamless transition across pathways will ensure that people are directed to the right support at the right time and emphasise parity between people experiencing distress and those experiencing an acute mental health crisis.

4.10 It is recognised within the City that people who experience significant mental health problems and use substances (often referred to as 'dual-diagnosis') have particular needs with a Corra Foundation bid advancing a test of change for the provision of more integrated and intensive care and treatment approach to try and better meet those needs. This 'high intensity' care and treatment approach is very different from the support and services delivered from the CWC which are low intensity in nature. Whilst the CWC will seek to be inclusive from the perspective of age and whether people use substances or not, it is important that it is seen as a *conduit* to the most appropriate resource available for people; it will not seek to provide all of these services.

4.11 The always open CWCs will also have access to short-term accommodation with support. The location of these has been influenced, where possible, by intelligence from the Tayside Multi-agency Suicide Review Group in order to achieve the correct balance between providing support where it is geographically close to the people with greatest need whilst avoiding locations of greatest risk for suicide.

4.12 A suitable building for the CWC has been offered to the Health and Social Care Partnership and an initial specification has been presented to the voluntary organisation who own the building, to establish feasibility. Two sites have been identified with a view to accommodation with support.

4.13 A contract to deliver Distress Brief Intervention has been issued to tender and it is anticipated that a contract will be awarded to the successful voluntary organisation in September 2021. Representatives of Dundee Health and Social Care Partnership are leading the tender process on behalf of the 2 other Health and Social Care Partnerships in Tayside. The value of the contract across Tayside is anticipated to be around £1,100k over a 2 year period. Funding from the Scottish Government of £200k to support the establishment of Distress Brief Intervention in Tayside has been agreed over this initial 2 year period. The net cost to Dundee IJB over this period is anticipated to be around £180k per annum which will be funded from additional Scottish Government funding for mental health.

4.14 The joint initiative between Scottish Ambulance Service (SAS) and the Dundee Health and Social Care Partnership to establish a Paramedic Mental Health Response Vehicle (PMHRV) has also progressed. Recruitment for four part-time mental health nurses to work with two specialist SAS paramedics has advanced and, in advance of these nursing appointments, the PMHRV has operated on a number of weekends with paramedic only staffing to respond to 999 calls triaged as arising from issues with mental health problems or high levels of emotional distress. Early outcomes indicate that most people have been successfully helped in their own home environment without the need for more specialist mental health assistance or being taken to the Emergency Department.

4.15 Tayside Mental Health and Wellbeing Strategy "Living Life Well" (Article Ref XIV) was endorsed by the IJB at its meeting of 15th December 2020. It was remitted to the Chief Officer to submit an implementation plan and financial framework to the IJB once these had been produced collaboratively with neighbouring Health and Social Care Partnerships in Tayside and NHS Tayside, who have operational responsibility for Mental Health In-patient Services.

4.16 An Integrated Leadership Group with representation from the 4 organisations outlined in 4.15 is now well established and meets monthly. Following discussion between respective Chief Finance Officers in Tayside it has been agreed that Dundee's Chief Finance Officer and his depute (Finance Manager for the Partnership) will join the Integrated Leadership Group and lead the development of a financial framework in conjunction with a range of finance/ operational/ strategic colleagues across the 4 organisations. This will support a range of priority areas of development at pace and offer a transparent, collaborative model of strategic financial planning.

4.17 "Living Life Well" was produced in response to a specific recommendation of the Independent Inquiry Into Mental Health Services in Tayside. The original Independent Inquiry Report highlighted a need to rebuild trust and respect in relation to Mental Health Services in Tayside, both with the public and within the workforce, by focussing on 5 cross-cutting themes: Strategic Service Design, Governance and Leadership, Engaging with People, Learning Culture and Communication. The report also stated a need to collectively focus more on developing community mental health and wellbeing supports as opposed to a predominant continued focus on in-patient care by taking a collective, and more strategic, whole system approach.

4.18 At the time of publication, the then Minister for Mental Health asked that Dr David Strang undertake a review of progress in Tayside in early 2021. This was duly commenced in February 2021 and Dr Strang's report "Independent Inquiry into Mental Health Services in Tayside Progress Report" (the Progress Report) was published in July 2021. The original Listen Learn Change Action Plan set out how the 51 Recommendations would be addressed.

4.19 The recent Progress Report (July 2021) highlights the importance of Tayside having realistic time scales with regard the "scale of the task ahead." Work has already taken place (led by Dr Jane Bray in Public Health) to better prioritise the required developments. Dundee HSCP staff are well engaged with all key pieces of work and are leading on developments for the previously referenced Review of Crisis & Urgent Care, Neurodevelopmental Disorders and Learning Disability Services. At present, there is no explicit implementation plan with regard to Living Life Well but this is in the process of development.

4.20 The NHS Tayside led work-stream with regard to the provision of adult mental health in-patient care supported the provision of these specialist services from one Tayside site. There has yet to be formal agreement as to where this in-patient care will be sited.

4.21 Within Dundee Community Mental Health Services, there continues to be a reliance on Locums for our specialist Consultant Psychiatry staffing. However, this has been provided by a largely stable group of individuals who have remained in longer-term contracts ensuring continuity of care for patients. Specialist Pharmacist and Pharmacy Technician posts have been created to increase the availability of medicines prescribing and review, and there are currently two Advance Nurse Practitioners training within the service. Together, these developments will increase the available workforce and ensure that Consultant Psychiatrists are used only for the complex and higher level tasks that only they can provide.

4.22 To ensure appropriate links with action at a local level, the MHWSCG supported a refresh of local Health and Wellbeing Networks at its meeting in July 2021. Led by Dundee Health Inequalities Service, the networks provide a forum for service providers and local people/ those with lived experience to come together to agree, shape and implement local responses to health and wellbeing priorities, including mental health. The networks will improve communication and coordination, avoid duplication, and ensure clear lines of reporting including to Local Community Planning Partnerships and strategic partnerships.

4.23 The MHWSPG membership offered its support to the Health and Wellbeing Networks and agreed to provide staff and other resources to support the local structure and associated developments. In terms of additional Scottish Government funding, it was agreed that consideration will be given to the provision of financial resources for mental health recovery in communities and that the networks will be a useful forum for these discussions.

4.24 Good communication and liaison have been maintained with our Advocacy Partners; Dundee Independent Advocacy Support (DIAS), Partners in Advocacy and Advocating Together. Close working networks are in place which allows for collaborative and partner working at a local level. A forum for collective training and learning has been established with good links to the national advocacy context. Demand for independent advocacy support has increased over the last few months and we have agreed to invest additional funding to support this and ensure additional capacity is available.

4.25 In conclusion, mental health and wellbeing continues to be a high priority for a range of partners within the city. Plans for improvement, both locally and pan Tayside, are ambitious and are being escalated at an unprecedented scale and pace.

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 level of interdependency between the two pathways (acute mental health crisis and people experiencing emotional distress) described above. Should either not be implemented as envisaged with closely aligned time-scales, there is a danger that we may not be able to deliver safe and effective person centred care to people in crisis
Risk Category	Operational
Inherent Risk Level	Likelihood (4) x Impact (4) = Risk Scoring (16)
Mitigating Actions (including timescales and resources)	Urgent/Crisis pathway work has already arrived at a single recommendation; Distress Brief Intervention (DBI) scheduled to be implemented by September 2021; accommodation with support scheduled for Autumn 2021. The Dundee Mental Health and Wellbeing Strategic and Commissioning Group has appointed a subgroup to drive forward developments and ensure coordination and 'best-fit' across wider community resources.
Residual Risk Level	Likelihood (3) x Impact (3) = Risk Scoring (9)
Planned Risk Level	Likelihood (1) x Impact (2) = Risk Scoring (2)
Approval recommendation	The risk should be accepted.

Risk 2 Description	Evidence demonstrates that the ability to predict completed suicide, even where assessment is undertaken by skilled professionals, is limited. There is a risk that the development of an "always open" Community Wellbeing Hub (CWH) does not result in a demonstrable reduction in the number of people engaging in serious or fatal self-harm
Risk Category	Reputational
Inherent Risk Level	Likelihood (3) x Impact (3) = Risk Scoring (9)
Mitigating Actions (including timescales and resources)	Models of best practice from elsewhere have been considered in developing the model of care; levels of care can be stepped up where necessary; the provision of brief interventions (or equivalent) should assist people in addressing some of the core psycho-social factors fueling their distress
Residual Risk Level	Likelihood (3) x Impact (1) = Risk Scoring (3)
Planned Risk Level	Likelihood (3) x Impact (1) = Risk Scoring (3)
Approval recommendation	The risk should be accepted.

Risk 3 Description	The Tayside prioritisation of work in addressing Listen, Learn, Change and Living Life Well may not align with local priorities and adversely impact on the speed of implementation of local service improvements
Risk Category	Operational
Inherent Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Mitigating Actions (including timescales and resources)	Influence by Locality Manager & Clinical Lead at ILG; Influence by Chief Officer at ELG; increase Leadership capacity within MH & LD
Residual Risk Level	Likelihood (1) x Impact (3) = Risk Scoring (3)
Planned Risk Level	Likelihood (insert scoring) x Impact (insert scoring) = Risk Scoring (insert overall risk scoring)
Approval recommendation	This risk should be accepted

7.0 CONSULTATIONS

7.1 The Chief (Finance) 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	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None.

Vicky Irons
Chief Officer

DATE: 23 July 2021

ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **FINANCIAL MONITORING POSITION AS AT JUNE 2021**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB42-2021**

1.0 PURPOSE OF REPORT

1.1 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 2021/22 including an overview of the costs and financial risks associated with Dundee Health and Social Care Partnership's response to the COVID-19 crisis.

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 2021/22 financial year end as at 30th June 2021 as outlined in Appendices 1, 2, 3 and 4 of this report.

2.2 Notes the costs and financial risks associated with Dundee Health and Social Care Partnership's response to the COVID-19 crisis as set out in section 4.5 of this report.

2.3 Notes that officers within the Health and Social Care Partnership will continue to carefully monitor expenditure and develop a range of actions to mitigate any overspend.

3.0 FINANCIAL IMPLICATIONS

3.1 The underlying financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 30th June 2021 (excluding any implications of additional COVID-19 spend) shows a net projected underspend position at the year-end of £139k.

3.2 Dundee Health and Social Care Partnership continues to incur additional expenditure associated with the response to the Covid19 pandemic in line with the remobilisation plan as agreed by Dundee IJB at its meeting held on 21st April 2021 (Article X of the minute refers). The Scottish Government provided additional funding throughout 2020/21 to support these additional costs which included provision for unforeseen additional expenditure at the year end period due to the uncertainty of a range of costs. The Scottish Government instructed that any surplus funding at the year end would sit as earmarked in IJB's reserve balances and must be drawn down to cover additional Covid19 related spend in 2021/22 before any additional funding would be provided to cover 2021/22 Covid19 spend. Dundee IJB has a total of £6.1m of Covid19 reserves.

3.3 The projected total cost of the most recent Mobilisation Plan financial return submitted to the Scottish Government in July 2021 (Quarter 1 return) is £7.3m and they have advised that this return will be used as the basis for any future additional funding allocations.

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's final budget for delegated services was approved at the meeting of the IJB held on the 26th March 2021 (Article IV of the minute of the 26th March refers). This set out the cost pressures and funding available with a corresponding savings plan to ensure the IJB had a balanced budget position going into the 2021/22 financial year. An updated assessment of the status of the savings plan is set out in Appendix 4 of this report.

4.1.3 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 the IJB's projected financial position. Officers within the Partnership will continue to explore areas to control expenditure and achieve the savings targets identified.

4.1.4 The enclosed financial reporting has been enhanced to include more detail of operational services financial performance as requested by IJB members.

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. These figures exclude the potential cost implications of responding to the COVID-19 crisis.

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 underspend of around £1,266k by the end of the financial year. Assuming all additional Covid costs are covered by additional funding, community based health services managed directly by Dundee Health and Social Care Partnership are projected to be underspent by approximately (£933k) and overall prescribing is projected to be underspend by (£841k). Further underspends totalling (£315k) are anticipated within Public Health, Primary Care and Keep Well services.

4.3.2 Service underspends are also reported within Community Based Psychiatry of Old Age (£610k), hosted services such as Psychology (£200k), Tayside Dietetics (£60k), Learning Disability (Tayside Allied Health Professionals) (£150k) and Sexual & Reproductive Health (£300k) mainly as a result of staff vacancies.

4.3.3 Service overspends are anticipated in Enhanced Community Support £525k, Medicine for the Elderly £426k and Psychiatry of Old Age In-Patients £427k. Occupational Therapy budgets are projected to be overspent by £600k with further overspends arising in Community Nursing of £447k, Substance Misuse Services of £100k and General Adult Psychiatry of £250k. Additional staffing pressures have contributed to the adverse position, mainly through the Covid-19 response with additional Scottish Government funding anticipated to cover these additional costs.

4.3.4 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 impact of hosted services to Dundee being an overspend of £315k which mainly relates to higher spend within Out of Hours Services hosted by Angus IJB.

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 £1,126k.

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. As a result of this, care at home services are projected to be overspent by around £1,750k at this stage of the financial year. This is partly offset by an underspend in older people care home placements of £210k and in respite care for older people of £199k, both partly as a result of the Covid Pandemic. Care home spend for mental health service users is projected to be £393k overspent however a review will be undertaken to realign care home budgets for adults given large underspends in learning disability and substance misuse care home budgeted expenditure.

4.4.3 Demand for learning disability services continues to be high with overspends projected in the provision of day services (£250k) and accommodation with support (£349k).

4.5 Financial Impact of the COVID-19 Response

4.5.1 The Health & Social Care Partnership's response to the Covid19 pandemic continues to evolve as the impact of the pandemic changes and is reflected in the HSCP's remobilisation plan. Consistent with the remobilisation plan, a quarterly financial return outlining Covid19 additional expenditure is required by the Scottish Government. The 2021/22 quarterly return was submitted to the Scottish Government at the end of July 2021, the detail of which is set out in table 1 of this report.

4.5.2 The Scottish Government provided additional funding throughout 2020/21 to support these additional costs which included provision for unforeseen additional expenditure at the year end period due to the uncertainty of a range of costs. The Scottish Government instructed that any surplus funding at the year end would sit as earmarked in IJB's reserve balances and must be drawn down to cover additional Covid19 related spend in 2021/22 before any additional funding would be provided to cover 2021/22 Covid19 spend. Dundee IJB has a total of £6.1m of Covid19 reserves. The quarter 1 finance return will be used by the Scottish Government to determine any further Covid19 funding requirements of IJBs. Until this is confirmed, there is therefore a risk that the additional funding and value of the reserves brought forward is insufficient to meet the additional costs.

4.5.3 The Scottish Government recently agreed to extend the financial support offered to social care providers throughout the pandemic to date and funded through IJB remobilisation funding until March 2022. This element has been the most significant cost within the remobilisation plan to date and includes continued payment of underoccupancy payments to care homes (until the end of September 2021), payments for additional staff sickness and cover and additional PPE.

4.5.4 The providers financial support claim process involves assessment and scrutiny as well as benchmarking where possible by contracts officers and commissioning leads with a recommendation made to the Chief Finance Officer of Dundee IJB as to the reasonableness of the request. The Chief Finance Officer considers these recommendations and other considerations prior to authorising additional provider payments.

4.5.5 The latest financial summary of the mobilisation plan as submitted to the Scottish Government in July 2021 (Quarter 1 return) is as follows:

Table 1

Mobilisation Expenditure Area	Estimated Additional Expenditure to Year End (2021/22) £000
Additional Care Home Placements	150
PPE	58
Additional Staff Cover / Temporary Staff	2,560
Provider Sustainability Payments	1,474
IT / Telephony	50
Additional Family Health Services Contractor Costs	113
Additional Family Health Services Prescribing Costs	276
Loss of Charging Income	488
Additional Equipment and Maintenance	207
Primary Care	205
Additional Services within Remobilisation Plan	1,118
Other Costs	158
Anticipated Underachievement of Savings	481
Total Projected Mobilisation Costs	**7,338**

Please note this is based on a range of assumptions, including national agreements therefore is subject to change as actual expenditure figures become clearer throughout the financial year.

4.6 Reserves Position

4.6.1 The IJB's reserves position considerably improved at the year ended 31st March 2021 as a result of the IJB generating an operational surplus of £2,041k during 2020/21 and the impact of the release of significant funding to all IJB's by the Scottish Government for specific initiatives to be held as earmarked reserves. This results in the IJB having total committed reserves of £11,734k and uncommitted reserves of £2,094k. This leaves the IJB with more flexibility to respond to unexpected financial challenges and provides the opportunity for transition funding for transformation of services. The reserves position is noted in Table 2 below:

Table 2

Reserve Purpose	Reserves Balance @ 31/3/21
	£k
Primary Care	2,424
Mental Health Action 15	527
ADP	358
Service Specific Projects	129
Community Living Change Fund	613
Covid-19	6,084
NHST - shifting balance of care	1,600
Total Committed Reserves	11,734
General Reserves (Uncommitted)	2,094

4.6.2 Scottish Government funding in relation to Primary Care Improvement Fund, Mental Health Strategy Action 15 Workforce and Alcohol and Drugs Partnerships can only be spent on these areas and reserve balances will be taken into consideration for these funds by the Scottish Government when releasing further in-year funding.

4.6.3 Similarly the provision of Covid19 funding can only be set against Covid19 related additional expenditure and this must be drawn down first before the Scottish Government will release any further funding during 2021/22.

4.6.4 Due to the nature of how reserves must be treated within the IJB's accounts, the actual position at the end of 2021/22 will show a significant overspend against these funding streams as the total reserves to be applied (nb the funding of these services) can only be drawn down at the financial year end. The figures included in this financial monitoring report present these additional costs as having already been met from reserves.

4.7 Savings Plan

4.7.1 The IJB's savings for 2021/22 were initially agreed at the IJB meeting of 26 March 2021 (item IV of the minute refers) and subsequently revised following confirmation of additional Scottish Government Funding as agreed at the IJB meeting of 23 June 2021 (Item IX of the minute refers.) The total savings to be delivered during 2020/21 amount to £2,042k and at this stage of the financial year it is considered that the risk of these not being delivered are generally low. This assessment is set out in Appendix 4.

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 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

9.1 None.

Dave Berry
Chief Finance Officer

Date: 23rd July 2021

Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2021/22 Jun-21

	Dundee City Council Delegated Services		NHST Dundee Delegated		Partnership Total	
	Net Budget	Projected Overspend / (Underspend)	Net Budget	Projected Overspend / (Underspend)	Net Budget	Projected Overspend / (Underspend)
	£,000	£,000	£,000	£,000	£,000	£,000
Older Peoples Services	41,405	446	16,942	930	58,348	1,376
					0	0
Mental Health	4,702	245	3,867	250	8,569	495
Learning Disability	28,042	802	1,509	(60)	29,551	742
Physical Disabilities	5,012	86	0	0	5,012	86
Drug and Alcohol Recovery Service	1,213	(392)	2,805	100	4,018	(292)
Community Nurse Services/AHP/Other Adult	498	(97)	14,263	931	14,761	834
Hosted Services			21,266	(309)	21,266	(309)
Other Dundee Services / Support / Mgmt	2,625	37	29,214	(165)	31,839	(128)
Centrally Managed Budgets			2,196	(494)	2,196	(494)
Less: Covid 19 Spend			0	(2,117)	0	(2,117)
Total Health and Community Care Services	**83,498**	**1,126**	**92,063**	**(933)**	**175,560**	**193**
Prescribing (FHS)			32,928	(856)	32,928	(856)
Other FHS Prescribing			194	15	194	15
General Medical Services			27,183	186	27,183	186
FHS - Cash Limited & Non Cash Limited			22,166	7	22,166	7
Large Hospital Set Aside			0	0	0	0
Total	**83,498**	**1,126**	**174,534**	**(1,581)**	**258,031**	**(455)**
Net Effect of Hosted Services*			(3,543)	315	(3,543)	315
Grand Total	**83,498**	**1,126**	**170,990**	**(1,266)**	**254,488**	**(139)**

*Hosted Services - Net Impact of Risk Sharing Adjustment

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

Appendix 2

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2021/22						Jun-21
	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
Psych Of Old Age (In Pat)			4,808	427	4,808	427
Older People Serv. - Ecs			1,138	525	1,138	525
Older Peoples Serv. -Community			594	-15	594	-15
Ijb Medicine for Elderly			5,672	426	5,672	426
Medical (P.O.A)			713	-10	713	-10
Psy Of Old Age - Community			2,345	-610	2,345	-610
Intermediate Care			13	-13	13	-13
Medical (MFE)			1,659	200	1,659	200
Care at Home	19,500	1,754			19,500	1,754
Care Homes	25,243	-210			25,243	-210
Day Services	1,009	-57			1,009	-57
Respite	590	-199			590	-199
Accommodation with Support	276	58			276	58
Other	-5,213	-900			-5,213	-900
Older Peoples Services	41,405	446	16,942	930	58,348	1,376
General Adult Psychiatry			3,867	250	3,867	250
Care at Home	-243	-28			-243	-28
Care Homes	372	393			372	393
Day Services	63	-34			63	-34
Respite	0	22			0	22
Accommodation with Support	4,109	0			4,109	0
Other	401	-107			401	-107
Mental Health	4,702	245	3,867	250	8,569	495
Learning Disability (Dundee)			1,509	-60	1,509	-60
Care at Home	42	63			42	63
Care Homes	2,801	-232			2,801	-232
Day Services	7,886	250			7,886	250
Respite	549	-114			549	-114
Accommodation with Support	20,293	349			20,293	349
Other	-3,529	486			-3,529	486
Learning Disability	28,042	802	1,509	-60	29,551	742

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Care at Home	807	-89			807	-89
Care Homes	1,856	-41			1,856	-41
Day Services	1,226	-202			1,226	-202
Respite	16	-59			16	-59
Accommodation with Support	572	2			572	2
Other	535	474			535	474
Physical Disabilities	5,012	86	0	0	5,012	86
Substance Misuse Dundee			2,805	100	2,805	100
Care at Home	0	0			0	0
Care Homes	284	-161			284	-161
Day Services	60	1			60	1
Respite	0	0			0	0
Accommodation with Support	327	-74			327	-74
Other	543	-157			543	-157
Drug and Alcohol Recovery Service	1,213	-392	2,805	100	4,018	-292
A.H.P.S Admin			452	0	452	0
Physiotherapy			4,423	-70	4,423	-70
Occupational Therapy			1,562	600	1,562	600
Nursing Services (Adult)			7,075	447	7,075	447
Community Supplies - Adult			310	-5	310	-5
Anticoagulation			440	-41	440	-41
Other Adult Services	498	-97			498	-97
Community Nurse Services / AHP / Other Adult Services	498	-97	14,263	931	14,761	834
Palliative Care - Dundee			2,954	129	2,954	129
Palliative Care - Medical			1,286	127	1,286	127
Palliative Care - Angus			372	17	372	17
Palliative Care - Perth			1,868	45	1,868	45
Brain Injury			1,848	75	1,848	75
Dietetics (Tayside)			3,213	-60	3,213	-60
Sexual & Reproductive Health			2,307	-300	2,307	-300
Medical Advisory Service			106	-50	106	-50
Homeopathy			29	6	29	6
Tayside Health Arts Trust			65	0	65	0
Psychology			5,428	-200	5,428	-200
Psychotherapy (Tayside)			915	53	915	53
Learning Disability (Tay Ahp)			875	-150	875	-150
Hosted Services	0	0	21,266	-309	21,266	-309

	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
Working Health Services			0	20	0	20
The Corner			445	-15	445	-15
Grants Voluntary Bodies Dundee			0	0	0	0
Ijb Management			543	145	543	145
Partnership Funding			26,383	0	26,383	0
Urgent Care			76	0	76	0
Public Health			531	-125	531	-125
Keep Well			600	-90	600	-90
Primary Care			636	-100	636	-100
Support Services / Management Costs	2,625	37			2,625	37
Other Dundee Services / Support / Mgmt	2,625	37	29,214	-165	31,839	-128
Centrally Managed Budget			2,196	-494	2,196	-494
Less Covid-19 identified spend			0	-2,117	0	-2,117
Total Health and Community Care Services	**83,498**	**1,126**	**92,063**	**-933**	**175,560**	**193**
Other Contractors						
FHS Drugs Prescribing			32,928	-856	32,928	-856
Other FHS Prescribing			194	15	194	15
General Medical Services			27,183	186	27,183	186
FHS - Cash Limited & Non Cash Limited			22,166	7	22,166	7
Large Hospital Set Aside			0	0	0	0
Grand H&SCP	**83,498**	**1,126**	**174,534**	**-1,581**	**258,031**	**-455**
Hosted Recharges Out			-12,625	-172	-12,625	-172
Hosted Recharges In			9,081	488	9,081	488
Hosted Services - Net Impact of Risk Sharing Adjustment			**-3,543**	**315**	**-3,543**	**315**
Grand Total	**83,498**	**1,126**	**170,990**	**-1,266**	**254,488**	**-139**

NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee Integration Joint Board

Appendix 3

Risk Sharing Agreement – June 2021

Services Hosted in Angus	Annual Budget	Forecast Over (Underspend)	Dundee Allocation
Forensic Service	1,061,715	(250,000)	(98,500)
Out of Hours	7,679,846	(750,000)	(295,500)
Locality Pharmacy	2,085,159	0	0
Tayside Continence Service	1,517,184	(33,000)	(13,000)
Speech Therapy (Tayside)	1,237,773	10,000	3,900
Hosted Services	**13,581,677**	**(1,023,000)**	**(403,100)**
Apprenticeship Levy	46,000	(3,000)	(1,200)
Baseline Uplift surplus / (gap)	98,028	0	0
Balance of Savings Target	(24,734)	(24,734)	(9,700)
Grand Total Hosted Services	**13,700,971**	**(1,050,734)**	**(414,000)**
Services Hosted in Perth & Kinross			
Prison Health Services	4,043,310	(97,000)	(38,200)
Public Dental Service	2,182,873	48,500	19,100
Podiatry (Tayside)	3,303,887	167,000	65,800
Hosted Services	**9,530,070**	**118,500**	**46,700**
Apprenticeship Levy - Others	41,700	600	200
Baseline Uplift surplus / (gap) - Others	81,876	0	0
Balance of Savings Target	(306,208)	(306,208)	(120,600)
Grand Total Hosted Services	**9,347,438**	**(187,108)**	**(73,700)**
Total Hosted Services	**23,048,409**	**(1,237,842)**	**(487,700)**

Appendix 4

	Dundee IJB - Budget Savings List 2021/22		
	Agreed Savings Programme		
		2021/22 £000	**Risk of non-delivery**
(A)	**Full Year Effect of 2020/21 Savings**		
1)	New Meals Contract Price from Tayside Contracts under new CPU arrangements	*52*	Low
	Total Base Budget Adjustments	**52**	
(B)	***Non Recurring Savings 2021/22***		
1)	Reduction in GP Prescribing Budget	500	Low
2)	Reduction in Discretionary Spend (eg supplies & services, transport costs)	175	Low
3)	Anticipated Increased Staff turnover	350	Low
4)	Review Anticipated Additional Carers Funding for 2021/22	397	Low
5)	Delayed Utilisation of Reinvestment funding	400	Low
	Total Non-Recurring Savings	**1,822**	
(C)	**Recurring Savings**		
1)	Impact of DCC Review of Charges	168	Medium
	Total Recurring Savings	**168**	
	Total Savings Identified	**2,042**	
	Savings Target	**2,042**	

ITEM No …10……..…..

REPORT TO: **DUNDEE HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **ALCOHOL AND DRUG PARTNERSHIP: SELF-ASSESSMENT FINDINGS**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB43-2021**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Integration Joint Board of the findings of the Alcohol and Drug Partnership's self-assessment process undertaken between May and July 2021 to evidence and evaluate the Dundee Partnership's performance in implementing the Action Plan for Change and addressing the 16 recommendations made by the Dundee Drug Commission in 2019.

2.0 RECOMMENDATIONS

It is recommended that Integration Joint Board:

2.1 Note the contents of the report, including the overview of the self-assessment process undertaken between May and July 2021, and findings of the self-assessment (section 4.4 and 4.5 and appendix 1).

2.2 Note that the self-assessment report has been submitted to the Dundee Drugs Commission to support their work to independently evaluate progress towards implementation of the recommendations made by them in 2019 (section 4.6.1).

2.3 Note that amendments will be made to the Action Plan for Change based on the self-assessment findings (section 4.6.2) and instruct the Chief Officer to submit the revised plan to the Integration Joint Board for information once it has been agreed by the Dundee Partnership.

2.4 Note the additional funds provided by Dundee City Council and the Scottish Government and planned investment to support and accelerate actions contained within the Action Plan for Change (section 4.7).

2.5 Seeks additional opportunities to increase funding from both local and national sources, in order to progress the revised action plan and to address developing service requirements.

3.0 FINANCIAL IMPLICATIONS

3.1 There are no additional financial implications associated with the recommendations in this report.

3.2 When setting the 2020/2021 revenue budget, Dundee City Council set aside funding of £500k to support the delivery of the action plans in response to the Dundee Drugs Commission and the Independent Mental Health Inquiry. As a result of the pandemic, only £100k was committed to fund an additional five nurses (part year funding). A further £500k was provided in 2021/2022 resulting in a total of £900k being available. In conjunction with the Alcohol and Drug Partnership and Health and Social Care Partnership it was agreed that this funding should be allocated as follows:

- Continuation of additional nurses £196k
- Third sector supports and outreach £334k
- Resilient communities work £70k
- Children and Families support £79k
- Self-assessment activities £10k
- Dundee Drugs Commission 2 £20k

The remaining balance of £191k is being held for mental health crisis intervention.

3.3 The Dundee Alcohol and Drug Partnership has been notified by the Scottish Government that it is to receive funding of £391k from 2021/22 (recurring for 5 years) to support the implementation of the National Mission to reduce drugs deaths and harm. This funding will be transferred to NHS Boards for onward delegation to Integration Authorities for ADP projects. The Alcohol and Drug Partnership is currently considering proposals for investment as described in section 4.7.

4.0 MAIN TEXT

4.1 In April 2021 the IJB considered a report providing a comprehensive update regarding progress achieved in implementing the Alcohol and Drug Partnership's Action Plan for Change (Article XV of the minute of the Dundee Integration Joint Board held on 21 April 2021 refers). The report also advised that the Dundee Community Planning Partnership has invited the independent Dundee Drug Commission to reconvene and assess the progress made in response to the original report.

4.2 As part of the Dundee Alcohol and Drug Partnership's (ADP) commitment to continuous improvement and to support the work of the Drug Commission, the ADP has prepared a self-assessment which evaluates the performance of community planning partners against the 16 recommendations within the Commission's original report published in 2019.

4.3 The self-assessment sets out in detail the significant progress that has been achieved across the Dundee Partnership over the last 2 years, progressing the recommendations made by the Commission and implementing the Action Plan for Change in the face of extra challenges presented by the COVID-19 pandemic. It summarises the findings of a thorough self-assessment process, led by the Alcohol and Drug Partnership, that included speaking with people affected by drug use, family members/carers, service providers and the workforce about the impact of drug related deaths, changes to pathways of care and support, personalisation of service provision and the development of a culture of collaborative working. It also contains reflections from leaders about the effectiveness of leadership, governance and scrutiny arrangements and behaviours in supporting the implementation of the Action Plan for Change.

4.4 The self-assessment focuses on opportunities for learning and improvement, on conducting an honest, rigorous process that does not shy away from difficult issues. The self-assessment has been informed by evidence gathered through:

- Focus groups with the workforce (30 participants) and people with lived experience of drug use (38 participants);
- Service monitoring reports from 24 individual services working with people impacted by drug use;
- A workforce survey (59 responses);
- The submission of case studies from service providers;
- A leadership self-assessment and supporting workshop; and,
- A review of key strategic and operational reports and documents, as well as an analysis of relevant performance information.

4.5 Self-Assessment Findings

4.5.1 Through the self-assessment process 6 key focus areas have been identified: communication with the workforce and stakeholders / partnership working; staffing issues, staff retention and pressures; treatment options and choice / support choice; mental health; lived experience and leadership. In each of these areas, whilst progress has been made over the last two years, all partners recognise that significant work is yet to be done. In some cases, the challenge set out in the original report from the Drug Commission has been further compounded by the impact of the COVID-19 pandemic, with additional actions now required to address the specific needs and risks arising from the pandemic for people who use drugs and for the workforce.

4.5.2 Overall, during the past two years, the ADP has assessed that partners have made reasonable progress in implementation of 12 of the Drug Commission's original recommendations, with partial progress being made against 4 recommendations. A full summary of progress against each recommendation made by the Drug Commission is included within the self-assessment report (appendix 1, page 70).

4.5.3 Despite the challenges presented by the COVID-19 pandemic during most of this period, the evidence gathered for the self-assessment demonstrates that significant improvements have been made in some areas. This includes the response to non-fatal overdoses and assertive outreach work, extending the naloxone programme, pre COVID-19 introduction of direct access and same-day prescribing, Independent Advocacy, Peer Support programme, developing a gendered approach, progress with trauma-informed approach, anti-stigma work, and improving the governance and function of the ADP. Furthermore, the self-assessment found that during the COVID-19 lockdowns significant innovative practices were developed. There was also an improved collaborative approach between service providers (specifically between public and third sector organisations), trust and relationships between key partners strengthened, and a more focused shared improvement agenda emerged for all partners.

4.5.4 However, the evidence also identifies that partners still have significant progress to make in specific areas. These include responding to pressures and capacity issues within treatment services, accelerating progress with whole-system change (including a shared-care model with Primary Care and an integrated approach for substance use and mental health), improving treatment options (including access to residential support), progressing the Dundee Lead Professional model, eliminating stigmatising behaviour from the workforce, enhancing the focus on prevention and the need to improve communications with the workforce and other key stakeholders.

4.6 Next Steps

4.6.1 The self-assessment has been submitted to the Drug Commission and will inform their programme of work over the next 5 months. Through their activity the Drug Commission will seek to validate the self-assessment findings and to identify any additional evidence regarding progress made to date and remaining challenges. The report provided by the Drug Commission at the end of their review will add further value to the self-assessment work already undertaken by the ADP.

4.6.2 The ADP will now take forward work to adjust the Action Plan for Change to reflect the findings of the self-assessment. This will include:

- Changes to some of the existing actions based on feedback collated through self-assessment process;
- Adding actions to address new areas where gaps have been highlighted by the self-assessment process; and
- Utilising the opportunity to consolidate change and learning from the COVID-19 experience, and take this into next phases of the change process for improvement.

The revised Action Plan for Change will subsequently be shared with the Drug Commission and submitted to the Integration Joint Board and Dundee City Council Policy and Resources Committee for information.

4.6.3 The ADP believes that the work that has taken place over the past two years to improve responses to people who use drugs and the collective work to respond to the challenges presented by the pandemic evidences that there is significant capacity within Dundee, at leadership, strategic and operational levels, to continue to drive forward the full implementation of the Action Plan for Change. The Dundee Partnership is ambitious about its plans for pandemic recovery and the ADP is focused on accelerating key areas of work to address the needs of the most vulnerable people in the city, including those people impacted by drug use. The Dundee Partnership, the Chief Officers Group, the Alcohol and Drugs Partnership and the Leadership Oversight Group for the Action Plan for Change have demonstrated consistent focus and dedication to monitoring and supporting diverse and complex programmes of work over the last two years and will continue their leadership support into the next phase of implementation.

4.6.4 The self-assessment process has identified a number of actions where the ADP recognises an urgent need to accelerate work and to strengthen partnership working to overcome any remaining barriers to progress and full implementation:

- Increasing the focus on the development of a shared care model;
- Intensifying the focus on bringing the integration of substance use and mental health through full delivery of the Dundee Substance Use and Mental Health Integration Project (funded through Corra Foundation);
- Increasing the focus on early intervention and prevention;
- Resolving the current pressures on Dundee Drug and Alcohol Recovery Service (DDARS) (initially short-term but also focusing on the longer-term approach including a system-change and greater focus on a shared-care model); and
- Working to secure future investments (be more systematic about anticipating investments) and how there are utilised to maximise improvements to outcomes.

As described in the existing Action Plan for Change, programmes of work have begun in relation to shared care, integration with mental health services and addressing pressures within DDARS supported by additional investment secured from Dundee City Council, through the funds allocated by the CORRA Foundation on behalf of the National Drugs Death Taskforce and additional recurring funds to ADPs from the Scottish Government (see section 4.7 for further details of investments). The immediate focus will therefore be on accelerating the pace of implementation in order that people who use drugs, their families and communities and the workforce can realise the positive impact of these changes as soon as possible. The process of updating the Action Plan for Change (as described in section 4.6.2) will reflect the focus on acceleration and on further strengthening the interface between these mutually supporting workstreams. Detailed progress will continue to be reported to the Dundee Partnership, Dundee Chief Officers Group, Integration Joint Board and Dundee City Council through the regular update reporting arrangements that are already in place in relation to the Action Plan for Change.

4.6.5 The multi-agency workforce remains the biggest asset in collective work to implement improvements and they have demonstrated commitment, flexibility and resilience in the most exceptionally challenging of circumstances; the ADP and Health and Social Care Partnership recognise the need to continue to invest in their wellbeing in order to achieve the immediate priorities we have identified and to progress the whole of the action plan for change to full implementation over the coming months and years.

4.7 Additional Investment

4.7.1 When setting the 2020/2021 revenue budget, Dundee City Council set aside funding of £500,000 to support the delivery of the action plans in response to the Dundee Drugs Commission and the Independent Mental Health Inquiry. As a result of the pandemic, only £100,000 was committed to fund an additional five nurses (part year funding). A further £500,000 was provided in 2021/2022.

4.7.2 The Alcohol and Drug Partnership has agreed investment of these additional funds with a specific focus on supporting key programmes of work within the Action Plan for Change. This includes:

- Additional nursing capacity within DDARS to address pressures within the service and support ongoing service redesign (196k over 1 year);
- Funds to support a test of change in relation the assessment and referral of people who are in custody delivered by the third sector (£9k over 1 year);
- Further investment to support Dundee City Council, Children and Families Service to continue to develop approaches to children and young people impacted by parental drug use informed by learning from tests of change already carried out within the service (£79K over 2 years);
- Additional funds to third sector to support the continuation of the Albert Street Hub (£90k over 2 years) and Non-Fatal Overdose Assertive Outreach provision (£188k over 18 months);
- Extension of the gendered-services project (hosted by DVVA) to align to the duration of the programme of work funded by CORRA Foundation focused on the integration of substance use and mental health responses (£48k over 1 year); and,
- Additional investment in work to build resilient and supportive communities and to progress anti-stigma work, including the language matters campaign (£70k over 1 year).

In addition, £191k has been set aside for investment to enhance mental health crisis interventions.

4.7.3 The Scottish Government has notified Alcohol and Drug Partnerships of the allocation of additional funds to support the implementation of the National Mission to reduce drugs deaths and harm from 2021/22, recurring for 5 years. A total allocation of £391K has been made for investment as follows:

- £145k to support the priorities of the National Mission (focused on fast and appropriate access to treatment);
- £145k to support access to residential rehabilitation; and,
- £101k to support the implementation of the whole family approach.

The Alcohol and Drug Partnership is currently considering proposals for investment, informed by the outcomes of the self-assessment process and priorities and actions within the Action Plan for Change. Once priorities for investment have been agreed, expected in August 2021, further work will be progressed to support the detailed allocation of funds in-line with social care procurement regulations. This will include taking account of existing procurement arrangements for relevant services across children and adults health and social care as well as the possible need to procure new services.

4.7.4 In addition, the CORRA Foundation is managing four funds with a combined value of £18 million on behalf of the Scottish Government which opened at the end of May 2021:

- £5 million Local Support Fund to provide resources to community and third sector organisations to increase capacity.
- £5 million Improvement Fund to support improvements to services for outreach, treatment, rehabilitation and aftercare, with dedicated support for women.
- £3 million Families and Children fund to support children, young people and families affected by drug use.
- £5 million Recovery Fund for additional residential rehabilitation capacity.

Each fund is open to non-profit organisations working in the drugs sector, including third sector organisations, community organisations and IJBs. The Scottish Government has encouraged ADPs to work with local partners to support bids to these funds which meet local need, strategy and priorities. The Dundee Alcohol and Drug Partnership is currently gathering expressions of interest from local organisations and will evaluate these against local priorities, including those identified through the self-assessment process.

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 implementation of the revised Action Plan for Change, to support the reduction in substance related deaths, does not progress in line with the proposed action and timescales, including a delay in change for those services delivered through the Dundee Health and Social Care Partnership.
Risk Category	Operational, governance and political
Inherent Risk Level	Likelihood 4 x Impact 5 = Risk Scoring 20
Mitigating Actions (including timescales and resources)	Additional funding and national support will lever in additional resources to support the delivery of the action plan.
Residual Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Planned Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Approval recommendation	The risk should be acepted

7.0 CONSULTATIONS

7.1 Members of the Dundee Alcohol and Drug Partnership, members of the Action Plan for Change Leadership Group, members of the Chief Officers Group, the Chief Finance Officer and the Clerk of the IJB were consulted in the development 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.

Authors: DATE: 14 July 2021

Vicky Irons, Chief Officer
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Vered Hopkins, Lead Officer Protecting People
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DUNDEE ALCOHOL AND DRUGS PARTNERSHIP

SELF ASSESSMENT REPORT

JULY 2021

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Foreword

The Dundee Drugs Commission report *'Responding to Drug Use with Kindness Compassion and Hope'*, was published in August 2019. The Dundee Partnership has now agreed that the Commission will undertake a two-year review to determine the extent to which the recommendations made by the Commission in 2019 and actions subsequently agreed within the Alcohol and Drug Partnerships Action Plan for Change have been effectively implemented.

As a Partnership we are committed to continuous improvement of all of our services, particularly those focused on the identification, protection, support and recovery of Dundee's most vulnerable citizens. Reducing drug and alcohol use and supporting people, families and communities who are affected by problem substance use are key priorities in our efforts across the Dundee Partnership to improve health, care and wellbeing. We welcome this opportunity to reflect on our performance in this area of work as part of our ongoing commitment to continuous improvement and anticipate that the review activities carried out by the Dundee Drug Commission will add significant value to our internal performance management, self-evaluation and quality assurance processes and information.

As leaders we have committed to:

- winning the trust and confidence of the public and partner agencies through effective leadership, governance and accountability;
- supporting practitioners with the right resources and structures to deliver the best possible services to those who need them;
- ensuring meaningful involvement and engagement of people who experience problems with drugs, their families and carers and those that advocate for them;
- confronting and addressing stigma and strengthening mutual and community support;
- tackling the root causes of substance use;
- keeping children safe from substance use and its consequences;
- implementing trauma informed approaches, targeting support to those at increased risk of substance use and death;
- ensuring gendered approaches are considered in all activities and accommodated in design and delivery of services; and,
- implementing a revised person-centred, seamless, sustainable and comprehensive model of care.

This self-assessment sets out in further detail the significant progress that has been achieved across the Dundee Partnership over the last 2 years, progressing the recommendations made by the Commission and implementing the Action Plan for Change in the face of extra challenges presented by the COVID-19 pandemic. It summarises the findings of a thorough self-assessment process, led by the Alcohol and Drug Partnership, that has included speaking with people affected by drug use, family members/carers, service providers and our workforce about the impact of drug related deaths, changes to pathways of care and support, personalisation of service provision and the development of a culture of collaborative working. This self-assessment also contains our own reflections as leaders on the effectiveness of our leadership, governance and scrutiny arrangements, and behaviours in supporting the implementation of the Action Plan for Change. We have focused on opportunities for learning and improvement, on conducting an honest, rigorous process that does not shy away from difficult issues.

As leaders within the Dundee Partnership we recognise that, whilst progress has been made, we have much more to do to improve services and supports to people who use drugs and to reduce drug deaths in the city. We are pleased to see some early evidence of the positive impact that our work to deliver the Action Plan for Change has had on people who use drugs, their families and carers, communities

and the workforce. We know that the full impact of some of the changes that we have made to supports and services may have been masked by the additional difficulties that have been experienced during the COVID-19 pandemic and we will continue to monitor this closely, learning and adapting as we go.

We acknowledge that some of our most ambitious developments, such as implementation of a shared-care model with GPs and the provision of integrated services for people who use substances and experience mental health challenges, are in the early stages of implementation and that positive benefits we hope will be delivered have not yet been felt by individuals, communities and the workforce. It is imperative that we maintain and, wherever possible, increase the pace of implementation in these major programmes of redesign because we know that people who use drugs, their families and communities need to experience the positive benefits they will bring as soon as possible.

We want to thank people with lived experience, their families and carers, Dundee's communities and our workforce for the contribution they have made over the last 2 years to implementing the Action Plan for Change. Your hard work, support and dedication has been invaluable and has been the driving force behind all that we have been able to achieve so far. We look forward to continuing to work with you on the next phase of our improvement journey.

Simon Little
Independent Chair, Dundee Alcohol and Drug Partnership

Grant Archibald
Chief Executive, NHS Tayside

Greg Colgan
Chief Executive, Dundee City Council

Phil Davison
Chief Superintendent, Police Scotland Tayside Division

Vicky Irons
Chief Officer, Dundee Health and Social Care Partnership

Eric Knox
Chief Executive, Dundee Volunteer and Voluntary Action

List of Abbreviations

ADP	Alcohol and Drug Partnership
BBV	Blood born virus
C&F	Children and families
CJS	Community Justice Service
COG	Chief Officers Group
CPR	Child protection register
DCC	Dundee City Council
DDARS	Dundee Drugs and Alcohol Recovery Service (previously ISMS)
DIAS	Dundee Independent Advocacy Service
DVVA	Dundee Volunteers & Voluntary Action
DWA	Dundee Women's Aid
DWP	Department of Work and Pensions
ESG	Early screening group
HSPC	Health and Social Care Partnership
HR	Human resources
IA	Independent advocacy
IEP	Injecting equipment provision
KPI's	Key performance indicators
KWHC	Keep Well health checks
LCPPs	Local Community Planning Partnership
NHST	NHS Tayside
NFOD	Non-fatal overdose
NMP	Non-medical prescribing
MARAC	Multi-Agency Risk Assessment Conference
MAT	Medically assisted treatment
MCN	Managed care network
OST	Opiate substitution therapy
RAG	Red-Amber-Green rating
Rating	
SA	Self-assessment
SDF	Scottish Drugs Forum
SIMD	Scottish Index of Multiple Deprivation

SLA	Service Level Agreement
SMART	Self-Management and Recovery Training
SW	Social work
TCA	Tayside Council on Alcohol
TAY	Team Around You
VAW	Violence against women
WRASAC	Women's Rape and Sexual Abuse Centre

1. Executive Summary

This self-assessment (SA) process has been conducted by the Dundee ADP. As well as being an important part of the ADPs commitment to continuous improvement and self-evaluation it has also been undertaken in a way that will inform the work of the Dundee Drugs Commission (the Commission) during its review activity that will take place from July to December 2021. This process evaluates our own performance in Dundee against the 16 recommendations within the commission's report published in August 2019. It aims to evidence how change achieved to date has led to improvement in the lives of individuals (including any unexpected outcomes) and to develop an understanding of where we need to target our efforts to support further improvement.

This self-assessment is based on information already in the public domain, evidence and views from a wide range of sources. We have utilised existing information and undertaken specific activities, including focus groups, surveys and workshops, to gather new information. We have also gathered case studies from individuals with lived experience.

Through the self-assessment process 6 key focus areas have been identified: communication with the workforce and stakeholders / partnership working; staffing issues, staff retention and pressures; treatment options and choice / support choice; mental health; lived experience and leadership. In each of these areas, whilst progress has been made over the last two years, all partners recognise that significant work is yet to be done. In some cases, the challenge set out in the original report from the Dundee Drug Commission has been further compounded by the impact of the COVID-19 pandemic, with additional actions now required to address the specific needs and risks arising from the pandemic for people who use drugs and alcohol and for the workforce.

Overall, during the past two years, we have assessed that we have made reasonable progress in implementation of 12 of the Drug Commission's original recommendations, with partial progress being made against 4 recommendations. Despite the significant challenges presented by the COVID-19 pandemic, during most of this period the evidence gathered for this self-assessment demonstrates that significant improvements have been made in some areas. This includes the response to non-fatal overdoses and assertive outreach work, extending the naloxone programme, pre COVID-19 introduction of direct access and same-day prescribing, Independent Advocacy, Peer Support programme, developing a gendered approach, progress with trauma-informed approach, anti-stigma work, and improving the governance and function of the ADP.

However, the evidence also identifies that we still have significant progress to make in specific areas. These include responding to pressures and capacity issues within treatment services, accelerating progress with whole-system change (including a shared-care model with Primary Care and an integrated approach for substance use and mental health), improving treatment options (including access to residential support), progressing the Dundee Lead Professional model, eliminating stigmatising behaviour from our workforce, enhancing our focus on prevention and the need to improve communications with the workforce and other key stakeholders.

At the same time, the COVID-19 pandemic had an inevitable impact on our ability to progress with some improvement plans. Although substance use services (especially those defined as 'COVID-19 critical', including DDARS, We Are With You, Hillcrest, TCA and Positive Steps) continued to provide a service, organisations had to adopt different delivery options. There was rapid and significant change to ensure the safety of the individuals accessing services and of staff, and during lockdown limited face to face work could take place.

Furthermore, we are aware that during the COVID-19 lockdowns significant innovative practices were developed, we are committed to maintaining and building on such innovative practices. In addition, an improved collaborative approach has developed between service providers (specifically between public and third sector organisations), trust and relationships between key partners has strengthened, and a more focused shared improvement agenda has emerged for all partners.

Going forward, as a partnership we are clear about the actions that are now required to continue to embed the progress made and accelerate the implementation of further improvements wherever possible. Specific priorities for the immediate future have been identified, including addressing the capacity issues within specialist services, and increasing the focus on the development of whole-system change and on early intervention and prevention. We are also committed to embedding an annual self-assessment process to evaluate progress against the action plan for change until full implementation has been achieved.

2. Introduction and Context (Why Conduct a Self-Assessment?)

This self-assessment (SA) process has been conducted by the Dundee ADP. As well as being an important part of the ADPs commitment to continuous improvement and self-evaluation it has also been undertaken in a way that will inform the work of the Dundee Drugs Commission (the Commission) during its review activity that will take place from July to December 2021.

The Commission was established by the Dundee Partnership in May 2018 with key objectives, including:

- Consider the context, nature, extent and impact of drug use and drug-related deaths in Dundee;
- 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;
- 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;
- 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;
- Consider evidence of what has worked elsewhere to combat drug use and drug-related including approaches to achieve prevention and recovery; and,
- 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.

The Commission's report was presented in August 2019 and included 16 recommendations, all of which were accepted by the Dundee Partnership and the ADP.

Following an initial period of actions to address some of the most urgent issues identified by the Commission, including establishing the Non-Fatal Overdoses Rapid Response and Direct Access Clinics, the ADP developed a detailed Action Plan for Change responding to each of the Commission's recommendations. This plan reflected a broad partnership approach for working with vulnerable individuals and families affected by substance use and was developed in collaboration with a wide range of stakeholders.

The implementation of the Action Plan is the responsibility of the entire Dundee Community Planning Partnership, 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 (COG) and onwards to the Dundee Partnership. The Action Plan for Change has been continuously reviewed and updated to reflect progress made and to adapt to emerging challenges, information and evidence. This has included updates that have been required to reflect the impact of the COVID-19 pandemic on the actions contained within the plan.

Key achievements delivered through the Action Plan for change include:

- ✓ We have developed, established and evaluated the multi-agency non-fatal overdose response team;
- ✓ We have extended the availability and reach of naloxone;
- ✓ We have appointed Non-Medical Prescribing nurses (NMP), including 3 NMP nurses placed within the Children & Families Service;
- ✓ Pre COVID-19 lockdown we introduced same-day prescribing;
- ✓ We have developed an Independent Advocacy test of change;

- ✓ We have strengthened the membership of the ADP and developed a new governance structure;
- ✓ We have established the Peer Support program for Dundee and developed the Lived Experience Framework;
- ✓ We progressed the Anti-Stigma and language matters campaign;
- ✓ We have developed a programme of work to embed trauma informed leadership and practice across statutory and third sector services;
- ✓ We have progressed a range of activities to support mainstreaming of gender sensitive services and supports, with a specific focus on meeting the needs of vulnerable women; and
- ✓ We participate in the Planet Youth pilot.

The Action Plan for Change also outlines the remaining challenges that still need to be progressed or completed in Dundee. Some of these challenges relate to restrictions during the COVID-19 pandemic, others include change processes that are being progressed over a longer timescale than the two-year period that has elapsed since the Dundee Drug Commission report was published.

Remining challenges:

- ➢ Capacity in the specialist treatment services, including recruiting and retaining qualified staff;
- ➢ Our specialist treatment service is under considerable pressure;
- ➢ Coming out of the COVID-19 lockdown, expanding the capacity of the direct access provision;
- ➢ Progressing the implementation of a low threshold model of substitute prescribing;
- ➢ Acting on and expanding the test of change to develop shared care;
- ➢ Progressing with the whole system change – focusing on an integrated approach to substance use and mental health
- ➢ Improve scrutinising governance of statutory organisations; and,
- ➢ Development of a five-year commissioning plan.

In early 2021 it was agreed the Commission will reconvene for a period of 6 months (July – December 2021) to review progress against the original recommendations.

This SA process evaluates our own performance in Dundee against the 16 recommendations within the commission's report published in August 2019. We have focused on establishing the following:

- What works well and is progressing well?;
- What is not progressing well and / or needs improvement?;
- Where there are barriers to further progress?; and,
- What requires additional focus and / or resources?

Overall the SA aims to evidence how change achieved to date has led to improvement in the lives of individuals (including any unexpected outcomes) and to develop an understanding of where we need to target our efforts to support further improvement.

More generally, we recognise the process of self-assessment as good practice; we aim to learn from it and establish it as part of an approach to on-going self-evaluation. We have focused on opportunities for learning and improvement, on conducting an honest, rigorous process that does not shy away from difficult issues.

3. What we have achieved so far

As described in Section 2, the Action Plan for Change sets out the Dundee Partnership's response to the recommendations made by the Dundee Drugs Commission in 2019. The plan sets out a range of actions across 12 key priority areas. All the stakeholders, including people with lived experience, have been working together to implement these actions over the last 18-month period.

Despite the significant challenges presented by the COVID-19 pandemic during most of this period, progress has been made. A summary of progress achieved is provided below alongside additional information about key actions that were undertaken during COVID-19 to meet the needs of people affected by drug use.

3.1 Key Priority 1 – Tackling the immediate risk factors for drug deaths

Dundee Non-fatal Overdose (NFOD) Rapid Response Team

One of the major achievements has been the implementation and evaluation of a sustained, immediate, collaborative, flexible response to non-fatal overdoses, including assertive outreach components.

Prior to November 2019, individuals who experienced non-fatal overdoses (NFODs) in Dundee were formally discussed once per week by the Early Screening Group (ESG). At that time, there was often a delay in contacting these individuals, and many did not meet the statutory three-point test that would enable an adult protection response to be provided (Adult Support and Protection (Scotland) Act 2007). A decision was made in 2019 to improve the process of responding to all known NFODs by ensuring a quick (within 72 hours) response/ contact with all known individuals who have experienced a NFOD. The multi-agency NFOD rapid response team was set up, initially as a six-week 'test of change' that sought to improve the co-ordination of the various organisations responding to an NFOD. This joined-up, acute response has now been established as the Dundee Non-Fatal Overdose Response. To date (May 2021) there have been 460 people discussed through the NFOD Response Team, accounting for 824 incidents. Of these 460 individuals, 146 recorded more than one NFOD incident.

The Dundee NFOD Response Team meets every week day and discusses all of the known NFODs that took place the previous day. A safety plan is developed and the aim is to contact each individual within 72 hours of their overdose experience. A number of outreach workers are in place to contact the individuals who are not in touch with services and progress with the safety plan. Full evaluation report is available in appendix 3.

Additional Key achievements for Priority 1:

- Commenced research to inform the development and implementation of an effective behaviour change intervention following NFOD.
- Strengthened our approach to reviewing drug related deaths and NFODs to include early trends monitoring and commenced comprehensive clinical toxicology testing within NHS Tayside. We are also participating in a national project led by Stirling University, involving multiple ADPs, focused on drug checking.
- Direct involvement from the VAW services to the NFOD Rapid Response team.
- Strengthened assertive outreach capacity, including additional capacity for the SafeZone Bus delivering Harm Reduction and other support to communities across the city, including support out of hours. Positive feedback from those using the SafeZone Bus service has led to the expansion in both the frequency of operation and number of localities visited.

Dundee Take Home Naloxone Programme

A number of steps have been taken to widen access to take home naloxone and address challenges posed by COVID-19 across Dundee, including:

- Naloxone training and kits are supplied by statutory services, third sector partners and non-drug treatment services in Dundee, this has continued during COVID-19. Kits are also issued on prescription from DDARS as part of a risk management strategy during COVID-19;
- A number of services also hold naloxone for use in an emergency, for example some community pharmacies (including all Boots pharmacies) and hostels;
- 8 non-drug treatment services in Dundee registered to supply naloxone under the letter of comfort provided by the Lord Advocate during COVID-19;
- A postal supply service of naloxone has been established and is provided by Hillcrest Futures and We Are With You;
- Health and safety policies in DCC and NHS Tayside have recently been amended to facilitate and encourage carrying and use of Naloxone by relevant staff;
- A naloxone guideline has also been approved for in-patient mental health services;
- Training for trainers was moved to online training during COVID-19 and resources have been developed to support this. For example, a webpage hosted by BBV MCN directing staff/volunteers to training resources from SDF and a locally developed training video;
- An information pack to support non-drug treatments services has been developed;
- Scottish Ambulance Service in Dundee are participating in a national project for paramedics to supply a naloxone kit where a person declines to attend A&E
- A peer naloxone training and supply project has been established in Dundee which is a collaboration between SDF and Hillcrest Futures, supported by the ADP. The project is funded through the innovation fund and has been very successful since its launch. In April and May the peer project has issued over 120 kits across Dundee; and,
- All frontline Police Scotland officers in Dundee have been trained in responding to overdose and offered the opportunity to carry intranasal naloxone kits as part of a national pilot. Police officers in Dundee have used intranasal naloxone in overdose situations on a number of occasions in Dundee since the launch of the pilot.

3.2 Key Priority 2 – Urgently increase the capacity and capability of specialist services to support access, quality and safety

Key achievements:

- Invested in additional capacity within treatment services, with an additional five Band 5 nurses appointed within DDARs to contribute to managing demand within the service.
- Introduced arrangements to support Same Day Prescribing within DDARS prior to the onset of the COVID-19 pandemic through Direct Access Clinics in several localities in the city. These clinics included options for Same Day Prescribing supported by an additional 3 NMP nurses. During the pandemic public health restrictions meant that direct access clinics could no-longer operate safely, however the intention is to reinstate this approach once social distancing requirements are eased.
- Up to beginning of 2021 sustained good overall performance against national waiting time targets despite additional pressures during the COVID-19 pandemic (however, there has been a deterioration in performance in 2021).
- Advance negotiations are in place to expand the role of community pharmacies in providing care and support to individuals affected by drug use.

3.3 Key Priority 3 – Improve retention and treatment in recovery services

Housing First

The aim of Housing First Pathfinder is to support extremely vulnerable people, often with complex needs who require a high level of support and who have a history of homelessness. Housing First gives people a safe home of their own and then puts in place a support structure to help them sustain their tenancy, re-integrate into society; and ultimately thrive. Housing First is a model that provides a human-centred, kind and compassionate response to the systemic issue of homelessness.

Housing First Dundee aims to cause a structural shift away from the use of temporary accommodation that perpetuates repeat homelessness, towards people being housed as quickly as possible in permanent homes with appropriate wraparound support. 82 Housing First tenancies had been achieved by the end of April 2021 and as of end May 2021 the sustainment level for those with Housing First tenancies in Dundee was 88% (further detail is available at the Homeless Network Scotland).

Dundee City Council, Transform Community Development and Dundee Health and Social Care Partnership are currently in the process of mainstreaming Housing First across Dundee. In March 2020 the partnership closed one of the largest hostels in the city with Transform and reconfigured the service to deliver outreach housing support aligned with Housing First principles. This service will continue delivering Housing First support to residents of Dundee and work with the Pathfinder throughout this transition before their planned end date along with other services across the Homeless Partnership to mainstream Housing First across Dundee. The partnership is committed to make Housing First Dundee successful and to continue delivering a person-centred wrap around support service to service users who require this level of support whilst closing the door on a homeless recurring cycle for a number of individuals. Housing First is a key strand within our Rapid Rehousing Transition Plan.

In a joint approach with Criminal Justice Service, a review is taking place of the resources currently in place (mainly based within the Community Justice Social Work service in Friarfield House and managed jointly with DDARS). A report will be presented to the ADP in August with a view to ensure best use and maximise the impact of the available resources.

Key achievements:

- Reduction of unplanned discharges at DDARS.
- Increase in retention and re-engagement with individuals, and a rise in the number of individuals accessing treatment.
- Developed an assertive outreach model to support those most at risk of withdrawing from support.
- Specific assertive outreach for vulnerable women as part of the Housing First model.
- Identified protected capacity (6-month secondment from May 2021) to develop a pathway and framework for accessing residential rehabilitation care.
- Agreed a clear pathway across Tayside for the transition of substance use supports for people leaving prison to community and secured additional capacity (2-year post within a third sector service) to progress full implementation of the pathway in collaboration with the multi-agency Prison Release Working Group
- There has been increased investment from Dundee City Council to support improvements.

3.4 Key Priority 4 – Implement a revised person centred, seamless, sustainable and comprehensive model of care

Shared Care Test of Change

A bid was submitted under the National Drug Deaths Taskforce funding to develop and implement a pilot, known as the CORRA project, within Dundee looking at strengthening and enhancing the current shared care arrangements within the city. Further information about the project can be found here.

The pilot commenced with the appointment of a 35-hour joint GP/substance use post based within the Maryfield practice. The GP appointed will direct approximately one third of this time working with patients who use drugs, in a combination of service delivery and development. An element of the service development work relates to assisting in the design of a sustainable, desirable, high quality Service Level Agreement which will be offered to all of the 21 GMS practices in Dundee. This GP started work on 7/6/21.

An existing GP working within the Lochee practice is also starting joint work with DDARS, with a view to seeing Lochee patients, ultimately within the Lochee practice. The substance use element of this post is initially 5 hours per week, increasing to 10 hours later in the year. In addition, one of the two practices which participates that currently has an existing SLA to provide shared care has agreed to increase the number of patients seen within the practice. Work is taking place within DDARS on identifying patients suitable for transfer.

A further one 'career-start' GP will commence post in August and will dedicate between 4 – 8 hours per week for direct work within DDARS. The funded pilot post will support:

- An understanding of and scoping of the clinical requirements for GP's to commence this approach.
- The review of the model for Dundee.
- The development of the model of clinical support for Dundee Practices.
- The review of the current service level agreement.

Progress with the Dundee Lead Professional model

Lead Professional coordinated meetings continue to take place, involving a multitude of statutory services, third sector and faith-based organisations. These meeting are usually called Team Around You (TAY) and are based around the support provided, with the individual at the centre of any decision making. For example, one recent meeting, to support an individual to move on to a tenancy from homelessness support, involved services attending a TAY meeting to develop a multi-agency support plan, bespoke to the individual's needs and aspirations. Attendance included Transform Communities, Housing First, Dundee Woman's Aid, Hillcrest Futures and We are With You.

Key achievements:

- Secured significant additional resources from the Drug Death Taskforce to progress a 2-year project to develop and test an integrated approach to substance use and mental health. Stage 1 of the project, 'getting ready for change' has commenced, including the establishment of a project board. Recruitment of project support staff is underway.
- Following delays associated with COVID-19, a Tayside Oversight Group has been established to complete a health needs assessment.
- We set up a shared-care test of change based in 2 localities in Dundee.
- We have reviewed the work of community pharmacies
- We have set up a working group to lead on the implementation of MAT standards.

3.5 Key Priority 5 – Win the trust and confidence of all stakeholders through effective leadership, governance and accountability

Protecting People Strategic Risk Register

As part of their response to the COVID-19 pandemic the Chief Officers Group and Protecting People Committees, including the ADP, have developed a strategic risk register to support them to identify, manage and mitigate strategic risks arising from the pandemic. Reporting formats between the ADP and the COG have also been amended to support this approach, with a greater focus on reporting against the risk register.

The risk register has been an effective way for the ADP to maintain an overview of strategic risks, receive assurance about how risks are currently being mitigated and to collectively identify further action that is required. This has included a strong focus on the potential for hidden harm amongst the Dundee population during period of lockdowns and public health restrictions (see a link to the Hidden Harm Report in appendix 3 below). Escalation routes to the COG have also been utilised where further leadership support is required to effectively manage and mitigate risks. The risk register has also encouraged more collaborative working with other Protecting People Committees, including the Child Protection Committee and Violence Against Women Partnership, where cross-cutting risks have been identified.

Next steps include transitioning the risk register to reflect both COVID-19 generated and 'business as usual' strategic risks, adjusting ADP report formats to enhance the focus on impact on risk levels and further development of the interface between the strategic risk register held by the ADP and operational risk registers held by the individual agencies who are represented on the ADP. Regular oversight meetings for the ADP Independent Chair with Chief Officers have been set up.

Key achievements:

- Completed a review of the ADP governance structure and subsequently strengthened membership and revised supporting structures. The effectiveness of these changes has also been evaluated through the leadership self-assessment process undertaken as part of this report.
- Agreed a detailed role descriptor for the Independent Chair, with a focus on values and behaviours as well as skills and abilities.
- Strengthened leadership from third sector organisations, especially in developing tests of change.
- Strengthened our approach to reporting against Key Performance Indicators and begun the process of planning for reporting against new national KPIs, MAT standards and from the DAISy information system as well as addressing known gaps in information gathering and reporting.
- Established a regular reporting schedule to the Dundee Partnership and to Elected Members via DCC Committee and, as part of the ADP governance review, appointed 2 Elected Members as ADP members.
- Appointed Trauma Champions within NHS Tayside, Dundee Health and Social Care Partnership and delivered Scottish Trauma Informed Leaders Training to all COG members, with further sessions planned for other leadership groups.

3.6 Key Priority 6 – Ensure the meaningful involvement & engagement of people who experience problems with drugs, families and carers and those that advocate for them

Independent Advocacy (IA)

We invested in independent advocacy capacity utilising funding from the Drug Death Taskforce to support a 2-year project led by DIAS in close collaboration with DDARS. This is a test of change project and early feedback indicates that it is very beneficial in terms of providing independent support to individuals while they access treatment and support from DDARS. In addition, the IA service supports individuals to take control over housing situations, through transition periods and to engage with mental health services.

Key achievements:

- We developed a Peer Support Project model and appointed DVVA to lead the implementation, in partnership with a number of third sector organisations. To date, the project supported 10 peer volunteers to complete training and begin contributing to the provision of recovery support in a variety of different services across the city, with a further 3 volunteers currently undertaking training.
- Progressed the establishment of a Dundee Lived Experience Framework, supported by third sector organisations and Scottish Recovery Consortium.
- Established Lived Experience group specifically for women.

The Dundee Lived Experience Framework

The Framework was developed by a group of organisations co-ordinated by DVVA and it is now being implemented at a range of levels. There is already a variety of peer involvement activities and engagement of people with lived experience in the design and delivery of public services in Dundee.

The purpose of developing a Lived Experience Engagement Framework is to create a shared understanding of lived experience, peer involvement, peer-led recovery and service user and carer engagement.

The Gendered Services Group is supporting a group of women with lived experience of gender-based violence, substance use and a range of complex issues to direct the work of the project. The group has met several times and has co-designed the gendered services project self-assessment tool and contributed to the design of the gendered approach training course which is being piloted during July 2021.

The following organisations undertake Lived Experience work in Dundee (which is still limited due to COVID-19 restrictions):

Community Health Team	Maxwell Centre
Dundee Healthy Minds Network	New Futures
Eagles Wings Trust	Peer Recovery Network
Gendered Services Project	Positive Steps
Haven	RecoverTay
Hillcrest Futures	Scottish Recovery Consortium
Housing First/Transform Community Development	Street Soccer
Lifeline Group (Carers Centre supported)	Tayside Council for Alcohol (TCA)
Lochee Community Hub	We are with You
Making Dundee Home	Albert Street Hub (WRWY)

The main areas where future improvement efforts will focus is on communication, engagement, co-production and decision making.

3.7 Key Priority 7 – Confront and address stigma and strengthen mutual and community support

Language Matters Campaign

Following delays due to COVID-19, the steering group for the Language Matters campaign has now commissioned a production company to develop a short awareness-raising animation to tackle stigma. The group have been liaising closely with the production company and individuals with lived experience, and a co-ordinated commitment to the campaign been agreed across the three Tayside ADPs.

Anti-stigma Commitment

To support actions to reduce stigma among services and organisations, the Language Matters steering group produced an Anti-Stigma commitment which was presented to and approved by the Dundee ADP. This was informed by the Drug Deaths Taskforce Stigma Strategy and local engagement. This Commitment will ensure consistent understanding of the actions required to address stigma across both services and communities, and will act as a tool to review progress. Part of this commitment involved a review of services' titles, which was closely followed by a name change from ISMS to Dundee Drug and Alcohol Recovery Service, recognising the commitment to avoid stigmatising terminology such as substance *misuse.*

Building community capacity and delegation of funding to Local Community Planning Partnerships (LCPPs)

Funding has recently been allocated to each of the eight Local Community Planning Partnerships (LCPPs) to develop and test locally-led responses to achieve priorities within the ADP Action Plan for Change. The key aim is to support people who experience substance use problems to participate actively and be supported within their local community. This is a demonstration of the ADP's commitment to the empowerment of communities, including individuals with lived experience of substance use. The process will be facilitated by local Community Learning and Development teams and will be a unique opportunity for communities and services to work together to develop solutions.

This process will build on the existing positive connections that community teams have with people who are affected by substance use. A wide range of community capacity-building projects have been supported prior to the first Drug Commission Report. COVID-19 has not halted this support with various alternative delivery platforms being used and a significant number of IT devices being distributed via the Scottish Government's Connecting Scotland funding, including people affected by substance use.

Key achievements:

- Utilised capacity available during the pandemic to review the range of existing stigma training resources and to test virtual alternatives.
- Approved an Anti-Stigma Commitment and begun the development of campaign messages and resources for implementation across Tayside.
- Agreed the distribution of funds to each LCPP to support locally-led responses to tackling stigma and building resilient and supportive communities as part of our approach to embedding Recovery Friendly Dundee. It is anticipated that LCPPs will begin to agree specific allocations of these funds for work within their locality in August 2021.
- Renamed ISMS to the Dundee Drug and Alcohol Recovery Service (DDARS).

3.8 Key Priority 8 – Keep children safe from substance use and its consequence

Children and Families Non-medical Prescribing (NMP) Nurses

In 2019 we have located 3 NMP nurses within the Children and Families Social Work Service. Two of the nurses have now completed their NMP training and one will do so shortly. This involves 3 DDARS nurses co-locating and working directly with children's services teams. The nurses provide a range of support alongside children's services colleagues, this includes intensive therapeutic input to parents, initial assessment and sign posting. Indicators are that this co- located model allows for a swift response to support parents who are experiencing challenges due to drug use, there are improved levels of communication across children and adult services and the opportunity to work jointly to provide an intensive level of support to families. There has also been a significant increase in adult services engagement with the child protection process.

During the first lockdown, the NMP nurses had to move back to support DDARS' pandemic response but this has also had positive consequences whereby the nurses were able to navigate their way through communication challenges across the 2 services in a supportive and non-threatening manner. This has appeared to support knowledge and understanding of roles and responsibilities across both staff groups.

An evaluation of this initiative is ongoing, however a workforce survey across the social work and DDARS teams took place to support our understanding of the impact of the pilot across the staff teams and the feedback is very positive (see a link to the evaluation report in appendix 3 below).

Key achievements:

- Completed and evaluated a test of change focused on the co-location of Aberlour and Children 1st to provide additional support to children and families, including at the point of crisis. Based on evaluation results this is now being embedded in ongoing practice.
- Implemented a range of actions to improve support to vulnerable women, including: disseminating a directory of services for vulnerable women; enhancing support pathways for women involved in commercial sexual exploitation; and, providing guidance and additional on-line training for work with vulnerable women.
- Significantly strengthened arrangements for the completion of chronologies and for routine case file auditing within the Children and Families Service, with new chronologies formats now being tested by third sector services.

Initial Assessment Partnership

The Care and Protection Social Work Team, Aberlour and Children 1st have piloted an approach to responding to children and families where an initial assessment is required and drug and/or alcohol use is impacting the parenting that children are receiving. Aberlour or Children 1st have undertaken initial assessments in anticipation that this will encourage families to engage more fully in the process. Since January 2020 a total of 11 families (consisting of 19 children) have received a service through this pilot.

Key achievements identified through the pilot include: more appropriate levels of support being available to families at the point of crisis and beyond, better involvement of third sector organisations in child protection processes subsequent to assessment, stronger partnership working amongst the teams involved and improved outcomes for children and young people. The staff working within the pilot identified strengthened partnership working, supported learning links and supporting families as the three most notable benefits for families and for the workforce.

3.9 Key priority 9 – Implement trauma informed approaches, targeting those at increased risk of substance use / and death

We have established the Trauma Steering Group, including membership from DCC (C&F SW, Education, HR, Neighbourhood Services) NHS Tayside, DDARS Psychology Services, third sector, and the HSCP. The group developed a trauma informed action plan, including delivery of training and supporting professionals with lived experience.

A knowledge exchange event took place to share local learning from tests of change already underway in the city, including within drug and alcohol services, and briefing sessions on trauma informed approach were delivered to all leads of service areas within DCC and most recently a team of health visiting staff.

The group has mapped the trauma informed training needs within DDARS and DCC workforce and begun the delivery of Safety & Stabilisation and Survive & Thrive with third sector drug and alcohol services. Sessions of the Scottish Trauma Informed Leadership Training were delivered to the Chief Officers Group, and will be delivered to senior managers, the Dundee Partnership and IJB members in September.

Trauma champions were nominated from DCC, HSCP and NHST and links established with the Improvement Service leading on trauma work nationally.

Key achievements:

- Agreed initial priorities for inclusion within a trauma informed action plan, including delivery of training and supporting professionals with lived experience.
- Held a knowledge exchange event to share local learning from tests of change already underway in the city, including within drug and alcohol services.
- Mapped the trauma informed training needs within DDARS and begun the delivery of Safety & Stabilisation and Survive & Thrive with third sector drug and alcohol services.

3.10 Key Priority 10 – Tackle the root cause of substance use

The Prevention Workgroup has progressed two key priority areas of work to support the achievement of the outcomes above:

1. The development and implementation of a Dundee Drug & Alcohol Prevention Framework
2. Support the development and implementation of the Planet Youth model in Dundee

Development of Drug & Alcohol Prevention Framework

The Dundee Prevention group has closely studied the Glasgow Prevention Framework and anticipates adopting a similar approach in Dundee. A report was presented to the ADP in June 2021 outlining a plan for developing a framework which holds an ethos rooted in the need for a comprehensive, whole population approach that develops and sustains action across the whole life-course, addresses underlying determinants and causative factors and focuses on inequalities and equity dimensions as integral to the response. This framework will also support a sustained, well-resourced multi-partner response and have the prospect of making a difference, given the complex nature of the problems faced.

Planet Youth Model

Planet Youth is a prevention programme developed by the Icelandic Centre for Social Research and

Analysis (ICRSA) at Reykjavik University. Planet Youth instigated major improvements in the health and wellbeing of teenagers in Iceland, including a huge drop in substance use, increased physical activity levels and families spending more time together. This approach has led to young people in Iceland earning the label of 'the cleanest living teens in Europe'.

Winning Scotland will take a catalytic role in the project, leading the co-ordination of local steering groups and the engagement with Planet Youth for the data collection / analysis phases of the project. Winning Scotland is working alongside Dundee City Council and other partners and the work will be supported with governance and steering groups. The work is currently in phase one with delivery of the survey planned for one secondary school in Dundee in September 2021.

The work will be developed with learning and work undertaken during the Youth in Iceland knowledge exchange project funded by the Society for the Study of Addictions, University of Stirling.

3.11 Key Priority 11 – Ensure gendered approaches are considered in all activities and accommodated in design and delivery of services

Gendered Services Self-Assessment Tool

At the centre of the gendered services project are women with lived experience who are steering the direction the project takes. This group of women have been recruited through the support of many third sector organisations in Dundee.

Members of the lived experience group have worked with the project to discuss the barriers they have experienced when trying to engage with services, and to talk about what would make a service more accessible. The input from the group members has been incorporated into a self-assessment tool which will be used with services to identify gaps in service delivery and any gaps in knowledge for staff. Once gaps or support needs have been identified, the project manager will source training if needed, provide gendered approach training if required, advise on policies and procedures, and support services when they are applying a gendered approach to their service delivery. The tool is currently being tested by Dundee Women's Aid and Hillcrest Futures.

Key achievements:

- Developed a range of information sources to support the workforce to provide enhanced responses to vulnerable women, including a directory of women's services, the VAWP website and multi-agency guidance on responding to commercial sexual exploitation.
- Developed and delivered virtual training and awareness sessions regarding gendered response and violence against women.
- Implemented new approaches to promote collaborative working with women's services and include gender responses within existing service models. This includes implementing arrangements for violence against women services to participate in the Tayside Drugs Death Review Group and Dundee NFOD group and developing fast track sexual health pathways for vulnerable women.

3.12 Key Priority 12 – Ensure clear and consistent communications are delivered through a partnership approach

There has been a renewed focus on public, workforce and staff communications, with key organisations working together and closer than ever to ensure timely, accurate and consistent information is distributed to relevant audiences. Updates were provided to the workforce on a

number of matters, including a recent leadership statement of intent on substance use which included an update on progress against the ADP action plan.

There has also been regular engagement with print and broadcast media, and use of social media channels to distribute information. Key updates in recent months have included work to develop an integrated substance use and mental health response in communities, updates on service delivery during the COVID-19 pandemic and the convening of the Dundee Drugs Commission review. There has also been regular signposting to services during lockdowns using a variety of channels including leaflet distribution and radio advertising.

Communications officers are also now embedded within the ADP structure, providing strategic advice for effective communications and maximising opportunities to provide the public, the workforce and other stakeholders with updates on developments.

Key achievements:

- Agreed a co-ordinated approach to managing communications activity across ADP partners and enhanced the direct involvement of Communications Officers in working groups of the ADP.
- Developed a cross-cutting protecting people workforce communication strategy.
- Developed a cross-cutting approach to public information and awareness raising during the COVID-19 pandemic, including radio campaigns, social media campaigns and distribution of information materials.

4. Self-Assessment Methods (What We Did)

Summary of the process and method of gathering the information for the self-assessment

This self-assessment has been informed by information, evidence and views from a wide range of sources. We have utilised existing information and undertaken specific activities, such as focus groups and surveys, to gather new information.

With respect to routine monitoring information from service providers, we have focused on evidence already collated to minimise the burden on organisations as they continue to respond to the ongoing pandemic. However, with respect to views and experiences of change, improvement or progress, we obtained new evidence to inform the self assessment.

More specifically, we did the following:

- We gathered service-based data from 24 front-line services, including routine service monitoring information which also includes hospital discharge data;
- We conducted 10 focus groups with front-line staff and individuals with lived experience (including separate focus groups for women and for those who have progressed with recovery). The focus groups had a broad focus on improvements, remaining challenges and ways to overcome these challenges. 68 individuals participated in the 10 focus groups;
- We held a workforce survey for staff delivering services to individuals and families affected by substance use. 59 staff responded to the survey;
- With support from the national Improvement service, we evaluated the leadership element (focusing on 'how good is our ADP' approach) around substance use. This process included an online survey (18 respondents) and follow-on seminar with 22 participants from the ADP and wider stakeholders from across the Dundee Partnership;
- With support from statutory and third sector organisations, we collected a range of stories/ case studies and examples. These are included in this report in appendix 1 below; and,
- We collected a range of relevant and informative reports that have been completed since August 2019. These are available in appendix 3.

Given that each data source available to us only tells a partial story, our aim was to utilise a range of information sources so that we can use a triangulation process of comparing multiple sources of evidence.

We are very clear about our information gaps and have plans in place to improve access to robust real-time information. Some of these gaps will be resolved as we progress with the implementation of the national Drug & Alcohol Information System DAISY (commenced March 2021).

We have also included a significant real-time information improvement element to the Dundee CORRA project, an additional member of staff will be placed with Public Health for the duration of the project and will provide dedicated support to statutory and third sector substance use organisations to improve access to collating and reporting information.

What we did

ADP Leadership Assessment	Focus Groups	Workforce Survey	Service Monitoring Data	Case Studies	Review of documents and reports

Leadership Self-Assessment

Supported by the Improvement Service
Self-evaluation survey/ report
Workshop/Seminar
Priorities for improvement and action plan

Focus Groups

Staff (2) 30 participants	Women (2) 21 participants	Lived Experience (1) 6 participants
Parents (3) 3 participants	Carers (1) 4 participants	Service Users (1) 4 participants

Service Monitoring

24 Monitoring reports received from services/projects

Workforce Survey

59 Surveys were completed

Case Studies

9 Case studies received

5. Data / evidence gathered (What we Found)

Introduction to section 5

Section 5 includes the following key data elements:

- It presents the (mainly) numerical data available locally on drug use and its impact on individuals and families (section 5.1);
- It outlines services-based reporting and information (including access to treatment / support, governance processes and experience during the COVID-19 lockdowns (section 5.2);
- It reports back from the focus groups conducted specifically to inform this self assessment (section 5.3);
- It presents the results of the staff survey (section 5.4); and
- It reports back from the specific self evaluation process, supported by the Improvement service, that focused on the leadership of the ADP and the Dundee Partnership (section 5.5).

As much as possible, this section also highlights the gaps in real-time reliable information available locally and clearly identifies areas for development.

5.1 Data and Information

5.1.1 Prevalence data for Dundee

The official national prevalence data for drug use in Scotland was last collated as a snapshot for the period of 2015-16 and published in 2019. This information outlines Dundee as having the 4th highest prevalence of drug use in Scotland. It is estimated there are 2,300 problem drugs users in Dundee – 1600 are male and 700 are female, a ratio of 70% males and 30% females (Scotland has a ratio of 71% males and 29% females). It is important to note that this data is now historical.

5.1.2 Drug Deaths

The number of drug related deaths in Dundee have increased since 2001, with 2019 being the highest number on record. In 2019, there were 1,264 drug related deaths registered in Scotland, of which 72 were in Dundee.

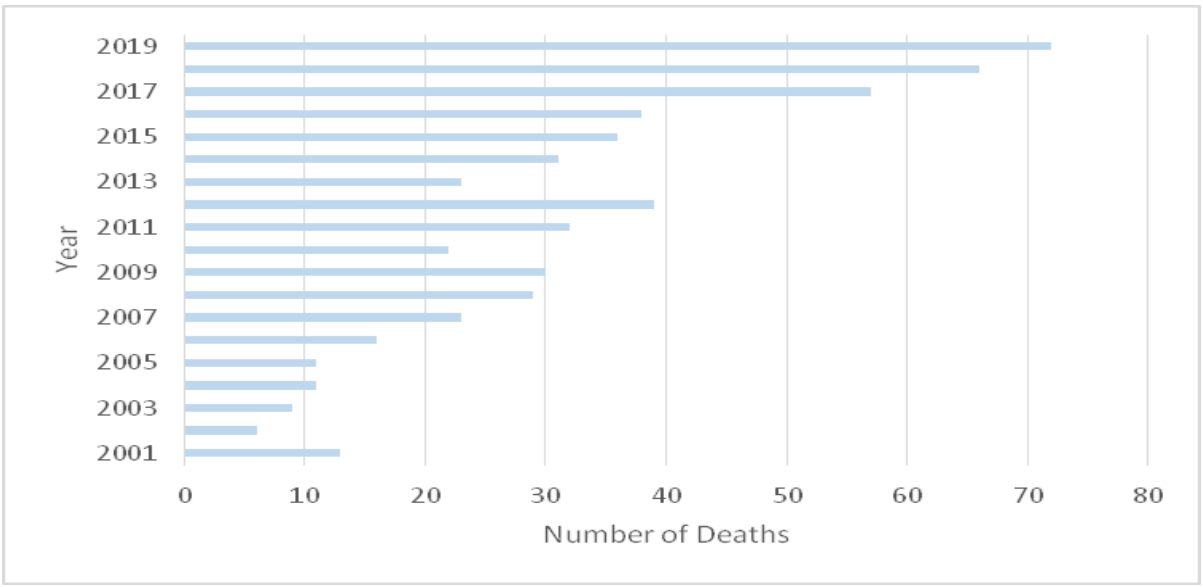


Figure 5.1: Number of drug related deaths in Dundee 2001 – 2019 (Source: National Records of Scotland)

The data above covers the period 2001-2019. Using a five-year average mitigates any annual fluctuations, the graph below shows that for 2015-2019:

- For Scotland as whole, the average of 992 drug related deaths per year represented a death rate of 0.18 per 1,000 of the population.
- Dundee had an average of 54 drug related deaths per year, representing a death rate of 0.36 per 1,000 of the population. This is the highest rate of all local authority areas in Scotland.

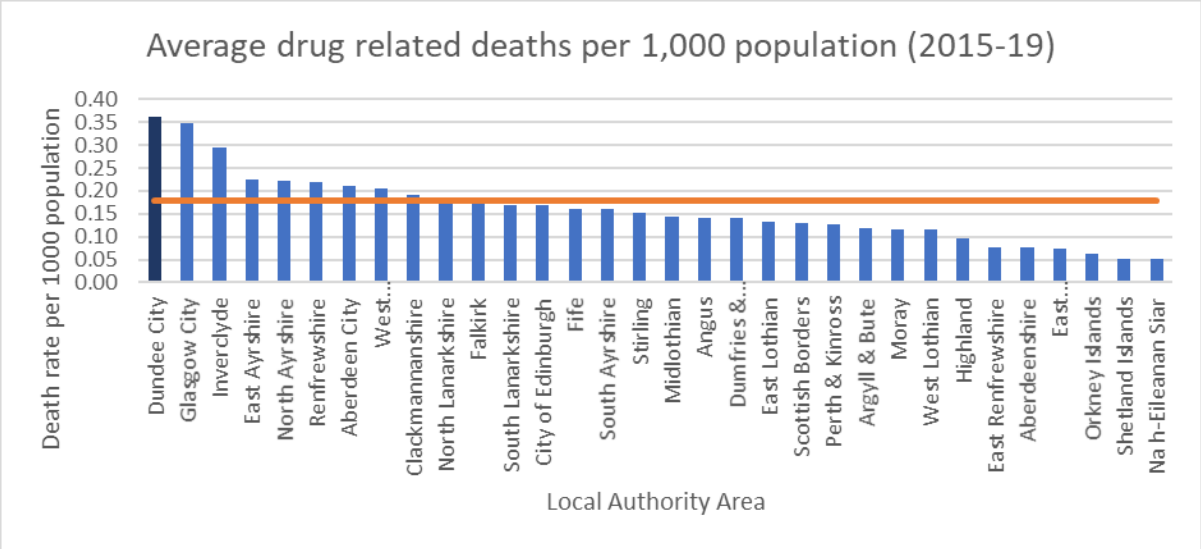


Figure 5.2: Average drug related deaths per 1,000 population by local authority area in Scotland 2015-19 (Source: Drug deaths in Scotland, National Records of Scotland, 2019)

It is significant to note that Glasgow and Inverclyde (as the only two local authority areas in Scotland with higher levels of deprivation than Dundee) follow Dundee with the next highest rates of drug related deaths. These figures demonstrate the strong link between deprivation and drug use, as well as the impact drug use has on some of our most vulnerable communities in Dundee.

Activities to prevent Drugs Deaths Naloxone Project

The table below list the organisations in Dundee currently participating in the take home naloxone distribution in Dundee:

Table 1: Naloxone distributors in Dundee

Organisation type	Organisation
Statutory	DDARS
Third Sector drug treatment	Hillcrest Futures We Are With You
Non-drug treatment	Positive Steps Social Work Community Justice Service Navigators Venture Trust Safe Zone Street Outreach Team The Corner Parish Nurses Women Rape & Sexual Assault Centre (WRASAC)

In addition to the list above, some homeless hostels in Dundee hold naloxone but none have signed up as non-drug treatment services (hostels in other areas in Scotland have signed up). This means that other services go into the Dundee hostels and do provide naloxone from the premises, for example Positive Steps, Hillcrest Futures and our Peer Volunteers who supply naloxone. Furthermore, DDARS are issuing naloxone as part of their routine assessment/ treatment processes, 176 kits were prescribed and dispensed Q1-Q3 2020/21.

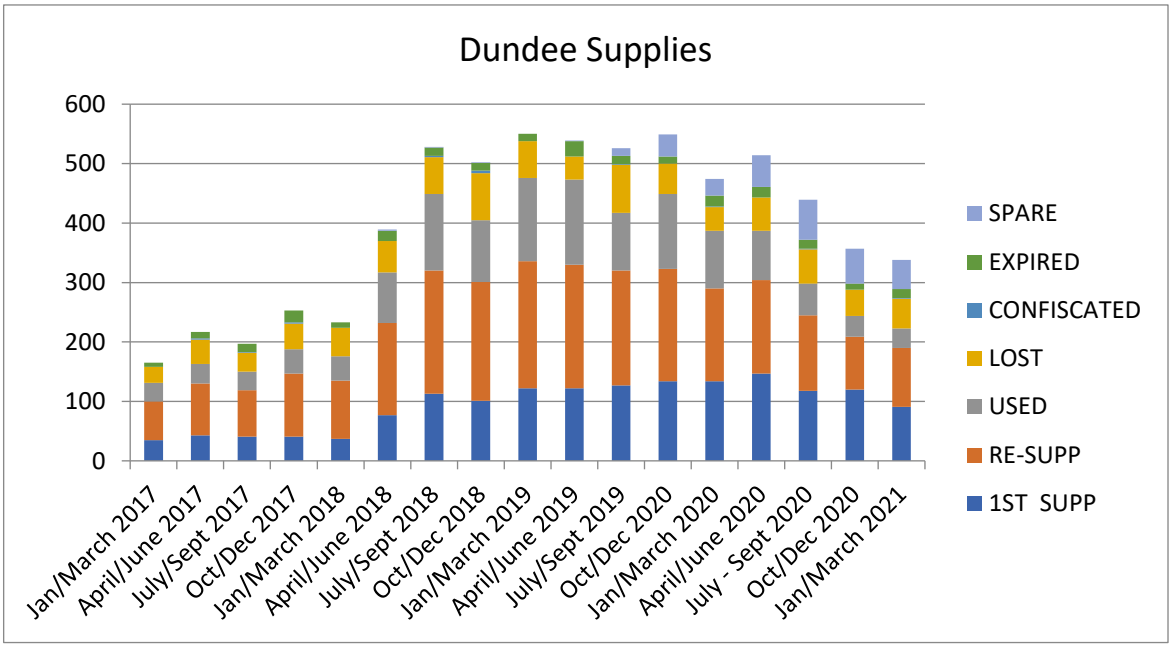


Figure 5.3: Number of naloxone supplies in Dundee since January 2017

The above chart shows the growth of naloxone supplies across Dundee over the last four years. The COVID-19 pandemic had an impact on the number of kits issued due to a decrease in the ability to see people face to face. A number of steps to mitigate this were implemented, including introducing postal naloxone, naloxone supply during outreach and in addition, DDARS issuing naloxone via a prescription to be dispensed at the community pharmacy as part of a risk assessment. 176 kits were prescribed and dispensed in Q1-Q3 2020/21 and are not included in the above chart due to the way data is captured.

5.1.3 Drug related Hospital discharges In Dundee 2015-2020

The most frequently recorded reason for drug related discharges between 2015 and 2020 is due to opioid use, followed by polysubstance use and then poisoning by sedatives/hypnotics. The proportion of opioid use has however dropped significantly and the use of sedatives/hypnotics has in contrast increased accordingly. This highlights a significant change of behaviour around drug use.

In May 2021 a study was conducted by the Health Intelligence Team, NHS Tayside on the numbers of drug related hospital discharges from 2015 to 2020. This was in order to see the relative numbers per year, the split between genders and to examine the age groups for the years. Drug related discharges are increaseing year on year until 2020 whereupon the figures drop to 2018 levels. No conclusions on the reasons can be made for this due to exceptional circuamstances that the COVID-19 pandemic has brought.

This analysis also highlighted a significant shift towards poisoning by sedatives/hypnotics from that of opioid use in recent years. Opioids in 2015 accounted for 74% of drug related hospital discharges with sedatives/hypnotics accounting for 5%. This is part of a pattern that in 2020 changes to 36% for opioids and 20% for sedatives/hypnotics.

Dundee City Drug Related Hospital Discharges:

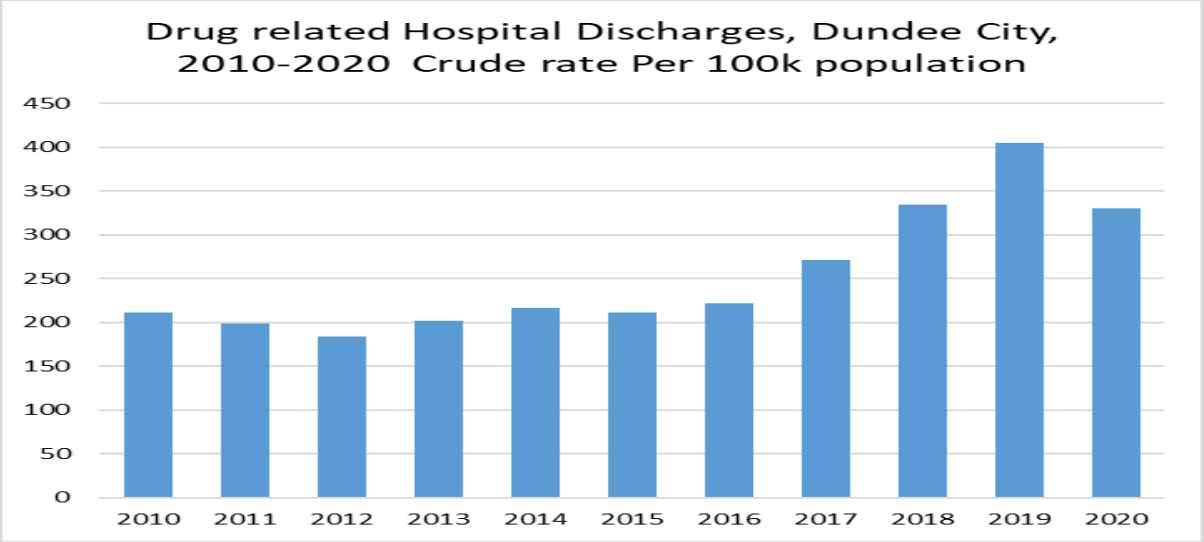


Figure 5.4: Drug related hospital discharges, Dundee City 2010-20 (Source: Health Intelligence Team, NHS Tayside)

Note: In 2020 the trend upwards reversed and hospital discharges for drug related reasons decreased. This could partly be due to the overall drop in hospital attendances because of the impact of the pandemic. However, it is hard to draw any conclusions due to the relative incomparability of 2020 with previous years under the circumstances.

Dundee City Drug Related Hospital Discharge: By Gender

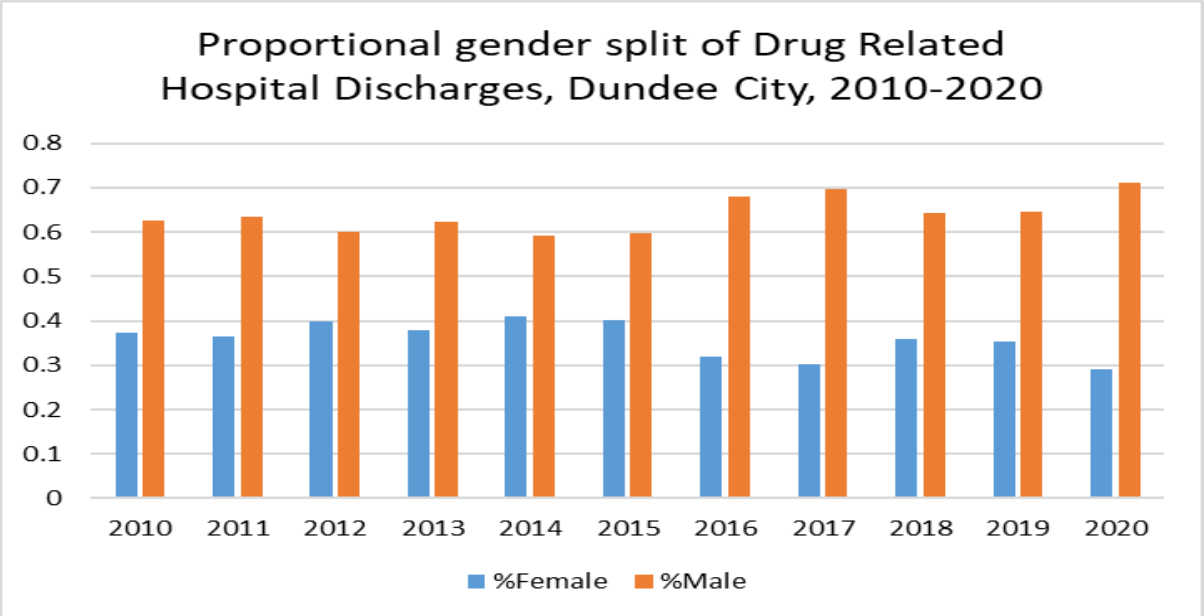


Figure 5.5: Proportional gender split of drug related hospital discharges, Dundee City 2010-20 (Source: Health Intelligence Team, NHS Tayside)

As we know from the data provided above, there are less women accessing specialist substance use services, and this is also reflected in hospital discharge data. It also appears that proportionately women experience less acute problems due to drug use and are less likely to require hospitalisation. However, this needs to be further interrogated.

Dundee City Drug Related Hospital Discharge: Age Groups

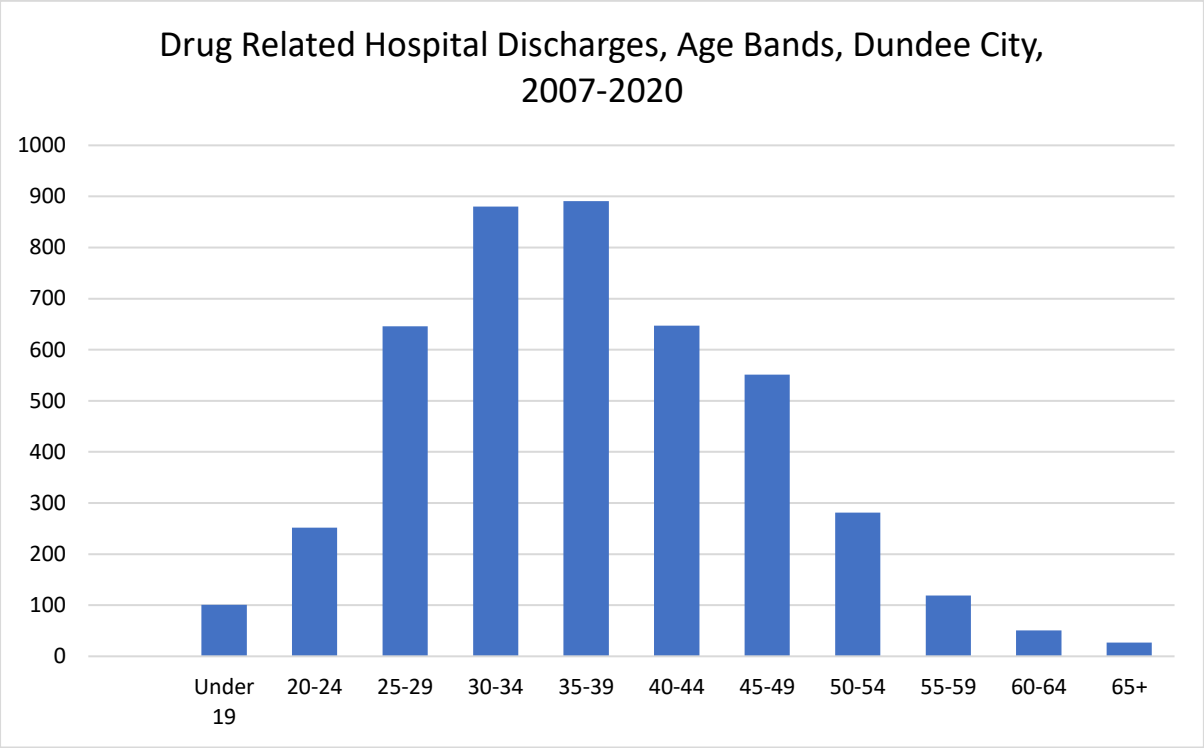


Figure 5.6: Dundee City Drug related hospital discharges by age bands (Source: Health Intelligence Team, NHS Tayside)

Caveats: It is likely that the large bandings in under 19s and over 65s include cases where the recording is not always indicative of illicit substance use but more likely to reflect adverse effects of therapeutic drugs. In the older age group in particular there are diagnostic codes in many of these individual cases where the person is also recorded as suffering from terminal/ serious conditions and therefore are legitimately in receipt of some of the classes of drug that are used to denote a drug related hospital attendance. It is impossible to filter these out without reviewing an individual's medical notes in full and that is not possible from SMR01 data.

Dundee City Drug Related Hospital Discharge: SIMD

There appears to be a clear inequality gradient exists in drug related hospital discharges by quintile. The rate of drug related discharges in the financial year 2019/20 is 20 times higher in the most deprived SIMD quintiles (Quintile 1) than the least deprived (Quintile 5). There should be some caution exercised in interpreting the exact rate of difference however, as the numbers in SIMD Quintiles 4 and 5 are considerably lower.

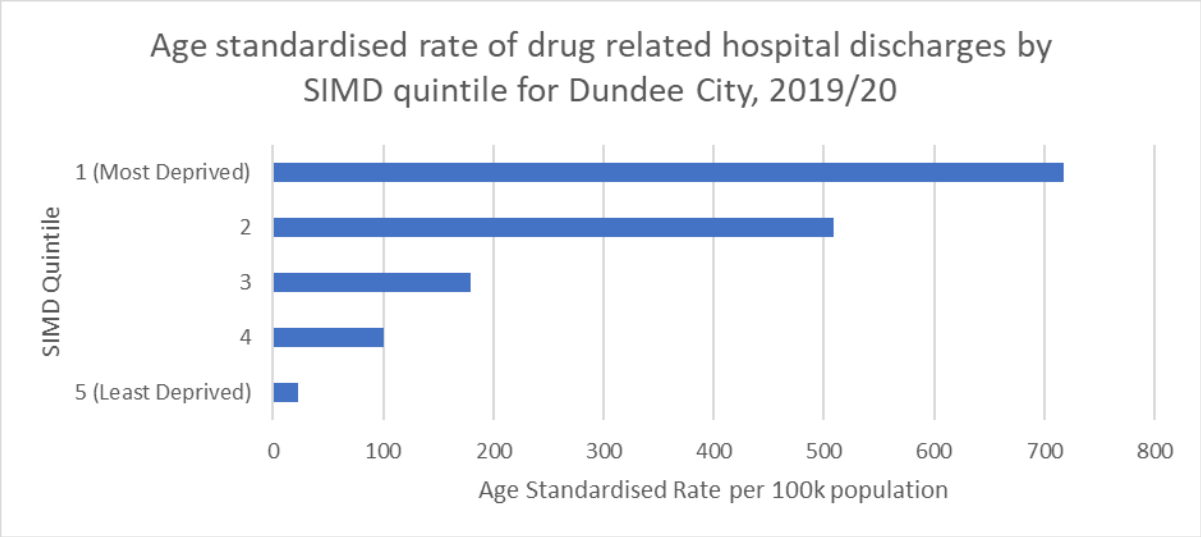


Figure 5.7: Age standardised rate of drug related hospital discharges by SIMD quintile for Dundee City 2019/20 (Source: Health Intelligence Team, NHS Tayside)

5.1.4 Profile of DDARS (formally known as ISMS)

Number of referrals to drug treatment

The chart below presents the number of individuals starting drug treatment with DDARS per quarter. It includes information for both drugs and alcohol treatments. With some small variations, it is clear that number of referrals to the service remains consistently high. Some individuals are re-referrals (i.e. they have accessed a service in the past and are returning).

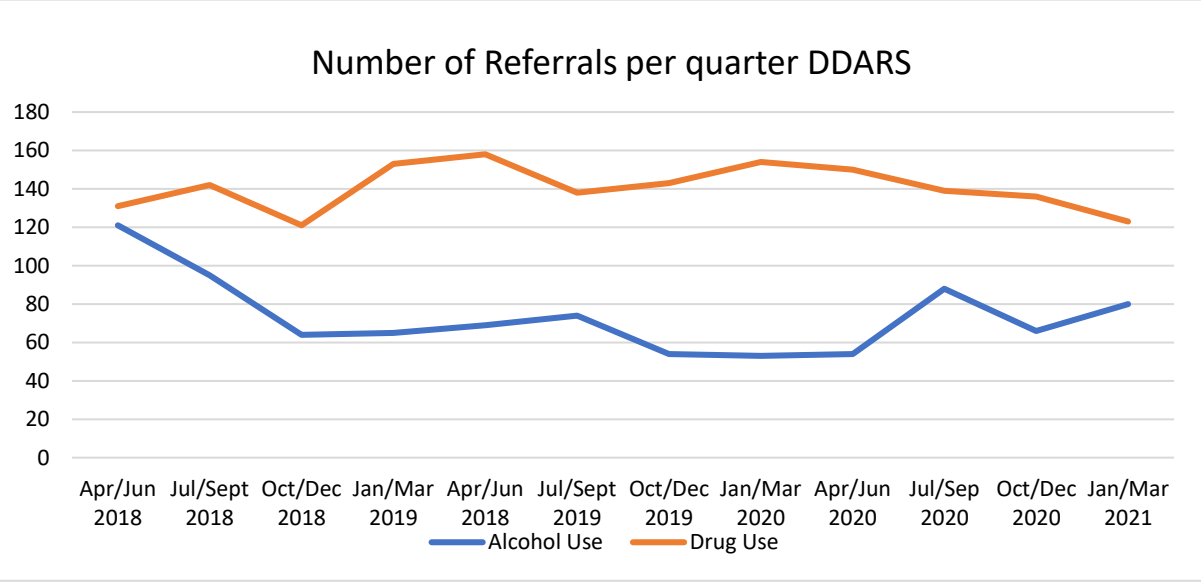


Figure 5.8: Number of referrals per quarter DDARS 2018-21

Age of individuals referred to DDARS (new individuals entering the service/ and returned referrals) Referrals by age group have narrowed in range since 2017/18 where there were two peaks in the groups, including specifically those in age groups 35-39 and 45-54. In 2020/21 over half of the referrals to DDARS were in the age range of 35-44.

Since 2019 there has been an increase in referrals to DDARS of older individuals (mainly the age groups of 35-44). However, we recognise that it is still likely to be the case that most individuals use drugs for a number of years prior to presentation to services, and therefore we cannot assume that there has been an increase in the onset of the age at which people begin to use drug.

DDARS Capacity

Source: EMIS (NHST Client Information System), quarterly monitoring reporting

A snapshot was extracted from the EMIS system of clients that are open on the combined DDARS services caseload on 25th June 2021. It showed that the service had a current client list of 1,374 open clients (including 336 unallocated cases at that time). Of these clients 62.7% were male and 37.3% were female.

The biggest single age group among the clients was aged 40-44 who made up quarter (24.6%) of the total. In total 45% of the clients currently open to the services have been with them since at least November 2019 when the current service structure was implemented on the EMIS system. The total above includes all people in receipt of both drug and alcohol treatment within the service.

Within Dundee Drug and Alcohol recovery Service (DDARS), there are 21 front facing key working Nurses who provide direct clinical care for people who require Opiate substitution Treatment. At this time there are 1144 people who would be included within this category. Of the 21 key working staff we have 4 staff who are undergoing induction and 3.6 current nursing vacancies.

As a result of the numbers of people accessing the service for OST and staffing levels, the average caseloads are 55 (54.8).

There are further specialist nursing roles within DDARS who provide input for people who have additional needs including Alcohol, Detoxification, support for pregnant women, children and families and community Justice.

Dundee Waiting Times Performance 2018-2021

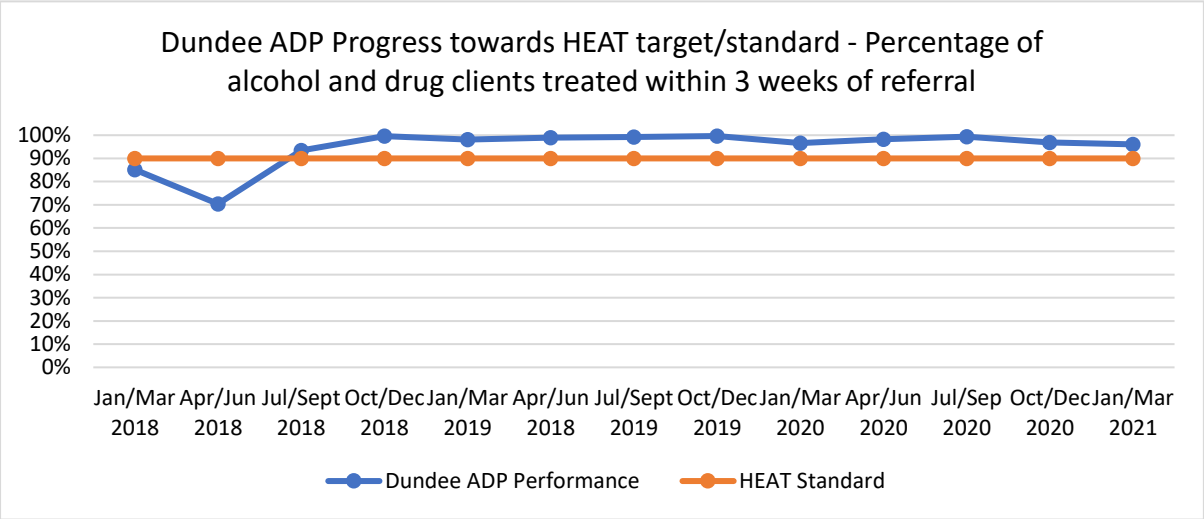


Figure 5.9: Percentage of alcohol and drug clients treated within 3 weeks of referral

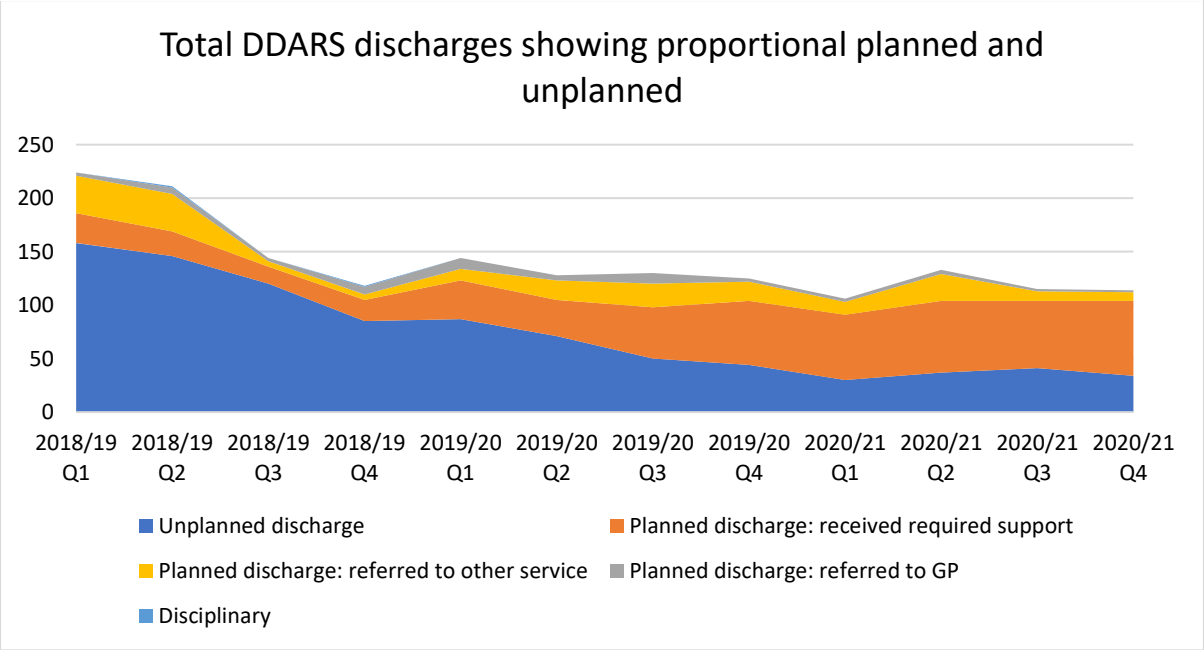


Figure 5.10: Total DDARS discharges showing proportional planned and unplanned (Source: National Waiting Times database)

There has been a steep decline in numbers of unplanned discharges from the first quarter of 2018 until the last quarter of 2018/19. Figures thereafter seem to be levelling off and remain reasonably stable. Overall, there is a continuing decline in numbers of unplanned discharges, proportional levels also dropping since quarter 4 of 2018/19

It is worth noting that there has been a change in the use of categories (e.g. in the past those clients incarcerated were previously counted as 'unplanned discharges' despite the fact that their treatment continued once in prison). There are also further limitations with the database, namely once an individual has not responded to 5 engagement attempts, the only option provided by the system is to record them as an 'unplanned discharge'.

5.1.5 Prescribing / prescription drugs

Information provided by NHS Tayside shows that as of March 2021, there were 1,241 people in Dundee in receipt of Opiate Substitution Therapy (OST) prescriptions. Please note that linking prescription patient data to DDARS and other service data is not currently possible without national data sharing agreements being in place.

Methadone prescription

In recent years there has been an increase in prescriptions of Methadone alternatives. This gives more choice for treatment, allows more stability for the individual and takes less time to dispense.

Recent data shows a shift from the use of opioids to benzodiazepines and consequently there has been a slight decrease (from 2018-2020) in the prescribing of methadone. Expanding/ shifting from methadone to other alternatives – including Buvidal and Buprenorphine – see details in the tables below:

Table 2: Number of patients prescribed methadone during time period (2018-20)

Time period	Total number of patients
01.01.2018 – 31.12.2018	1,228
01.01.2019 – 31.12.2019	1,144
01.01.2020 – 31.12.2020	1,167

Methadone dose ranges

Optimal therapeutic dose 60-120mg daily as per Orange Guidelines. Please note that the total number of patients will not match the above figures as patients may receive prescriptions in each dose range as they are titrated up or down. These figures provide an overview of dosage range only.

Table 3: Number of individuals per methadone dosage range (2018-20)

Time period	< 60ml daily	60 – 120ml daily	>120ml daily
01.01.2018 – 31.12.2018	583	832	11
01.01.2019 – 31.12.2019	542	808	10
01.01.2020 – 31.12.2020	557	870	8

Buprenorphine prescribing

Table 4: Number of individuals prescribed buprenorphine for time period (2018-20)

Time period	Buprenorphine (generic, Suboxone, subutex, espranor)	Buvidal (numbers are too small to report here)
01.01.2018 – 31.12.2018	271	
01.01.2019 – 31.12.2019	367	
01.01.2020 – 31.12.2020	471	

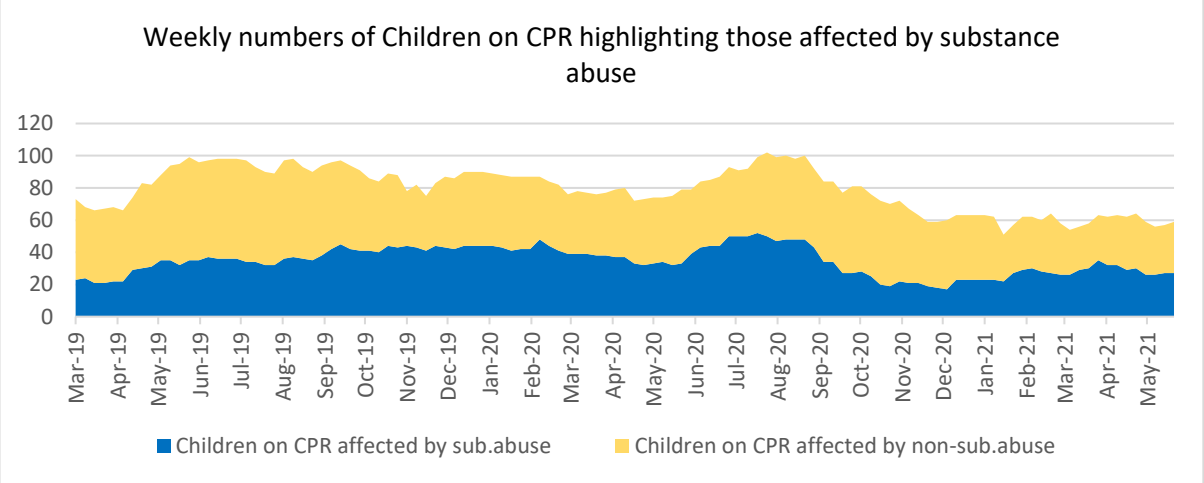
Please note: Buprenorphine dose range not provided as daily dose is not extractable from controlled drugs.

5.1.6 Child Protection Data

Weekly reports have been made to the Child Protection Committee, highlighting the number of children on the Child Protection Register (CPR) since March 2020. These numbers compare the

numbers to the equivalent period in the previous year and breakdown the numbers by those affected by domestic abuse and substance abuse.

The average proportion of children affected by substance use in relation to the entire weekly population on the CPR is 44% for financial year 2019/20 and 43% for financial year 2020/21. (Both have a similar range of 32-56% and 27-55% respectively.)Overall, since the start of the current financial



year there has been a drop in the number of children placed on CPR. However, there has been no drop in the number of children placed on the CPR due to parental substance use.

Figure 5.11: Weekly numbers of children on CPR highlighting those affected by substance abuse (Source: Mosaic, June 2021)

5.1.7 Community Justice Social Work data: dedicated Keep well Nurse

The Keep Well service uses anticipatory care health checks to engage with populations who are at higher risk of health inequalities. Dundee Community Justice Service funds a 0.5 WTE Senior Keep Well Nurse who is co-located within this service. The nurse engages with individuals as they attend supervision, unpaid work, throughcare appointments and/or when on home leave from prison.

The situation with COVID-19 has had a great impact on the delivery of Keep Well health checks to offenders, as there was a period of less than 4 weeks in 2020-2021 whereby anticipatory care and assessment was recommenced prior to another lockdown. Therefore, data is included for this year on all additional aid given to respond to individual need.

Table 5: Number of Keep Well health checks (Source: Keep Well Nurses)

Keep Well Health Checks	**2019/20**	**2020/21**
KWHC (fully)	114	6
KWHC (partially complete)		1
Face-to-face health consultations (Nurse)		10
Telephone health consultations (Nurse)		29
Face-to-face and/or telephone support consultations from the KW Associate Practitioner		13
Individuals on waiting list for a KWHC as at 20 April 2021		13

Table 6: Number of referrals from Community Justice social work to mental health nurses

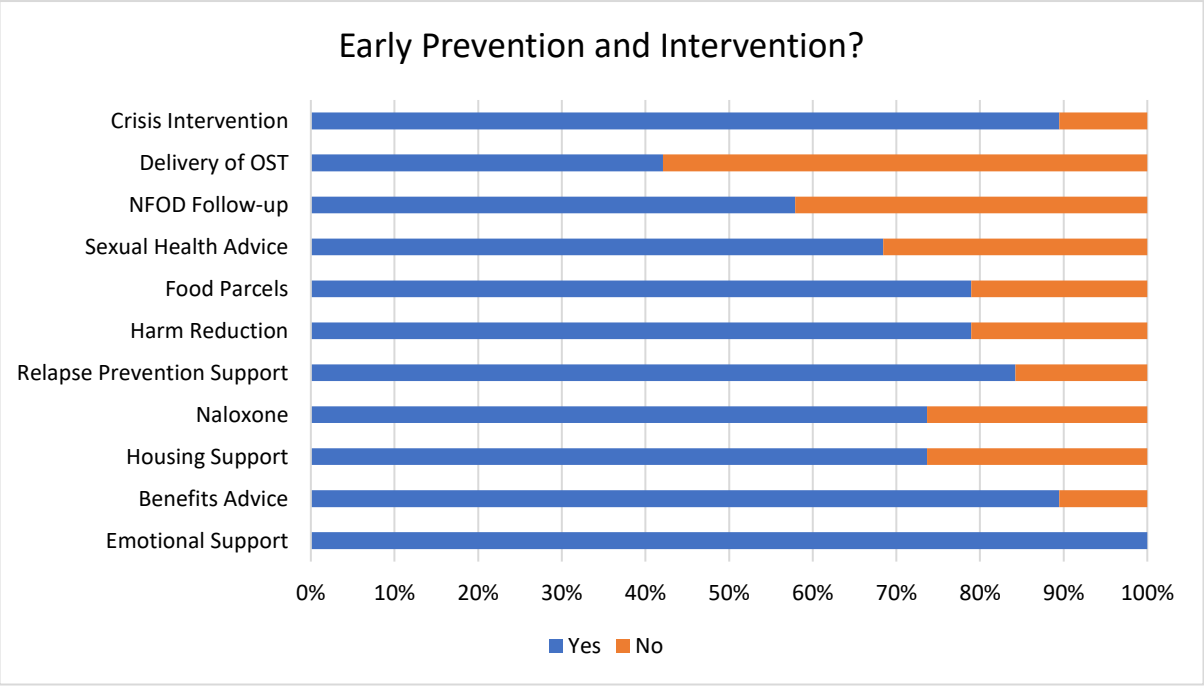
Community Mental Health Nurse	**2019/20**	**20/21**
Referrals from Community Justice Social Work	87	64
of whom engaged with service	55	48
of whom had co-existing Mental Health and Substance Use issues	14	12

5.2 Organisations/ services activity information

The information in this section is based on a questionnaire survey circulated to front-line specialist substance use services. It outlines the type of services / interventions delivered in Dundee, work on quality standards, staff development activities, and how individual organisations responded to / coped during COVID-19 to maintain services and support to vulnerable people. 24 front-line services/projects provided monitoring reports for this section.

Dundee Drug and Alcohol Recovery Service (DDARS)	Children and Families Service
Criminal Justice Social Work	We are With You
Hillcrest Futures	Tayside Council on Alcohol (TCA)
Positive Steps	Aberlour
Dundee Independent Advocacy Service (DIAS)	Axis (Crossreach)
Dundee Women's Aid	Women's Rape and Sexual Abuse Centre (WRASAC)
MIA Barnardo's	Dundee Carers Centre
NHS Public Health	Community Health Team (HHOT)
DVVA Peer Recovery Network	DVVA Lochee Community Hub
DVVA Northeast Project	DVVA Public Social Partnership (PSP)
Gendered Services Project	Police Scotland/CJS
Housing 1st	Action for Children
Children 1st	

5.2.1 Services and support provided during 20/21



Other forms of support that have been provided by services:

- Social Work: Case management (DDARS), community case support (DDARS), adult care, assessment and plans in respect of children and families,
- Advocacy support (DIAS, WRASAC, MIA)

- Mental Health: Support/addiction direct support (Lochee Hub), Structured Psychosocial Intervention (We Are With You), Psychological support (DWA), Counselling/Use of creative therapies (TCA)
- Peer Support (DVVA, Hillcrest)
- Community Engagement (Lochee Hub, Hillcrest)
- Christmas dinners/presents (Lochee Hub)
- Children: Lunch bags, activity packs (Lochee Hub)
- Safe Zone Bus – community outreach provision
- BBV testing and treatment (Hillcrest)
- Domestic Abuse and sexual violence support (DWA, MIA, WRASAC), including refuge accommodation
- Peer Naloxone training (Hillcrest)

5.2.2 Staff training/workforce development?

✓ Extensive training undertaken by staff including Trauma Informed, Naloxone training by 15 service and SMART Recovery by 7.

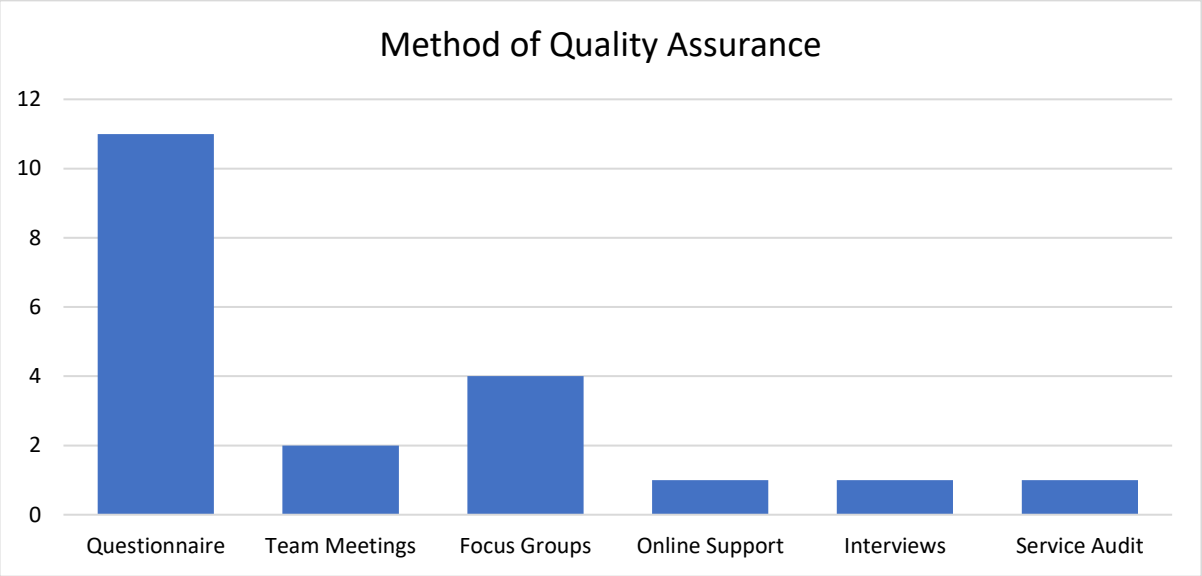
Of the 19 services that completed this question, 100% stated staff deliver or undertake extensive training/workforce development. Some of the training mentioned was general health and safety training that services are required to undertake (e.g. fire safety/PPE training) or mandatory training required within health and social care. Other training mentioned was service/role or substance use specific. Naloxone training was mentioned by 15 of the services involved and SMART Recovery training by 7 services. Other commonly mentioned training was trauma informed, domestic abuse and mental health related. Gender-specific training was also mentioned by some service highlighting the positive impact the Gendered Service project is having.

5.2.3 Quality Assurance and Engagement Activity

✓ Quality assurance tasks completed by both staff and services users to improve service delivery. Examples provided:

- Surveys
- Focus Groups
- Service User Outcomes
- Service Delivery Feedback
- Service User Informed Future Developments

Of the examples provided, questionnaires were the most commonly cited method of quality assurance used by services (11). Following this, focus groups were the second most frequently used (4).



Of the services that explicitly stated, service user feedback is the primary quality assurance process utilised. The types of feedback used to inform quality assurance were: service delivery feedback, service user outcomes and service user informed future developments.

Examples of service delivery feedback:

- Pandemic Survey conducted by Aberlour used to support and shape service design and delivery.
- Routinely asking service users for feedback to drive continuous improvement and ensure service is shaped by the people who will use it (We Are With You, Positive Steps).
- CrossReach involve service users in designated meetings to raise any issues or comment on any aspects of the project's delivery. Service users can also leave comments in their recovery cafe comments book.

- Service satisfaction questionnaires were conducted by TCA to understand how their altered COVID-19 service delivery was being received by clients. TCA also conduct regular, informal 'listening groups' for service users to voice their wishes and preferences for how the group should be conducted and what barriers they have to accessing the group.

Examples of service user outcomes:

- We Are With You use google forms to obtain feedback to review how clients have felt after discharge from their service, including housing support service.
- WRASAC send end of support surveys which can be completed with case worker or individually, however they are rarely returned. Occasionally WRASAC will get informal feedback via texts and include this in their monthly reporting.
- Exit evaluations are completed when women leave DWA refuge or outreach service.

Example of future development quality assurance:

- We Are With You have been developing gender specific work with women. Feedback has been provided by 11 women about how the service is delivered and what should be developed in the future.
- The Gendered Services Project is currently working with women with lived experiences. DWA helped recruit some women for this project. Focus group discussions have involved barriers they have experienced when engaging with services and how to make services more accessible in the future. This feedback has been used to inform a 'self-assessment tool' to be used by services in order to identify service gaps and areas for future development. Once we have identified and gaps or support needs, the project will source training if needed, provide gendered approach training if required, advise on policies and procedures, and support services when they apply a gendered approach to service delivery.
- Positive Steps interviewed individuals with lived experience of substance use to inform how outreach service should be developed and expanded and inform the pertinent skills the service look for when recruiting additional team members.

5.2.4 Support to families/carers

89% of the services that participated in the service monitoring survey stated they offered support to families/carers of the individuals they work with. DDARS primarily supported carers in relation to their involvement with support for family member who engage in substance use, including collection of medication and crisis calls. Whilst Positive Steps provide family members with Naloxone training and supply. TCA, like other services in Dundee, adopted a whole family recovery approach and through this offer counselling to 'significant others'. Other services tend to offer support groups for family member/carers, where individuals could discuss their lived experiences and turn to peers for advice (Hillcrest Futures/We Are With You). Groups such as RecoveryTay have been created to provide activities and a support system for anyone affected by substance use, ultimately aiming to reduce any stigma experienced. There are also two Community Recovery Cafes in Dundee run by CrossReach, which are frequented by families and carers; these cafes provide food parcels, hot food and access to health and mental health services.

The Dundee Carers Centre is a service that specifically aims to make a difference to the lives of carers of all ages. They do this by providing information and support services for carers, ensuring the rights of carers are upheld, empowering carers and developing new services in response to identified unmet needs. Existing services they deliver are in the form of advice, emotional support, peer group facilitation and much more. They have recently formed a partnership with Positive Steps to develop a new friends and families SMART recovery group which will be introduced as of June 2021.

Services which primarily focus on supporting individuals who engage in substance use, occasionally also offer one-off phone calls to family members and provide them with information on services who are better suited to aiding with carer support (e.g. DVVA Peer Recovery Project)

Key organisations providing support to family members:

- Dundee Carers' Centre and the Lifeline Group;
- We Are With You;
- Positive Steps;
- Hillcrest Future and Recover Tay;
- DVVA Peer Support Project

5.2.5 COVID-19

Statement of clarification

It is important to note that throughout all the lockdowns, face-to-face support has been provided on a risk assessed basis and when such support was assessed necessary to meet critical and urgent need. Although, face to face meetings remained exceptional, it is nevertheless the case that they continued and do take place when required.

When Scotland entered the first lockdown on 23rd March 2020 due to the COVID-19 pandemic, substance use services (especially those defined as 'COVID-critical', including DDARS, We Are With You, Hillcrest and Positive Steps) continued to provide a service, whilst considering and implementing different delivery options. There was rapid and significant change to ensure the safety of the individuals accessing services and of staff.

Ensuring clinically safe care for individuals on Medically Assisted Treatment (MAT) during lockdown

At the start of lockdown, the Scottish Government issued guidance in recognition of the specific challenges in balancing risk of death from overdose against risk of death from COVID-19 for patients on Opiate Replacement Therapy, whilst at the same time taking account of risks to all vulnerable patient groups using pharmacies and of pharmacy staff. In addition, the Royal College of Psychiatry also issued guidance for clinicians in respect of individuals on MAT. This stated that *"the clinical priority currently is to safeguard life-saving clinical treatments such as methadone and buprenorphine"*. This also reflected the advice from the Advisory Committee of the Misuse of Drugs (ACMD).

An intensive piece of work was carried out by consultants in the Tayside substance use services to review and assess the individuals who may be able to have their level of supervision reduced. However, in Dundee a large number of individuals remained on either daily / twice or three times supervised consumption, which provided a degree of challenge for some community pharmacies.

In April 2020 NHS Tayside Gold Command approved a multi-agency mitigating action-plan to ensure the safe dispensing of MAT and support community pharmacies.

The action plan was developed in line with the Scottish Government proposals and included the following principles:

- All changes in practice should be informed by an overdose and safety risk assessment;
- Individuals at highest risk should still receive frequent supervised consumption;
- Individuals deemed suitable can be moved to daily pick up;
- Moves to two or three times weekly should be considered rather than moving to weekly dispensing;

- Changes, if required should be made when a new prescription is due or when a consultation takes place to ensure key overdose prevention and safe storage advice is given to individuals. A blanket change to prescriptions is not recommended.
- Naloxone and injecting equipment provision are provided to all individuals on MAT.

Fortnightly update reports monitoring the action plan and any impact were provided to NHS gold Command during the first lockdown.

In addition, a multi-agency virtual team, led by 3rd sector organisations was created to provide rapid daily support to community pharmacies whenever and wherever in the city required. This included supporting social distancing within pharmacies, providing COVID-19 safety advice to individuals while they waited for a service at the pharmacies and information on other support available.

Additional changes and support in place during lockdown

DDARS were required to stop the Direct Access clinics and progressed to a Direct-Appointment system, based on booking slots for assessments. Individuals were able to book appointments directly and these would often be available for the next day. Very quickly and with support from third sector colleagues, DDARS implemented a home-delivery and visits service to individuals needing to shield.

We Are With You continued to deliver support from the Albert St Hub as this is a community pharmacy. Forming an integral part of the multi-agency NFOD pathway, Positive Steps continued to provide same day outreach responses to individuals who have experienced a NFOD and in person support to individuals at high risk of drug related death throughout the pandemic. This included providing vital harm reduction advice, naloxone and ensuring that individuals were linked into other appropriate services such as DDARS. CJS and Housing staff aided in delivery of OST/prescribed medication to individuals who were required to self-isolate or shielding. A further critical aspect of the COVID-response was the changes to prescribing provisions at pharmacies.

One of the most common service delivery changes, especially at the start was moving from face-to-face support to telephone/videocall (DIAS, North East Projects, Housing, DVVA Peer Recovery, DWA, MIA, TCA, CrossReach, DIAS). As restrictions began to ease, some services were able to restart face-to-face support adhering to PPE and other public health guidance. This at first began through outdoor visits in gardens and parks (DKWCT), hill walking groups (Lochee Hub) and health checks. However, when service users' needs were immediate and their safety was at risk, service would conduct visits face-to-face. Where possible Recovery Cafes provided food outdoors and where available provided a range of support (harm reduction advice, sign posting, help with benefits and relapse prevention).

Due to the heavy reliance on technology to remain in contact with many service users throughout the pandemic, many services were concerned for those did not have access to phones/laptops/Wi-Fi. One way to counteract this was to hold outreach face-to-face appointments within Dundee chemists. Other services were able to provide laptops and mobiles to vulnerable individuals/early release prisoners for support and their children for educational purposes through additional funding (Positive Steps, DWA, Dundee Carers).

Other examples of assertive outreach that occurred from various services was:

- Overdose awareness and naloxone kit distribution
- IEP including foil supply
- Wound Care
- BBV Testing and Treatment
- DDAR referrals were put in place.
- Food bags from Fare Share handed out

- Food bank referral made
- Health and Well Being packs
- Safezone Bus

With children at home as a consequence of schools being closed, services were also concerned for their wellbeing. Safeguarding plans for children whose parents engage in substance use were implemented through Children and Families, with them following a RAG rating system to prioritise face-to-face and remote contacts. Families were also provided with food parcels at the request of social work and health to ensure children had food in the absence of free school lunches. Through the Community Support Centres vulnerable children were prioritised for access to childcare and education support during the first lockdown period. All partners across the Protecting People structure worked collaboratively to identify and mitigate the risk of hidden harm to children and to vulnerable adults.

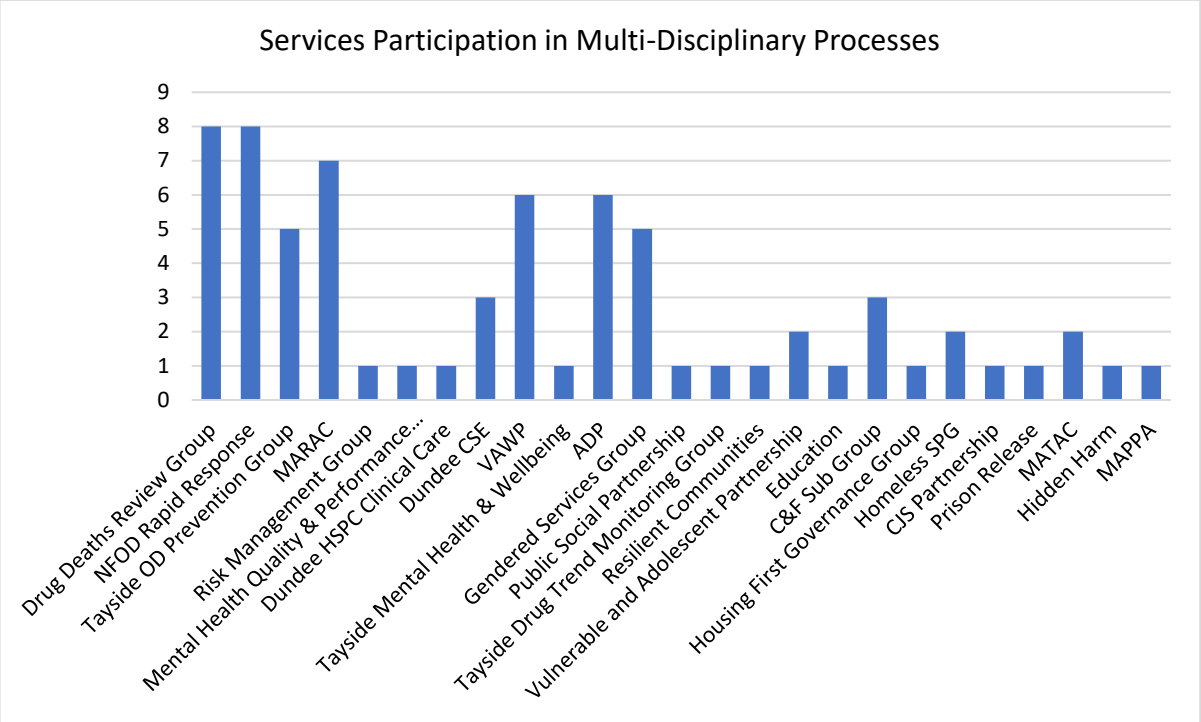
5.2.6 Collaborative work with other organisations (formal/informal)

18 of the services stated they engaged in collaborative work. Marginally more engaged in formal collaboration and 6 services engage in both formal and informal forms. Formal collaborations occurred when individual services agreed to deliver a project/service/support in collaboration and a contract was involved. They also occurred in some cases between services and Police, DCC, Criminal Justice, ADP, DDARS and Mental Health. The list of informal partnerships for each service was often more extensive and occurred between third sector organisations in relation to working together to complete projects together, tests of change and provided what is needed by the community. Some services also stated they are aiming to turn existing collaboration into more formal agreements in the near future to ensure clear project objectives and success.

5.2.7 Participation in multi-disciplinary processes

Of the services that completed the template, 89% participate in multi-disciplinary processes. Specifically, we have also noted very good participation of substance use services in the MARAC process. A small number of services / projects are unclear about how their work specifically fed into the multi-disciplinary process. This has been identified as an area for further improvement to ensure we are getting best value from all available resources.

From the services that gave detailed responses, the Drug Deaths Review Group, Tayside Overdose Prevention Group and MARAC were the most common for services to participate in.



5.2.8 Involving people in their care/treatment planning

The majority of the organisations who responded to the questionnaire said they followed a 'patient centred approach', involving individuals in the planning of their care/treatment informally or formally. Most organisations also adopt an outcome focussed assessments and/or recovery planning which is created between the individual and case worker during early support sessions (DDARS, Hillcrest, Dundee Carers Centre, TCA). More specifically, We Are With You, Hillcrest and CrossReach use or are in the process of implementing Recovery/Outcome Star Planning. This is a collaborative tool developed by individuals who use services. The Plan is agreed jointly between support worker and service users, and is reviewed monthly using the Outcome Star.

Other organisations, including DVVA Peer Recovery and the Lochee Hub adopt a 'bottom up approach' by facilitating peer support relationships to sustain and promote peer recovery. Particularly at the Hub, all group services delivered are requested by the community. To ensure groups are aiding individual recovery, the Hub conduct 6 monthly reviews.

Client feedback is also key to altering preferences for engaging with services and driving service improvement (Hillcrest, Aberlour, Positive Steps). One example provided by Hillcrest is the need to create women only spaces. This aspect of service delivery is currently being analysed through the Gendered Services Project where women who engage with services across Dundee have participated in focus groups discussing barriers to services and what they wish to see.

5.2.9 Challenges or priorities moving forward

As Scotland moves out of a second lockdown and into life post COVID-19, one priority and challenge that almost all services will come up against is resuming full face-to-face support. There is still some uncertainty surrounding which social distancing measures may remain and for how long, which will ultimately impact capacity of services regarding face-to-face support delivery. This has the potential

to reduce the number of individuals receiving support within a similar timeframe pre-COVID. Despite this, all services hope that face-to-face support can resume fully as it is a critical aspect of ensuring individuals safety and recovery. Although one positive that has surfaced from the altered method of delivering support has been flexibility for individuals. This is particularly evident in service users that have child caring responsibilities, additional support needs, physical disabilities or who are carers. Through this shift to delivering support online, individuals are not restricted by location and accessibility, although in some cases concerns around client safety when accessing support from home are present.

Due to social distancing restrictions, staff absences and general increased pressures from the pandemic, many services in Dundee are currently facing challenges surrounding capacity and long waiting lists. DDARS in particular are experiencing significant difficulties as a consequence of staffing issues, which the ADP are monitoring closely and supporting the Health and Social Care Partnership and other partners to manage and resolve. In other services there are backlogs of people waiting for full health check appointments (DKWCT), increased demand for refuge (DWA) and higher number requesting and accessing temporary accommodation (Housing). Community Justice are currently managing the high backlog of court cases which have been postponed due to COVID-19 and TCA are currently experiencing pressures with the increased demand on their alcohol service that the pandemic has brought.

With the impact of the pandemic, services are aware that individuals' needs may be greater post-COVID-19. This is especially true regarding mental health issues. The impact of the pandemic on mental health and well-being of the population has resulted in more individuals who are reporting poor mental health and suicidal thoughts or have attempted suicide (TCA, DWA, MIA, WRASAC). It is now more important than ever to improve communication with Mental Health services and treatment services, which many services are trying to do. Furthermore, services are aware of the strain the pandemic has had on workforce wellbeing, with some experiencing stress. With workload likely to increase as restrictions ease services aim to support their staff to ensure emotional wellbeing remains high.

Following COVID-19 many services aim to expand/participate in the Take Home Naloxone initiative. Positive Steps will support the expansion of Naloxone, engaging with individuals who have had an NFOD, whilst WRASAC aim to be able to distribute as soon as possible and provide internal training to all staff. Hillcrest has successfully recruited 6 peer Naloxone trainers who will soon begin to engage with individuals living in Dundee to support the rollout of Take Home Naloxone. They also aim to work closely with local partners and Community Police who have agreed to work in partnership to deliver outcomes on Naloxone. This initiative is to ultimately reduce drug deaths in Dundee with the hopes in the future to also reduce NFODs.

Moving forward, many services also aim to strengthen partnership working. As a consequence of the pandemic many services had to work together to endure individuals in Dundee were safe, many hope this can continue and be built upon post-COVID. In particular, some services aim to strengthen relationships with statutory services, CJS, Children and Families to embed effective referral pathways and support high risk individuals. Aberlour also hope to establish referral pathways for children impacted by Fatal Overdoses.

5.3 Focus Groups

We have conducted 10 focus groups and all focused on the same 3 broad questions:

- What improvements have been achieved over the past 2 years (especially against the recommendations form the Dundee Drugs commission)?;
- What are the remaining gaps/ what have we not yet progressed with?; and
- What more do we need to do to get to where we want to be?

5.3.1 Focus Groups with front line staff

- ✓ More treatment choices available to individuals
- ✓ Strengthened partnership working
- ✓ Increased willingness to change and adapt
- ✓ Employment of Non-Medical Prescribing nurses with Children & Families service
- ✓ Improved whole system care through Assertive Outreach Model
- ✓ NFOD Rapid Response

What has improved

It was highlighted that there have been specific improvements in the treatment choices available to individuals. Participants also welcomed that introduction of the national MAT standards and progress that has been made with their implementation.

Participants felt partnership working in Dundee has been strengthened, with different services and organisations working closer together, better co-operation, more effective information sharing and collaboration, support and understanding within the system as a whole. It was highlighted that, during the pandemic organisations adopted a 'can-do' attitude and had a sense of a reduction in 'red-tape' which enabled them to change/ adjust/ respond to need and risk almost immediately. There was greater a willingness to change, adapt and do what was needed.

The contribution of the Non-Medical Prescribing nurses based with Children & Families service was highlight as an important example of greater collaboration. Participants reported that many past and historical tensions between organisations have now been resolved, and that increasingly there is a problem-solving approach. There is an increasing sharing of the risks and a more of a joined-up conversation.

More specifically, there has been work on joint risk management, working collaboratively to support those taking responsibility for risks; sharing more information; and developing the lead professional model, to ensure it is not just on one agency carrying all the responsibility for risk. All participants felt that learning from the pandemic period demonstrated the need to further develop the lead professional approach for vulnerable adults.

Participants thought that the assertive outreach and OST delivery have been huge success. The increase in the number of assertive outreach workers is also helping to improve the whole system, including communications between services. The work of the NFOD rapid response team, and outreach workers attached to this response, is viewed by staff as a great success. Utilising outreach workers to deliver OST during lockdown also worked very well and the support delivered was more holistic with staff checking on every aspect of individuals' situations. This includes the dedicated support to individuals released from prison.

The introduction of independent advocacy was highlighted by participants to be very positive, the test of change is working well and there is good response from specialist organisations. Participants thought this will help with retaining individuals engagement with services.

On a more strategic level, participants mentioned the benefits of having an increasing number of front line staff participating in the ADP working groups and welcomed the sense they have a say and can contribute to strategic direction. Staff also welcomed the weekly (now monthly) multi-agency meetings and thought these improved relationships, sharing information and risks, alerting each other to potential risks, developing better understanding of pressures experienced by other services. There was a sense that collaboration and joint work have developed out of those meetings and they should continue.

Lastly, it was mentioned that more organisations participate in the take-home naloxone program, including the police who have been trained at issuing nasal naloxone kits.

What are the gaps/remaining challenges

Next, participants were asked to discuss the remaining gaps, especially in relations to the 16 recommendations presented by the Commission.

Participants highlighted that front line staff (and especially those working within DDARS) still work under considerable pressure, with high caseloads and not enough time to provide comprehensive support to vulnerable individuals. Difficulties with staff-retention were seen as contributing to this situation and some felt that nurses in particular are deterred from wanting to join the drug service due to stigma.

During COVID-19 DDARS had to return to appointment system as direct access was not compliant with public health restrictions. Lack of choice was raised by some participants who thought individuals are not given choices when on a daily treatment plan which impacts on their daily life, on their ability to move on, take up jobs or college places. Essentially individuals feel they are not trusted to take methadone appropriately. It was acknowledged however that the support from the Independent Advocate improves overall communication and addresses mistrust and a reluctance of some individuals to re-engage with DDARS due to previous experiences.

The need to address changes in prevalence and patterns of drug use, especially the shift from opiates use to crack cocaine, Crystal Meth and benzodiazepines was discussed. Participants reported an increase in mental health issues (specifically amongst young people and students) which highlighted the lack of available services and support. There was a clear sense that at the moment we do not have services to support those who are using different drugs. A joint approach for a trauma-informed mental health and substance use approach was seen as key requirement. Options for detoxing people off benzodiazepine and stabilise them while they remain on opiate replacement therapy for harm reduction is also needed.

Participants thought the development of a shared-care approach and creating better links with primary care, specifically for individuals who are on medication and methadone programs, and those that have relapsed during lockdown, remains a gap. Building relationships with individuals should be the focus, as is responding to their emotional and welfare needs. For example, some concerns were expressed regarding GP prescriptions. There is also a need to focus on women, many are affected by isolation but still concerned about re-engaging due to COVID-19.

Despite the increased support, some individuals released from prison are not engaging well and there have been a number of cases of re-lapse. During lockdown isolation has been a problem as work in groups has stopped and there were concerns that re-engaging may be an issue.

Participants highlighted that delays with toxicology reports means there is no access to 'real-time' information following drug deaths which seriously disrupts the review process and the learning/ improving responses.

All participants wanted to see the anticipated development of a lead professional approach strengthened and further embedded in their work. Staff within homeless service reported that there has been an increase in challenging behaviour through the pandemic (it was thought this was due to stress/mental health) and there was a concern that re-engaging people back into a routine could be difficult.

What do we need to do to get to there

Participants thought that there is a need to have greater focus on whole-family and parenting work. Staff within adult services are not always aware they can refer directly to children services, including third sector organisations. There was a general sense that independent advocacy can help facilitate this process and provide support to families.

Overall, participants wanted to see increased retention of staff within DDARS through better understanding of their role and challenges, having patience with the service and being non-judgemental. It was highlighted that there should be more sharing of information about what is happening, and the pressures on DDARS. The aim should be to build long-term partnership working and to increase onward referrals from DDARS to other services, especially in the third sector. An alternative referral system should be considered, or develop a process not based on a referral system to increase choice. Based on current drugs trends, participants also wanted to see a new seamless referral pathway for non-opiates responses.

As we emerge out of lockdown, participants thought there should be another review of prescriptions with a view of increasing the weekly option as this supports other recovery processes [see details of the originals of the initial review in 5.2.5 above]. There was awareness that progress in developing a shared care approach is slow but participants thought this should remain a key focus, along with the focus on the whole-system change. This should include increasing the focus on 'Recovery' and helping people move on, as just now people feel they come into treatment and get stuck. Most thought progress with the 'lead professional' approach and on joint risk management would help.

Going forward, participants wanted to see historical barriers and conflicts put to rest, and for the focus to be on whole-system partnership. They were keen to ensure this also includes individuals with lived experience, and that any inclinations to blame or judge certain staff groups for past situations or events should be let go of.

Remaining challenges – summary of the views of frontline staff

- Reduce the caseload of frontline staff;
- Address issues of recruitment and retention of qualified staff;
- Return to a direct Access system (as soon as COVID-19 restrictions allow);
- Respond to shift in pattern of drug use;
- Progress the development of a shared-care model based on the current test of change;
- Finalise the Dundee Lead Professional model.

5.3.2 Focus Groups: individuals with lived experience

- ✓ More consistent staffing in community hubs
- ✓ Greater focus on peer support
- ✓ Improved joint working between services
- ✓ Positive experiences with Housing First team

- ✓ Making good progress in challenging and eliminating stigma within Dundee
- ✓ Increase in local support groups for individuals while engaging in substance use/in recovery
- ✓ Quick support for parents through Children & Families

What has improved

Participants highlighted that there have been improvements within the community hubs, including more consistency of the staff working from hubs which helped them approach staff and build trust. The greater focus on peer support also meant individuals can learn from the experiences of others, and also benefit from the other activities that are going on, including Street Soccer/Gardening groups/allotment. All helps with building self esteem and confidence, feeling more included, developing strong peer network and watching out for each other's wellbeing.

Participants felt there was an improvement in the joint working between some services which meant they do not need to explain their situation to multiple people and multiple times. They felt issues are being listened to and followed through. The open access/drop in and flexibility of support (as and when needed) was seen as crucial for recovery.

Some reported they had more positive experiences with Housing First than with previous housing supports, and felt better supported to sustain their own tenancy. All participants welcomed the addition of the independent advocacy worker. Those accessing the Albert St Hub reported they have good relationship with pharmacy team, and that they feel cared for and listened too.

Participants in a separate focus group of individuals in recovery thought that in Dundee we are making good progress in challenging and eliminating stigma. The group highlighted that having people with lived experience working alongside staff and having meaningful involvement helps break down barriers to enable those who are not progressing to see someone they know moving in the right direction.

The group felt that the recovery community in Dundee has grown and there are now many groups locally to support people with substance use. There is also a variety of groups to meet people's needs including, walking, Art, Cinema, Allotments and more. Most importantly, lived experience is being recognised as a way to reach people at risk of overdose, for example the work of the Peer Naloxone Trainers.

Speaking specifically to a group of parents who focused on the support they receive from Children & Families Service, participants highlighted that the reduced waiting to get support from the service means they do not need to be in a crisis to receive support. Parents highlighted they received intense support after having their child which helped them to stop using drugs.

What are the gaps/remaining challenges

Focusing on their experiences with DDARS, most participants highlighted difficulties with the consistency of staff and were unable to name their key worker or the date of their last appointment. They reported finding it difficult to build meaningful relationships with a key worker and had a constant sense their key worker was simply too busy. Consequently, participants felt that decisions are being made without speaking to them first which made them feel they are not in control or able to make real choices. Some reported they feel anxious/nervous before attending DDARs appointment, and that they cannot be honest with workers for fear of losing prescription/being suspended/ or treated poorly.

With respect to mental health services, participants had a sense they have poor access to statutory mental health services and typically do not get access to psychiatrist/psychologist, even when they

ask for such support over the years. They felt that issues relating to past trauma are not being addressed.

Participants reported mixed views regarding access to GPs and Primary Care, with some felt they were listened to and others felt they were treated differently and stigmatised due to their drug use.

Focusing on their experiences of community pharmacies, participants reported feeling they are treated differently, especially due to the restricted times they can collect their prescriptions. For example, pharmacies open from 9am-9pm and they can only attend between 10am-1pm and 3pm-7pm. On Sundays participant reported they are unable to enter pharmacies before 12.30pm (opening time is 12.00) and one person said "I feel embarrassed when I need to tell other people who are waiting that I am not allowed in yet". When in the pharmacy, they are made to wait in different area, there is no confidentiality when getting prescription with other customers overhearing personal details.

Participants within the group of those in recovery felt that as a result of COVID-19 people feel more isolated and alone, now more than ever, and are using more drugs to help them cope.

It was highlighted that people still have a fear of speaking to others about their drug use, as they worry about being cut off, they worry about involvement of social service, and there is a general sense that these issues haven't changed in years.

It was highlighted that there needs to be services available for people 24hrs and 7 days a week as issues are not being faced, and do not only occur between 9am – 5pm. More generally, the group thought that, although we are making progress and people are told they have choice and options in terms of their treatment, when speaking to peers who are still in the system, these improvements are still not being recognised or felt by individuals.

The group of parents felt reviews of their methadone prescriptions are not taking place on a regular basis and thought people should only receive such prescriptions for a limited time. It was highlighted there are variations in the quality of support but that some individuals are not ready to change. Participants reported that once again drug dealers hang around community pharmacies in Dundee making it difficult for people to stop using drugs.

What do we need to do to get there

Participants wanted to see more flexibility with the services delivered through statutory organisations, including non-appointment based approach, where appointments are necessary have those in community settings and in a more comfortable/relaxed space. They asked to be listened to, for them to be able to drive decisions, express their views, with no pre-set agenda prior to appointments. Having consistency of key-worker to allow relationship and trust to be built, easier access to mental health services, focused on developing better understanding around the reasons for drug-taking and how to recover.

More generally, participants spoke of the value of feeling respected and listened to, the need to focus on community inclusion and work with the general public to help them understand substance use to reduce stigma.

Overall, participants in the focus group of those in recovery thought that there has been a lot of changes for the better in Dundee, especially around help for individuals to stop using drugs and moving on with their lives. However, those people still caught in the drug-using bubble, it is still hard

to see a way out and that is why services need to do better, to make the way out of drug-use clearer, through community rehabs, accessible community detox for benzo use and more.

There is also a need to have the work of Peer volunteers more visible in all services so that people can see that lived experience is happening and is there at the front of service delivery.
It is important to have more early intervention to stop children getting involved with drugs, more education in schools and reaching communities who do not usually engage.

The group of parents asked that more individuals should be offered the Depot medication in order to limit people having to attend pharmacy. There should be more education in schools to prevent children from getting involved in drug use, including input from those that have been involved in drug/alcohol use. Participants thought there should be more regular reviews of individuals, but also highlighted that some individuals should enter treatment with a more positive attitudes.

Remaining challenges - summary of views of individuals with lived experience

- Ensure consistency and continuity of key workers;
- Improve access to mental health services;
- Improve the consistency and quality of the services provided by Primary Care and GPs;
- Improve the quality of care and support delivered from Community Pharmacies. Including an improvement in the attitudes by staff at community pharmacies towards individuals affected by substance use;
- Develop out of hours support.

5.3.3 Focus groups and feedback from women with lived experience

- ✓ Improved partnership working between women's and substance use services
- ✓ Better understanding of substance use within women's services
- ✓ Increased flexibility in appointments
- ✓ Availability of new drug treatments
- ✓ Increased availability of peer support groups
- ✓ Greater understanding of women's vulnerabilities at homeless hostels

What has improved

Women spoke of the help they received from support workers (specifically within the women's services), and the improvements in partnership working between women's and substance use services. Women spoke of how staff within women's services better understand substance use issues, which the women found very helpful, but highlighted that the quality of the support often depends on the individual staff member delivering it.

Some women highlighted improvements in the support they received from substance use services, but most still felt that support was not available to them when asked for, and that over the past 2 years access to substance use services has not improved. At the same time, women spoke about increased flexibility over appointments and the availability of new drug treatments on offer as definite improvements.

Women highlighted the availability of group work as an improvement, and specifically community groups and peer support, which they all found very beneficial.

The experience of the care and support provided by some of the homeless hostels was highlighted, women felt that staff understood their vulnerabilities, understood the impact of domestic abuse, the links between substance use and mental health, were alert to the risk of suicide, and were overall caring in their approach. This was seen as real progress, despite the lack of available housing.

What are the gaps/remaining challenges

The lack of regular contact with support / key workers was highlighted. Some women noted they do not see their worker for several months at a time and highlighted that there is no opportunity for them to book appointments even when they feel they really need them.

Focusing on the link between substance use and mental health support, some women reported that when facing a crisis situation, they were turned away from Carseview, and often relapsed. This situation was seen as having deteriorated during lockdown with a sense of little support to prevent or respond to relapse. Women also reported they were refused residential mental health support on the ground of their substance use. There were reports of long waiting lists for mental health support, with women having a sense they are seen as a number rather than a person.

Focusing on recovery, some women spoke of being on methadone for over ten years and felt there is little encouragement to reduce their prescription levels. Women reported that, when they asked to reduce their methadone, often and without an explanation they were simply advised that 'this is not a good idea', and felt the lack of contact with their key worker made this situation worse.

Gaps in the provision for emotional support were discussed, with examples including occasions when women were switched to suboxone to replace methadone, often due to risk of suicide, but no emotional support was available to support them during this switch. Women spoke of their sense that staff do not listen to them, that their wishes and views regarding their own care plans and options are ignored, and an overall sense of disempowerment.

Furthermore, women spoke of feeling stigmatised and judged by staff, some spoke of their wish to have an opportunity to talk openly without repercussions or judgement. Women spoke of not wanting to hear comments like 'I've seen hundreds of you' from support workers.

Women described homeless hostels and temporary accommodation as dangerous places, with examples of being stalked and threatened by men, often requiring police intervention. Some described being in fear of leaving their room and any attempt at being friendly often being misunderstood. Women described the drug dealing taking place in hostels, the ease of getting hold of drugs, and had a sense that staff were unaware of this.

Woman spoke of the challenges of getting their own house and tenancy, with some having spent almost one year in a hostel. Many of the women spoke of their experience of domestic abuse, and the challenge of having to sit with a male worker or in a waiting room with men. They described a general gap in the understanding of trauma issues and a lack of a gendered approach to meet their specific needs.

What do we need to do to get there

The majority of the women felt there is a need for more workers and more appointments. They highlighted the need to better support the staff working in substance use and in mental health services, which they thought would help reduce staff turnover, and in turn the need for women to re-tell their story time and again.

Women wanted staff to listen to them, to understand their needs and support them rather than make decisions for them. They asked to be treated as individuals, for there to be recognition they are all different with own individual needs and wishes. They asked for the option to see only female workers.

Women spoke of the need for staff to be more compassionate and understanding, some thought that having more staff with lived experience / peer workers would help as they will have better

understanding of what they are experiencing. For example, women explained that when they are denied the option of being detoxed from Valium, they are then coerced by men to do things they don't want to do in order to get money to buy Valium. This also leaves them vulnerable to sexual assaults and incidents and inappropriate touching. Women had a strong sense that if they were given the option to detox, it will then not be possible for men to coerce then to do things they don't want to do. But this will require staff to listen to them and understand their situation.

The need for a rehabilitation centre was highlighted by several women, and after care/ follow on support once the person returns to the community.

Women highlighted that it can be challenging for those in recovery to attend the main DDARS building, where many people in much earlier stages in their support are also attending. It was suggested that those further on in their recovery should be able to attend a different location. It was highlighted that some key workers can be inflexible regarding timing and location of appointments.
The need for more support for those in recovery was mentioned, with more available choices and options, including simply being able to talk to someone and less focus on increasing medication.

There was a lot of discussion about the provision of crisis support. Several women felt there needs to be a 24 hour crisis support for vulnerable women, and that support between 9am and 5pm during week days is not enough.

More partnership working was also highlighted, in particular in relation to substance use and mental health. It was suggested that links should be improved between Primary Care/GPs and other services. Woman spoke of the benefits when agencies co-operate and talk to one another, and how this saves them the need to re-tell their stories.

Remaining challenges - summary views of women with lived experience

- More frequent contact with key workers;
- Better access to mental health, especially at time of crisis;
- More options and support to reduce methadone levels;
- Expand rehab opportunities for detox from Benzodiazepines;
- Reduce stigma;
- Improve safe accommodation for women.

5.3.4 Focus Group with Carers

- ✓ Increased access to rehabilitation provision
- ✓ New Independent Advocacy service

What has improved

In terms of tangible improvements, although the group recognise and are aware of increased discussion and planning for change, participants reported they are not yet experiencing any improvements in services.

At the same time, participants highlighted that there has been an increased access to rehabilitation provision. The new Independent Advocacy service was seen as important, but participants felt this should not be seen as something replacing the role undertaken by family members and friends who provide regular support. The key is to focus on what individuals want.

What are the gaps/remaining challenges

Participants felt that over the past 2 years there has been a deterioration in the care provided by statutory substance use services, especially during the COVID-19 lockdown. Participants reported of experiencing a reduced service or no service, without being able to contact anyone. It was identified that, unlike other social care services, in some cases individuals had no care plans or reviews. There is still very little choice being offered.

Participants highlighted they were unsure of what the 'recovery' element of the service was, they felt there was no continuity of service and big variations in the quality of service.

It was felt that involvement of carers and families in supporting individuals was discouraged, and that included attendance at appointments.

Participants spoke of the continued stigma around substance use, the derogatory treatment from members of the public and the devastating impact of this. Continued lack of understanding and empathy was highlighted.

What do we need to do to get there

Participants wanted to see an increase in the availability of psychological support and substantial change to statutory services, focusing mainly on the basic principles and values and starting with a respectful conversation and about what people want in their lives, how they are going to get there, and the support required of services.

It was proposed that a set of minimum standards of what people should expect from services should be clearly available, as currently people are hearing about 'what will happen' when they access services but often don't believe that it will. Participants expressed concern about how risk is managed, especially for women.

It was highlighted that often published data from services is out of date (e.g. Drug Deaths data) and wanted to see a focus on the testing of drugs.

Remaining challenges - summary of views of carers

- Availability of psychological support for carers;
- Clear communications of standards expected of services;
- Increase the testing of drugs.

5.3.5 Focus Group with Parents

This focus group included 3 individual parents who provided specific feedback about the support they receive from the Children & Families service.

- ✓ Reduced waiting time to receive support
- ✓ More intensive and comprehensive support after birth of children

What has improved

Participants welcomed the reduced waiting to receiving support from the service, which also meant they no longer needed to reach crisis point to get support. The support provided after the birth of their children felt intensive and comprehensive, with positive outcomes of parents no longer using drugs. All the participants commented they tried in the past to come off drugs but did not succeed.

What are the gaps/remaining challenges

Participants thoughts that reviews of treatment progress were still not happening often enough and that they still felt they are left on methadone for perhaps too long. They thought that OST should be a time limited option. There was also the sense that not all parents received the same level of help, and that some were not ready to change.

One participant thought that currently 'drugs were rife in Dundee' and that the drug dealers are back waiting outside community pharmacies offering drugs to people. But there was also the sense that individuals could choose not to engage with the dealers, and that the support on offer once they had their children helped to do so.

What do we need to do to get there

Participants thought that more individuals should be offered the Depot Medication in order to limit the number of times they need to attend the pharmacies. They thought there should be more education in schools to prevent children from getting involved in drug use. This should include having people that have been involved in drug/alcohol use going into schools to give real life education to children.

There should be more regular reviews of individuals' progress but also that some individuals should come into treatment with a different attitude and be more ready and willing to change.

Remaining challenges - summary of views of parents

- Introduce more frequents reviews of treatment progress;
- OST to become a time-limited process;
- Increase access to Depot Medication;
- Increase focus on prevention;

5.4 Staff Survey

Introduction

We conducted a survey with front line staff from Dundee City Council, Dundee Health and Social Care Partnership, NHS Tayside and third sector services, and received 59 responses. All sections of the survey followed the same 3 broad questions:

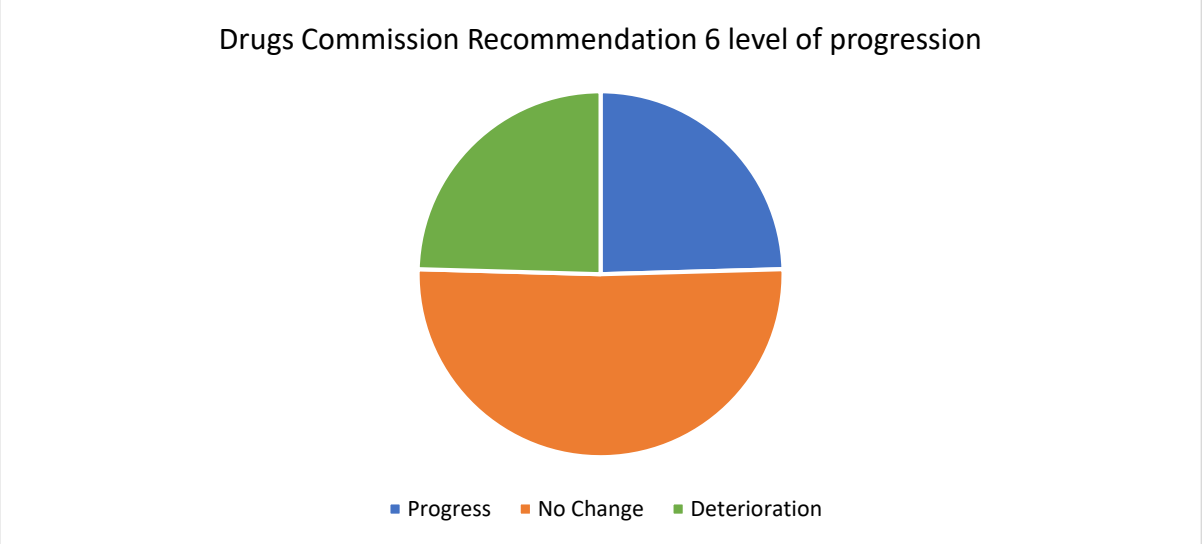
- What progress has been achieved over the past 2 years regarding specific recommendations from the Dundee Drug Commission?
- The impact this progress has had on services, individuals, families, children and communities.
- The improvements that still need to occur to fully achieve the recommendations.

Where relevant, we focused questions within the survey on some specific recommendations made within the Dundee Drugs Commission report.

Results

5.4.1 Recommendation 6: Learning from the things that have gone wrong

- ✓ Improved structure and governance of the ADP
- ✓ Increased transparency, understanding and accountability
- ✓ Increased multi-agency working
- ✓ Identified Trauma Informed Champions



What has improved

It was highlighted by some participants that progress had been made regarding the structure and governance of the ADP, with leadership more frequently in contact with services. Through the monthly service meetings, services feel involved in work and more aware of what is occurring within the ADP partnership, resulting in a clearer view of the progress of actions and their impact.

When lockdown occurred, there was great focus on developing and adhering to a joint Risk Register. Participants believed this helped focus efforts, created transparency on what could be progressed and strengthened understanding/accountability. The pandemic also increased multi-agency working, with organisations having to support each other. Participants stated this resulted in increased productivity

despite the difficult nature of operating during this time, which some believed benefitted individuals accessing support.

There has also been progress in identifying Trauma Informed Champions within NHS Tayside, Dundee City Council and Dundee Health and Social Care Partnership.

Of the participants that believed there had been no change in relation to Recommendation 6, most attributed this to the impact of the pandemic. Some mentioned they were still unclear regarding the ADPs role and few believed change was noticeable within day to day service delivery, with support not always being trauma informed.

What do we need to do to get there

Participants highlighted the need for more communication between the ADP and third sector/statutory services, and between services themselves. This is to ensure information is being passed down to all services who in turn can cascade to individuals and local communities they support. The information should be fully explained so services can understand why changes have been implemented, ensuring transparency within the partnership. Due to lack of communication and information sharing some third sector services were still unaware of the recommendations and wonder if any of Recommendation 6 has been completed.

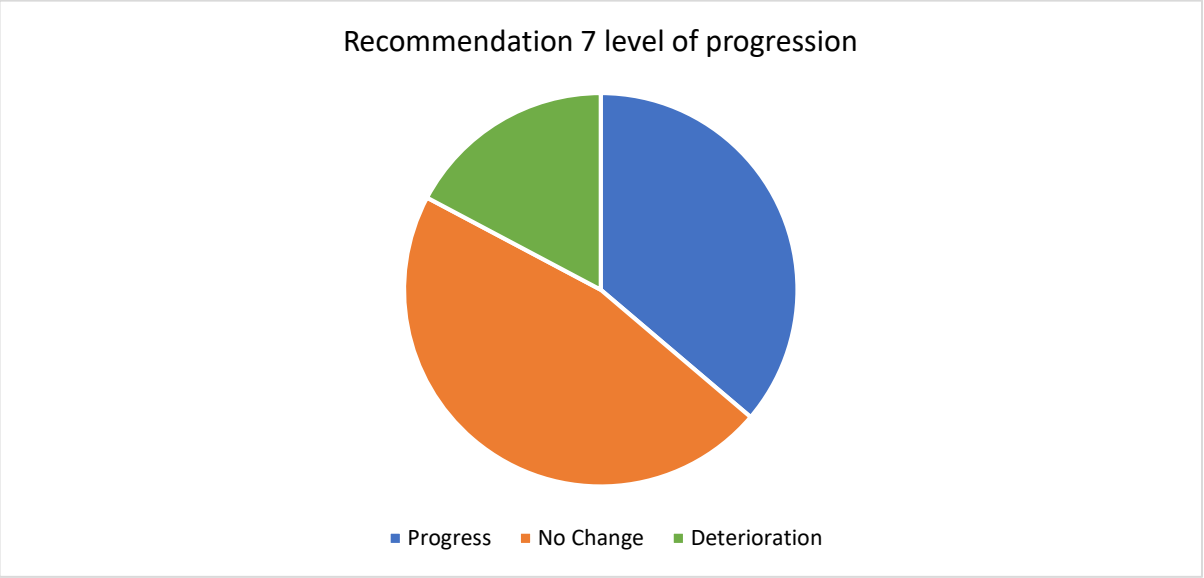
It was also highlighted that there needs to me more trauma training for practitioners and greater investment in staff training for workforce development which would in turn support the implementation of recommendations. Training would also allow nurses within services to operate at a higher band, benefitting the service that can be offered.

Remaining challenges

- Improve communications with frontline staff;
- Ensure services understand the reasons behind proposed change;
- Increase the focus on trauma training and on workforce development.

5.4.2 Recommendation 7: Choice is important

- ✓ Assertive Outreach Model
- ✓ Mainstreaming of Housing First Model
- ✓ Improved pathways for individuals leaving prison through Positive Pathways and Positive Connections



What has improved

Participants highlighted clear, positive progress with regards to the rollout of the Assertive Outreach Model. This model has currently helped identify people needing support quickly, who may have not accessed support on their own, and assists them to access the help they require. Participants also stated progress has been made regarding choice of services through Assertive Outreach. The model is particularly helpful to individuals who have experienced an NFOD or who have disengaged from DDARS. However, to ensure the model's success participants stated there needs to be improved communication between DDARS and third sector services and pathways into ongoing treatment/support need to be clearer to reduce the length of time for allocation/follow up.

The mainstreaming of the Housing First Model was also highlighted as showing excellent progress. This model is currently working well and is easily accessible for Dundee's most vulnerable. Some believe the model to be 'the epiphany' of person lead support, ensuring tailored support for each individual. The success of the model is clear with around 80 people who would normally be in direct access hostels/accommodation now having secured their own tenancy.

Pathways for individuals leaving prison through Positive Connections Service has also been improved, with them gaining easier access to community-based services. Organisations including Housing, Community Justice, Scottish Prison Service, Police Scotland, DWP, Health and DHSCP established a virtual meeting initially in response to the Early Prisoner Release Programme in May 2020. This group have continued to meet quarterly and report to the Community Justice Partnership. The key focus is communication and engagement across services involved in the prison release process, to make it as efficient for services and ensure collectively that our pathways and our processes are accessible for prisoners transitioning and reintegrating in to communities.

The above models/services mentioned have been designed to support individuals at a time of crisis and/or transition and many of the individuals believe and hope this has resulted in improved outcomes for them. Due to many being in the early stages, some believe it is too soon to understand the impact they have made on the wider community.

What are the gaps/remaining challenges

Despite some progress having been made with regards to prison releases, some believe not enough has been done so far and are concerned about the risk of fatal overdoses due to the lack of joined-up

approach between prisons and community. It was also mentioned that some individuals leaving prison are receiving one appointment with DDARS and then no further appointments are offered, with individuals just being placed on opiate replacement therapy. Particular concerns were raised for women who are exiting prison as they are particularly vulnerable and require input to reduce chance of overdose and relapse. More specialised intervention is needed to help women stabilise and increase the chance of contact with children. This would also help women to engage with other services to address other vulnerabilities if substance use is being addressed by specialist services already.

There are still some concerns over individuals not being offered and explained the full range of treatment options. More choices are available for individuals now through assertive outreach, however some feel that individuals are forced to engage with key substance services and this may not always be wanted. Concerns were also raised over the two major third sector recovery organisations having vastly difference approaches in terms of the levels of 1-to-1 support delivery. One is more group work orientated and the other is individualised support. The kind of support an individual receives is determined by their GP surgeries postcode which means type of support is not always appropriate for the individual. Some hope that both services will be available to the whole city. This arbitrary division of services by geographical location is not conducive to person-centered working, and does not encourage partnership working between services either.

Participants also highlighted that choice of treatment needs to be clearer when discussing with treatments instead of 'forcing them' to engage with DDARS. It was also mentioned that there is a lack of appropriate space to deliver support, especially in regards to Constitution House (DDARS). This is resulting in both clients and staff believing there is not any investment for them to work in a nice, welcoming environment.

Finally, some participants believed there has been little evidence to suggest the framework for residential rehab options is working.

What do we need to do to get there

It was highlighted that despite the Housing First Model being a great idea and already having some success, further expansion would be beneficial. Participants hope this expansion would include adequate support for people in new tenancies and removing some of the barriers to accessing housing. There is also hope that it would be available to all individuals who would benefit from the service/level of support. Already service users are questioning why they cannot receive the same level of support as their peers.

Despite some progress also having occurred with regards to Tayside Pathways, there still needs to be clearer, structured pathways for prison leavers. Some still leave prison with no support or plan set up for housing, benefits, drug treatments etc. Lead professional could already be offering support in prison and having all the necessary support in time for individuals release date. Some also suggested the third sector could offer support with this.

Regarding treatment options, some stated that further work needs to be done to streamline the number of agencies offering support as there is some overlap which leads to confusion when referring individuals. There also needs to be greater focus on therapeutic interventions as well as substance replacement. Increased availability of residential rehabilitation services also needs to occur; however, these have to be resourced effectively, financially and workforce wise. Therefore, great focus on the basics needs to occur before further progress is made, by employing more staff and improving partnership working.

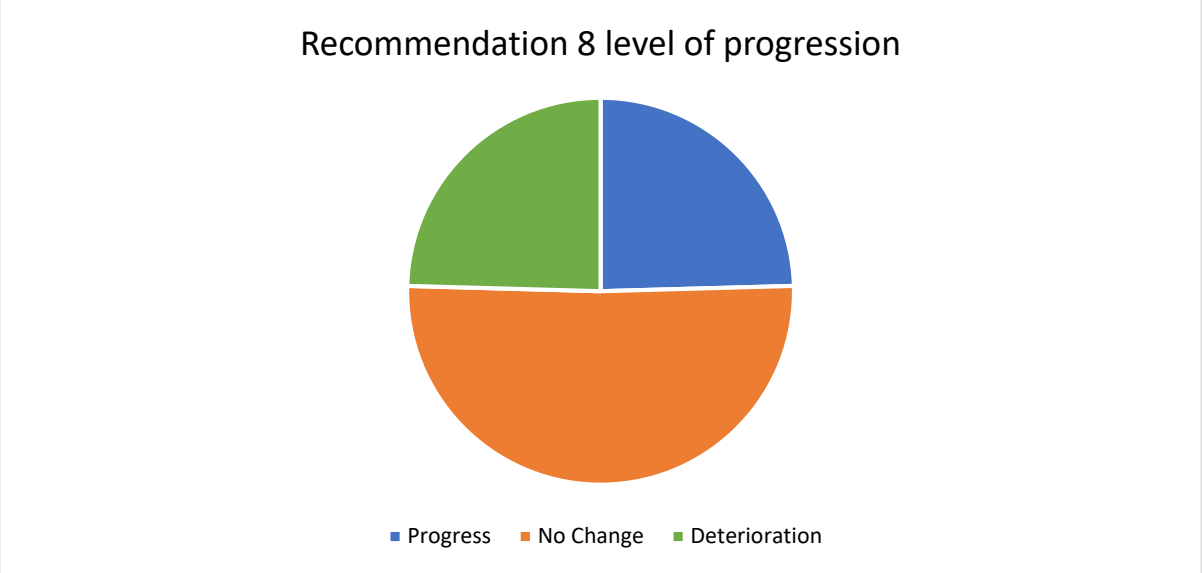
It was also highlighted that there needs to be greater transparency with individuals wishing to access support for their dependency to additional substances such as benzodiazepines. Participants believed that under current capacity it would be unrealistic to accommodate the scale of support that is required to address illicit benzodiazepine use, however this must be stated to individuals in order to avoid further frustration.

Remaining challenges

- Improve joined up support for individuals returning from prison, including a focus on women;
- Ensure treatment options are fully explained to individuals, and that consistent support options are available across the city;
- Improve the spaces available for the delivery of treatment and support;

5.4.3 Recommendation 8: Whole system of care

- ✓ Progress with whole system care
- ✓ Increased involvement and engagement between statutory and third sector services in partnership approaches
- ✓ Increased partnership working
- ✓ Increased support choices being offered
- ✓ Quicker responses to high risk individuals
- ✓ Community Hub Model being established
- ✓ CORRA application has refocussed thinking and enabled new pieces of work to be planned



What has improved

While progress has been made regarding 'Whole System Care', this has primarily occurred within the restrictions of the pandemic, with early work being stalled and/or changed to adapt to the current situation. This includes suspension of the direct access clinics, service delivery from community hubs and the development of the initial Health Needs Assessment. Despite this, participants highlighted there has been an increase in the involvement and engagement between statutory services and third sector services in decisions relating to partnership approaches. This has meant that during very challenging times, services have continued and mobilised to provide support in ways which were not required previously.

Staff believe current progress has resulted in more partnership working, more support choices being offered, quicker responses to high risk individuals and the Community Hub Model being established. Along with COVID-19, staff shortages have also impacted progression. However, with the recent CORRA application and additional Scottish Government funding, this has refocussed thinking and enabled new pieces of work to be planned to further progress whole system care.

What are the gaps/remaining challenges

Most participants highlighted the minimal progress that has occurred regarding mental health support. Access to mental services for anyone who is in receipt of methadone/suboxone continues to be difficult, with Community Mental Health Teams not accepting referrals and GPs generally referring back to DDARS. Due to staff shortages at DDARS, individuals continue to wait for long periods to see the psychiatry service. There is also an issue with individuals being refused by mental health services due to substance use and remaining a high-risk. Therefore, participants highlighted that a clear 'multi-agency pathway', holistic approach needs to be established between DDARS and mental health, to avoid the current detrimental effect on individuals who have experienced trauma such as relapse or overdose.

It was also highlighted that there is no clear model for shared care with GP surgeries or pathways ongoing into support/treatment. There is also too much pressure on the DDARS nursing staff to deal with their own caseload, and the large number of individuals who are unallocated a keyworker due to understaffing. Participants felt that situation contributes to an increased work-related stress, high caseloads and underachieved service outcomes.

What do we need to do to get to there

In order for a whole system of care approach to work participants stated there needs to be improved communication and better multi-agency working. This includes the ADP, DDARS, third sector, NHS and social work.

Staff highlighted that there needs to be a more holistic approach and better partnership working in particular between substance use services and mental health, which should include clearer pathways. Some suggested that a team created specifically for mental health intervention within the Alcohol and Drugs Service may be the way forward. Most of all, participants felt there needs to be increased provision of mental health services for those with substance use problems. Participants thought this will require an attitude shift and for NHS staff especially to understand substance use as being interlinked to mental health.

Some participants working within statutory services stated it would also be useful for third sector services to have a better understanding of what DDARS do and ways in which they can help without adding more pressure on staff.

With the increased use of benzodiazepine, some staff members highlighted the potential benefits of creating dedicated support to that need with a focus on benzodiazepine detox.

Finally, participants highlighted that despite staff shortages there needs to be quicker access into treatment, more choice and flexibility with recovery options. Some highlighted they do not agree with the 'methadone for life' approach that is often taken. Instead there needs to be a reduction programme or alternative choices offered.

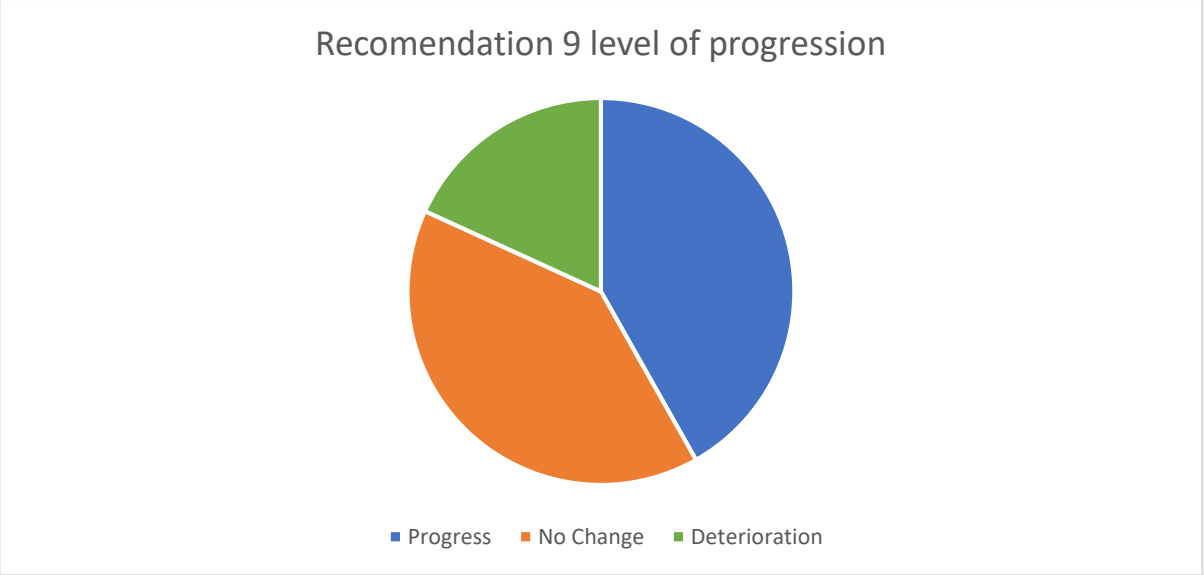
Remaining challenges

- Better access to mental health services and support, especially for those on OST;
- Clear model of Shared Care with Primary Care;

- Improved communications, including increase mutual understanding of what other services/ organisations do.

5.4.4 Recommendation 9: Prioritise access, retention, quality of care and safety

- ✓ More support choices available
- ✓ More joint working between services
- ✓ Easier access to services, especially those that are community based
- ✓ Hostel staff visiting women who would otherwise not engage
- ✓ Employment of peer workers with lived experience



What has improved

Some participants believed there has been some initial progress regarding more support choices available, more joint working, Housing First and easier access to services especially those that are community based. This has resulted in increased engagement. As a consequence, individuals are now meeting with services they would not normally access. Through this, retention of patients has been improved.

Further improvements highlighted were: workers in hostels visiting women who would otherwise not engage and employment of peer workers with lived experiences. In addition, the Housing Service have funded a Community Social Worker post as a test of change in partnership with DHSCP to be embedded within the Housing Options/Homeless Team and to support 3rd sector services delivering a homeless service.

What are the gaps/remaining challenges

Third sector services in Dundee are working closely together and hope they have bridged the gap that existed within statutory services, however it was highlighted that staff in these services are experiencing stress due to the high expectations and needs from clients. Despite this progress, there is still a gap between some third sector services and NHS services which needs to be addressed.

Whist overall access to treatment and retention has increased, some believe this has impacted on the quality of care/safety. There are currently not enough staff to manage the high retention of patients, which impacts the level of care received and ultimately poorer outcome for individuals.

What do we need to do to get there

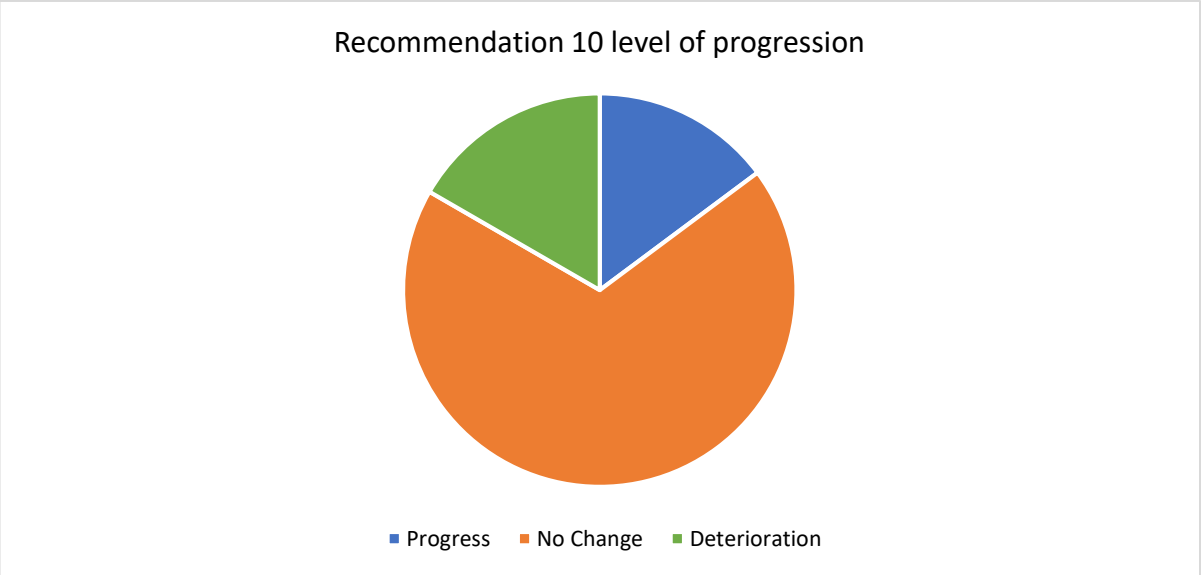
Staff highlighted that funding needs to increase for the continuation of services and more staff employed to deliver the required support. This would also involve investment in staff wellbeing, training and realistic caseloads where all being prescribed are allocated and regularly reviewed.
It was also highlighted that to retain service users and for them to engage in their own recovery, a service must first meet their needs. Suggestions included more treatment options through detoxes and for rehab facilities to be located within communities, essentially bringing services to the individuals to make treatment more accessible for all.

Service advertising and support options should also be discussed and written in 'plain language' for individuals to fully understand what services are available within Dundee and what each can offer. This will allow individuals to make more informed decisions on their own recovery journey.
More co-location of staff from different services should also occur, with DDARS becoming fully integrated with social workers and them becoming more involved in the care of individuals. It was suggested that healthcare staff should become more involved and greater accountability/ involvement should be placed on other third sector services, not just on DDARS. It was highlighted that staff need to work together for the good of the client. Training should also be provided for VAW services, however funding will be needed to allow them to provide this support.

Remaining challenges

- Improve working relationship between statutory and third sector organisations (including the women's services);
- Improve the capacity of services;
- Any information about services and support should be written in plain clear language.

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



What has improved

No examples of progress were highlighted due to this recommendation still being in the very early stages.

What are the gaps/remaining challenges

Progress has ultimately been delayed due to COVID-19 and the additional pressures this has caused for primary care services. Despite this, there seems to be a lack of knowledge regarding the primary care and shared care models, with many participants unaware of the current pilot. Those that are

aware commented on the persisting problems of communication with GPs and individuals still struggling to access primary care support.

Staff also highlighted that in general GPs do not give individuals the right support especially regarding mental health. Individuals also continue to be stigmatised as only contacting GPs to access 'drugs', however there is also a problem of individuals being prescribed benzodiazepines, for example, by GPs without any acknowledgement that they are open to recovery services.

What do we need to do to get there

Some participants believed the pilot has been paused until GPs return to operating under normal circumstances, however this is not the case. For the pilot to be successful there needs to be more communication encouraged between GPs and substance services. Following the initial pilot staff suggested applying the findings and expanding the model to more GPs. However, for this to be successful, there needs to better joint working, support without stigma and perhaps more localised services.

Remaining challenges

- Respond to additional challenges posed by COVID-19 pandemic;
- Progress the development of shared care model and ensure all staff are informed about it;
- Address stigma issues, including stigma from professionals.

5.4.6 Key priorities that must be addressed:

Towards the end of the survey staff were asked to highlight the critical issues that they believe should be prioritised for response by the partnership. Below is a summary of the responses.

Mental health and substance use must be viewed as being interlinked and appropriate support must be provided. This will involve taking a trauma approach and addressing root causes of substance use when offering support to aid recovery and harm reduction in individuals lives. A pilot service in a local community may be one way to address this.

In Dundee there has been an increase in polysubstance use that deviates from just opiates and alcohol over recent years. This has resulted in increased risks of harm and increased access to OST prescribing in the absence of integrated holistic care. With this in mind a priority must be addressing the harms posed by benzodiazepines and facilitating prescribing/detoxes. They are present in the majority of drug related deaths yet there are limited options currently available to support people using them and no consensus on best practice regarding treatment.

Staff retention: it was also highlighted through the staff survey that there is great focus on patient retention however not enough focus on healthcare staff retention. With DDARS currently being severely short staffed, this has resulted in long waiting list times and high care loads. This is also caused many staff to experience stress. Therefore, in order for real progress to occur a key priority must be to hire more staff and more support for current staff in the meantime to avoid stress.

Recovery options: with OST prescribing being the primary recovery option and is essentially replacing one medication with another, staff highlighted the need to make more recovery options available. This would help with the current waiting list for OST prescription. Some concerns surrounding the perceived '3 strikes of your off OST' approach was also highlighted and deemed as potentially leading to NFODs. Participants believed that due to OST being a medication it should not be used to control

people or make them comply with appointments. It is important to note that this policy is no longer in place within Dundee and raises further concerns if some believe this still to be in operation.

Prevention and early intervention: it was highlighted that prevention of substance use and early intervention need to be a key priority to address and reduce harm for future generations.

5.5 Leadership/ How good is our ADP?

Background

This element of the self assessment was supported by the Improvement Service. In April 2021, members of the ADP other key stakeholders were invited to complete a Self-assessment Check List where they were asked to rate the extent to which they agreed or disagreed with the statements in the *Leadership Checklist*. Current strengths and challenges were also highlighted and areas for improvement identified.

Findings from the checklist were shared with partners in early June 2021 and a development workshop was then held with partners on the 10th June, facilitated by the Improvement Service. This workshop allowed for discussion on the findings from the survey and identified priority areas for improvement.

Please see the Leadership Self-Assessment Checklist Results in Appendix 3 below.

Key Messages from the leadership checklist

- The ADP's strategic priorities and Action Plan for Change are largely being progressed effectively, albeit disrupted by the COVID-19 pandemic. Closer partnership work is developing, especially in the context of the CORRA project and the Whole System of Care work.
- A number of Action Plans have already been developed to strengthen work to improve outcomes for people affected by drug and alcohol use in Dundee. The ADP has a critical leadership role to play in ensuring these plans are implemented effectively through monitoring progress and performance, identifying and promoting best practice and fostering a culture of continuous improvement.
- ADP leadership have shown determination to bring about positive change and there is a useful degree of creativity and innovation across working groups. Improvements could be made to strengthen oversight and accountability within the ADP.
- It is important that the ADP improves communication about its work effectively to frontline staff, local communities and partner organisations, and improve emphasis on demonstrating impact and outcomes for people affected by substance use.
- Multi-disciplinary, partnership working across the Dundee Partnership needs to improve in order to achieve the greatest impact on outcomes in this area of work.
- It is recognised that currently systems and services providing care and support to individuals affected by substance use are under huge pressure and require support from the leadership to work differently.

As the workshop set up to discuss the Checklist report, key feedback from attendees included the following actions as **initial priorities for improvement by the ADP and Dundee Partnership:**

1. Consider how to strengthen partnership working between the ADP, existing Public Protection structures and other governance/planning forums.
2. Engage staff across the partnership around plans to support whole systems change through forums etc. to discuss and find solutions to challenges.
3. Identify ways to review 'what works' and 'what doesn't work', as part of core business to meet the partnership's agreed outcomes and support continuous improvement.
4. Ensure robust processes are in place to enable people with lived experience to feed into the work of the ADP at all levels.

Other areas identified as important for future consideration:

- Develop a robust performance management system for the ADP with an appropriate suite of indicators to support the monitoring of progress.

See the full report from the workshop (including the action plan) in appendix 3 below

Next steps: Leadership element

Following on from the workshop and the report, a Leadership Improvement Action Plan was developed to be progressed and implemented by the ADP and its governance structure, as well as the Dundee Chief Officers Group (COG) and the Dundee Partnership.

6. Assessment (What the Self-Assessment is Telling us)

Introduction

This section includes a summary of the key messages outlined within all the data presented in section 4. We have identified 6 key themes.

6.1 Communication/Partnership Working

Front line staff highlighted that in Dundee there is now closer working relationships between organisations. This was in the form of improved and better co-operation and more effective information sharing. Individuals with lived experience also echoed this and stated they now feel there is less need to explain their personal circumstances multiple times. The overall consensus is that the pandemic forced services to collaborate and support each other. In turn, this increased productivity, mutual understanding and respect despite the difficult nature of operating during the pandemic. This is an important cultural shift and provides a foundation on which to continue our improvement work.

More specifically, staff value the monthly meetings (weekly meetings during lockdown) for all substance use (and related) services that were established during COVID-19. Staff said as a consequence they feel more involved, informed and included in the work of the ADP.

There was a clear message that our most successful achievements/ impact and best outcomes (including assertive outreach, direct access clinics, community hubs, OST delivery during COVID-19, and the NFOD Team) are those that involve good partnership working, sharing and collaboration. The benefits of improvements in the quality of care/ support and responsiveness are clear for individuals with lived experience and for the staff delivering these services and supports.

However, despite the progress that has been made, there is also a clear message that specific gaps remain with communications across the partnership. More information should be shared with all stakeholders, with local communities in particularly being made more aware of challenges facing individuals who use drugs and the progress being made in improving our responses to them.

Gaps also remain in the sharing of information, especially to create transparency and a shared understanding/motivation to further progress with the recommendations from the Commission. For example, some third sector organisations highlighted they were still unaware of progress being made with the recommendations. The request is that individuals and communities across the city, including front line staff at all levels receive more information about what is happening, the progress made and the remaining challenges.

6.2 Staffing Issues, Staff Retention and Pressure

There is wide recognition from both staff and those with lived experience (backed by the data in section 5.1) of the considerable pressure on DDARS. Specific issues highlighted included high caseloads, the lack of sufficient time to see all individuals and the challenges with retaining staff in the service as well as recruiting staff. The risk of staff stress was also highlighted with a clear sense of the potentially detrimental impact on the overall functioning of the service. There is a clear consensus that these conditions also have an impact on the individuals seeking support from the service. Individuals are not always aware who their key worker is, there is not always opportunity to build relationship with key workers and sometimes long timespans between appointments. This is not the standard of service that the service and the workforce within it aspires to deliver.

Some of the individuals with lived experience feel that time and capacity pressures have resulted in them not always being in control of their treatment and recovery process and that decisions are being made for them without their knowledge.

However, the data also includes suggestions for improvement, including the need for DDARS to share more details of the pressures they are under so other services could support them, increase and improve onward referrals to third sector organisations, and increase focus on staff wellbeing, including training and development.

There are also clear messages of the need to finalise and fully implement the lead professional model in Dundee to create consistency, accessibility, regular contact, and individuals being listened to /involved in decisions affecting them.

6.3 Treatment Options & Choice/Support Choice

Staff members feel that overall improvements have been, and are being, made in relations to the MAT Standards but that there is still a way to go. The addition of independent advocacy is highlighted by staff and those with lived experience as a very important element in supporting individuals to access and act on choices. However, carers also noted they do not wish advocacy to replace their role and firmly believe treatment choice should be down to the individual. The conclusion is that individuals will be more invested in their recovery when they have more agency.

Individuals with lived experience feel that they are often not given an explanation regarding the full range/choices available to them, that they do not have enough choice regarding the dispensing of OST and that the requirement for a daily collection can interrupt with other elements of their lives, including work and/or attending college. Some felt that treatment choice is still limited (and exacerbated by the current pressures facing DDARS) and that this was more apparent during COVID-19.

The assertive outreach model is widely supported, especially as it assists individuals in accessing help. However, there is still a sense that better communication between DDARS and third sector will improve this model further. The Housing First model is also highlighted as a great success by services and service users.

In terms of options for improvements, limiting the overlap between services/streamlining services was proposed as a way to avoid confusion, and increasing access to residential options. There is a need for all organisations to advertise their services in clear, 'plain language' so that information is well understood and aids individuals making informed decisions regarding choice and increase involvement in treatment planning.

Many commented (confirmed by the data in section 4.1) on changes in the prevalence and the changing patterns of drug use in Dundee. There is a clear sense that this needs to be followed by changes to treatment/support options and to the way services operate.

Significantly, there is a lot of support for a 24/7 crisis intervention, with a specialist women's services, housing and welfare support.

6.4 Mental Health

Participants recognised the progress made with a trauma informed approach, especially through the specific training/workforce development and the appointment of Trauma Champions. However, individuals with lived experience and staff noted the slow progress in the development of a joint substance use and mental health approach. Specifically, participants highlighted their experience of

continued lack of access to statutory mental health services for those affected by substance use and issues related to past trauma that are not currently being addressed.

There is overall acknowledgement of how COVID-19 impacted on mental health, with increased isolation and loneliness, an increased use of substances, further increasing the need/demand for mental health support. It is also recognised that due to pressures on the NHS and more people within the wider community requiring mental health support, there is even greater pressure on the availability of support for those affected by substance use.

Specifically, the issue of individuals being refused residential mental health support on the grounds of their substance use was highlighted. As was the issue of waiting lists for mental health support and people reporting they feel that they are 'seen as a number' rather than a person in urgent need of support. Women reported being turned away from Carseview, which they believed directly impacted on relapse. Their GPs often then refer them back to DDARS and creating a vicious circle. This combined has resulted in a clear message of the need for a multi-agency pathway to resolve issues highlighted.

The data includes clear messages that there has been an attitude shift, especially from NHS staff and that there is greater understanding of the links between mental health and substance use, including the need to respond to both in a joint approach. The value of a trauma informed workforce, trauma care, shared care, anti-stigma training is also highlighted.

The increased role and support from community pharmacies is acknowledged, with people asking to see all working together in new pathways that are seamless, clear and well understood by everyone. The need for greater consistency of approach across all community pharmacies was highlighted and there was some criticism of individual models, restricted hours and remaining stigma issues.

Concluding self-assessment remarks to sections 6.2/ 6.3/ and 6.4
We recognise that the challenges described in sections 6.2, 6.3 and 6.4 are symptomatic of continuing Whole System of Care gaps in Dundee. During the past two years, whilst progress has been and is being made, elements of the current systems do not yet operate as a fully integrated model of care, with specific gaps around person-centred approaches and considerable pressures remaining.

6.5 Lived Experience

The data presented in this self assessment highlights some of the progress made over the past two years in providing structured opportunities for individuals with lived experience to participate, influence and shape progress. Participants noted that within the ADP membership there is now representation of carers and that the Lived Experience Framework has been developed and adopted by the partnership as a whole. We are being supported by the Scottish Recovery Consortium to implement the Framework and that individual organisations and services have developed a much clearer approach to their own engagement with individuals with lived experience. The Peer Volunteers project has progressed and there has been clear focus on tackling stigma, which is key to ensure people feel willing and able to participate.

Throughout COVID-19 lockdowns, SMART Recovery groups continued to operate virtually and a specific lived experience group for women was established.

However, there is also clear feedback that the partnership still needs to respond to, which currently is not progressed through developments around the influence of lived experience. This includes individuals with lived experience highlighting the lack of respect when accessing service from some

community pharmacies; carers talking about being continually stigmatised; and accounts of GPs and mental health services not willing to support individuals affected by substance use.

We are therefore aware of the feedback that progress in this area could be accelerated – especially in progressing with the implementation of the Framework which covers all the various aspects of the work. The message is that both the ADP and the Dundee Partnership need to do more to ensure discussions and decisions are well informed by the experiences and views of those with lived experience.

6.6 Leadership

Participants highlighted some developments in the leadership around substance use in Dundee, including strengthening of the membership of the ADP, improved functioning and governance of the ADP, better support from Chief Officers and example of whole system collaboration as in the CORRA project.

Areas for improvement included the need for better oversight and accountability to the work of the ADP, the need to improve links and joint working with other areas of vulnerability through the integrated protecting people agenda, clear gaps in communications (with frontline staff and communities), and providing opportunities for staff to participate in and influence change.

6.7 Overall Assessment of Progress

Having considered the evidence gathered through this self-assessment process, and reflected on the six themes identified, in the table below we have assessed our progress against the 16 recommendations made by the Dundee Drug Commission.

Overall, we have assessed ourselves as having made Reasonable Progress in relation to 14 recommendations and Partial Progress in relation to 4 recommendations.

Self-assessment against the 16 recommendations from the Dundee Drugs Commission

Score	Description	Colour chart
Excellent Progress	Recommendation is either completed in full or, where complex, all sub tasks have been completed to schedule. There are no barriers to further progress and the recommendation will be fully implemented	
Reasonable Progress	Progress against the recommendation has been made in many but not all areas. Expectation that current barriers to progress can be overcome by partners in the short-term / to medium term and full implementation achieved.	
Partial Progress	Progress **has been** made in some areas but significant further focus is required to overcome current barriers and to achieve full implementation.	
No Progress	There is no or very limited evidence of progress and significant barriers which there are no clear plans to overcome in order to achieve full implementation.	

Rec 1	***The Dundee partnership must do all that is necessary to achieve the required standard of leadership – the test of which will be that the agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families***. **Key achievements:** • The ADP has strengthened its governance structure and membership with greater clarity regarding responsibilities; this addresses several concerns raised by the Commission. (C) • There is strong evidence that the statutory and third sectors are united on agreed priorities and critical tasks. (SA sections 3, 5) • In general, partnership working between agencies has improved and a broader range of leaders are engaged in progressing activities. (SA sections 3, 5) • The COVID-19 response has brought organisations closer together and stimulated some innovation. (SA Section 5 and Leadership Report) • Multidisciplinary innovations such as the Non-Fatal Overdose response are exemplars. (SA Section 3, Section 5 and Leadership Report) • We have appointed two Trauma Champions to lead the focus on trauma-informed services • We have established regular reporting to Dundee Partnership, to Dundee City Council Policy and Resource Committee, and to Elected Members • The Dundee Chief |Officers' Group (COG) has adopted the Protecting People Strategic Risk Register, in collaboration with all the Protecting People Partnerships and committees.	**Reasonable progress**

	Remaining challenges: • Whilst the ADP has committed to engaging Lived Experience and structures have begun to take shape, progress has been slower than hoped for. There are positive examples of Lived Experience involvement in some areas but this is far from universal. There are mixed views amongst those with Lived Experience with some identifying progress but others not. (SA Section 5) • There is slippage against some tasks in (Action Plan for Change) the Action Plan for Change which cannot solely be attributed to the impact of COVID-19. • The Commission emphasised the need for a comprehensive performance framework, there have been improvements in scale and frequency of performance monitoring but further work is required. (SA Section 3, Action Plan for Change) • The Leadership Report identified that communication of ADP priorities and performance to stakeholders needs to be improved.	
Recs 2 & 3	***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.*** ***And*** ***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.*** **Key achievements:** • Anti Stigma and Language Matters campaign progressed (with support and input from local communities and individuals with lived experience), the ADP approved an anti-stigma commitment (SA Section 3, 5) • Employment of Peer workers and Peer volunteers identified as breaking down barriers (Section 5) • We have developed the Gendered Services project which engages women with lived experience at every aspect of the project • We have tested stigma training virtually, and progressed to delivery • We have allocated specific funds to each of the LCPP's to develop local initiatives led by local communities • We have renamed ISMS to DDARS (Dundee Drug and Alcohol Recovery Service) **Remaining challenges:** • We still receive feedback about incidents of stigmatising practices within community pharmacies, some GP surgeries and by individual support staff.	**Partial progress**
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.*** **Key achievements:** • The implementation of the ADP Governance review has contributed to increased transparency and accountability. (Self assessment sections 2,3,5 and Leadership Report)	**Reasonable progress**

	• There has been strengthened involvement of and leadership from the Third Sector, e.g. in development of innovative proposals to the DD Taskforce etc, and third sector organisations have benefitted from the success in bringing additional funding to the city. (Action Plan for Change). • The Chief Officer of DVVA co-chairs the ADP's Implementation Group. • Third sector partners are involved in all of the workstreams and subsidiary groups e.g. Drug Death Review Group, NFOD etc **Remaining challenges:** • Whilst some progress has been made, further work is required to provide the level of performance data necessary to properly scrutinise statutory services. (Action Plan for Change, Leadership report) • When compared with statutory services the Third Sector continues to be subject to more onerous contractual arrangements, monitoring requirements and insecure funding. • Whilst advocated for by the Commission, a five-year Commissioning Plan and Service Level Agreements with statutory service have not been put in place. The majority of our 3rd sector have very secured funding – as secure as statutory services	
5	***Meaningful Involvement of people who experience problems with drugs, their families, and advocates.*** **Key achievements:** • Many Third Sector organisations are routinely seeking feedback from service users and this influencing the development of some services (SA Section 5) • DVVA are leading development of a Lived Experience Quality Framework on behalf of the ADP and are assisted in this by the Scottish Recovery Consortium (Action Plan for Change) • The ADP Governance review has committed to all levels of its structure providing meaningful opportunities to engage with and influence decisions. (Governance Review) • We have established an Independent Advocacy test of change led by the Dundee Independent Advocacy service (DIAS) • We have established a lived experience group specifically for women, who co-produced a self-assessment tool for services **Remaining challenges:** • COVID-19 has impacted the pace of implementation of the Lived Experience Framework and levels of engagement are variable. (SA Section 3, 5)	**Reasonable progress**
6	***Learning from things that have gone wrong - attention to continuous improvement to benefit others who are vulnerable.*** **Key achievements:** • The NFOD response, implementation of Same Day Prescribing, expansion of Outreach, support to prisoners on release and expansion of Naloxone provision, all reflect examples of improvements to tackle drug deaths. (SA Sections & 5, Action Plan for Change)	**Reasonable progress**

	• The Tayside Drug Trends Monitoring Group established to act on learning from when things go wrong and propose / implement mitigating actions for the future • The CORRA application is founded on analysis of failings in the current system of and makes proposals for significant improvements. (CORRA application) • The Action Plan for Change has set out a comprehensive improvement programme structured around strategic priorities (Action Plan for Change, Leadership Report) • Focus on a gendered approach and helping organisations to focus on the specific needs of women and girls. **Remaining challenges:** • Whilst COVID-19 has had an impact on the ability to progress, some tasks in the Action Plan for Change have been delayed for other reasons or because original timescales were unrealistic (Action Plan for Change) • Significant learning is still to be implemented as part of the development of an integrated approach for substance use and mental health (CORRA Project).	
7 & 8	***Choice is important and having the choice of accessing a full menu of services (including community and/or in a residential setting) to support recovery should be available to people in Dundee.*** ***The provision of services currently offered by DDARS (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, the key purpose of utilising the unique strengths of all partners.*** **Key achievements:** • The CORRA project will deliver a key Test of Change in areas of Substance Use and Mental Health integration, expanded locality services and 24/7 Crisis Care (CORRA submission) • There has been significant additional investment by DCC (~ £1M over 2 years) to strengthen service provision in a range of areas (SEE PREVIOUS ADP reports) • There has been an increase in alternative prescribing options to Methadone with increased take up of Buprenorphine and Buvidal now on NHS Tayside formulary (Self-Assessment 3 and 5) • Proposal to significantly enhance the Community Pharmacy model across Tayside are well advanced. (see report to ADP) • The Independent Advocacy service has been well received and this can assist individuals to secure their desired treatment options (SA Section 5) • Direct access and same Day prescribing arrangements implemented pre COVID-19 (SA Section 3) • Establishing the Primary Care / DDARS Shared Care pilot (SA Sections 3 & 5) • Closer joint working between statutory and third sector organisation (Self-Assessment 3 and 5, Leadership report) • There is a greater focus on peer support (SA Section 3 & 5) • Work is underway to develop a coherent framework for access to and return from residential rehabilitation (SA Section 3 and 5)	**Reasonable progress**

	• Dundee is participating in national research into drug checking and a local group is investigating practical arrangements. **Remaining challenges:** • There are currently considerable pressures on DDARS which arise because of an unexpected turnover in staff, recruitment challenges, combined with growing caseloads. (SA Section 5) • It is anticipated that scaling up the shared care TOC with Primary care will be challenging for a range of reasons, including the current low level of experience amongst GP practices (report to ADP) • Consequently consideration of capacity, capability and sustainability of current and future models must be paramount • The CORRA project will demonstrate our commitment for a change in approach, and is awaiting the appointment of a Project Manager. • It is possible that models of care will require further adaptation to reflect the changing patterns of drug use (SA Section 5)	
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 attention to having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.*** **Key achievements:** • There has been considerable focus and effort to improve access, retention, quality and safety. (SA sections 3 & 5) • There has been investment in additional capacity at DDARS to support demand • The Non-Fatal Overdose Response is having a crucial impact on rapidly engaging those at high risk in treatment services. (SA sections 3 & 5) • Outreach services (including assertive outreach) have been very significantly expanded and play a crucial role in engaging those who are at high risk or who have variable/challenging relationships with services. (SA sections 3 & 5) • DDARS have continued to offer a scaled back assessment and treatment services during the pandemic, including some limited face to face work • A working group is examining how proposed Medically Assisted Treatment (MAT) standards will be implemented in the City. • Same Day prescribing at drop in etc was established practice pre COVID-19; currently limited by COVID-19 restrictions (SA Sections 3 & 5) • Housing First is playing a significant role on improving retention. The current Pathfinder Model is reviewed with a view to being mainstreamed (SA Section 3 & 5) • Unplanned discharges have reduced (SA Section 5) • Additional support has been put in place for those leaving prison (SA Section 3) including those released under the COVID-19 early release programme. **Remaining challenges:** • Caseload levels at DDARS are currently beyond capacity and there is a need to place additional focus on staff recruitment and retention (SA Section 5)	**Reasonable progress**

	• Increased retention in treatment has brought additional caseload pressures without an increase in staffing (SA Section 5)	
10	***Involvement of primary care and shared care models.*** **Key achievements:** • Primary Care shared care test of change – sessional work Maryfield and Lochee practices, supported by DDARS • Proposals to review Service Level Agreement arrangements and payments for GPs (report to ADP) **Remaining challenges:** • Starting from a low base of shared care in the city, with historical decisions to support alternative models. • In the short-term, very limited scope for GP practices to take pressure off DDARS.	**Partial progress**
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.*** **Key achievements:** • A review of the community pharmacy model in Tayside has been conducted and proposals to significantly enhance provision are well advanced **Remaining Challenges:** • We are still receiving reports of some stigmatising practice in community pharmacies	**Reasonable progress**
12	***Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.*** **Key achievement:** • There have been some outputs from national conducted work (Public Health Scotland) Scoping report and collaborative commissioning model agreed **Remaining challenges:** • The ability to progress this work has been severely impacted by Public Health resources being redirected to the COVID-19 response.	**Partial progress**
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 and substance use problems and most people with substance use problems also have mental health problems.*** **Key achievements:**	**Reasonable progress**

	• The CORRA project will progress the development and implementation of a Test of Change for the integrated approach of substance use and mental health. (SA Sections 3 & 5) • As part of stage one of the test of change, Healthcare Improvement Scotland are facilitating discussions with a wide range of local stakeholders. **Remaining challenges:** • There are significant vacancies in psychiatric services across Tayside; this may impact on the level of clinical engagement in service redesign • The required level of culture change will take longer term to achieve.	
14	***Address the root causes of drug problems.*** **Key achievements:** • Stakeholders have recognised the role of Trauma in contributing to substance use and there are initiatives underway to make services more trauma informed. (SA Sections 3 & 5) • Research into the Youth in Iceland model has concluded and Dundee will operate a pilot at a secondary school in Dundee from September. (SA section 3 and Stirling University Research study outputs) • Work is progressing on a prevention framework (ADP report) **Remaining challenges:** • It is possible that the true level of substance use and harms have been hidden during the COVID-19 crisis and that these, combined with significant and enduring economic impacts will increase demand on services.	**Reasonable progress**
15	***Ensure the needs of women who experience problems with drug use are assessed and addressed via adoption of gender sensitive approaches to service planning.*** **Key achievements:** • Gendered approach has been adopted across the partnership, with considerations being examined and collaboratively addressed for existing service models (SA Sections 3 & 5) assessment tool • New information and staff development resources are available (SA Section 3) • Lived experience involvement in service redesign discussions (SA Sections 3 & 5) • Pathways strengthened for those involved in commercial sexual exploitation (SA Section 3 & 5) **Remaining challenges:** • It is generally recognised that the women's services have been under considerable pressure during the COVID-19 crisis • Dundee records very high levels of Violence Against Women and especially domestic abuse.	**Reasonable progress**

16	***Attend to the intergenerational nature of substances problems and place the safety and well-being 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 requiring social work intervention.*** **Key achievements:** • Additional Non-medical Prescribing Nurse Practitioners (3) are in place in Children's Services and these are reported as having a very positive impact. (SA Sections 3 & 5) • Test of Change undertaken by Aberlour and Children 1st providing additional support to children and families, including at point of crisis (SA Section 3) • A Whole-family approach strengthened. **Remaining challenges:** • A recent independent review of SCRs (Significant Case Reviews) and ICRs (Initial Case Reviews) identified that parental substance use was an issue in a high proportion of cases in Dundee.	**Reasonable progress**

7. Next Steps

Introduction

In this section we outline our plans, focus and commitments for future improvement actions and for embedding annual self-assessment reviews (sections 7.1-7.4).

7.1 Adjustments to the Substance Use Action Plan for Change

Following the process of conducting this self-assessment, we now plan to introduce the following adjustments to the substance use action plan for change, our key partnership document/ tool for recording and monitoring progress against specific actions. Once these adjustments have been made the document will be shared with the Commission (anticipated sometimes towards the end of August 2021):

- We will make changes to some of the existing actions based on feedback collated through self-assessment process;
- We will add actions to address new areas where gaps have been highlighted by the self-assessment process;
- We will utilise opportunities to consolidate change and learning from the COVID-19 experience, and take this into next phases of the change process for improvement;
- We will put plans in place to repeat an annual self-assessment process.

7.2 Immediate priorities for next phase of implementation

The self-assessment process has identified a small number of actions where we recognise an urgent need to accelerate our work and to strengthen partnership working to overcome any remaining barriers to progress and full implementation:

- Increasing the focus on the development of a shared care model;
- Intensifying the focus on bringing the integration of substance use and mental health through full delivery of the Dundee Substance Use and Mental Health Integration Project (funded through CORRA);
- Increasing the focus on early intervention and prevention;
- Resolving the current pressures on DDARS (initially short-term but also focusing on the longer-term approach including a system-change and greater focus on a shared-care model); and
- Work to secure future investments (be more systematic about anticipating investments) and how we are utilising these to maximise outcomes.

We believe that our work over the past two years to improve responses to people who use drugs and our collective work to respond to the challenges presented by the pandemic evidences that we have significant capacity within Dundee, at leadership, strategic and operational levels to continue to drive forward the full implementation of the action plan for change. We are ambitious about our plans for pandemic recovery and are focused on accelerating key areas of work to address the needs of the most vulnerable people in the city, including those people impacted by drug use.

The Dundee Partnership, the Chief Officers Group, the Alcohol and Drugs Partnership and the Leadership Oversight Group for the Action Plan for Change have demonstrated consistent focus and dedication to monitoring and supporting diverse and complex programmes of work over the last two

years. Our multi-agency workforce remains our biggest asset and they have demonstrated commitment, flexibility and resilience in the most exceptionally challenging of circumstances; we recognise the need to continue to invest in their wellbeing in order to achieve the immediate priorities we have identified and to progress the whole of the action plan for change to full implementation over the coming months and years.

7.3 Ongoing self-assessment activity

It is our intention to repeat a self-assessment process in future on an annual basis as the primary mechanism through which we collectively review and evaluate progress against the action plan for change and evidence this to our internal and external partners.

The ADP will also continue to consider self-assessment findings from other programmes of self-evaluation activity taking place across the protecting people strategic structure and within individual service providers. In addition, we are committed to participating in the emerging national structures and processes responding to the impact of substance use, we are willing to share our learning from this self-assessment and to learn from other areas.

8. Appendices

Appendix 1: Case examples
Comments ADP members\Case Studies Submitted.docx

Appendix 2: Work on Lived Experience
T:\10 ADP\2021\Lived Experience\Final report Lived Experience Engagement Report - 9 March 2021.docx

Appendix 3: Evidence Portfolio - relating documents/ strategies/ reports

Dundee Action Plan for Change
Dundee Action Plan for Change

Dundee ADP Strategic Plan (2020-2022)
Dundee ADP Strategic Plan

Dundee ADP Annual Report (2020)
ADP Annual Report 2019-2020

Leadership Self-Assessment Checklist Results
T:\10 ADP\2021\Drugs Commission\Self Assessment\Leadership element\Dundee ADP Leadership Self-assessment_Draft Report.pdf

Leadership Workshop Report
T:\10 ADP\2021\Drugs Commission\Self Assessment\Leadership element\Dundee ADP Self Assessment Workshop Report - June 2021.docx

Dundee Drugs Commission Report, August 2019:
https://www.dundeecity.gov.uk/dundee-partnership/dundee-drugs-commission

Evaluation Report of Non-Fatal Overdose Rapid Response Multi-Agency Team
Tayside NFOD Report

Children & Families: Survey of NMP Nurses Pilot
Comments ADP members\Final NMP nurses survey report July 2021.docx

Community Pharmacy Report
Comments ADP members\Community Pharmacy Services and substance use April 2021.docx

Evaluation of Community Hubs (Dundee University)
Dundee Community Hubs Evaluation Report - University of Dundee October 2019

Designing a Behaviour Change Intervention to Reduce the Risk of Overdose
Designing a Behaviour Change Intervention to Reduce the Risk of Overdose

Dundee Hidden Harm Report to COG
Comments ADP members\Dundee Hidden Harm Report.docx
Comments ADP members\Hidden Harm Report supplementary information.docx.

ITEM No …11…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

REPORT ON: **ANGUS AND DUNDEE STROKE REHABILITATION PATHWAY REVIEW**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB44-2021**

1.0 PURPOSE OF REPORT

1.1 To report on the outcomes of the review of hyperacute and acute stroke care pathway as part of the Angus and Dundee Health and Social Care Partnerships respective redesign programmes.

2.0 RECOMMENDATIONS

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

2.1 Note the work to date to progress the development of stroke rehabilitation pathway review.

2.2 Support and approve the preferred model of care.

2.3 Request a detailed implementation plan is brought back to Dundee Integration Joint Board.

3.0 FINANCIAL IMPLICATIONS

3.1 Whilst finance was not part of the option assessment scoring criteria as described in 5.2, subsequent financial due diligence has been undertaken against each of the short listed options. The revenue cost of the preferred option 1 is c£3.7m and will release c£0.4m revenue resource. This option does not require any capital investment as the existing accommodation has sufficient space to support a 30 bed unit. The revenue cost of option 2 is c£3.9m and will release c£0.2m revenue resource. The increase in cost reflects the additional medical workforce required to provide safe patient care along with additional running costs associated with a new unit. In addition there will be c£11m capital investment required for a new unit. Lastly the revenue cost of option 3 is c £3.8m and will release c£0.3m revenue resource. The increase in cost from option 1 reflects the additional running costs associated with a new unit. Furthermore there is an additional c£11m capital investment required for a new unit.

3.2 It should be noted any request for capital funding requires to abide by the Capital approvals process and in the case for Options 2 and 3 the Scottish Capital Investment Manual (SCIM) guidance would require to be followed with delegated authority from the Capital Investment Group (CIG) at Scottish Government.

3.3 In summary the outcome from the financial assessment demonstrates the preferred option 1 as the most economically viable option and will result in an annual total net reduction of c£0.4m across both partnerships. This reduction can only be delivered through collaborative working with Angus HSCP and is interdependent on both IJBs supporting the preferred model.

4.0 MAIN TEXT

4.1 Hyperacute and acute stroke care pathways in Tayside were reviewed and reorganised in 2019 and are delivering improved acute care for people who have had a stroke, including delivery of thrombolysis ('clot busting') and thrombectomy ('clot removal').

There is now a need to review the stroke rehabilitation pathways to make sure that people who have had a stroke receive modern, evidence based and high quality rehabilitation in order to maximise their chance of making the best recovery possible.

4.2 There is strong research evidence to show that stroke survivors with mild-to-moderate disability benefit from receiving specialist stroke rehabilitation at home or in a community outpatient setting. This can reduce the length of stay in hospital and improve long-term functional outcomes for patient with mild-to-moderate stroke.

4.3 This review focuses on how stroke rehabilitation is provided to people who have traditionally received their stroke rehabilitation in an in-patient facility in either the Stracathro or Royal Victoria Hospital (RVH) Stroke Rehabilitation Units (for people aged 65 years and over) or in the Tayside Centre for Brain Injury Rehabilitation Unit (specialist in under 65 stroke rehabilitation.

4.4 The aim of this review is to ensure we deliver person-centred specialist stroke rehabilitation and ongoing support provided by our specialist clinical staff supported by third sector partners rather than a service centred approach, providing the ability to reinvest specialist stroke services in the community. Within the new pathway it is proposed this care will be delivered at home where clinically possible.

4.5 A multi professional group was formed to review the current rehabilitation pathway and consider options for an improved community stroke rehabilitation pathway that would be offered to residents of Dundee and Angus admitted to Ninewells following an acute stroke. Representatives from staff side, Tayside Stroke Managed Clinical Network and the Stroke Association also formed part of the group.

The group considered the following stroke rehabilitation components to determine the pathway options:

- National stroke rehabilitation guidelines
- Evidence-based practice
- Patient and carer feedback
- Staff feedback
- Third sector partners

4.6 A progressive stroke rehabilitation framework was also developed which incorporated best practice rehabilitation care to ensure best outcomes for patients receiving stroke rehabilitation care. Patient and staff feedback obtained through various engagement and feedback sessions was also an important consideration.

The most important factors identified throughout the review were:

- Workforce availability
- Length of hospital stay
- Community-based stroke rehabilitation at an appropriate intensity and beginning soon after discharge from hospital
- Specialist stroke rehabilitation staff across the rehabilitation journey including the community setting
- Access to the appropriate care and support for patients and carers across the pathway.

Stroke rehabilitation services must be resilient, equitable and sustainable for the future.

5.0 CURRENT POSITION

5.1 It is not possible to provide specialist inpatient stroke rehabilitation within two separate units and provide the level of home-based specialist rehabilitation that clinical standards recommend. As a result there are a number of people currently receiving inpatient stroke rehabilitation who could be receiving this support at home if the resources were realigned

An options appraisal was undertaken by members of the multi professional project group, with six options identified. Members of the group were invited to independently review and score each option before a collective discussion.

5.2 Scoring was based on the following criteria:

- **Person centred care:** Services are personalised with a programme of care that is aligned to person's needs and choices, provided at home when clinically safe and appropriate.
- **Quality and quantity of rehabilitation**: Provision of evidence based, specialist stroke care at an intensity appropriate to the person's needs, in keeping with recommended levels of rehabilitation, focussing on the best possible outcomes and recovery with smooth transitions of care across the whole patient journey.
- **Workforce**: Right professional with the right skills at the right time in the right place. Availability of a flexible workforce with specialist stroke skills and training.
- **Safety**: Care is delivered in a safe and effective way within an appropriate environment where risks are assessed and managed safely.
- **Accessibility**: People recovering from stroke, and their carers will have access to a care pathway, information and support they need to live a fulfilled life. This will be delivered in a flexible and person centred manner supported by third sector partners.
- **Environment:** The environment is suitable to accommodate specialist stroke rehabilitation considering estates and buildings and is sustainable for the future (5years +).

5.3 The long list of options considered were:

1. RVH and Stracathro stroke rehabilitation with limited home based rehabilitation (status quo)
2. Home based rehabilitation with inpatient rehabilitation in RVH
3. Home based rehabilitation with inpatient rehabilitation in Stracathro
4. Home based rehabilitation with inpatient rehabilitation in Ninewells Hospital
5. Home based rehabilitation with inpatient rehabilitation (non-stroke specialist) in community hospitals
6. Home based rehabilitation with no inpatient rehabilitation.

Following the scoring process a short list of options was agreed and are detailed below:-

1. Home based rehabilitation with inpatient rehabilitation in Royal Victoria hospital
2. Home based rehabilitation with inpatient rehabilitation in Stracathro
3. Home based rehabilitation with inpatient rehabilitation in Ninewells Hospital.

Thereafter the multiprofessional group considered the options, taking into consideration the feedback from service users, carers and staff and the following preferred option was agreed upon:

- Home based rehabilitation with inpatient rehabilitation in Royal Victoria Hospital.

Based on all the information available it was agreed that RVH presents the best opportunity to provide the inpatient element required for stroke rehabilitation and the ability to reinvest in community based services. This is because RVH:

- already has a suitable environment to support the required number of beds without the need to significantly invest in other sites.

- is in close proximity to the acute stroke ward based in Ninewells Hospital which improves safety in the event of a patient's deteriorating medical condition. The close proximity to Ninewells also allows the specialist teams to work flexibly across acute and rehabilitation in response to fluctuating demand. This will also improve staff knowledge of the whole stroke pathway.

6.0 QUALITY/ PATIENT CARE

6.1 Providing non acute specialist stroke rehabilitation services on one site will ensure we can deliver safe, effective, high quality person-centred care. This will also ensure adequately staffed clinical teams which can offer specialist inpatient rehabilitation services over 7 days to enhance optimal recovery and earlier discharge from hospital. One unit will also mean that people who have a stroke, irrespective of age, will have equitable access to high quality stroke rehabilitation.

7.0 WORKFORCE

7.1 Current roles will be required to be reviewed and adapted to deliver a new model of care, however the benefits of having one in–patient stroke rehabilitation unit are:-

- the ability to staff it more efficiently and flexibly and develop expertise, which will create a more skilled unit.
- improve access to specialist stroke education, training and support.
- create a service which is attractive to newly graduated practitioners and potentially improve recruitment and retention of all staff.

It is important that adequate time is taken to plan and make any changes suitably, with minimum disruption to staff and patients. Further discussions will take place with health and social care staff, Third Sector partners and people with lived experience of stroke to prepare a detailed implementation plan following approval of the proposed new model of stroke rehabilitation.

The professional and personal experience and ideas our staff and stroke survivors will continue to be invaluable in shaping how services will be delivered. A number of suggestions have already been given by a variety of people and we are keen to get further ideas to help improve rehabilitation and support for stroke survivors and their families.

8.0 COMMUNICATIONS AND ENGAGEMENT

8.1 The Tayside Stroke Managed Clinical Network has already undertaken a considerable amount of work to engage with people with lived experience of stroke and with staff, in order to identify improvements to the stroke rehabilitation pathway. Feedback has identified priorities from patients, carers and staff. Examples of engagement include:

- Stroke Voices Group met with patients and carers to understand their rehabilitation experiences and preferences. A 'Working Together' Group has been set up to work in partnership with Third Sector partners, charities and patient groups including Stroke Association, Chest Heart and Stroke Scotland, Headway and Carers Centres.
- Participation in the national 'Programme for Government' review of Stroke rehabilitation
- Three engagement sessions were held for staff and 120 staff completed a staff stroke care survey.

Patients and carers told us that it was important to have timely access to appropriate rehabilitation to support their needs throughout their recovery and enable them to live their best life possible after their stroke. This was endorsed by staff.

8.2 As part of our responsibility regarding involvement and engagement, it was important that feedback was sought from people with lived experience of stoke, staff and members of the public about our proposal to redesign the Dundee and Angus stroke rehabilitation pathway. A range of engagement opportunities took place from 26 July – 12 August. These included:

- Public Engagement Events via MS Teams
- Joint Angus and Dundee IJB Event via MS Teams
- Staff Engagement Events via MS Teams
- Angus and Dundee HSCP Strategic Planning Groups

A press release was prepared and various social media and website postings invited people to become involved and provide feedback by joining one of the sessions and/or to complete a survey monkey questionnaire. Staff were also invited to complete a separate questionnaire. A frequently asked questions document has been produced based on questions received from staff, people with lived experience of stroke and members of the public. This is an evolving document. Further questions and answers will be added during the ongoing staff and public engagement activities.

8.3 In addition to the above the pathway review has been discussed and supported by the following forums/meetings:

- Frailty Strategic Planning Group (Dundee HSCP)
- NHS Tayside Operational Leadership Group
- Angus Clinical Partnership Group with representatives from GP Cluster Leads
- The Stroke Association in Scotland have been involved throughout this piece of work and involved in the development and appraisal of options. They also provided a statement of support for the proposed stroke rehabilitation pathway and highlighted the importance of the voice of lived experience as being vital in informing the delivery of services.

8.4 **Public Survey**

105 people responded to the public survey monkey

- 75% of those who responded shared where they lived with
  - o49% from the North East Locality,
  - o27% from the North West,
  - o7% from the South East Locality
  - o4% from the South West Locality.
  - oThe remainder of respondents were from Dundee or neighbouring areas.
- 55% respondents had lived experience of stroke.
  - o62%thought that early supported discharge would have a positive impact for someone with mild to moderate stroke.

38 staff responded to a survey

- 13 Allied Health Professionals
- 8 GPs
- 4 Hospital Doctors
- 13 Other professional

The main area of concern, from members of the public and staff, about all specialist inpatient stroke rehabilitation being provided in RVH, was around the perception of withdrawing in – patient services from Angus and the distance to travel, especially if people lived in more remote areas of Angus however were supportive of rehabilitation being provided at home.

9.0 PROPOSALS

9.1 It is proposed that the preferred option to develop home rehabilitation with one in patient facility at Royal Victoria Hospital is supported and approved by Dundee IJB.

9.2 Dundee and Angus HSCP will continue to work together to develop a fully costed implementation plan for the provision of home based rehabilitation with inpatient rehabilitation in Royal Victoria Hospital.

9.3 Further discussions will take place with health and social care staff, Third Sector partners and people with lived experience of stroke to prepare a detailed implementation plan. It will be important that we build upon our strong foundation of multidisciplinary team working, eliminating barriers to effective integrated working and develop pathways of care which improve patient outcomes.

10.0 EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment is required and is included in Appendix 1.

11.0 RISK ASSESSMENT

11.1 This is a mandatory field and an explanation must be provided which covers the fields below. Please fill in and copy this table for each individual risk identified.

Risk 1 Description	Workforce
Risk Category	High
Inherent Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Mitigating Actions (including timescales and resources)	There are existing workforce issues across the 2 sites, being mitigated by a pooling of available staff resource across both Angus and Dundee partnerships, as well as realignment of existing staff resource to maximise skills
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	Given the level of risk inherent in the existing structure, this is manageable

Risk 2 Description	Governance
Risk Category	low
Inherent Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Mitigating Actions (including timescales and resources)	Extensive negotiations and consultations with both staff and the public have taken place in preparation
Residual Risk Level	Likelihood 1 x Impact 2 = Risk Scoring 2
Planned Risk Level	Likelihood 1x Impact 1 = Risk Scoring 1
Approval recommendation	All mitigation has been progressed in preparation, therefore risk level is now regarded as low

12.0 CONSULTATIONS

12.1 The Chief (Finance) Officer and the Clerk were consulted in the preparation of this report.

13.0 DIRECTIONS

13.1 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: NHS Tayside	
	1. No Direction Required	
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

14.0 BACKGROUND PAPERS

14.1 NONE

Vicky Irons
Chief Officer

DATE: 9th August 2021

DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

1	Reference	DIJB44-2021
2	Date Direction issued by Integration Joint Board	25 August 2021
3	Date from which direction takes effect	25 August 2021
4	Direction to:	NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Stroke Rehabilitation
7	Full text of direction	Dundee Integration Joint Board directs NHS Tayside to remodel the stroke rehabilitation pathway for Dundee and Angus patients in line with the agreed model of service detailed within this report
8	Budget allocated by Integration Joint Board to carry out direction	£3.7m
9	Performance monitoring arrangements	Through regular financial monitoring reports to Dundee Integration Joint Board.
10	Date direction will be reviewed	25 August 2022

Integrated Impact Assessment Report.

Committee Report No: DIJB44-2021

Document Title: Proposed redesign of Dundee and Angus Stroke Rehabilitation Pathway

Document Type: Policy

New/Existing: new

Period Covered: 29/05/2020 - 29/05/2023

Document Description:
IJB Paper

Intended Outcome:
Approval to proceed with proposed redesign of stroke pathway

How will the proposal be monitored?:
By lead officers through strategic redesign process

Author Responsible:

Name: Lynne Morman

Title: Associate Locality Manager

Department: Health and Social Care Partnership

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Address: Ninewells Hospital Dundee DD1 9SY

Director Responsible:

Name: Vicky Irons

Title: Chief Officer

Department: Health and Social Care Partnership

E-Mail: vicky.irons@dundeecity.gov.uk

Telephone: 01382 436310

Address: Dudhope Castle

A. Equality and Diversity Impacts:

Age:	positive
Disability:	positive
Gender Reassignment:	no impact
Marriage and Civil Partnership:	no impact
Pregnancy and Maternity:	no impact
Race/Ethnicity:	no impact
Religion or Belief:	no impact
Sex:	no impact
Sexual Orientation:	no impact

Equality and diversity Implications:

Positive impact in providing equitable service across Dundee and Angus for all age groups

Proposed Mitigating Actions:

n/a

Is the proposal subject to a full EQIA? : No

B. Fairness and Poverty Impacts:

Geography	
Strathmartine (Ardler, St Mary's and Kirkton):	no impact
Lochee(Lochee/Beechwood, Charleston and Menzieshill):	no impact
Coldside(Hilltown, Fairmuir and Coldside):	no impact
Maryfield(Stobswell and City Centre):	no impact
North East(Whitfield, Fintry and Mill O' Mains):	no impact
East End(Mid Craigie, Linlathen and Douglas):	
. **The Ferry:**	no impact
West End: no impact	
Household Group	
Lone Parent Families:	no impact
Greater Number of children and/or Young Children: no impact	
Pensioners - Single/Couple:	no impact
Single female households with children:	no impact
Unskilled workers or unemployed:	no impact
Serious and enduring mental health problems:	no impact
Homeless:	no impact
Drug and/or alcohol problems:	no impact
Offenders and Ex-offenders:	no impact
Looked after children and care leavers:	no impact
Carers:	no impact

Significant Impact	
Employment:	no impact
Education and Skills:	no impact
Benefit Advice/Income Maximisation:	no impact
Childcare:	no impact
Affordability and Accessibility of services:	no impact
Fairness and Poverty Implications:	
Positive impact	
Proposed Mitigating Actions:	
n/a	

C. Environmental Impacts

Climate Change

Mitigating greenhouse gases:

Adapting to the effects of climate change:

Resource Use	
Energy efficiency and consumption:	no impact
Prevention, reduction, re-use, recovery or recycling waste:	no impact
Sustainable Procurement:	no impact
Transport	
Accessible transport provision:	no impact
Sustainable modes of transport:	no impact
Natural Environment	
Air, land and water quality:	no impact
Biodiversity:	no impact
Open and green spaces:	no impact
Built Environment	
Built Heritage:	no impact
Housing:	no impact
Is the proposal subject to Strategic Environmental Assessment no	
No further action is required as it does not qualify as a Plan, Programme or Strategy as defined by the Environment Assessment (Scotland) Act 2005.	
Proposed Mitigating Actions:	
n/a	
Environmental Implications:	
n/a	

D. Corporate Risk Impacts

Corporate Risk Implications:
The risk implications associated with the subject matter of this report are 'business as normal' risks. The subject matter is routine and has happened many times before without significant loss. There is comfort that the risks inherent within the activity are either transferred to another party, shared equally and fairly between the Council and another party or are negligible.

Corporate Risk Mitigating Actions:
Risks shared equally between Angus and Dundee HSCPs, and constitute service improvement.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - ATTENDANCES - JANUARY 2021 TO DECEMBER 2021

Organisation	Member	Meeting Dates January 2021 to December 2021						
		24/2	26/3	21/4	23/6	25/8	27/10	15/12
Dundee City Council (Elected Member)	Cllr Ken Lynn	✓	✓	✓	✓			
Dundee City Council (Elected Member)	Cllr Lynne Short	✓	✓	✓	✓			
Dundee City Council (Elected Member)	Bailie Helen Wright	✓	✓	✓	✓			
NHS Tayside (Non Executive Member)	Trudy McLeay	✓	✓	✓	✓			
NHS Tayside (Non Executive Member)	Jenny Alexander	A/S	A	A/S				
NHS Tayside (Non Executive Member)	Anne Buchanan				✓			
NHS Tayside (Non Executive Member)	Donald McPherson	✓	✓	✓	✓			
Dundee City Council (Chief Social Work Officer)	Diane McCulloch	✓	✓	✓	✓			
Chief Officer	Vicky Irons	✓	✓	✓	✓			
Chief Finance Officer	Dave Berry	✓	✓	✓	✓			
NHS Tayside (Registered Medical Practitioner (whose name is included in the list of primary medical performers)	Vacant							
NHS Tayside (Registered Nurse)	Wendy Reid	A	A/S	✓	✓			
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Dr James Cotton	✓	✓	✓	✓			
Trade Union Representative	Jim McFarlane	✓	✓	✓	✓			
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	✓	A	✓	✓			
Voluntary Sector Representative	Eric Knox	A	✓	✓	-			
Service User Representative	Linda Gray	✓	✓	✓	✓			
Person Providing unpaid care in the area of the local authority	Martyn Sloan	✓	✓	✓	A			
NHS Tayside (Director of Public Health)	Dr Emma Fletcher	A	A	A/S	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