East Dunbartonshire HSCP

Performance Audit & Risk Committee Meeting

Tuesday 21st March 2023 at 2pm
Meeting will be held virtually via MS Teams

AGENDA

Item.	Lead	Description	Update	For Noting/Approval
1.	Councillor Smith	Welcome and Introductions	Verbal	Noting
2.	Councillor Smith	Minutes of Last Meeting – Extraordinary Performance, Audit and Risk Committee Meeting of 27th October 2022	Paper	Approval
3.	G McConnachie	HSCP Internal Audit Update Feb 23	Paper	Noting
4.	J Campbell	HSCP Delivery Plan 2022/23 Update	Paper	Noting
5.	A Cairns	HSCP Performance Monitoring Report – Qtr3	Paper	Noting
6.	D Aitken	Mental Welfare Commission – "Ending the Exclusion"	Paper	Noting
7.	J Campbell	HSCP PAR Agenda Planner	Paper	Noting
8.	Councillor Smith	A.O.C.B	Verbal	Noting
9.	Councillor Smith	Date of next meeting – 26th June 2023 tbc?	Verbal	Noting

East Dunbartonshire
Health & Social Care Partnership

Minutes of
East Dunbartonshire HSCP
Extraordinary Performance, Audit & Risk Committee Meeting

Date: Tuesday 27th October 2022, 3pm
Location: Via MS Teams

Present:	Calum Smith (Chair)**CSm**	Ketki Miles	**KM**
	Susan Murray **SM**	Fiona Mitchell Knight	**FMK**
	Jean Campbell **JC**	Gillian McConnachie	**GM**
	Caroline Sinclair **CS**	Alan Moir	**AM**
	Ian Ritchie **IR**	David Aitken	**DA**
	Peter Lindsay **PL**	Brian Gillespie	**BG**
	Jacquie Forbes **JF**		

Minutes :   Vandrew McLean   **VM**

No.	Topic	Action by
1.	**Welcome and Apologies**	**CSm**
	The chair welcomed the Committee members to the meeting and explained this was an Extraordinary meeting to sign off the Annual Audited Accounts for period 2021/22 and authorise the Chair, Chief Officer and Chief Finance & Resources officer to accept and sign the Final Annual Accounts on behalf of the IJB. Apologies received: Derrick Pearce	
	Minutes of last meeting	**JC**
	The minutes of the meeting of 27ᵗʰ September 2022 will be reviewed and approved at the first Performance, Audit and Risk meeting in January 2023.	
2.	**Audit Scotland – Proposed Annual Audit Report 2021/22**	**FMK**
	FMK detailed that Audit Scotland had reviewed the clean, unmodified accounts and were satisfied they present a true and fair view of the accounts of the IJB up to end March 2022. The accounts were fit for approval being properly prepared, and there was no areas highlighted for adjustment, misstatements to be corrected being reflective of the annual audit and a written assurance of the accounts being in order. The meeting today was an opportunity for committee members to bring to the Committee's attention any fraud or relevant issues prior to sign-off of the accounts.	

East Dunbartonshire Council
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NHS
Greater Glasgow
and Clyde

No.	Topic	Action by
	FMK highlighted the scope of the audit as detailed in Page 16 and the key messages, highlighting; • Exhibit 2, Page 23 explains any changes made to comply. • Significant increase in reserves held, for information. FMK referred back to the key messages for the IJB, and the uncertainty in the financial future. The overall position looks good but has been due to Covid related expenditure received late in the financial year and should be a cautionary note. With regards to the medium term financial plan, the IJB needs to work with partners to ensure they maintain a secure position. The Pay Award is higher than budget, and there remains workforce pressures for both organisations with the Workforce Plan under development. FMK spoke to the governance transactions and best value, livestreaming of meetings, which can be seen as efficient but risks a lack of openness and transparency where the public do not have access to in person meetings. Good management and performance along with reporting are essential. Performance has declined from the previous year and could be attributed to the pandemic. On Page 39, Action Plan points are detailed with the recommendations accepted by HSCP management. FMK confirmed that this was the final year of a 6 year audit appointment and there will be a full and smooth handover to the newly appointed auditors. FMK opened the floor to questions. No questions asked. CSM thanked FMK and Audit Scotland for the last 6 years working with the HSCP and the support given to the IJB.	
3.	**East Dunbartonshire IJB Annual Audited Accounts 2021/22**	**JC**
	JC presented the final audited accounts for 2021/2022, setting out the 7th year of accounts for the partnership. There is a requirement for the Chair of the HSCP Integrated Joint Board, Chief Financial Officer and Chief Officer to sign these off with publication on the HSCP webpage.	

No.	Topic	Action by
	JC detailed that the HSCP generated a surplus of £14.146m during 2021/22, a significant element relating to funding received from SG in year for a number of policy initiatives which was not spent in full. Adjusting for funding received late in the financial year to be taken to ear marked reserves provided the HSCP with an underlying surplus of £3.142m which will be taken to general reserves bringing the IJB into line with the Reserves policy provisions. The overall reserves position provides a balance of £26.9m giving opportunity to progress IJB strategic priorities.	
	IR asked whether Scottish Government will be pulling back reserves. JC noted that this was 2021/2022 earmarked reserve position rather than 2022/2023 and discussions were ongoing to seek to recover unspent reserves related to Covid and for other policy areas requiring that reserves balances are utilised first prior to any further allocations of funding for 2022/23.	
	The Chair of the IJB noted approval of the Accounts for 2021/2022.	
	PL offered thanks to JC for the work that had been undertaken by Audit Scotland and EDHSCP.	
	No further Questions/comments.	
	Date of next meeting – tbc January 2023	**JC**

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING: **21st MARCH 2023**

REPORT REFERENCE: **PERF/210323/03**

CONTACT OFFICER: **GILLIAN MCCONNACHIE, CHIEF INTERNAL AUDITOR, 0141 574 5642**

SUBJECT TITLE: **INTERNAL AUDIT UPDATE**

1.0   PURPOSE

1.1   The purpose of this report is to update the Committee on internal audit work completed in the period since the last Committee.

1.2   The information contained in this report relating to East Dunbartonshire Council or NHSGGC audits has been presented to the Council's Audit & Risk Management Committee (A&RMC) and the NHSGGC Audit & Risk Committee (ARC) as appropriate, where it has received scrutiny. Once noted by the these committees, this report provides details on the ongoing audit work, for information, to the H&SCP Performance, Audit & Risk Committee and to allow consideration from the perspective of the H&SCP.

2.0   RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1   Note the contents of the report and

- Request the Chief Finance & Resources Officer to submit performance monitoring reports detailing progress against Plan and audit results to future meetings of the Committee.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0   BACKGROUND/MAIN ISSUES

3.1   In the period since the last committee update, the Internal Audit Team finalised and reported on the outputs as shown in Table 2 below. The table below represents a continuation of the reporting on the Internal Audit work for 2022/23, with Outputs 1 to 4 having previously been completed and reported to committee.

Table 2 – Analysis of Internal Audit Outputs September 2022 to February 2023

	Audit Area and Title	Areas Noted	High Risk	Medium Risk	Low Risk
	Systems				
5	HSCP Governance Arrangements	**4**	-	1	3
6	Social Work Charging	**5**		1	4
	Consultancy				
7	Care Payments Interim Process	**1**	-	1	-
	Regularity				
8	Interim Review Audit Actions	**-**	-	-	-

3.2   Four outputs were completed in the period, representing a year to date cumulative achievement of 8 outputs or 89% completion of the 9 outputs planned for the year 2022/23, at 92% through the year.

3.3   There were nine outputs planned for completion in the original audit plan to 31 March 2023. It is now expected that this figure will be 8 outputs.

3.4   Auditors will complete 'in progress' audit work relating to Self Directed Support and Interim Care Home funding as soon as possible following the year end. This work is largely complete and so it is expected that the results of this work will be presented to the June Performance, Audit and Risk Committee, alongside and in support of the annual audit opinion.

3.5   Auditors have provided the following summary of the audit output completed since the last monitoring report for Members.

HSCP Governance Arrangements

3.6   Auditors reviewed the HSCP's Governance Arrangements as an HSCP specific audit. This work is reported to this committee in the first instance and thereafter may be referred to in papers to Council and NHS audit committees for their information.

3.7   This is an important piece of assurance in support of the annual audit opinion on the HSCP's controls, risk management and governance. The arrangements were concluded as being generally satisfactory, with one Medium risk being identified relating to the completeness of declaration of interest forms. It was noted that not all HSCP Board members had completed a form at the time of the audit.

3.8 In addition, three low risk issues were identified relating to:

- The clarity of HSCP whistleblowing arrangements in the event that an HSCP specific concern arose. To address this, the HSCP will provide links to the relevant Council/NHS policies on the HSCP website and develop a statement in line with good practice guidance for any specific issues related to HSCP matters.

- The updating of service risks registers; and

- The completion of a Performance, Audit & Risk Committee Self-Assessment. A self-assessment is designed to assist audit committees in evaluating how well they are executing their responsibilities. This would help to identify any ongoing goals for the Committee and ensure that responsibilities are being fulfilled, which adds to the practice of good governance. The Chief Internal Auditor will draft a template for consideration at the next PAR meeting to assist with the self-assessment.

Social Work Charging – Non Residential Services

3.9 Auditors have also recently completed a review of the charging process for individuals receiving non residential Social Work services. This included policies and procedures, fees and charges being set at approved rates, adequate training of staff and management information being available on charges income.

3.10 The Audit Team concluded that the key controls in the Social Work Charging control environment for non residential services is reasonable and should be subject to the one medium and four low risk agreed improvement actions to provide further assurances within the area.

3.11 The Medium risk that was identified related to the charging for day care. Charges for alternatives to day care were suspended during the Covid-19 pandemic and charging had not yet resumed at the time of the audit. Charging has now resumed for service users attending day care centres at up to £20.80 per day, in line with the charging policy.

3.12 The four low risks identified related to; the updating of the Kelvinbank Resource Centre Leaflet, the timely submission of attendance reports by providers of day care, the completeness of income maximisation forms by service users, and ensuring that old versions of the Social Work Non Residential Charging Policy are removed from the HSCP website.

Care Payments Interim Process

3.13 The HSCP's Chief Finance and Resources Officer approached the Chief Internal Auditor for advice on temporarily amending the controls relating to payments for services delivered through Homecare and Supported Living Providers.

3.14 The proposal was to temporarily amend the process for monitoring of actual services delivered through the Homecare and Supported Living Providers.

3.15 The process was specified as relying on monthly returns from service providers detailing actual hours delivered. These returns should to be compared to planned hours recorded in Carefirst, with any variations passed to Homecare Organisers or

Team Leads for verification before any amendments are made to subsequent payment to providers. This process predominantly relates to providers on the Scotland Excel Framework. The verification of amendments has been subject to delays due to staff capacity constraints and therefore typically no amendment was being made to provider payments. This was resulting in known overpayments being made to providers, which in turn, impacts on the accuracy of financial management information available to the HSCP, the ability to manage budgets and to make sound management decisions based on reliable data.

3.16 The temporary amendment proposed was to remove the final checks through Homecare Organisers and Team Leads on the basis that it was not happening timeously, and in some instances was not occurring at all. Instead, the temporary process would involve the providers return being taken as the actual hours delivered and payment made on this basis. This would be compared to the Carefirst remittance advice with any variations advised to Shared Services to amend subsequent payments to providers. The total hours as reported by providers is less than the hours being paid through Carefirst. Another benefit of the temporary solution is that it would provide more reliable management information for service decision making, with a robust account of the actual hours being delivered through each provider within each area being available.

3.17 The control measures that have been proposed for the temporary process are:

- Providers complete a declaration that the information they provide is accurate. Auditors, with the assistance of Corporate Fraud, have provided comment on the draft declaration wording, which has been updated to reflect the suggestions.

- The temporary controls will only apply to variations. Any new service or service cessation will still require a standard CC4 or CC5 form to be completed, with appropriate authorisations remaining in place for these.

- There will continue to be a process of regular audit of providers through the contract management framework. This includes monitoring and site visits to providers where spot checking of hours delivered is carried out by the Strategic Commissioning Team.

- Any significant increase in hours from providers compared to the Carefirst remittance will be sense checked with the service (Homecare Organisers and Team Leads) to verify this is reasonable. This is by exception and is being monitored overall to ensure there is not a general increase in provider returns on actual hours delivered compared to that on Carefirst.

- Finance (Social Work Accountant) continue to undertake a monthly reconciliation to Carefirst.

3.18 Auditors have reviewed the interim process as proposed and have identified a number of risks with regards to the proposed temporary solution. These relate to Best Value, Governance/Financial Integrity, Budgetary risk, Duty of Care, and the Service Perception of Controls. Whilst auditors concluded that it is a reasonable and short term pragmatic solution, a timeline should be established for reverting to stronger controls to ensure that controls are reintroduced within an acceptable timeframe. In the interim, it should be ensured that spot checks are carried out by Strategic Commissioning on providers as planned and that the results of this monitoring is closely monitored by management.

<u>Temporary Controls for Care Payments – **Medium** Risk</u>

- The changes that have been outlined above are more acceptable as a short term solution than a medium term solution. There needs to be a realistic plan to re-implement the controls to ensure that it does not become a longer term arrangement. The HSCP aspires to re-implement these controls once recruitment is completed and a level of capacity to complete the required checks is established.

3.19 A decision has been taken by management to implement the proposed temporary solution. Auditors will establish how well the temporary controls are working and any progress towards a longer term solution and will report back to committee in 2023/24.

Interim review of Outstanding Audit Actions

3.20 An interim follow up report has been produced, covering outstanding audit actions for East Dunbartonshire Council and the HSCP. This interim follow up report demonstrates the Council and the HSCP's commitment to maintaining compliance with the Public Sector Internal Audit Standards.

3.21 Of particular relevance to the HSCP is the following outstanding High risk action:

- *Social Work Contract Monitoring -* The action relating to Social Care Contractual Arrangements action is in progress. The original finding was that a large percentage of providers (68%) and services (65%) were operating without a contract. This is still the case, although the %s have reduced to 38% of providers and 41% of services, these remain material figures. A risk assessment template has been developed and given the fragility of the market conditions, consideration will be given on a risk based basis to direct award of contracts. This will be documented and signed off by the Head of Service for each contract.

- In conjunction with the above, a model contract is being developed by Legal Services. This will help to speed up the process for agreeing contractual terms with providers.

- To provide support and documentation to the above process, a form for alerting the need to commission emergency care service will be developed in consultation with Legal Services and Corporate Procurement teams and distributed to all staff. There has been slippage in completing this action due to pressures of Covid-19 response and recovery.

3.22 A further Medium risk relating to HSCP Bad Debt Benchmarking is in progress – a review was undertaken at the prior year end of criteria for considering bad debts. Regular process of reporting to be established. Internal audit consultancy audit work underway in this area will support improvements.

3.23 A final Medium risk relates to data cleansing of the service register. The risk relates to manual manipulation that is required to categorisation of information obtained from Carefirst (Social Work Care Management System) in order to obtain meaningful management reports. Reliance is placed on Officer knowledge, rather than the

system providing an accurate picture. This process is inefficient and creates a risk that incorrect information is relied upon by management.

3.24   The Carefirst Steering Group has now been re-established and this action has been added to the list of considerations in order to agree ownership, responsibilities and to make progress on this action. This action will be considered alongside other priorities for the system.

3.25   Other significant outstanding actions for the Council include eight actions relating to Cyber Security. A new structure for the ICT Service with dedicated security team has recently been implemented and recruitment completed which should enable these actions to be progressed.

3.26   Internal Audit's follow up work has identified that 38 total risks remain outstanding across the Council and HSCP in comparison to 36 risks outstanding in the 2021/22 Final Follow Up report. Within these figures, for the HSCP and Social Work actions specifically, the decrease has been from 4 to 3 outstanding risks. Of the three HSCP related risks outstanding, one is High risk, as outlined at 3.21 above and Auditors have asked Council management, and where appropriate HSCP management, to prioritise this for completion in line with revised target dates that have been set. Full detail on the HSCP related outstanding audit actions is included at *Appendix 1*.

3.27   Responding to the requirement of the Public Sector Internal Audit Standards, the Audit and Risk Manager has not revised any opinions previously reported to members. All residual issues will be considered in the 2022/23 final follow up report and will inform future audit work, including the specification of the 2023/24 internal audit plans.

EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

3.28   Work continues to a conclusion on the 2022/23 Internal Audit Plan. Progress against the plan will be reported in the first instance to the Council's Audit & Risk Management Committee (A&RMC). Following reporting to the A&RMC, the HSCP's PAR committee will be appraised of any findings relevant to the HSCP.

3.29   To date, work completed has included work on the Procurement system, reconciliations support, Education work, and Totalmobile system work. The findings relating to Social Work Charging as detailed above have also been reported to the A&RMC. Two High risks have been identified to date, relating to data risks regarding the use of personal mobile phones by trade operatives and to the resources in the Finance team associated with prior difficulties in recruiting. Action plans are in place to address the risks and there is no direct risk associated with these to the HSCP. A large number of audits (ten) are in progress, with auditors managing audits around service demands.

NHSGGC INTERNAL AUDIT PROGRESS

3.30   An update on the NHSGGC's internal audit activity has been received by Internal Audit. The following audits were finalised and reported on to the ARC in December 2022: Covid-19 Recovery – Annual Delivery Plan and Telecommunications Project – Post Implementation Review. These were both assessed as Yellow (minor improvement required.

4.0   **IMPLICATIONS**

The implications for the Board are as undernoted.

4.1   Relevance to HSCP Board Strategic Plan;- None.

4.2   Frontline Service to Customers – None.

4.3   Workforce (including any significant resource implications) – None.

4.4   Legal Implications – Legal risks are presented in the body of internal audit reports with reference to relevant legislation where appropriate.

4.5   Financial Implications – Internal Audit reports are presented to improve financial controls and aid the safeguarding of physical and intangible assets.

4.6   Procurement – Where applicable these are referenced in the body of internal audit reports with associated management actions for improvement.

4.7   ICT – None.

4.8   Corporate Assets – None.

4.9   Equalities Implications – None

4.10   Sustainability – None

4.11   Other – None.

5.0   **MANAGEMENT OF RISK**

The risks and control measures relating to this Report are as follows:-

5.1   The Risks are highlighted to management in audit reports. The risks are addressed through agreed action plans, appended to internal audit reports.

6.0   **IMPACT**

6.1   **STATUTORY DUTY** – None

6.2   **EAST DUNBARTONSHIRE COUNCIL** – The risks identified in the internal audit reports relevant to East Dunbartonshire Council have been highlighted to the Council's Audit & Risk Management Committee.

6.3   NHS GREATER GLASGOW & CLYDE – The risks relevant to the NHS Greater Glasgow & Clyde identified in the internal audit reports have been highlighted to the NHSGGC's Audit & Risk Committee.

6.4   DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH – No Direction required.

7.0   POLICY CHECKLIST

7.1   This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0   APPENDICES
8.1   Appendix 1 – Summary of HSCP Outstanding Actions

Parent	Sub Action	Risk Rating	Description	Improvement Target	Original Due Date	Due Date	Latest Note
Social Work Contract Monitoring	EPB-CM-02 Contractual Arrangements	High	Examination of the contract register illustrated a number of providers operating without a contract with the Council (68%) and services (65%)	The Team will be refined to further enhance efficiencies within the area and this will see steady improvements within the area.	31-Dec-14	In progress - full mitigation of risk date to be confirmed	The original finding was that a large percentage of providers (68%) and services (65%) were operating without a contract. This is still the case, although the %s have reduced to 38% of providers and 37% of services these remain material figures. A risk assessment template has recently been developed and given the fragility of the market conditions, consideration is being given on a risk based basis to direct award of contracts. The risk assessment has been documented and signed off by the Head of Service for each contract. Next steps are to prioritise contracts to be negotiated or to go out to tender and to commence this process.

In conjunction with the above, a model contract is being developed in conjunction with Legal Services. This will help to speed up the process for agreeing contractual terms with providers. |
| HSCP Financial Outturn and Key Controls | CF0-HSCP-FOKC-5 Data Cleansing - Service Register | Medium | The service register on Carefirst contains key financial and other data relating to suppliers. A review and data cleansing exercise is required.

Auditors were unable to identify the owner of the data contained on the service register. | A data cleansing exercise of the service register should be carried out. | 31-Jan-20 | Initial review and decision on approach 31-Mar-23

Timeline for mitigation of risk TBC following this. | The risk relates to manual manipulation that is required to categorisation of information obtained from Carefirst (Social Work Care Management System) in order to obtain meaningful management reports. Reliance is placed on Officer knowledge, rather than the system providing an accurate picture. This process is inefficient and creates a risk that incorrect information is relied upon by management.

The Carefirst Steering Group has considered this risk and noted that the schedule of rates have been updated in Carefirst with controls are in place to ensure that these rates are applied. Further work is required to cleanse headers within Carefirst Service Register. The Carefirst System Team will run a report and provide this to the Strategic Commissioning Manager for her to review and determine the work that is required. A decision will then be taken on any further action to be taken. This will be completed by 31 March 2023 with a timeline for any further work required to be considered and agreed at that time. |

Parent	Sub Action	Risk Rating	Description	Improvement Target	Original Due Date	Due Date	Latest Note
HSCP Outturn Variance	CFO-HSCPAOVCN-4 Benchmarking	Medium	Local authorities in Scotland submit multiple performance indicators on an annual basis to a benchmarking process where the authorities are compared against each other across multiple factors. In the period 2017/18, EDC were ranked 16 out of 32 authorities for aged debt indicators. Benchmarking enables EDC to have a greater understanding of how they are performing against other authorities, but this may not provide the granularity required by HSCP.	It may be appropriate to consider a review of credit control arrangements to improve the overall position in relation to local authority benchmarking statistics.	31-Mar-20	31-May-23	Remaining action relating to Bad Debt Benchmarking is in progress – a review was undertaken at the year end of criteria for considering bad debts. Regular process of reporting to be established. Consultancy audit work planned in this area for 2022/23 will support improvements.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING: 21ST MARCH 2023

REPORT REFERENCE: PERF/210323/04

CONTACT OFFICER: JEAN CAMPBELL, CHIEF FINANCE &
                                      RESOURCES OFFICER, TELEPHONE
                                      NUMBER, 0141 232 8216

SUBJECT TITLE: HSCP DELIVERY PLAN 2022/23 UPDATE

1.0 PURPOSE

1.1   The purpose of this report is to update the Committee on the delivery of the HSCP Delivery Plan for 2022/23.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1   Note the update to the HSCP Delivery Plan for 2022/23.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The HSCP Board agreed the HSCP Delivery Plan 2022/23 at the IJB meeting on the 24th March 2022. The HSCP Delivery Plan draws together our strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements.

3.2 The Delivery Plan is monitored through the HSCP Annual Delivery Plan Board comprising the Chief Officer, Chief Finance & Resources Officer, HSCP Heads of Services and organisational development and HR support from both the Council and NHS.

3.3 The projects within the Annual Delivery Plan have been classified to more clearly identify where these relate to efficiencies, improvements to service delivery, statutory / legal responsibilities, corporate priorities, sustainability and enhancement to assets. Each of the HSCP Delivery planning priorities has been classified according to these criteria and this is reflected within the highlight report for each priority. Some priorities will have more than one classification as a project may deliver efficiencies as well as improving services and outcomes for patients and service users.

HSCP Delivery Plan 2022/23

3.4 The dashboard setting out progress on delivery of the projects to be delivered during 2022/23 is attached as **Appendix 1** with a more detailed update on the final position for each project attached as **Appendix 2.**

3.5 The delivery of the service redesign aspects of the Delivery plan for 2022/23 included as part of the Budget 22/23 is indicating a small shortfall of £0,01m at this point in the financial years. This means the HSCP expects to achieve £0.439m of savings against a target of £0.449m during 2022/23. A copy of the financial implications of projects approved as part of the Budget 2022/23 are included as **Appendix 3.**

3.6 There are a total of 31 projects to be delivered within the Delivery Plan for 2022/23:-

- 21 (28) are considered at Green status – on track

- 2 (3) are considered Amber status (at risk) – work is underway with some risk or delay to delivery.

- 5 are considered Red status – more significant risks / delays to delivery.

- 3 have been closed as complete

3.7 The projects identified as in exception will not be completed by the end of the financial year given the limited progress on these projects due largely to resource issues or reliance on SG partners to support the delivery on these priorities. These relate to:

    3.7.1 Implementation of Digital Action Plan 2022/23 – work has continued throughout the year with SG colleagues to conclude the work on

developing a digital maturity assessment for the HSCP with limited progress.

3.7.2 Review of commissioned mental health and alcohol and drugs services – failure to recruit to a project post to drive this work forward has led to a re assessment of the project which will form part of the programme for 2023/24 in a re-structured form.

3.7.3 Review of Community Occupational Therapy and Re-ablement service – some work has progressed within the HSCP to collate data to inform the review and progress elements of recruitment to support a re-ablement model, however a lack of resources to conduct a formal review and engagement with relevant stakeholders will mean this will not be concluded in this year.

3.7.4 Development of a compassionate communities model – this is reliant on endowment funding to support delivery and a change in the proposed model for delivery has required a further consideration of the use of funding for this purpose leading to delays in implementation. This will be implemented during 2023/24 now that the re-purposing of funding has now been confirmed.

3.7.5 Implementation of the recommendations from the Public Dental Service Review – changes to the structure for payment and delivery of dental services, post covid, requires to be considered and reflected in the review of services locally – this will be progressed in 2023/24.

3.8 The projects identified at risk have experienced some delays in progress, largely due to delays in recruitment of critical posts to take forward the work and based on the milestones set to be achieved at this point in the year. These are progressing and will continue to be monitored through the year with significant or full achievement expected by the end of the financial year.

3.9 There are 3 projects which are 100% completed and this has been closed and moved to the List of Completed Projects, attached as **Appendix 4**. There are a further 6 projects which have been completed and will be moved to the list of completed projects in the next cycle.

4.0 <u>IMPLICATIONS</u>

The implications for the Committee are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022-2025 Priorities – All. The Strategic Plan sets out the priorities and ambitions to be delivered over the next three years to further improve the opportunities for people to live a long and healthy life. The HSCP Delivery Plan sets out the priorities which will be delivered during 2022/23 in furtherance of the strategic priorities set out in the Strategic Plan.

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery

7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None

4.3 Workforce (including any significant resource implications) – None

4.4 Legal Implications – None

4.5 Financial Implications – The HSCP Delivery Plan includes the transformation and service redesign priorities for the year including the areas requiring investment and dis-investment.

4.6 Procurement – None

4.7 ICT - None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.1 The risks to the delivery of each priority are set out in the highlight report specific to each area. The overall risks associated with the delivery of the plan comprise financial risk in the event that savings are not delivered as planned or areas highlighted for service improvement do not progress as planned.

6.0 IMPACT

6.1 **EAST DUNBARTONSHIRE COUNCIL** - None

6.2 **NHS GREATER GLASGOW & CLYDE** - None

6.3 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.0 POLICY CHECKLIST
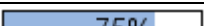
7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0   APPENDICES

8.1   Appendix 1 – HSCP Delivery Plan Dashboard 2022/23 March 23
8.2   Appendix 2 – HSCP Delivery Plan Highlight Report 2022/23 March 23
8.3   Appendix 3 – HSCP Savings Update 2022/23 March 23
8.4   Appendix 4 – List of Closed Projects March 23

	HSCP TRANSFORMATION PROGRAMME 2022/2023							
	Programme overview			**Summary of RAG Status**				
Projects **28**		Decisions **6**		On Track **21**		At Risk **2**		In Exception **5**
Priority	Project Name	Previous Status	Current status	Progress	Reason for RAG Status	Original Project End Date	Forecast Project End Date	Decision Required
65	Delivery of Year 2 of Children's House Project	▶	▶	95%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
52	Learning Disability: service review, action plan and implementation	⚠	▶	95%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
51	Implement 22/23 Digital Action Plan	⚠	🔴	50%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
47	Social Support for Older People Strategy	▶	▶	80%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Review of commissioned mental health and alcohol and drugs services. Develop action plan for reshaping of services	🔴	🔴	15%	In exception	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**
n/a	Review of Community Occupational Therapy and Reablement services across the HSCP	⚠	🔴	30%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Review of HSCP organisational structures	▶	⚠	50%	At risk	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Redesign of HSCP website	▶	▶	75%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.

n/a	Review current model of Post Diagnostic Support delivery	⚠️	▶️	75%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Increase uptake of support at a distance	▶️	▶️	60%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team	▶️	▶️	80%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Review and redefine operational approach to community led support	▶️	⚠️	50%	At risk	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Develop compassionate communities model in East Dunbartonshire	⚠️	🔴	45%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Refresh HSCP Locality Plans	▶️	▶️	75%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Identify a staff base in the West locality	▶️	✅	100%	Completed	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**
n/a	Prioritising Public Protection	▶️	▶️	90%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Refresh HSCP Carers Strategy	▶️	▶️	75%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Implementation of The Promise	▶️	▶️	90%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Implementation of the Children and Young People's Mental Health and Wellbeing Framework	▶️	▶️	90%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.

n/a	Review accommodation arrangements in line with SG guidance and GGC and EDC policies	▶	✔	100%	Completed	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**
n/a	Organisational Development Plan in support of staff orientation back to buildings	▶	✔	100%	Completed	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**
n/a	Unpaid work services backlog	▶	▶	90%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Joint Commissioning Plan for Unscheduled Care	▶	▶	75%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Delivery of a range of measures to support staff wellbeing.	▶	▶	90%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Implementation of the recommendations from the Public Dental Service review Programme Board	▶	⬤	25%	In exception	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Review engagement framework to support collaborative approach with third and independent sector	▶	✔	100%	Completed	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**
n/a	Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)	▶	▶	85%	On track	31-Mar-2023	31-Mar-2023	There are no decisions required.
n/a	Property Strategy development and implementation	▶	✔	100%	Completed	31-Mar-2023	31-Mar-2023	**Transformation Board is asked to agree on closure of project**

HSCP TRANSFORMATION 22

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PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–01–TRA Delivery of Year 2 of Children's House Project	▶	▶	95%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	24–Mar–2022

Project Description

Ensure that cohort 2 of young people identified complete the programme and are offered permanent accommodation with support within East Dunbartonshire.

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• House Project continues to deliver positive and improved outcomes for young people leaving care as well as financial efficiencies.	• Continue to support young people in Cohort 2: 15 young people have now successfully completed the programme and moved into their own accommodation. • Develop a business plan to outline plans for Year 3.

Key Issues and Risks Requiring Escalation

Sustainability of the House project given the short–term nature of the funding.
Support staff are moving to new posts so we require to fill these vacancies from within the service.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
£200,000	£400,000	3	N/A	• Improve outcomes for Care Experienced Young People moving on from care placements. • EDC and HSCP fulfil duties are Corporate Parents, ensures The Promise is embedded and Children's Rights (UNCRC) is enacted.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✅	✅	✅	✅	✅	✅

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-02-TRA Learning Disability: service review, action plan and implementation	⚠️	▶️	95%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	28-Apr-2022

Project Description

Move to new Allander Day Service and development of employability, and community-based support alternatives to formal day care.

Project Sponsor	Project Manager
David Aitken	Richard Murphy; Gayle Paterson; David Radford; Caroline Smith

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Delay with the building/construction of the new Centre. The building will now be ready for handover to the HSCP on 31 January 23 as opposed to 31 October 22.	• Conclude Project Plan • Staff training for returning service users – tracheotomy • Finalise employability pathway and continue to develop employment opportunities/programmes. • Continued development of community assets; continuing communication/engagement with Carers, SU, Staff, Stakeholders. • Recruitment of volunteers and Outreach staff; Management/Staff Induction to New Premises, Equipment, Heating, Lighting etc • Decant 6-8 March 23; close Kelvinbank by 14 March 23; open Allander on 9 March 23; visits for SU, Carers, Stakeholders pre and post key handover 17 Feb 23

Key Issues and Risks Requiring Escalation

Kelvinbank sale date extended to 14 March 23.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5	N/A	• Improved facilities and services.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔️	✔️	✔️	✔️	✔️	✔️

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-03-TRA Implement 22/23 Digital Action Plan	⚠️	🔴	50%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board	
31-Mar-2023	31-Mar-2023	08-Nov-2022	

Project Description

Implement 22/23 Digital Action Plan, which seeks to maximise experience of remote technology for a digitally enabled workforce, implement Analogue to Digital Telecare Transformation by 2024.

Project Sponsor	Project Manager
Jean Campbell	James Gray; Elaine Marsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Local digital projects continue to progress locally • IT solutions for shared desktop, ISE solutions progressing, which will support staff working across premises.	• Finalise Digital Maturity Assessment, which will inform the Digital Action Plan in collaboration with the SG Digital Office. Continue progress on a number of key initiatives – evaluate Ask Sara, roll out ARMED, shared desktop, analogue to Digital.

Key Issues and Risks Requiring Escalation

Some delay in procurement progressing through SXL for a cloud based solution to support analogue to digital project, resources at digital office to finalise digital maturity assessment. Engagement continues with both organisations to mitigate these risks. Not expected to be fully delivered in year as planned.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3. 5, 6	N/A	• Increase in digitally enabled workforce • Reducing carbon footprint of HSCP

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔️	✔️	❌	✔️	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–04–TRA Social Support for Older People Strategy	▶	▶	80%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	19–Jan–2023

Project Description
Development and consultation on new model for the delivery of social support options for older people to include interim contractual arrangements pending full implementation in April 2024.

Project Sponsor	Project Manager
Derrick Pearce	Kelly Gainty; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Force Field Analysis complete. • Financial framework information finalised. • Strategy and accompanying appendices finalised. Submitted to HSCP Integrated Joint Board alongside IJB Report and Strategy EQIA for approval of preferred delivery option and authorisation for publication of approved Strategy.	• Consistency checking across options appraisal/forcefield analysis • Conclusion of options decision • Presentation of preferred option(s) at January IJB

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	5, 6	N/A	• Sustainable model of service delivery in place for medium to long term	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✘	✘

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-05-TRA Review of commissioned mental health and alcohol and drugs services. Develop action plan for reshaping of services.	🔴	🔴	15%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Review of commissioned Mental Health and Alcohol & Drugs recovery services to develop enhanced, holistic recovery focused services across adult mental health and alcohol and drugs recovery.

Project Sponsor	Project Manager
David Aitken	Gillian Healey; Stephen McDonald

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• At the last Delivery Plan review in September the development of a locality Mental Health Strategy had been progressed. • Challenges recruiting to Project Lead post identified.	• Project Lead post was advertised three times but could not be recruited to, due to a lack of suitable applicants. Issues identified re changes to wider landscape; decision reached not to proceed with full review of MH and ADRS commissioned services at this time as project would not be deliverable.

Key Issues and Risks Requiring Escalation
Project will not proceed as originally proposed and recommendation is to close the project as currently identified as not deliverable in year. Wider review of Commissioned Services being completed and MH & ADRS commissioned services will be reviewed as part of this process.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it is not currently identified as deliverable within 22-23 timescales.

Benefits				
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	4, 5	N/A	• Enhanced service provision • Modernised commissioned services, which better meet the needs of those within our community who use and need these services.

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✅	✅	✅	✅	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-06-TRA Review of Community Occupational Therapy and Reablement services across the HSCP	⚠️	🔴	`30%`	Red – Project in exception

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2023	31-Mar-2023	N/A

Project Description

Review of community OT and reablement service and implementation of review outcome to deliver an improved service model which addresses OT waiting times and maximise use of equipment digital options for supporting people within the community.

Project Sponsor	**Project Manager**
Derrick Pearce	Fiona Munro; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Still awaiting approval from EDC to prgress with review.	• Undertake inspection self-evaluation exercise • Complete recruitment of reablement OT staffing • Continue to pursue recruitment of reablement carers • Secure resource and sign-off for formal service review

Key Issues and Risks Requiring Escalation

Risk of delay to Strategic Service Review due to competing priorities and capacity challenges in EDC Digital and Business Change Team/ HR and OD. Request to progress service review is pending. Not expected to be delivered in year as planned.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	5, 6	N/A	• Integrated delivery of a Reablement approach • Increased capacity to absorb Reablement packages of care • Increase in the number of customers requiring a reduced or no package following their 6 weeks of Reablement	

Drivers for Change

Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
❌	✔️	❌	✔️	❌	❌

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–07–TRA Review of HSCP organisational structures	▶	⚠	50%	Amber – Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description

Review and implement a revised operating model which is fit for purpose and aligned to the strategic priorities of the HSCP post–pandemic.

Project Sponsor	Project Manager
Caroline Sinclair	Caroline Sinclair

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Recruitment continues to key roles to increase adult social work capacity, carers lead, review of interim management arrangements continues to move this onto a more permanent footing. Key posts subject to job evaluation processes are being held up due to resource constraints within this team.	• Continue with recruitment process to fill roles to increase adult SW capacity, consolidation of interim management arrangements and service manager capacity still to be progressed. • Continue to recruit to social care / healthcare workers / health professionals to increase capacity across health & social care in line with additional SG monies for Adult Winter Planning. • Recruitment of Carers Lead to progress and support Carers agenda – post held up within job evaluation process.

Key Issues and Risks Requiring Escalation

Delays in consolidation of HSCP management structure, recruitment issues to increase capacity across a range of service areas including homecare, social work which will impact on ability to spend allocated funding in year and deliver on key priorities. Resource issues to timeously evaluate jobs and processes for recruitment to post are causing delays.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3. 5, 6	N/A	• Structure is fit for purpose, maximises integration and delivers on Scottish Government commitments to enhance capacity across health & social care services	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–08–TRA Redesign of HSCP website	▶	▶	75%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description
Redesign of HSCP website within scope of full EDC website design

Project Sponsor	Project Manager
Norma Marshall	Vandrew McLean; Alison Willacy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Awaiting award of new website contract by EDC to enable redesign of HSCP website to begin. • Update of site content ongoing to reflect any service changes.	• Continue with identification and creation of other relevant pages to enhance the information available on the website. • Review the format of current and historic HSCP consultations in partnership with EDC. • Await award of new website contract by EDC to enable redesign of HSCP website to begin.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits	

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3, 5, 6	N/A	• Increased hits on HSCP website pages.

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✔	❌	✔	❌	✔

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–09–TRA Review current model of Post Diagnostic Support delivery	⚠️	▶️	75%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description

Review current model of PDS delivery in line with refreshed Dementia Strategy and action plan

Project Sponsor	Project Manager
Derrick Pearce	Fiona Munro

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Review completed. • Approval granted from SMT to bring service in-house. • Alzheimer's Scotland informed of the intention to end contract with them	• Reconvene and Refresh East Dunbartonshire Dementia Strategy Group • Commence development of East Dunbartonshire Dementia Strategy and Action Plan

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6	N/A	• Improved access to Post Diagnostic Support within 6 weeks of diagnosis

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔️	✔️	❌	✔️	❌	❌

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-10 Increase uptake of support at a distance	▶	▶	60%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board		
31-Mar-2023	31-Mar-2023	N/A		

Project Description

Increase technological and digital options through Telecare, digital support and supported self-management to increase uptake of support provided at a distance.

Project Sponsor	Project Manager
Derrick Pearce	James Gray; Elaine Marsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• 3 practices registered for pilot of blood pressure monitoring. • ARMED lead has passed Digital Leader course – project continues. • Remote diabetic monitoring slowly progressing – ehealth capacity limited/ appetite in service. • All local care homes registered with Near Me as part of refreshed falls pathway	• Progress in line with current project scope, within confines of resources to support and service ability to engage.

Key Issues and Risks Requiring Escalation

Capacity in services to engage, slow national leadership, local eHealth capacity pressures.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	5, 6	N/A	• Increase in choice and control and flexibility for service users.	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✔	✔	✔	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-11 Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team	▶	▶	80%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Develop HSCP Public Health Strategy and refresh objectives for Public Health Improvement Team

Project Sponsor	Project Manager
Derrick Pearce	David Radford

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• This update includes actions for Dec and Jan. Delays in timeline reflected in action.	• Draft Public Health Strategy for East Dunbartonshire will be presented to HSCP SMT on 21.12.22 and IJB in January 2023. • Consultation timeline and process/model agreed.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	5	N/A	• Renewed focus on public health and tacking health inequalities across the HSCP	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–12 Review and redefine operational approach to community led support	▶	⚠	50%	Amber – Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description

Develop and implement model of community led support locally based on best practice which seeks to reduce waiting lists and divert needs to more appropriate service models

Project Sponsor	Project Manager
Derrick Pearce	Kelly Gainty; David Radford

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Community drop–in sessions piloted to support healthy ageing; Local Area Coordinators brought together to provide support and advice for residents. • Venue for session in east of locality changed to Park Centre to increase engagement. Other amendments have included more varied promotion and use of banners. Evaluation ongoing. • HSCP supporting ED Asset Map to help people find local groups and facilities.	• Continue to pilot model and expand as test of change. • Hold local workshop to consider application of community led support in practice in East Dunbartonshire in new year. • Agree preferred model and seek sign off via SMT and IJB. • Pilot first of the proposed Community Led Support 'Clinics'.

Key Issues and Risks Requiring Escalation

Project will run over a number of years and while this will not be fully delivered in year, work will continue to progress to develop this model.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6	N/A	• Maximised use of community assets • Maximised self–management Increased choice and control

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✘	✘

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-13 Develop compassionate communities model in East Dunbartonshire	⚠️	🔴	45%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Develop and implement a delivery plan for No One Dies Alone (NODA) within East Dunbartonshire. Dependent on outcome of funding bid through endowments.

Project Sponsor	Project Manager
Leanne Connell; Derrick Pearce	Kathleen Halpin; David Radford

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Further discussion with regards to the hosting arrangement for Service continuing.	• Confirm governance for both elements of programme/service. • Establish local project board and project team. • Clarify local vision and objectives for project. • Develop year 1 action plan and financial framework. • Benchmark and gain learning with neighbouring HSCP who have already implemented.

Key Issues and Risks Requiring Escalation
Potential delays in rolling out programme and awaiting confirmation from funding body on revised approach to delivering programme. Not expected to be fully delivered in year.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	5, 6	N/A		

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✅	❌	✅	❌	❌

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-14 Refresh HSCP Locality Plans	▶	▶	75%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description

Review and redefine aims of locality planning groups to deliver improved outcomes for local people via collaboration and partnership action.

Project Sponsor	Project Manager
Jean Campbell; Derrick Pearce	Kathleen Halpin; Vandrew McLean; Fiona Munro; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• First meeting of full Locality Planning membership held. • Membership of East and West Locality Groups agreed. • First meetings of new groups being arranged. • Locality Profiles updated.	• Continue to profile commissioned services by locality. • Develop 2022/23 Locality Plans. • Embed Locality Planning into BAU.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6	N/A	• Locality focused and integrated delivery model • Reduction in Care at Home travel

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✔	✔

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-22-15 Identify a staff base in the West locality	▶	✅	100%	Project Complete

Original Project End Date	**Forecast Project End Date**	**Date of last project board**
31-Mar-2023	31-Mar-2023	N/A

Project Description
Identify and progress options for re locating staff within Milngavie Clinic to create more clinical / front facing space within the clinic.

Project Sponsor	**Project Manager**
Jean Campbell; Derrick Pearce	Kathleen Halpin; Vandrew McLean; Fiona Munro; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Infrastructure works to establish a staff base within Milngavie Enterprise Centre now complete and staff have successfully moved into their new accommodation. • Capital funding secured through NHS Board for refurbishment of shop front premises in Milngavie and Bishopbriggs for additional clinical/drop down space – preparatory design/tender work to be carried out 22/23, majority of work planned for 23/24 – this element of project will carry forward to next year's Annual Delivery Plan.	• Arrangements for infrastructure within Milngavie Enterprise centre and facilitate staff moving in is now complete and staff successfully re-located. • Preparatory works underway to progress programme of refurbishment within shop front premises in Milngavie with the bulk of work scheduled for 2023/24.

Key Issues and Risks Requiring Escalation
Project progressing for other elements of accommodation provision in the West locality – risk to slippage in project due to resource constraints/tendering processes/ refurbishment works to be concluded in 2023/24. Project Board to be established to focus on this area to mitigate these risk.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits	

Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
N/A	N/A	N/A	N/A	N/A

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✅	✅	✅	✅	❌	✅

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP–22–16 Prioritising Public Protection	▶	▶	90%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description
Ensuring the highest quality standards in identifying and responding to actual and potential social work public protection concerns through the implementation of 'Safe and Together', implementation of the Violence and Sex Offenders register (VISOR) and updating and implementation of the new Child Protection Guidelines

Project Sponsor	Project Manager
Claire Carthy	Alex O'Donnell

HIGHLIGHT REPORT	
Actions completed within the last reporting period	**Actions planned in the Next Reporting Period**
• Public protection continues to be a priority. The Public Protection Leadership Group oversees and monitors all data relating to CP, ASP and MAPPA.	• Safe and Together Training has progressed and the majority of the workforce re now trained. • VISOR; fully compliant with SG requirements and staff are going through the vetting process. Implementation date has been deferred by SG. Change to the MAPS system is underway. All data monitored by PPLG. • Currently undergoing a Joint Inspection for Services to Children At Risk Of Harm which will lead to an improvement plan. • Child Protection Guidance: West of Scotland Consortium has commissioned an external agent to write the local guidance. Staff training will commence thereafter.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**	
N/A	N/A	3	N/A	N/A	

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✔	✔	✔	✔	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–17 Refresh HSCP Carers Strategy	▶	▶	75%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	N/A

Project Description

Development of a new Carers Strategy for East Dunbartonshire for implementation from 2023 – review of existing strategy, consultation and engagement on new strategic objectives and delivery of new strategy to be completed.

Project Sponsor	Project Manager
David Aitken	Alan Cairns; Kelly Gainty

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Consultation document completed, engagement plan established to consult and engage with relevant stakeholders • Engagement and consultation on strategy has been completed utilising Summary Engagement Document and Engagement and Consultation plan which was approved at HSCP Board on the 17.11.22.	• Engagement Plan will be taken forward and a series of community and agency events are planned. • Engagement phase concluded on the 31.12.2022. Draft strategy will be prepared before final consultation and approvals are sought. • Report to be presented to HSCP Board in March 2023.

Key Issues and Risks Requiring Escalation

Carers Lead Post authorisation has been delayed and other officers have had to be brought in to deliver against this objective.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6	N/A	• Updated Carers Strategy to enhance access to carer support services and improve carer support and access to information. • Improved engagement and carer lead services. • Enhanced public awareness and carer friendly communities.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✘	✔	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-18 Implementation of The Promise	▷	▷	90%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description

Implementation of The Promise with a focus on Family Group Decision Making, ensuring that every child grows up loved, safe and respected, able to realise their full potential.

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• The Promise Steering Group has implemented an action plan and is ensuring ED is compliant with The Promise and key principles are being embedded: (i) listening to children and young people, (ii) relationships, (iii) quality of care, (iv) sibling contact.	• We were unsuccessful with our bid for further funding. We are exploring options as we are committed to continuing with the post of The Promise Co-ordinator. • Family Group Decision Making goes live on Monday 30th January. • We are fully engaged with CoSLA and SG on the national approach to the implementation of The Promise.

Key Issues and Risks Requiring Escalation

Year 1 funding ended in August; alternative funding sources are being explored.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3	N/A	• Improve outcomes for Looked After Children. • Ensure EDC and HSCP fulfil duties as Corporate Parents.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✔	✔

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–19 Implementation of the Children and Young People's Mental Health and Wellbeing Framework	▶	▶	90%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	24–Mar–2022

Project Description
Implementation of the Children and Young People's Mental Health and Wellbeing Framework

Project Sponsor	Project Manager
Claire Carthy	Claire Carthy

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Report for July–Dec 2022 due with SG week beginning 31st Jan 2023. This multi-agency summary has been drafted and will be submitted on time. • Year 3 funding has been agreed.	• Continue to develop Tier 1 and 2 services. • Ensure bids for additional partnership funding are considered by DCYPP. • Year 3 funding has been confirmed.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
There are no decisions required.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3	N/A	• Improve Tier 1 and Tier 2 mental health and wellbeing services for children, young people and families.	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✖	✖

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-22 Review accommodation arrangements in line with SG Guidance and GGC and EDC policies	▶	✅	100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	

Project Description

Ensure arrangements for accommodation remain compliant with SG guidance on physical distancing, infection control measures, mask wearing, ventilation etc and are in line with NHSGGC and Council policies

Project Sponsor	Project Manager
Jean Campbell; Caroline Sinclair	Jean Campbell

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Guidance within buildings now aligned and staff operating within a blended working approach. No further changes expected during 22/23 which will impact on further capacity within current accommodation.	• No further opportunities expected in 22/23 for expanding capacity within current buildings. • Improvements will continue to be reviewed and changes to location of teams within building to ensure maximum opportunities for integrated working.

Key Issues and Risks Requiring Escalation

Space continues to be restricted to support full extent of requests to resume service delivery within buildings – continual review to ensure this is prioritised to teams which need to work together within buildings. Work within blended working policies for staff across the HSCP.

Decision Required

The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3, 5, 6	N/A	N/A	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✅	✅	✅	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-23 Organisational Development Plan in support of staff orientation back to buildings	▶	✅	100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Development and implementation of OD Plan aligned to changes in Covid guidance which ensure staff are safely re-orientated back to offices.

Project Sponsor	Project Manager
Caroline Sinclair	Jean Campbell

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Staff working to respective partner hybrid working policies and coming into the building as needed.　• Wider accommodation review at KHCC underway to re locate staff groups within the building – captured as part of another project. No further work required in context of Covid.	• No further actions required in context of covid

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3, 5, 6	N/A	N/A	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✔	❌	✔	❌	❌

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-24 Unpaid work services backlog	▶	▶	90%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	24-Mar-2022

Project Description

Addressing the unpaid work services backlog and ensuring those sentenced are able to complete their hours and are not breaching any order.

Project Sponsor	Project Manager
Claire Carthy	Alex O'Donnell

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Work continues to address the backlog and we are confident that no orders will be breached due to lack of opportunity to complete hours.	• Continue to ensure our performance targets are met.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	4	N/A	• Enable those sentenced to complete unpaid work hours.	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✔	✘

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-25 Joint Commissioning Plan for Unscheduled Care	▶	▶	75%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board		
31-Mar-2023	31-Mar-2023			

Project Description				
Implementation of 22/23 actions within the Joint Commissioning Plan for un scheduled care including the establishment of a frailty hub and spoke model.				

Project Sponsor	Project Manager
Derrick Pearce	Eleanor Hughes; Fiona Munro; Alison Willacy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Home First Response daily huddles commenced with QEH. • Frailty Practitioner recruited and in post. • Framework to support Frailty Practitioner competencies has been developed. • CAPA completed test of change and continuing to embed programme across East Dunbartonshire Care Homes. • Participating fully in board wide Discharge Without Delay programme.	• Implement model of enhanced overnight care and support, at pace of recruitment successes • Continue to progress CAPA Project based on findings from pilot programme. • Utilise Delayed Discharge Tracker to inform and improve performance management • More rigours scrutiny and structure being put in place to review 10 day plus patients and review at 24, 48 and 72 hours post admission.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time

Decision Required
There are no decisions required

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	5, 6	N/A	N/A	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✔	❌	✔	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-26 Delivery of a range of measures to support staff wellbeing.	▶	▶	90%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board	
31-Mar-2023	31-Mar-2023	N/A	

Project Description
Delivery of a range of measures to support staff wellbeing and support options

Project Sponsor	Project Manager
Tom Quinn	Tom Quinn

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Activity calendars now published through the SMT and Staff forum for the period Jan – March 2023, focus is on Physical, Mental and Financial wellbeing and includes dates for information sharing based coffee mornings. • Snack food available from all base locations from January 2023. • Individual relaxation sessions extended through Edvar.	• Looking to organise at least 2 resilience conversation session before end of March 2023. • Work is starting to focus on the period April – Sept 2023.

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time

Decision Required
There are no decisions required

Benefits				
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3, 5, 6	N/A	N/A

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✔	❌	✔	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-27 Implementation of the recommendations from the Public Dental Service review Programme Board	▶	🔴	25%	Red – Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	

Project Description
Implementation of the recommendations from the Public Dental Service review Programme Board

Project Sponsor	Project Manager
Lisa Dorian	Karen Gallacher

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Agreement to revisit recommendations to ensure continued relevance, and to establish additional recommendations need to be added.	• Develop implementation plans to reflect revised/updated recommendations. Ensure ongoing work feeds into development of new Board Primary Care Strategy and paediatric pathway work.

Key Issues and Risks Requiring Escalation
The pandemic had a significant impact on this programme of work, the review was completed pre Covid but the implementation was stalled. The PDS review has now been re-reviewed due to the impact of the pandemic on services and an implementation plan is being drawn up. This action will be carried forward and delivered in 23/24.

Decision Required
There are no decisions required.

Benefits				
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3, 5, 6		• To maximise current and future estate, that is fit for purpose and future proof • To review service delivery model to identify gaps in staff resources and skill mix • To ensure focus on providing appropriate clinical care to those most in need • To ensure the Public Dental Service is part of the Board's Digital Strategy

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	❌	✔	✔	✔

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-29 Review engagement framework to support collaborative approach with third and independent sector	▶	✅	100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	30-Aug-2022

Project Description
Review engagement framework to support collaborative approach with third and independent sector.

Project Sponsor	Project Manager
David Aitken; Gillian Healey	Gillian Healey

HIGHLIGHT REPORT	
Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Project complete	• Proposal approved by SMT – revised provider forum structure and format to be implemented

Key Issues and Risks Requiring Escalation
There are no significant risks or issues at this time.

Decision Required
The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3, 5, 6	N/A	N/A	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✖	✖

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-22-30 Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)	▶	▶	85%	Green – Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2023	31-Mar-2023	N/A

Project Description
Conclude implementation of the Primary Care Improvement Plan Memorandum of Understanding (2)

Project Sponsor	Project Manager
Derrick Pearce	James Johnstone; Dianne Rice

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Update includes delivery up to January 2023 and remaining actions up to the end of March 2023.	• Review and evaluate current levels of delivery against plan and models of delivery in place. • Continue to review accommodation levels and financial framework – reporting to SG and IJB as required. • Continue with engagement sessions with General Practice. • Deliver Practice staff engagement and training session(s) • Deliver protected development session for Practice Mangers. • Re-establish links with Primary Care colleagues as part of Covid recovery.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3, 5, 6	N/A	N/A

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✅	✅	✅	❌	❌

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP–22–31 Property Strategy development and implementation	▶	✅	100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31–Mar–2023	31–Mar–2023	24–May–2022

Project Description

Development of an HSCP Property Strategy which reflects and delivers on the priorities to support delivery of PCIP, wider HSCP property requirements and maximises opportunities related to hybrid working

Project Sponsor	Project Manager
Jean Campbell	Vandrew McLean

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Capital funding secured from NHS Board to progress shop front options in Milngavie and Bishopbriggs – majority of programme to continue into next financial year, preparatory work underway, project board being established. • Procurement process underway for to progress feasibility studies within existing premises to maximise use of current space.	• Next stages of programme to update East Dunbartonshire HSCP Property Strategy, conclude feasibility studies on existing premises – Milngavie Clinic, Woodlands, KHCC to maximise use of existing space within building and work with NHS Estates to progress refurbishment works within shop front options will continue within the 2023/24 Annual Delivery Plan.

Key Issues and Risks Requiring Escalation

Procurement timescales for feasibility studies progressing in this financial year to inform capital programme for HSCP going forward. Delay to build timescales for refurbishment of shop front premises.

Decision Required

The HSCP Transformation Board is asked to agree on closure of this project as it is complete.

Benefits					
Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits	
N/A	N/A	3, 5, 6	N/A	N/A	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
❌	✅	❌	✅	❌	✅

East Dunbartonshire HSCP
Financial Planning 2022/23 - Savings Programme   APPENDIX 3

Workstream	Action	Project Lead	Full Year Approved Saving 22/23	Full Year Achieved Saving 22/23
	Service Redesign (21/22 Savings Cfwd)			
Policy	Fair Access to Community Care	David	140	140
Efficiency / Service Improvement	Children's Services 'House' Project Development	Claire	200	200
	Total C/fwd Savings 21/22		**340**	**340**
	New Savings 22/23			
Efficiency / Income Generation	Charging for Telecare	Derrick	10	0
Efficiency	OP Daycare Commissioning - review	Derrick	51	51
Efficiency	Management Savings	Derrick	48	48
	Total New Savings 22/23		**109**	**99**
	Total Savings Programme 22/23		**449**	**439**

HSCP Transformation Programme 2022/23
Completed/Concluded Projects
Ranking from Highest Priority to Lowest – Assessed by the Priority Scoring Matrix

Priority Scoring	Title	Current Due Date	Comments	Indicative Full Year Financial Benefit	Estimated Financial Benefit 2022/23
-	Mainstream testing	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 25 November 2022.	N/A	N/A
-	Refresh and streamline PPE arrangements	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 25 November 2022.	N/A	N/A
-	Development of Annual Strategic Delivery Plan for 22/23	March 2023	Project completed. Transformation Board agreed closure of this project at the meeting held on 30 August 2022.	N/A	N/A

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**21st MARCH 2023**
REPORT REFERENCE:	**PERF/210323/05**
CONTACT OFFICER:	**ALAN CAIRNS / ALISON WILLACY (J/S) PLANNING, PERFORMANCE AND QUALITY MANAGER**
SUBJECT TITLE:	**HSCP QUARTER 3 PERFORMANCE REPORT 2022-23**

1.0 PURPOSE

1.1 The purpose of this draft report is to update the Committee on the HSCP Board of progress made against an agreed suite of performance targets and measures, relating to the delivery of the HSCP strategic priorities, for the period October to December 2022 (Quarter 3).

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Note the contents of this report; and

2.2 Consider the Quarter 3 Performance Report 2022-23 at **Appendix 1**.

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 The 2022-23 HSCP Quarter 3 Performance Report contains a range of information, most of which is available and complete for the full reporting period.

3.2 This report is currently in draft format and not for onward circulation pending IJB approval at its meeting on the 23rd March 2023.

3.3 There are routine delays with the publication of validated data by Public Health Scotland, due to incomplete hospital-derived data in Section 3 of the report and the timing of certain waiting times data publications. In order to provide an indication of up to date performance in these areas, Greater Glasgow and Clyde Health Board's own hospital-derived activity data has been included. These are presented in a way that also permits summary comparison of our performance against targets and with other HSCP areas across the Health Board area. The methodology of local Health Board data differs in aspects from national data publications, so is not precisely comparable. However it provides an accurate proxy set of data while waiting for published national figures.

3.4 The new Child Protection National Guidance has resulted in changes in terminology and timescales for the stages within the national child protection process. What was previously known as an Initial Child Protection Case Conference (6.2) is now known as an Initial Child Protection Planning Meeting and the associated national target timescales have changed from 21 days to 28 days. The associated national target timescales for First Child Protection Review Conference (6.3) has also changed from 3 months to 6 months.

3.5 The Performance Audit and Risk Committee are invited to consider performance across each of the indicators and measures, which are aligned to the delivery of the national Health and Wellbeing Outcomes and the HSCP strategic priorities.

4.0 IMPLICATIONS

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022 – 2025 Priorities;-

1. Empowering People
2. Empowering Communities
3. Prevention and Early Intervention
4. Public Protection
5. Supporting Carers and Families
6. Improving Mental Health and Recovery
7. Post-pandemic Renewal
8. Maximising Operational Integration

4.2 Frontline Service to Customers – None.

4.3 Workforce (including any significant resource implications) – None.

4.4 Legal Implications – None.

4.5 Financial Implications – None.

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None.

4.11 Other – None.

5.0 <u>MANAGEMENT OF RISK</u>

The risks and control measures relating to this Report are as follows:-

5.1 None

6.0 <u>IMPACT</u>

6.1 **STATUTORY DUTY** – None

6.2 **EAST DUNBARTONSHIRE COUNCIL** – The report includes indicators and measures of quality and performance relating to services provided by the Council, under Direction of the HSCP Board.

6.3 **NHS GREATER GLASGOW & CLYDE** – The report includes indicators and measures of quality and performance relating to services provided by NHS Greater and Clyde, under Direction of the HSCP Board.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction required.

7.0 <u>POLICY CHECKLIST</u>

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 <u>APPENDICES</u>
8.1 **Appendix 1** – HSCP Quarter 3 Performance Report 2022-23

PERFORMANCE REPORT 2022-23 QUARTER 3 DRAFT

SECTION 1
Introduction

This HSCP Quarterly Performance Report provides an agreed suite of measures that report on the progress of the priorities set out in the Strategic Plan. Information is reported from national and local NHS sources and East Dunbartonshire Council sources to provide the most up to date information available. For clarity and ease of access, the data are set out in defined sections in accordance with where the data are sourced and reported. However, all the indicators set out in Sections 3-5 are inter-dependant; for example, good performance in social or health care service targets can contribute to improved performance elsewhere across the whole system.

Each indicator is reported individually. Charts and tables are provided to display targets, trend data, and where available, improvement trajectories. A situational analysis is provided to describe activity over the reporting period, and improvement actions are provided for all indicators that are below target.

Covid-19 Pandemic Impact:

The Covid-19 pandemic impacts on a number of the performance metrics covering 2022-23 with the diversion of health and social care resources to support the crisis response, as well as service access challenges during periods of high levels of community and hospital disease transmission.

The HSCP has business continuity plans in place to guide the delivery of essential services. Covid-19 Recovery and Transition Plans are also in place which guide service recovery through and out of the pandemic. During ongoing response planning we will be working across service areas in collaboration with partner organisations, service users and the wider community to maintain and re-establish service provision to meet the needs of our residents.

The sections contained within this report are as listed and described below.

Section 2: Performance summary
This section provides a summary of status of all the performance indicators provided in this report by indicating which indicators have improved and which have declined.

Section 3: Health & Social Care Delivery Plan
The data for unscheduled acute care reported in this document is provided by National Services Scotland for the Ministerial Steering Group for Health & Social Care (MSG). This section provides the latest available data for those indicators identified as a priority by the MSG.

Section 4: Social Care Core Indicators
This is the updated report of the Social Care core dataset, provided by EDC Corporate Performance & Research team.

Section 5: NHS Local Delivery Plan (LDP) Indicators
LDP Standards refer to a suit of targets set annually by the Scottish Government, and which define performance levels that all Health Boards are expected to either sustain or improve.

Section 6: Children's Services Performance
This is the updated report of Children's Services performance, provided by EDC Corporate Performance & Research team.

Section 7: Criminal Justice Performance
This is the updated report of the Criminal Justice performance, provided by EDC Corporate Performance & Research team.

Section 8: Corporate Performance
Workforce sickness / absence, Personal Development Plans (PDP) & Personal Development Reviews (PDR) are monitored, and reported in this section.

This section of the quarterly report ranks each of the performance indicators and measures that feature in the report against a red, amber and green (RAG) rating, reflecting activity against targets and improvement plans.

As a result of the Covid-19 pandemic, presenting need, demand, service activity, performance and impact have been significantly affected in ways that affect the metrics and interpretations that are normally used to measure performance.

We have re-introduced the pre-Covid summary RAG rating (below), but caution should continue to be applied to interpretation. Full information on the impacts on performance is set out for each individual measure within the report.

✅ Positive Performance (on target) improving

✅ Positive Performance (on target) declining

❌ Negative Performance (off target) improving

❌ Negative Performance (off target) declining

✅ **Positive Performance (on target & maintaining/improving)**

4.1	Number of homecare hours per 1,000 population 65+
4.3	Percentage of service users (65+yrs) meeting 6wk target
4.5	% of Adult Protection cases where timescales are met
4.6	Adult Social Work: Service User Personal Outcomes
5.2	% of people waiting <18 weeks for psychological therapies
5.6	Child and Adolescent Mental Health Services (CAMHS) waiting times
6.1	Child Care Integrated Assessments (ICAs) submission timescales to Reporters Administration
6.2	% of Initial Child Protection Planning Meetings taking place within Child Protection National Guidance
6.3	% of first Child Protection review conferences taking place within 6 months of registration
6.6	% of children receiving 27-30 months assessment
7.1	% of individuals beginning a work placement within 7 days of receiving a Community Payback Order

7.3	Percentage of Court Report Requests Allocated to a Social Worker within 2 Working Days of Receipt

✅ Positive Performance (on target but declining)

4.2	Percentage of People Aged 65+yrs with Intensive Needs Receiving Care at Home
7.2	% of Criminal Justice Social Work reports submitted to court on time

❌ Negative Performance (below target but maintaining/improving)

3.1	Number of unplanned acute emergency admissions
3.2	Number of unscheduled hospital bed days
3.3	Quarterly Number of Delayed Discharge Bed Days
6.4	% of children being Looked After in the community

❌ Negative Performance (below target and declining)

3.4	Number of Accident and Emergency attendances (all ages)
5.1	Percentage of People Waiting <3wks for Drug & Alcohol Treatment
5.3	% of people newly diagnosed with dementia receiving post diagnostic support
5.4	Total number of ABIs delivered
5.5	Smoking quits at 12 weeks post quit in the 40% most deprived areas
6.5	% of first Looked After and Acccommodated Children (LAAC) reviews taking place within 4 weeks of accommodation
8.5 / 8.6	NHS Knowledge & Skills Framework and Council Performance Development Review achievement against target (EDC sickness absence data is unavailable)

The following targets relate to unscheduled acute care and focus on areas for which the HSCP has devolved responsibility. They are part of a suite of indicators set by the Scottish Government, and all HSCPs were invited to set out local objectives for each of the indicators. They are reported to and reviewed quarterly by the Scottish Government Ministerial Strategic Group for Health & Community Care (MSG) to monitor the impact of integration. Delays can occur with completeness of hospital-based data, so these tables and charts are based upon the most recent reliable data relevant to the reporting period (minimum 95% complete).

- **3.1** Emergency admissions
- **3.2** Unscheduled hospital bed days; acute specialities
- **3.3** Delayed Discharges
- **3.4** Accident & Emergency Attendances

3.1   Emergency Admissions

Rationale: Unplanned emergency acute admissions are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting.
Aim = to minimise.

Table 3.1: Quarterly Number of Unplanned Acute Emergency Admissions

Q3 2021-22	Q4 2021-22	Q1 2022-23	Q2 2022-23	Q3 2022-23	Target (2022-23)
2,520	2,526	2,675	2,665	Full Q3 not available	2,351

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.1a: Rolling Year Number of Unplanned Emergency Admissions*

Emergency Admissions Performance Against Target (aim = to minimise)
(Monthly figures are rolling year)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Target	11763	11326	10394	11284	9918	9403	9403	9403	9403	9403	9403	9403	9403	9403	9403	9403	9403	9403	9403
Actual	11771	11340	10339	10675	10888	9057	10226	10249	10251	10272	10238	10327	10386	10494					

*Based on availability of complete data for quarter at time of report – subject to update

Figure 3.1b: Unplanned Emergency Admissions by Age Group

Number of Emergency Admissions by Age-Group

Month	65+	18-64yrs
July-21	488	338
Aug-21	428	290
Sept-21	403	308
Oct-21	407	298
Nov-21	464	296
Dec-21	452	284
Jan-22	443	338
Feb-22	417	288
Mar-22	465	317
Apr-22	499	316
May-22	468	322
June-22	466	310
July-22	469	315
Aug-22	487	321
Sept-22	447	309
Oct-22	518	311

Situational Analysis:

The number of people being admitted unexpectedly to hospital is a key indicator of how well we are doing to maintain people in their own homes, particularly later in life.   It is also a proxy indicator of the level of complexity being managed in the community, and how much of a burden of disease is potentially being experienced by our residents.

Since the height of the Covid pandemic, when emergency admissions reduced substantially, admissions have, since the start of 2021-22, shown a steady increase and we have been in excess of our target for admissions since May 2021.

Improvement Actions:

The HSCP continues to deliver on our local Unscheduled Care plan in partnership with the acute sector. Improvement activity is focused on the continued development of the Home First Response Service at the Queen Elizabeth University Hospital with corresponding expanded and enhanced community based rehabilitation services, providing rapid assessment to assist in the prevention of admission and expedite discharge from acute services. Learning from the Covid-19 experience has and is being used to inform ways of working, this includes the expansion of falls prevention work in care homes and an increase in access to advanced clinical decision making in community services through our Advanced Practitioner cohort. Key to this work will be to ensure that behind these trends, people are not having proper diagnosis and treatment compromised.
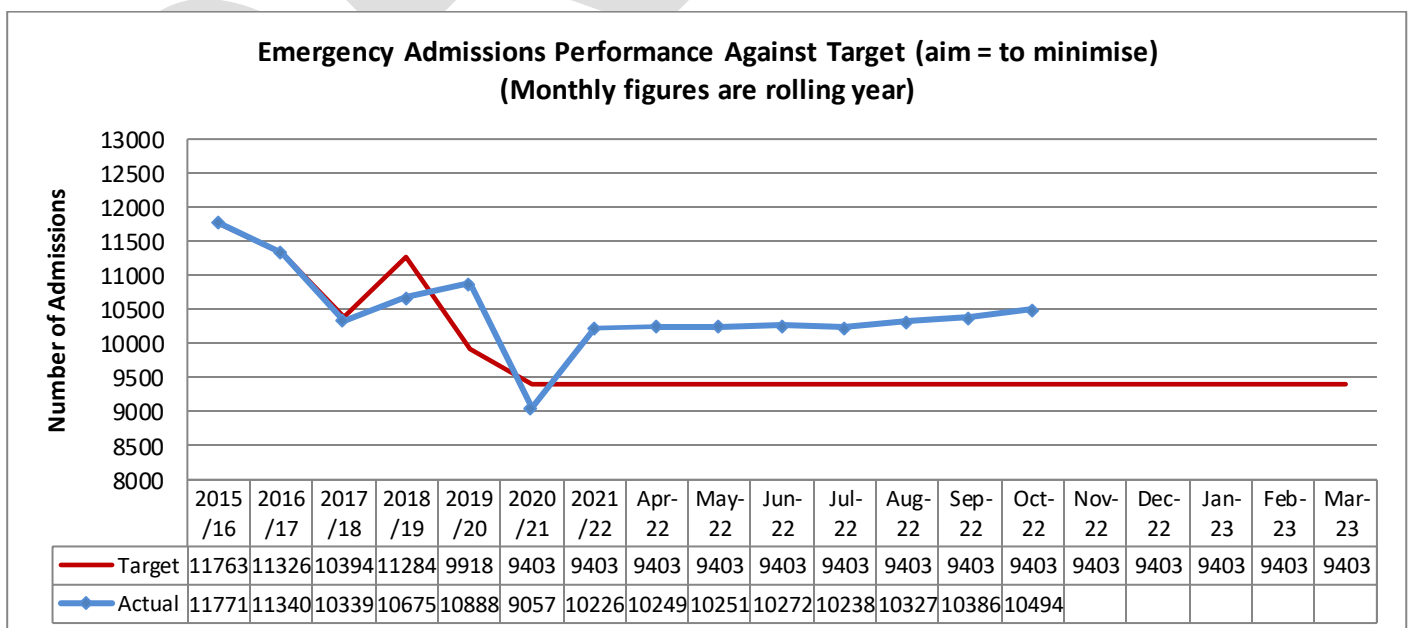
3.2 Unscheduled hospital bed days; acute specialities

Rationale: Unscheduled hospital bed days are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting.
Aim = to minimise

Table 3.2: Quarterly number of Unscheduled Hospital Bed Days (all ages)

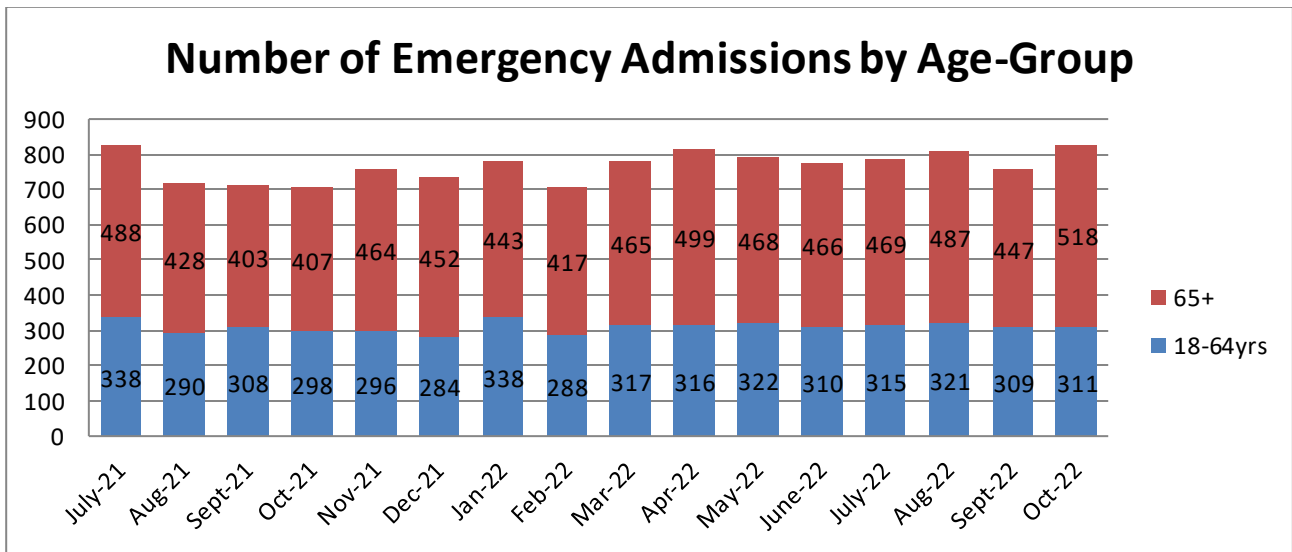| Q3 2021-22	Q4 2021-22	Q1 2022-23	Q2 2022-23	Q3 2022-23	Quarterly Target (2022-23)
21,643	22,392	22,797	22,717	Full Q3 not available	20,181

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.2a: Rolling year number of Unscheduled Hospital Bed Days

Emergency Bed Days Against Target (aim to minimise)
(Monthly figures are rolling year)

	2015/16	2016/17	2017/18	2018/19	2019-20	2020-21	2021-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Target	83286	81767	81229	79806	76927	80723	80723	80723	80723	80723	80723	80723	80723	80723	80723	80723	80723	80723	80723
Actual	83296	81808	81660	81973	85929	75757	86652	87805	88266	88134	88725	89293	89549	88512					

Figure 3.2b: Number of Unscheduled Admissions/Hospital Bed Days by Age Group *

Emergency Admissions & Unscheduled Bed Days by age group*

	<18yrs	18-64yrs	65+
Bed days	496	4,268	17,953
Admissions	317	945	1,403
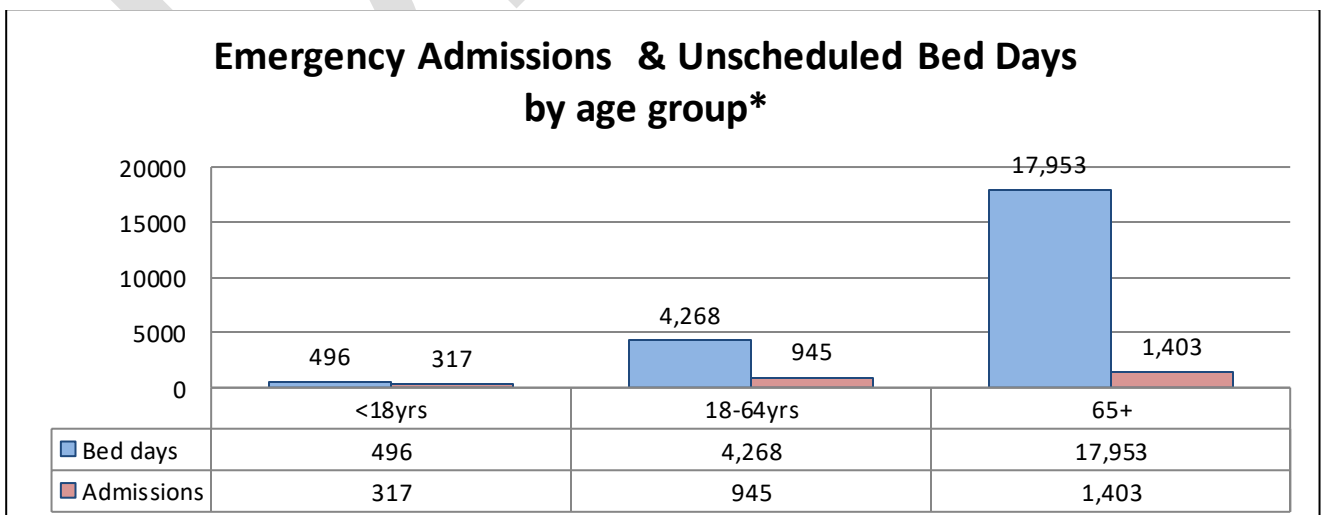
*Based on most recent complete 3 month data period (July to September, >=98% complete)

Situational Analysis:

This indicator describes the number of bed days in secondary care used by patients who have been admitted unexpectedly. Fig 3.2a illustrates what was a challenging trend away from the target trajectory over the years to 2019-20, the short term impact of the pandemic significantly reversed this trend during 2020-21. The "bounce-back" during 2021-22 which has been sustained into quarter 2 of 2022-23, has taken emergency bed days back to pre-Covid levels and off-target. This is linked to the increasingly complexity and frailty of people from East Dunbartonshire admitted as an emergency, and the impact of their experience during the pandemic on their suitability/safety for immediate discharge home. The most recent rolling year published data to October 2022 shows a slight downturn in bed days.

Improvement Actions:

As in normal circumstances, our primary focus continues to be on prevention of admission, where possible, so that unnecessary accrual of bed days is avoided. This continues to be an important component of managing hospital capacity. Improvement activity continues to include daily scrutiny of emergency admissions and proactive work with identified wards to facilitate safe discharge. This operates alongside further proactive work to support people currently in our services who are at greatest risk of admission via activity such as falls prevention, polypharmacy management and anticipatory care planning. As referenced above, new developments are being progressed to support the turnaround of patients who present to emergency departments who can be supported towards a planned rather than emergency episode of care by tailoring community support at home, or to provide this as soon after an avoidable admission as possible.

3.3 Delayed Discharges

Rationale: People who are ready for discharge will not remain in hospital unnecessarily.
Aim = to minimise

Table 3.3: Quarterly Number of Delayed Discharge Bed Days (18+)*

Q3 2021-22	Q4 2021-22	Q1 2022-23	Q2 2022-23	Q3 2022-23	Quarterly Target (2022-23)
1,438	1,742	1,989	1,813	**Full Q3 not available**	1,210

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.3a: Rolling year number of Delayed Discharge Bed Days (18+)

Delayed Discharge Bed Days - Rolling Year (aim = to minimise)
(performance against target trajectory)

Legend:
- Target trajectory
- Actual
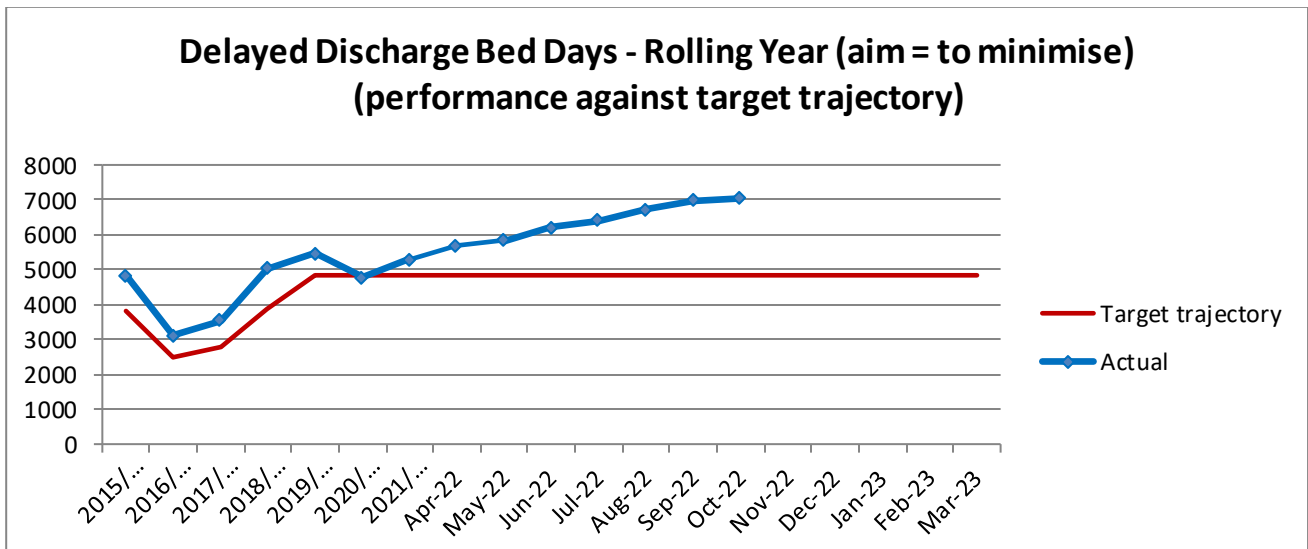
Figure 3.3b: Number of Delayed Discharges by Age and Reason

Delayed Discharge by Age Group & Reason*

	18-74yrs	75+yrs
Patient/family/carer	9	10
Health & Social Care	189	1041
Code 9	162	402

*Based on most recent complete 3 month data period (July to September 2022)

Situational Analysis:

Facilitating discharge from hospital when a patient is clinically fit to return home is an important component of the health and social care whole system. This ensures that people are supported safely at home where possible, reduces the loss of independence and de-habilitation that can occur while an inpatient and allows hospital resources to be used for people in need of clinical care. National data is only available to October 2022, but figure. 3.3a illustrates the very challenging circumstances that continue to be experienced nationwide in relation to patients delayed in their discharge. The HSCP continues to be confident and can evidence significant efforts in relation to delayed discharges. The HSCP recognise the specific challenge for us regarding complex cases (particularly where patients are subject to Adults with Incapacity legislation), is the impact of the sustained throughput of our delayed patients, our experience of the nationwide

challenges in securing care at home and the emotionally charged nature of choosing to place a loved one in long term care when a return to home is not possible.

Improvement Actions:
Use of electronic operational activity "dashboards" continues to enable local oversight of community patients who have been admitted to hospital so that a response can be made quickly, prior to these patients being deemed fit for discharge. The HSCP can also see patients who have been admitted who are not currently known to us, again allowing early intervention. In addition, all of the actions described in the previous indicator around prevention of admission are relevant to avoiding delayed discharges. Home for Me continues to coordinate our admission avoidance and discharge facilitation work (including discharge to assess) across a range of services. Attempts to expand the care at home component of the service have been thwarted by the nationally experienced workforce challenges in social care where recruitment has not been fruitful. The HSCP continue to work closely with care homes and continuously develop our Care Homes Support team, and have attempted to increase our use of interim placement in line with Scottish Government expectations and recent funding. Acceptance of a move to interim care remain at the choice of the individual and their family, however, and cannot be mandated by the HSCP.

3.4 Accident & Emergency Attendances

Rationale: Accident & Emergency attendance is focussed on reducing inappropriate use of hospital services and changing behaviours away from a reliance on hospital care towards the appropriate available support in the community setting. Aim = to minimise

Table 3.4 Quarterly Number A&E Attendances (all ages)*

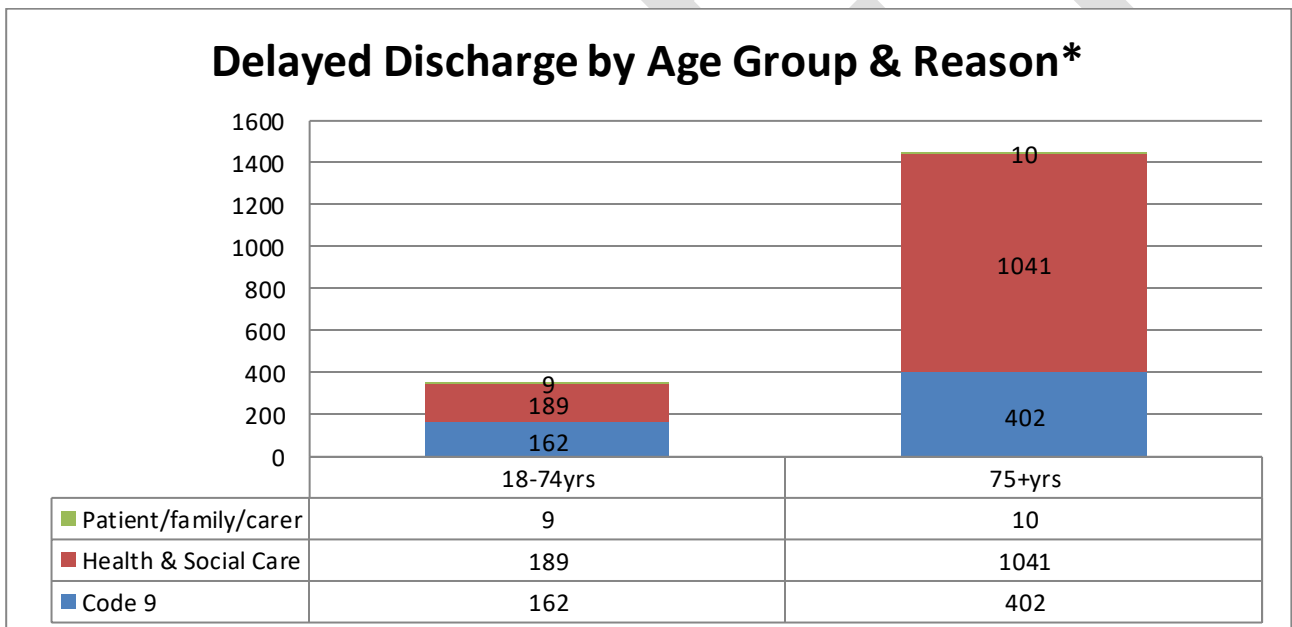| Q3 2021-22	Q4 2021-22	Q1 2022-23	Q2 2022-23	Q3 2022-23	Quarterly Target (2022-23)
6,226	6,441	6,961	7,059	Full Q3 not available	6,740

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.4a: Rolling year number of A&E Attendances

A&E Attendance Rolling Year (aim = to minimise) (performance against target trajectory)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-23
Target	27122	27289	27719	26037	27122	26962	26962	26962	26962	26962	26962	26962	26962	26962	26962	26962	26962	26962
Actual	27122	27384	27756	28322	28042	19854	26935	26850	27078	26940	26739	26787	26687	26782				

Figure 3.4b: A&E Attendances Admitted to Hospital by Age Group

A&E Attendance / Admissions by Age Group

	<18yrs	18-64yrs	65+yrs
Attendances that did not become Admissions	1,748	2,206	440
Attendances that became Admissions	317	945	1,403
Total number of Attendances	2,065	3,151	1,843

*Based on most recent complete 3 month data period, July to September 2022 (>=95%)

Situational Analysis:

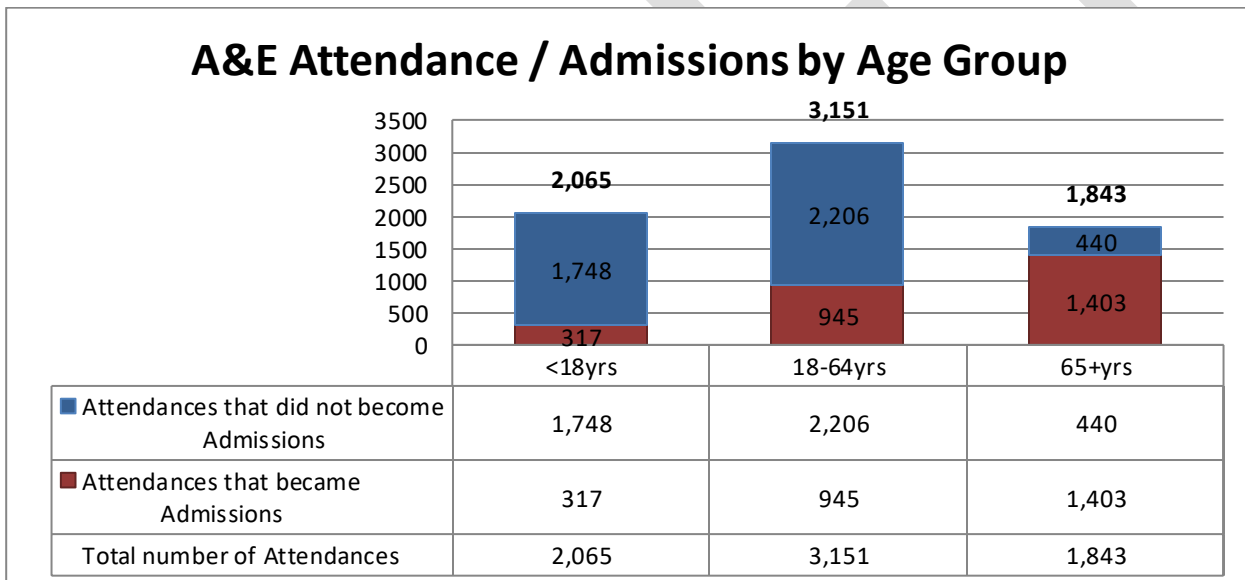Pre-Covid, East Dunbartonshire had the second lowest level of emergency department attendances, per 1,000 population, across Greater Glasgow and Clyde which has continued since then. After a very steep reduction in attendances during the first year of the pandemic, attendances have still to return to pre-Covid levels (as shown at 3.4a), however attendance levels are currently on-target for the 2022-23 year to date.

The data at 3.4b shows the proportion of those who attended A&E who were subsequently discharged, suggesting that a significant number of those in the younger age-groups attending A&E could have had their needs met in the community or via self-care. In order to address this on a national level "Right Care, Right Place" is now operating across Scotland. Scotland's new approach to urgent care has those with non-life threatening conditions who would usually visit an emergency department first, asked to call NHS 24

day or night on 111 through the NHS Board's Flow Navigation Hub. People can also continue to call their GP practice for urgent care or access help online from NHS Inform.

Improvement Actions:
From an HSCP perspective we continue to progress all developments supporting the transformation of patient access to the right advice and support from the appropriate professional and/or alternative community resources. Additionally, as referenced above, we are improving our response to people attending hospital following emergency conveyance or self-presentation – initially at the Queen Elizabeth University Hospital with plans to expand to the Glasgow Royal Infirmary through the Home First response service and our pre-existing local services.

3.5 Local Data Updates and Benchmarking

As indicated at the start of this section, the data reported in this report is provided as part of a national publication by Public Health Scotland (PHS). Data linkage and verification results in a time-lag, which explains why the most recent reporting month is December 2022 for a number of these core indicators.

In order to provide a local update to these figures, the table below is included here. This table is populated with NHSGGC data, which applies a slightly different methodology to PHS but is accurate for use as proxy data to show more up to date figures. The table compares our performance for the reporting year to date against target and against other HSCP's in Greater Glasgow and Clyde. As indicated above, the Covid-19 pandemic continues to significantly impact the pattern of unscheduled care during the reporting period:

East Dunbartonshire HSCP Unscheduled Care
Data Summary: April to December 2022

Measure	Actual (Year to Date)	Target (Year to Date)	Target RAG*	Rank in GGC (most recent month)
Emergency Dept. Attendances (18+)	13,879	14,756		2
Emergency Admissions (18+)	6,961	7,052		4
Unscheduled bed days (18+)	73,700	60,542		4
Delayed discharge bed days (all ages)	5,420	3,629		2

* RAG rating used:
   Green: equal to or ahead of target (ahead of target is 'positive')
   Amber: off-target by less than 10% (off-target is 'negative')
   Red: off target by 10% or more

(Source: NHSGGC - East Dunbartonshire HSCP Analysis)

This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council's Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in the Health and Social Care Annual Delivery Plan and HSCP Unscheduled Care Plan.

    4.1   Homecare hours per 1,000 population aged 65+yrs
    4.2   People aged 65+yrs with intensive needs receiving care at home
    4.3   Community assessment to service delivery timescale
    4.4   Care home placements
    4.5   Adult Protection inquiry to intervention timescales

4.1   Homecare hours per 1,000 population aged 65+yrs

Rationale: Key indicator required by Scottish Government to assist in the measurement of Balance of Care.
Aim = to maximise in comparison to support in institutional settings

Figure 4.1: No. of Homecare Hours per 1,000 population 65+ (IHSC-89-LPI-6)

	Q3	Q4	Q1 (22/23)	Q2	Q3
Actual	474.14	476.51	483.33	483.1	492.69
Target	389	389	389	389	389
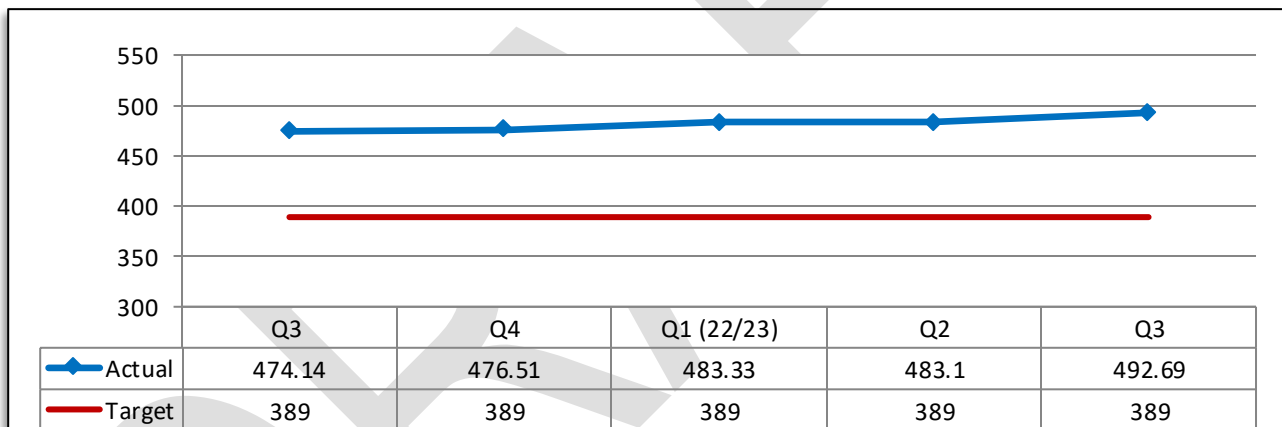
Situational Analysis:
This indicator was first established nationally to measure the extent of community-based support, in comparison with institutional care. The number of homecare hours per 1,000 population over 65 is continuing to be ahead of target for 2022-23 quarter 3. Whilst this demonstrates success in supporting people in the community, the increase is also a result of rising demand and complexity. Our analysis on the reasons for this rising demand point to the disproportionate increase in people aged 85+ in East Dunbartonshire, which has been the highest in Scotland over the past 10 years at +5% per year. We are projected to continue to have the fastest growing increase over the next 10 years. People aged 85+ overall have the greatest level of need in terms of volume and intensity of older people's health and social care services. Approximately 40% of people 85+ are in receipt of at least one social/personal care at home service.

Improvement Action:
Care at home is a cornerstone service in the community health and social care landscape. Performance in relation to maintaining people in their own home, facilitating people to die in

their preferred place of care and reducing the number of people living in long term care are all dependant on care at home.

The service continues to experience a sustained demand for service from customers who are presenting with more complex needs or whose needs have escalated or significantly changed, resulting in enhancements to the care package provided, and some customers have experienced a delay in their care package starting which is atypical in the East Dunbartonshire system. This illustrates the capacity pressures described throughout this report, and which are being actively managed by the service

4.2 People Aged 65+yrs with Intensive Needs Receiving Care at Home

Rationale: As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important. This target assures that home care and support is available for people, particularly those with high levels of care needs.
Aim = to maximise.

Figure 4.2a: Percentage of People Aged 65+yrs with Intensive Needs Receiving Care at Home (aim = to maximise) (HSCP-SOL-SW3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	30.7%	30.9%	31.2%	36.2%	34.4%
Target	32%	32%	32%	32%	32%
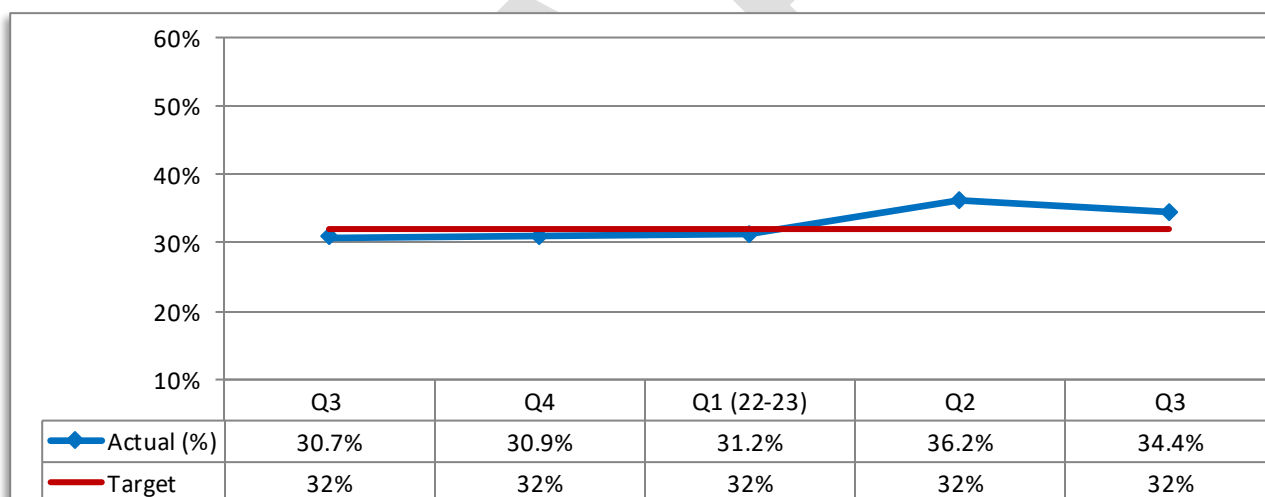
Situational Analysis:
This indicator is above target for quarter 3, 2022-23. The indicator measures the number of people over 65 receiving 10 hours or more of homecare per week, which is a historic measure of intensive support. Our policy is to support people with intensive care needs in the community as far as possible, traditionally the aim has been to maximise this value. However we also have to be mindful of the need to maximise independent living using "just enough" support rather than creating over-dependency. The increase during 2022-23 is reflective of higher levels of presenting need and complexity across the whole system. This is further supported by the 35% increase in the number of care at home customers requiring the assistance of two carers for each care visit in the last 6 months.
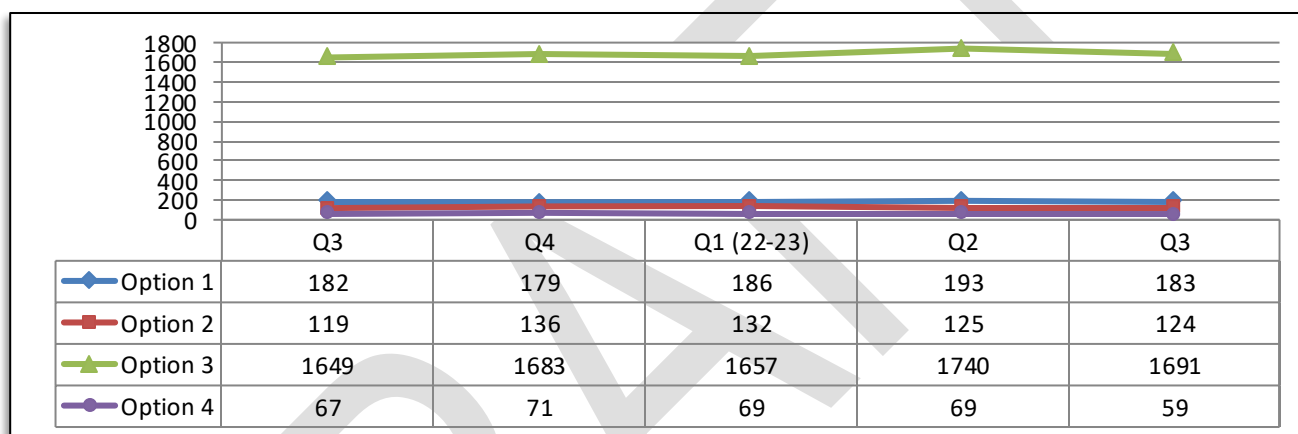
Improvement Action:
Our intention is to maintain good, balanced performance in this area, addressing capacity challenges and maximising rehabilitation and reablement opportunities wherever possible

for customers. The HSCP continue to experience challenges in meeting all demand for care at home services in house and through our commissioned provider partners. Workforce pressures remain the most common reason for capacity shortages. The service continue to meet excellent performance standards in undertaking reviews to ensure that optimum levels of care are provided, reducing packages where appropriate thus enabling care to be freed up for others. The in-house service continues to operate with very high levels of overtime use due to a sustained 10-12% vacancy factor particularly in relation to reablement and response carer cohorts.

4.2b Systems supporting Care at Home

Rationale: The following indicators contribute partly to support the previous indicators. They are important in improving the balance of care and assisting people to remain independent in their own homes, but do not have specific targets.

4.2b (i): Number of people taking up SDS options

	Q3	Q4	Q1 (22-23)	Q2	Q3
Option 1	182	179	186	193	183
Option 2	119	136	132	125	124
Option 3	1649	1683	1657	1740	1691
Option 4	67	71	69	69	59

Situational Analysis:

The indicators measure the number of people choosing Self Directed Support Options to direct their own support package. Their choice will be dependent upon the amount of control and responsibility that the customer or their family wish to take in arranging the delivery of care. None of the options are considered inferior to the other options and the statistics reflect customer choice.

This quarter has seen a slight decrease in Option 1, Option 2 and Option 4 which is indicative of the ongoing recruitment challenges facing the social care sector meaning that customers are finding it difficult to source their own agency or employ Personal Assistants. Option 3 has also seen a decrease, however we have seen an increase in people entering long term care and this may therefore be impacting on Option 3 at this time.

Option 1 – The service user receives a direct payment and arranges their own support
Option 2 – The service user decides and the HSCP arranges support
Option 3 – After discussing with the service user, the HSCP decides and arranges support
Option 4 – The service user uses a mixture of options 1-3.

Improvement Action:
We will continue to ensure that we provide Self Directed Support training to Social Work and Health practitioners to instil confidence and knowledge about the options amongst the

workforce. We will also continue to work in partnership with the Third Sector to raise awareness about self-directed support to local communities, customers and carers to ensure that the benefits associated with each option are fully explained and recognised.

4.2b (ii): People Aged 75+yrs with a Telecare Package (aim to maximise)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual	2359	2399	2425	2473	2544
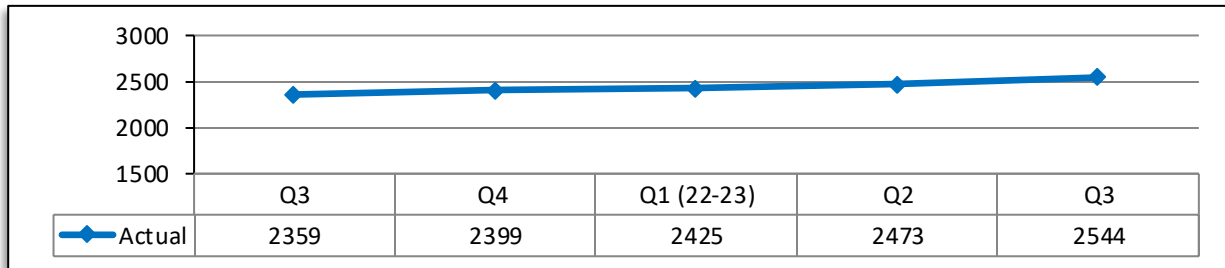
Situational Analysis:
There has continued to be a gradual increase in the number of people aged 75 and over with a telecare package. This is in line with expectations, as the population of people in East Dunbartonshire aged 75+ increases and telecare opportunities are maximised.

Improvement Action:
We continue to implement the actions of our Digital Health and Social Care Action Plan, seeking to link traditional telecare with telehealth monitoring and technology enabled care. The specification for a shared alarm receiving solution across all 32 Local Authorities is in the final stages which includes a shared data set for monitoring and reporting. The programme of work to transition telecare from analogue to digital channels is also progressing well.

4.3 Community Care Assessment to Service Delivery Timescale

Rationale The HSCP has a duty to undertake community care assessments for those in need, and are responsible for developing packages of care to meet identified need. The national standard is to operate within a six week period from assessment to service delivery, which encourages efficiency and minimises delays for service-users.
Aim = to maximise.

Figure 4.3: Percentage of service users (65+yrs) meeting 6wk target (Aim = to maximise) (HSCP-06-BIP-6)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	96.3%	98.8%	100%	94.1%	98.9%
Target	95%	95%	95%	95%	95%
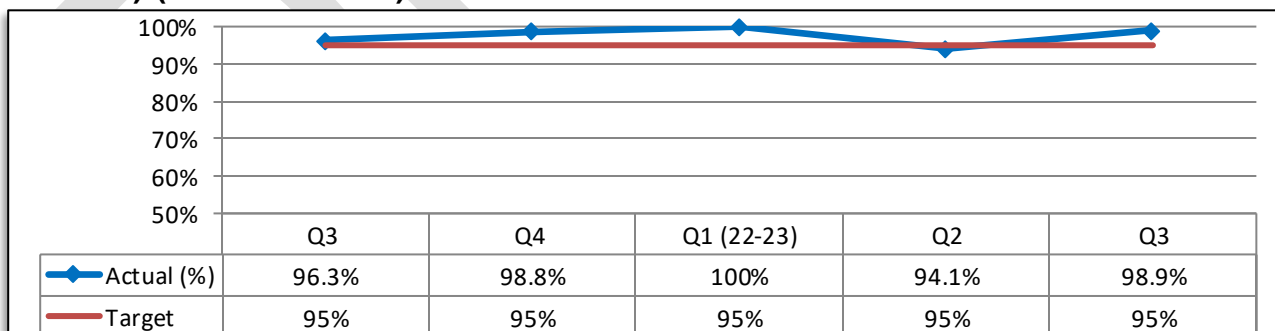
Situational Analysis:
The HSCP has reported consistently high levels of compliance against this indicator. Indeed, many people receive services well within the 6 week target from the completion of their community care assessment. In quarter 3 2022-23, this above target performance has been achieved again.

Improvement Action:

The focus is to continue to deliver high levels of performance in this area.

4.4   Care Home Placements

Rationale: The focus of the HSCP is to maximise opportunities for people to live active, independent lives for as long as possible which will prevent avoidable long term care placement. Aim = monitor care home placement numbers/maintain baseline

Figure 4.4a Number of People Aged 65+yrs in Permanent Care Home Placements (snapshot) (HCP-14-LPI-6)

	Q2	Q3	Q4	Q1 (22/23)	Q2
Number	674	676	673	695	724
Target	640	640	640	640	640
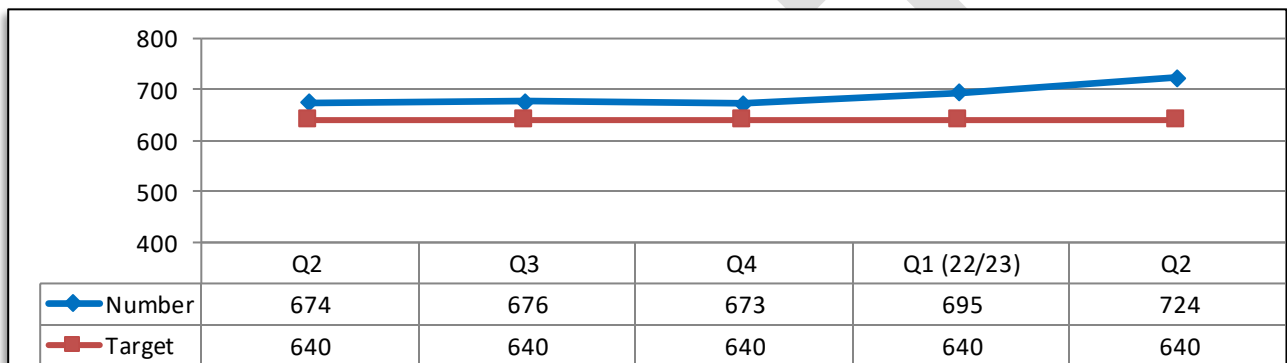
Figure 4.4b Number of Care Home Admissions and Discharges (including deaths) (HCP-13-LPI-6 & HSCP-AS-LPI-1)

	Q2	Q3	Q4	Q1 (22/23)	Q2
Admissions	64	74	67	82	80
Discharges	71	72	70	58	53
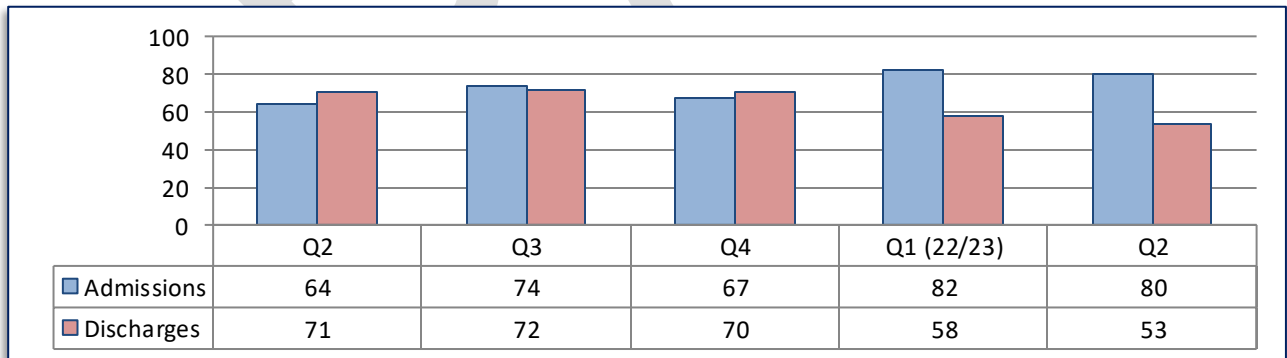
Situational Analysis:

Care home admissions are determined at an individual level, based upon an assessment of support needs and with consideration to the balance of care and cost thresholds. The HSCP policy is to support people in the community for as long as possible, which is generally the preference of the individual concerned. National and local policy is also geared towards carefully balancing the use of placements in long term care. Increases in care at home provision to older people demonstrates that this has been successful, but demand pressures continue across all service sectors and we have experienced an increase in cases where long term care need is indicated.

The availability of care home admission and discharge data is generally subject to time lag, due to transactional processes and recording, so the most recent data relates to July to September 2022. Admissions to Care Homes have returned to pre-Covid levels but continue to be affected by outbreaks of Covid-19 and other viruses which results in the Care Home being closed to admissions, or to staffing shortages impacting on the ability to accept new residents. Increases in admission during the reporting period reflect rises in levels and complexity of presenting needs across the whole system.

Improvement Action:
Work continues to analyse and manage care home admission pressures, taking into account the potential consequences, both personal and organisational, of long term care decision-making. Intensive support and assurance work is being provided by the HSCP for to care homes in the area, enhanced by the input of our integrated care homes support team.

4.5   Adult Protection Inquiry to Intervention Timescales

Rationale: The Health & Social Care Partnership have a statutory duty to make inquiries and intervene to support and protect adults at risk of harm. It is crucial that such activities are carried out in a timely and effective fashion. This indicator measures the speed with which sequential ASP actions are taken against timescales laid out in local social work procedures. Aim = to maximise.

Figure 4.5 Percentage of Adult Protection cases where timescales were met (Aim = to maximise) (HSCP-05-BIP-6)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	92.2%	94.9%	92.9%	94.1%	94.7%
Target	92%	92%	92%	92%	92%
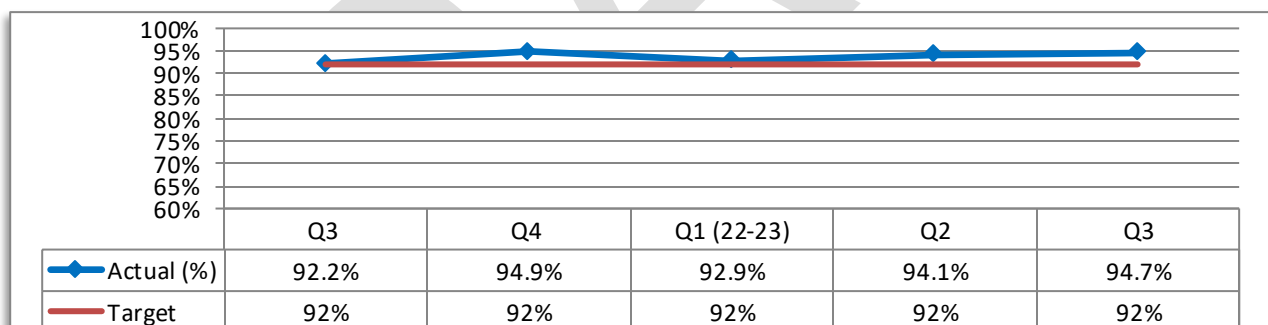
Situational Analysis:
Quarter 3 continued to see an above target performance despite fluctuating pressures on workforce capacity caused by variable COVID-19 infection rates over time. Business continuity measures continue to be applied as and when required.

Improvement Action:
Continue to pursue achievement of compliance with target timescales. Performance is regularly scrutinised by the Adult Protection Committee to identify improvement opportunities and these are progressed where possible. An updated national performance reporting framework has been developed with testing underway during 2022/23. Any necessary adjustments to reporting will be made once the framework has been agreed for implementation.

4.6 Adult Social Work: Service User Personal Outcomes (*new measure for 2022-23*)

Rationale: When preparing a support plan, social workers agree with service users the personal outcomes that and care and support should be aiming to meet. As a minimum, these should be designed to reduce risks from a substantial to a moderate level, but the arranging of informal support may additionally contribute to improving quality of life outcomes. When services are reviewed (at least annually), social workers consider with service users the extent to which these personal outcomes have been fully or partially met, or not met. This measure reports on the extent to which personal outcomes have been fully or partially met, with data on all reviews being collated for the period. Aim = to maximise.

Figure 4.6 Percentage of adults in receipt of services who have had their personal outcomes fully or partially met (Aim = to maximise) (HSCP-BIP-10)

	Q1 (22-23)	Q2	Q3
Actual (%)	100%	100%	100%
Target	90%	90%	90%
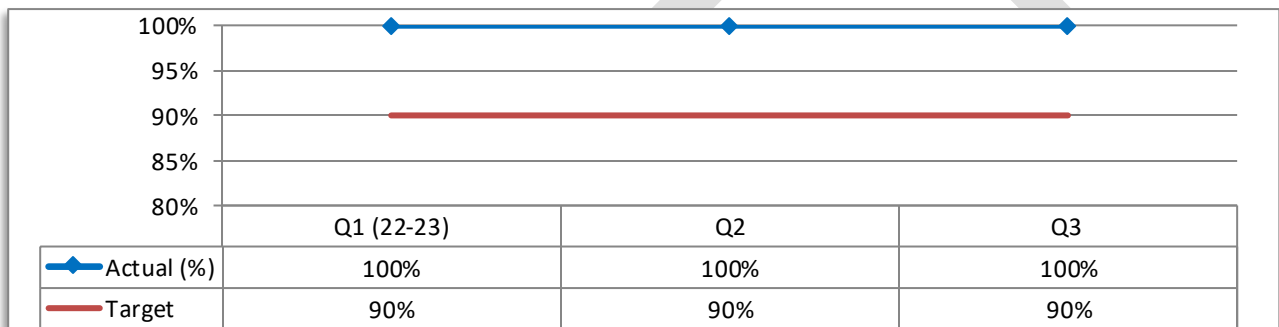
Situational Analysis:
Quarter 3 has reported strong performance again for this new indicator, at 100%, well above the target of 90%.

Improvement Action:
The aim is that social work assessment and support management remains focused and specific on improving agreed outcomes for the people we support. This data is also produced at a team level, to permit examination at a more granular level on how effectively support is being targeted towards measurably reducing risks and also improving quality of life by maximising the potential benefits of informal as well as formal supports options.

LDP Standards refer to a suit of targets, set by the Scottish Government, which define performance levels that all Health Boards are expected to either sustain or improve. This section reports on the Standards delivered by, or relevant to, the HSCP.

    5.1   Drugs & Alcohol Treatment Waiting Times
    5.2   Psychological Therapies Waiting Times
    5.3   Dementia Post Diagnostic Support
    5.4   Alcohol Brief Interventions
    5.5   Smoking Cessation
    5.6   Child & Adolescent Mental Health Services Waiting Times

5.1   Drugs & Alcohol Treatment Waiting Times

Rationale: The 3 weeks from referral received to appropriate drug or alcohol treatment target was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy. The first stage in supporting people to recover from drug and alcohol problems is to provide a wide range of services and interventions for individuals and their families that are recovery-focused, good quality and that can be accessed when and where they are needed.

Figure 5.1: Percentage of People Waiting <3wks for Drug & Alcohol Treatment (aim = to maximise)

	Q2	Q3	Q4	Q1 (22/23)	Q2
Actual (%)	88.3%	87.0%	91.7%	92.1%	88.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%
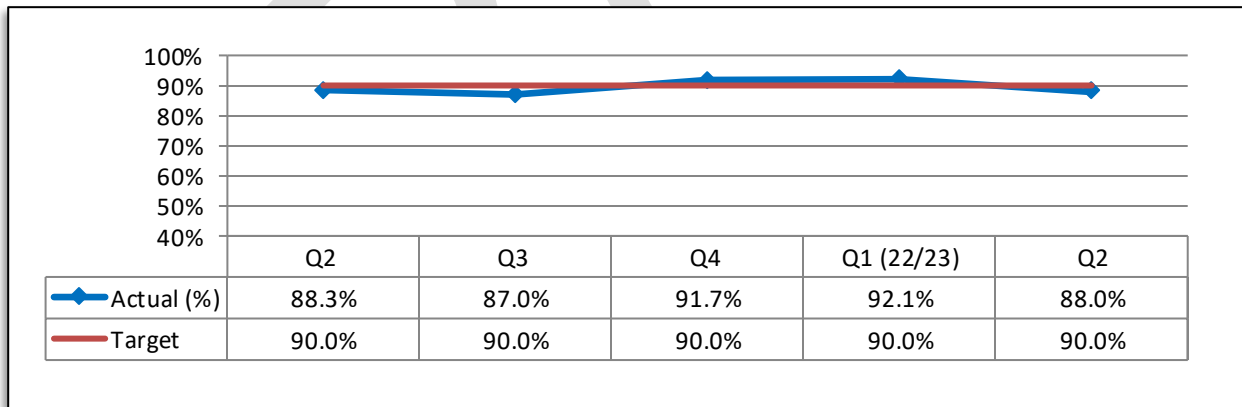
Situational Analysis:
2022-23 quarter 3 waiting time performance data had not been published at the time of preparing this report, so the most recent data relates to April – September 2022. Performance was slightly below target for this quarter after a steady improvement over the previous 12 months.

Improvement Action:

The team will continue to work to maintain and further improve performance in this area in the longer term utilising the DAISy database and are continuing to support staff in updating the database. The Alcohol and Drug Partnership (ADP) is also looking to increase capacity within the ADP support team and within the ADRS.

5.2 Psychological Therapies Waiting Times

Rationale: Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.

Figure 5.2: Percentage of People Starting Treatment <18wks for Psychological Therapies (aim = to maximise)

	Q3	Q4	Q1 (22/23)	Q2	Q3
Actual (%)	88.9%	99.1%	97%	98.30%	99.60%
Target	90%	90%	90%	90%	90%
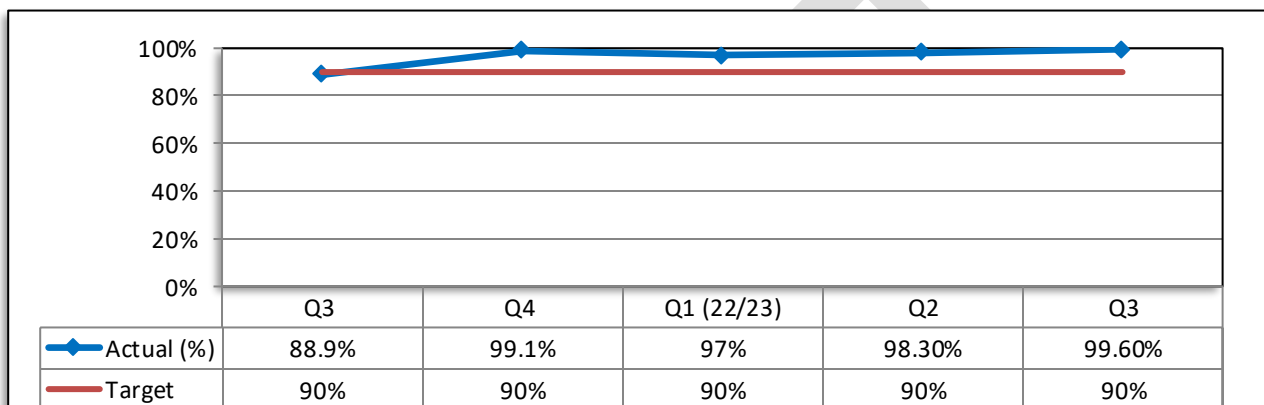
Situational Analysis:

This includes the Community, Primary and Older People's Mental Health Teams. The performance standard is measured as the percentage of people seen within 18 weeks from referral to delivery of service. The service has delivered comfortably above target by this measure for the past year, despite the pressures presented by the pandemic. This level of performance was achieved despite the service experiencing recurring recruitment challenges over Clinical Psychology posts and Covid-19 restrictions. Alternative innovative mechanisms for providing support have been utilised, which have successfully met the needs of the people being supported.

Improvement Action:

The Mental Health Teams have developed service continuity plans and recovery and transition plans to inform the way forward, to ensure that people continue to have access to therapeutic support. This will continue to include maximising digital methods where this works for patients.

5.3   Dementia Post Diagnostic Support

Rationale: This Standard supports the improvement of local post-diagnostic services as they work alongside and support people with a new diagnosis of dementia, and their family, in building a holistic and person-centred support plan. People with dementia benefit from an earlier diagnosis and access to the range of post-diagnostic services, which enable the person and their family to understand and adjust to a diagnosis, connect better and navigate through services and plan for future care including anticipatory care planning.

Figure 5.3: Percentage of People Newly Diagnosed with Dementia Accessing PDS (aim = to maximise)

	Q3	Q4	Q1 (22/23)	Q2	Q3
Actual (%)	2%	7%	9%	0%	0%
Target	90%	90%	90%	90%	90%
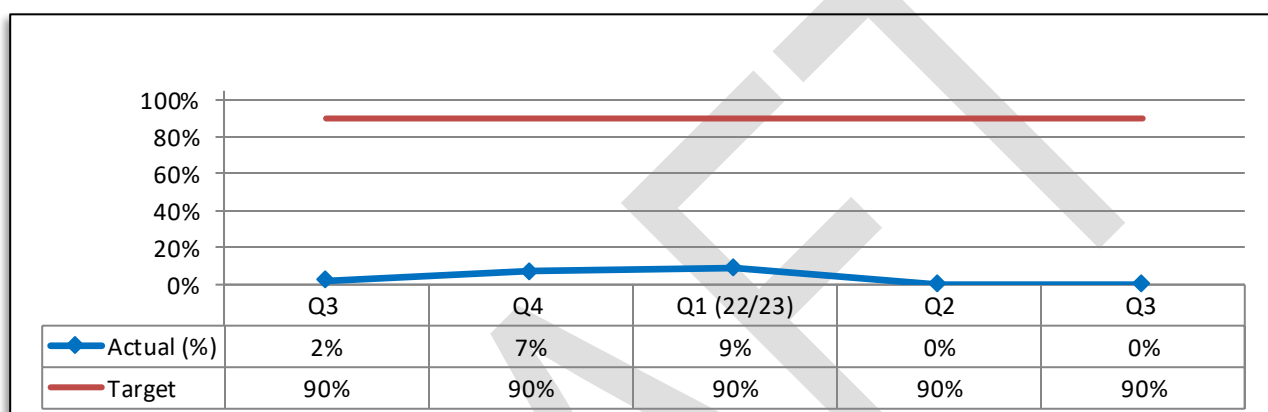
Situational Analysis:

This indicator examines how many patients are accessing PDS within 12 weeks of new diagnosis. In the early part of 2021-22, the service was operating almost at target levels, but was severely impacted later in the year by non-Covid related staffing issues, which persisted into the first half of quarter 3 in 2022-23.

Improvement Action:

Work is ongoing to return performance to target levels. More hours have been recruited to within the service and the HSCP has now completed its review of PDS provision which is currently in the process of being implemented. It is expected that these changes will bring better performance in relation to people being seen within 12 weeks from their diagnosis.

5.4   Alcohol Brief Interventions (ABIs)

Rationale: To sustain and embed alcohol brief interventions in the three priority settings of primary care, A&E and antenatal. This standard helps tackle hazardous and harmful drinking, which contributes significantly to Scotland's morbidity, mortality and social harm. Latest data suggests that alcohol-related hospital admissions have quadrupled since the early 1980s and mortality has doubled.

Figure 5.4: Total number of ABIs delivered (aim = to maximise)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (no.)	61	117	75	100	71
Target	122	121	122	122	122
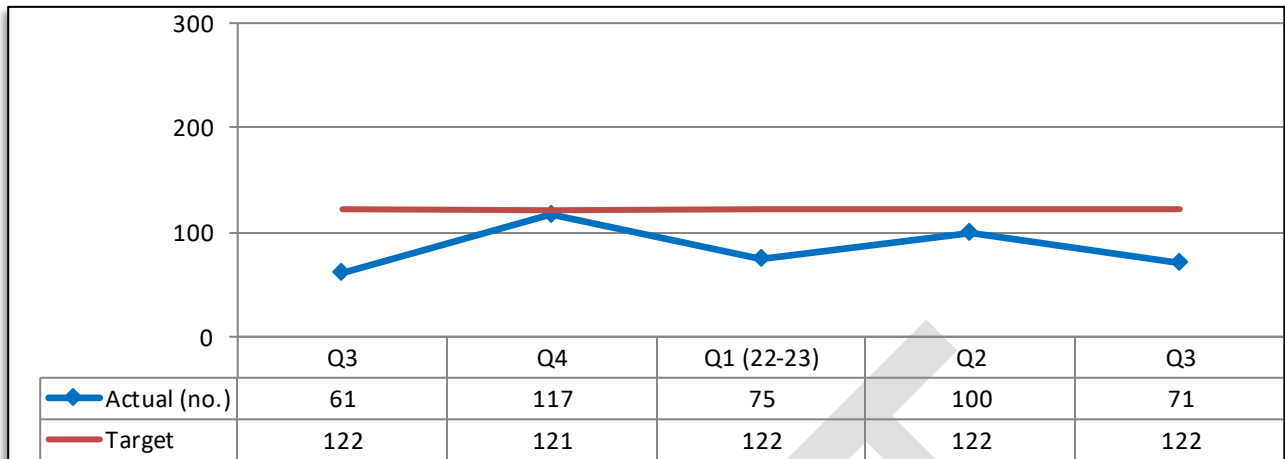
Situational Analysis:

Fig 5.4 shows that the delivery of ABIs continues to be below target and has been since 2020-21 due to the severe impact of Covid-19 restrictions on these therapeutic interventions. Performance has been improving sporadically over the course of the last year, but it continues to be challenging. The target overall for 2022-23 is to deliver 487 interventions over the full year.

Improvement Action:

Recovery plans continue to be used to inform the return to previous levels of service. Alternative engagement methods will be maximised, such as use of digital technology and rebuilding capacity within GP surgeries.

5.5 Smoking Cessation

Rationale: To sustain and embed successful smoking quits at 12 weeks post quit, in the 40 per cent most deprived SIMD areas. This target sets out the key contribution of NHS Scotland to reduce the prevalence of smoking. Smoking has long been recognised as the biggest single cause of preventable ill-health and premature death. It is a key factor in health inequalities and is estimated to be linked to some 13,000 deaths and many more hospital admissions each year.

Figure 5.5: Smoking quits at 12 weeks post quit in the 40% most deprived areas (aim = to maximise)

	Q2	Q3	Q4	Q1 (22/23)	Q2
Actual (no.)	7	11	10	5	3
Target	5	6	6	5	5
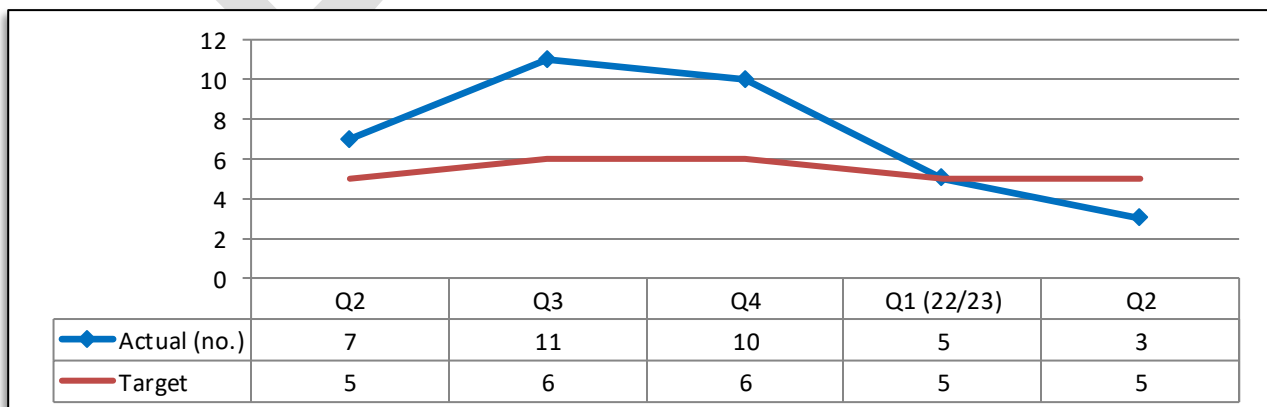
Situational Analysis:
Targets for smoking cessation are set centrally by NHSGGC. Data is generally 3 months behind, so Fig 5.5 shows the most recent data available. The target of 5 quits has been missed in quarter 2, performance has however been above target in previous reporting periods. The service is currently facing difficulties due to the unavailability of Varenicline and intermittent stock issues with other Nicotine Replacement Therapies. There have also been issues with accessing NHS and community venues to enable a return to full face-to-face service delivery. The target of 22 quits was exceeded during 2021-22, with a total of 37 quits achieved
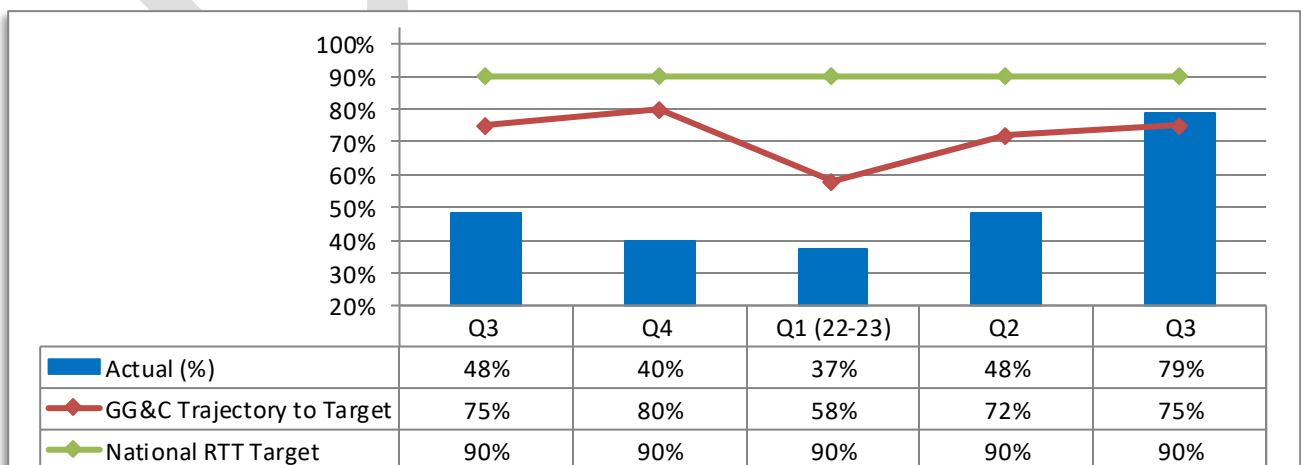
Improvement Action:
Remobilisation of face-to-face community services commenced mid-way through Q2, however identifying suitable NHS and community venue access has been challenging. To support ongoing remobilisation efforts, the service is continuing to link with key partners and stakeholders to identify opportunities to raise the profile of the service and to scope alternative suitable venues for face-to-face service delivery. Alternative methods of intervention will continue to be used on a blended basis as some "virtual" approaches have been found to be successful. The Quit Your Way Pharmacy service have recommenced pharmacy visits and pharmacy training, however the impact of these actions are unlikely to be realised until late quarter 3 and into quarter 4 of 22/23.

5.6 Child & Adolescent Mental Health Services (CAMHS) Waiting Times

Rationale: 90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.

Figure 5.6: Percentage of Young People seen or otherwise discharged from the CAMHS waiting list who had experienced a wait of <18wks (aim = to maximise)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	48%	40%	37%	48%	79%
GG&C Trajectory to Target	75%	80%	58%	72%	75%
National RTT Target	90%	90%	90%	90%	90%

Situational analysis:

NHSGGC CAMHS aims to prioritise improvement on the Referral to Treatment (RTT) performance in a managed way that acknowledges the considerable task of balancing demand and capacity. Increases in demand, and increases in complexity of cases, over the last 18 months in particular have had a significant impact on clinical capacity. CAMHS are working to resolve this as efficiently and safely as possible. At the end of quarter 3 in East Dunbartonshire, 86% of children on the waiting list were waiting for less than 18 weeks. While 79% of children seen, or discharged from the waiting list, had waited less than 18 weeks.

The increases in proportions of children waiting less than 18 weeks are a sign that the shape of the waiting list has changed. Improvements in waiting times are thus predicted to continue. It should also be highlighted that the total number of children discharged from the waiting list month on month continues to increase substantially (For 2021/22 Q2 – 83, Q3 – 139 of which 67 waited less than 18 weeks, Q4 – 171 of which 69 waited less than 18 weeks, 2022/23 Q1 – 260 discharged with 95 waiting less than 18 weeks, and for 2022/23 Q2 – 194 discharged with 94 waiting less than 18 weeks, Q3 - 217 discharged with 171 waiting less than 18 weeks). These improvements are a consequence of increased staffing associated with the Mental Health Recovery and Renewal funding.

Improvement Actions:

The following improvement actions are in progress to address demand on the service:

- Focus on waiting list and RTT targets continues. First treatment appointment activity levels are being maintained, as the number of children waiting has reduced and NHSGGC Board reaches the national RTT target. Activity will now shift to providing return appointments.
- The CAMHS Mental Health Recovery and Renewal Programme Board continues to meet to oversee plans to utilise the Phase 1 funding to improve waiting times in CAMHS, deliver the full revised CAMHS service specification, and increase the transition timescales up to age range 25 years for targeted groups. Workforce planning in relation to Phase 1 of MHRR funds agreed and recruitment ongoing.
- CAMHS Waiting List Initiative Group meet bimonthly to monitor performance of the improvement plan for waiting lists.
- Comprehensive review / validation of the current waiting list to ensure up to date information is available in relation to those who have had lengthy waits, to establish any reduction or escalation of difficulties, and/or any additional supports that may be beneficial. The letter to families has been amended with an invite to call and book an appointment, with choice of when and how families would like to be seen.
- Regular performance updates supplied to CAMHS management and teams to ensure the most effective use of clinical capacity for the waiting list and open caseload. Regular monitoring of CAMHS clinical caseload management available to the service on a monthly or as required basis.
- The learning and development plan to be refreshed to include implementation of the finalised standardised care bundles for CAMHS to ensure evidence based programmes are adopted and that new staff are well inducted and developed.
- Refresh of CAPA to improve through put and to move to a full booking position where children are allocated a case manager and next appointment at onset of treatment.
- Ongoing use of NearMe and remote/digital group options, to increase numbers of children seen and clinical capacity. A Clinical Psychologist has been appointed to

lead on the delivery of digital groups, which will improve uptake, and ensure children, young people and families are appropriately identified for this form of treatment.

- There is an increased focus on DNA rate for choice appointments, data has been reviewed and an audit of actions undertaken to identify any weakness in the appointing process. Triage calls added to operational guidance to engage with families ahead of first appointments. SMS text checked and delivered, voice message reminders setup.

- Scottish Government funding has been provided to HSCPs for the development of community mental health and wellbeing Tier 1 and 2 resource for children and young people.

Agreed Trajectory until March 2023

The timeframe for both RMP3 and RMP4 targets has passed. The targets for 2022/23 are included in the table below. Please note that this trajectory is for GGC CAMHS and not specific to East Dunbartonshire. Specialist Children's Services leadership and CAMHS management are closely monitoring this progress and aim to keep the service on track for a return to achieving the national RTT target.

Figure 5.6a National & Revised NHSGGC Targets for CAMHS

| CAMHS	Apr 22	May 22	Jun 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
% NHSGGC CAMHS patients seen <= 18 weeks	53.2%	54.5%	65.8%	61.6%	68.0%	84.2%	84.2%	91.3%	94.9%			
NHSGGC Projection Lower range	56.0%	58.0%	60.0%	62.0%	66.0%	70.0%	72.0%	74.0%	76.0%	76.0%	78.0%	79.0%
NHSGGC Projection/ Target	62.0%	64.0%	66.0%	68.0%	72.0%	76.0%	78.0%	80.0%	82.0%	82.0%	84.0%	85.0%
NHSGGC Projection Upper range	68.0%	70.0%	72.0%	74.0%	78.0%	82.0%	84.0%	86.0%	88.0%	88.0%	90.0%	91.0%
National RTT Target	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**

This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

6.1 Child Care Integrated Assessments for Scottish Children Reported Administration timescales
6.2 Initial Child Protection Case Conferences timescales
6.3 First Child Protection review conferences timescales
6.4 Balance of care for Looked After Children
6.5 First Looked After & Accommodated reviews timescales
6.6 Children receiving 27-30 month Assessment

6.1 Child Care Integrated Assessments (ICA) for Scottish Children Reporters Administration (SCRA) Timescales

Rationale: This is a national target that is reported to (SCRA) and Scottish Government in accordance with time intervals. Aim = to maximise

Figure 6.1: Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within 20 days (aim = to maximise) (HSCP-01-BIP-3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	86%	91%	85%	85%	88%
Target (%)	75%	75%	75%	75%	75%
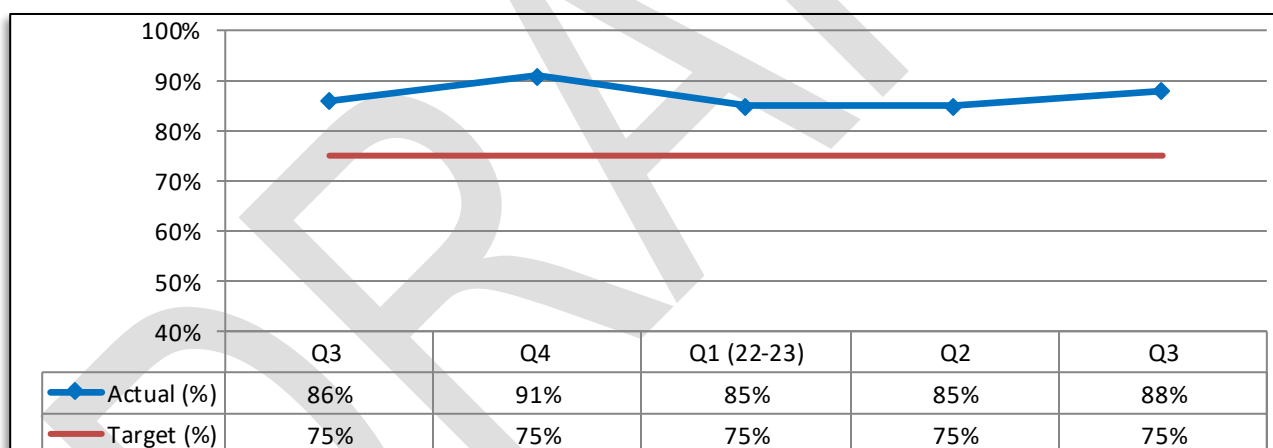
Situational Analysis:
Quarter 3 demonstrates continued performance above target, with 7 out of 8 ICA reports submitted to SCRA arrived within the target timescale.
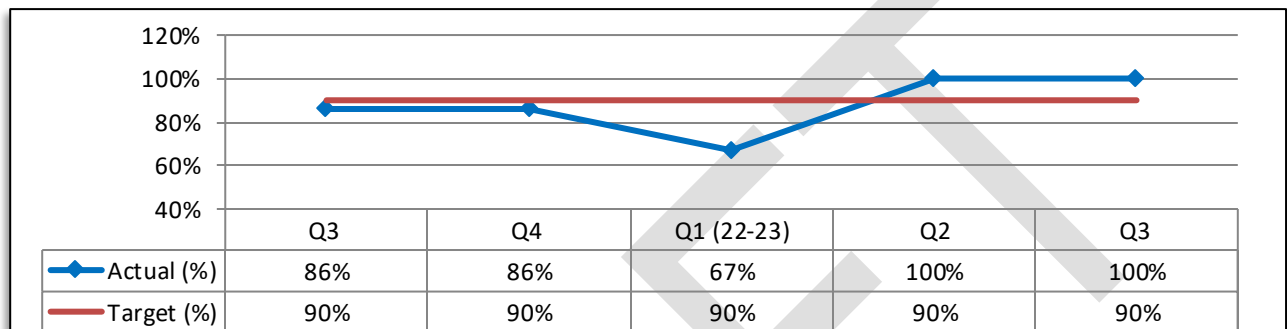
Improvement Action:
Maintain good performance.

6.2 Percentage of Initial Child Protection Planning Meetings taking place within Child Protection National Guidance target timescales
(previously referred to as Initial Child Protection Case Conferences)

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

Figure 6.2: Percentage of Initial Child Protection Planning Meetings taking place within 28 days of concern being raised, as per Child Protection National Guidance. (aim = to maximise) (HSCP-94-LPI-3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	86%	86%	67%	100%	100%
Target (%)	90%	90%	90%	90%	90%

Situational Analysis:
The new Child Protection National Guidance has resulted in changes in terminology and timescales for the stages within the national child protection process. What was previously known as an Initial Child Protection Case Conference is now known as an Initial Child Protection Planning Meeting. The associated national target timescales have also changed from 21 days to 28 calendar days.

Performance in Quarter 3 is above target at 100% compliance. 4 First Review Child Protection Planning Meetings were held during quarter 3; all were within timescale.
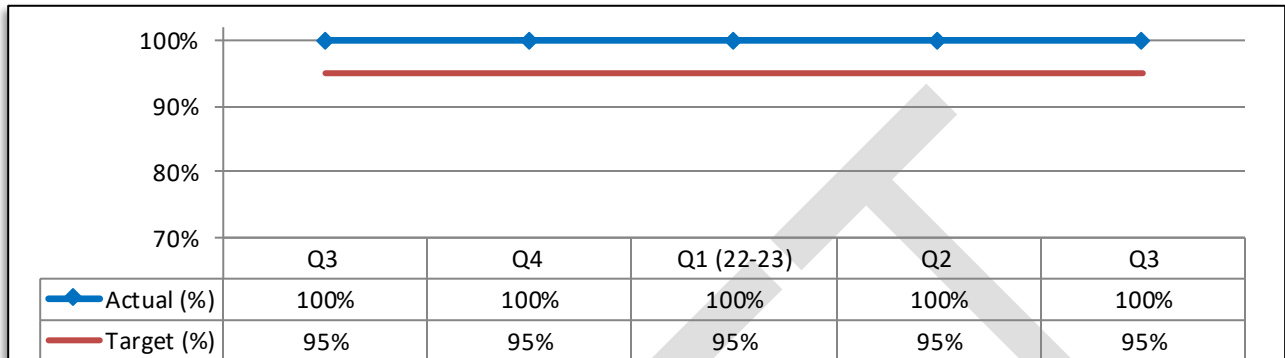
Improvement Action:
To continue to maximise performance at or above target levels.

6.3   First Child Protection Review Conferences Timescales

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

Figure 6.3: Percentage of first review conferences taking place within 6 months of registration (aim = to maximise) (HSCP-02-BIP-3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	100%	100%	100%	100%	100%
Target (%)	95%	95%	95%	95%	95%

Situational Analysis:
Performance in quarter 3 continues to be above target at 100%, with all 4 Child Protection Reviews within the quarter taking place within timescale.

Improvement Action:
Service and Team Managers will continue to maximise the achievement of Review Case Conferences timescales.

6.4   Balance of Care for Looked After Children

Rationale: National performance indicator reported to Scottish Government and monitored by Corporate Parenting Bodies. Aim = to maximise

Figure 6.4: Percentage of Children being Looked After in the Community (aim = to maximise) (HSCP-SOL-CHN9)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	82%	83%	83%	81%	83%
Target	89%	89%	89%	89%	89%
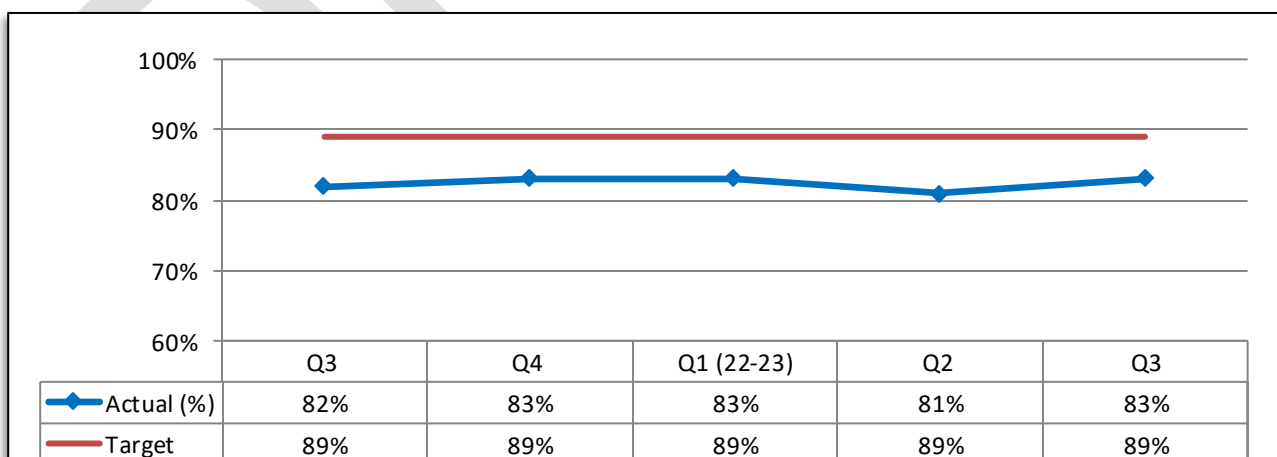
Situational Analysis:
Performance in 2022-23 quarter 3 has improved slightly from the previous quarter but remains off-target. There has been a decrease in residential placements this quarter with

community placement numbers remaining steady, which had led to a slight shift in the balance of care.

Improvement Action:
Work continues to redress the balance of care by reviewing out of authority placements and continuing the Foster Carer recruitment campaign.

6.5   First Looked After & Accommodated (LAAC) Reviews Timescales

Rationale: This is a local standard reflecting best practice and reported to the Corporate Parenting Board

Figure 6.5: Percentage of first LAAC reviews taking place within 4 weeks of accommodation (aim = to maximise) (HSCP-04-BIP-3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	100%	100%	75%	89%	88%
Target	100%	100%	100%	100%	100%
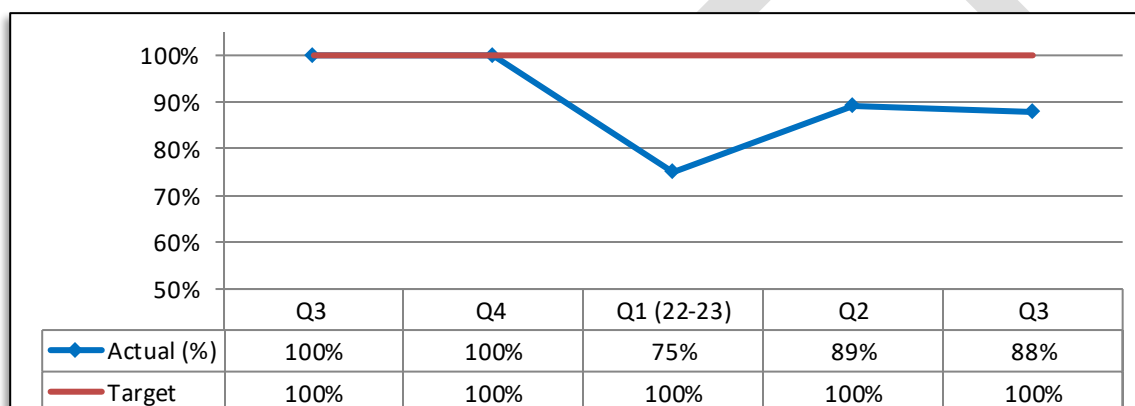
Situational Analysis:
Performance in quarter 3 has declined slightly and remains below target. There were 8 first LAAC Reviews held during the quarter and 7 took place within the target timescale. The 1 LAAC Review that was out with timescale was to accommodate Worker and Team Manager attendance.

Improvement Action:
To maintain high levels of performance.

6.6   Children receiving 27-30 month Assessment

Rationale: The central purpose of the 27-30 month contact is to seek parental concerns to identify children whose social, emotional and behavioural development puts them at risk of adverse life course outcomes.

Having identified these children, interventions must be put in place to optimise child development in preparation for education. The plan is that wherever possible, children's needs should be met in time for them to benefit from universal nursery provision at the age of 3.

The Scottish Government target is for at least 85% of children within each SIMD quintile of the CPP will have reached all of their developmental milestones at the time of their 27–30 month child health review.

Figure 6.6: Percentage of Children receiving 27-30 month assessment (aim = to maximise)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	98%	95%	98%	97%	97%
Target (%)	85%	85%	85%	85%	85%
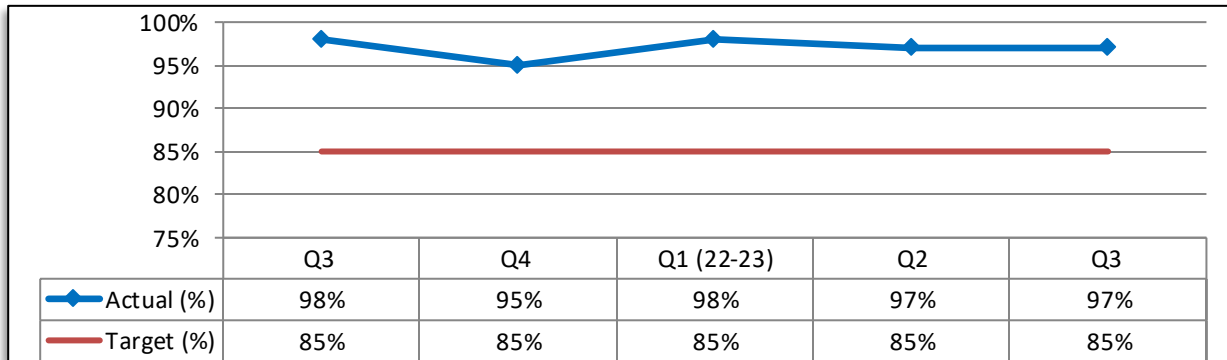
Situational Analysis:
This indicator relates to early identification of children within the SIMD quintiles with additional developmental needs. Where additional needs are identified, children are referred to specialist services. Uptake of the 27-30 month assessment across East Dunbartonshire HSCP has been consistently high and above target. Quarter 3 performance continues to be above target performance.

Improvement Action:
Monitor and continue to maximise performance. Data reports are monitored on a monthly basis at team meetings to support early identification of variances and allow improvement plans to be developed where required. Covid-19 service recovery planning is in place and will be followed to support these actions.

This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

7.1   Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order
7.2   Percentage of CJSW reports submitted to Court by due date
7.3   Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt

7.1   Percentage of Individuals Beginning a Work Placement Within 7 Days of Receiving a Community Payback Order

Rationale: The CJSW service must take responsibility for individuals subject to a Community Payback Order beginning a work placement within 7 days.

Figure 7.1: Percentage of individuals beginning a work placement within 7 days (aim = to maximise) (HSCP-08-BIP-6)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual (%)	94%	97%	88%	88%	97%
Target	80%	80%	80%	80%	80%
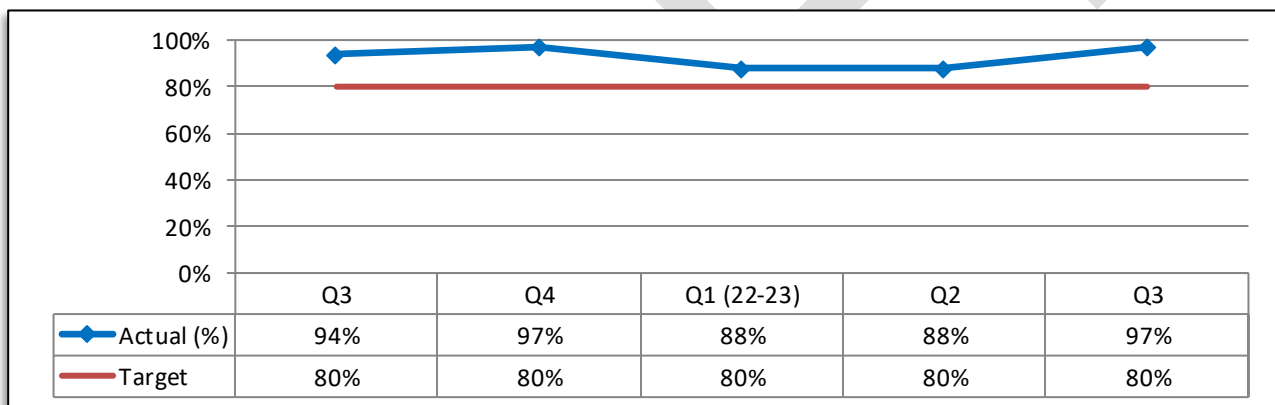
Situational Analysis:

29 people were due to begin work placements during quarter 3 and 28 of these started within timescale. There is a challenge with full compliance on this performance metric, because service users may be unable to commence due to a further conviction, ill health with GP line, employment contract clashing with immediate start or if they are subject to an existing order which means the new order cannot commence until the original one is completed. These factors are out with the control of the service.

Improvement Action: The focus will be on the recovery of services in line with national and local public health guidance**.**

7.2 Percentage of CJSW Reports Submitted to Court by Due Date

Rationale: National Outcomes & Standards (2010) states that the court will receive reports electronically from the appropriate CJSW Service or court team (local to the court), no later than midday on the day before the court hearing.

Figure 7.2: Percentage of CJSW reports submitted to Court by due date (aim = to maximise) (HSCP-07-BIP-6)

Rationale: National Outcomes & Standards (2010) stresses the importance of providing reports to courts by the due date, to facilitate smooth administrative support arrangements.

|	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual	100%	91%	92%	97%	95%
Target	95%	95%	95%	95%	95%
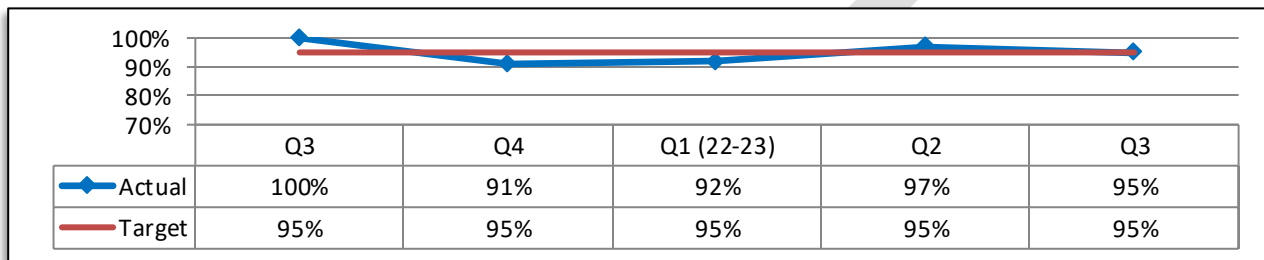
Situational Analysis: Performance in quarter 3 is on target for this indicator. 55 reports were submitted to Court during the quarter and 52 were within target timescale.

Improvement Action: Monitor and improve performance.

7.3 Percentage of Court Report Requests Allocated to a Social Worker within 2 Working Days of Receipt

Rationale: National Outcomes & Standards (2010) places responsibility on Criminal justice service to provide a fast, fair and flexible service ensuring the offenders have an allocated criminal justice worker within 24 hours of the Court imposing the community sentence.

Figure 7.3: Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt (aim = to maximise) (HSCP-CS-LPI-3)

	Q3	Q4	Q1 (22-23)	Q2	Q3
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%
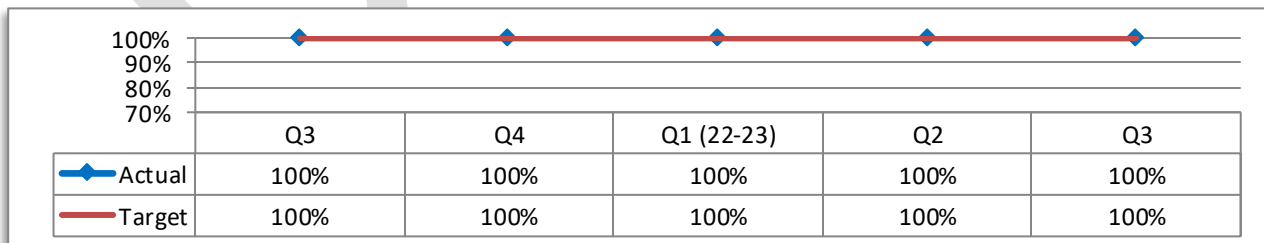
Situational Analysis: Performance continues to be on target with all 79 reports being within the target timescale.

Improvement Action: The service will continue to maximise performance levels.

- Workforce Demographics
- Sickness / Absence Health Staff and Social Care Staff
- Knowledge & Skills Framework (KSF) / Personal Development Plan (PDP) / Personal Development Review (PDR)

8.1   Workforce Demographics

| Employer	Headcount				WTE			
	Mar 22	Jun 22	Sept 22	Dec 22	Mar 22	Jun 22	Sept 22	Dec 22
NHSGGC	354	370	368	375	297.8	313.23	311.68	321.7
EDC	623	616	607	598	526.7	527.18	520.3	512.78
Total	977	986	975	973	824.5	840.41	831.98	834.48

The picture for the NHS workforce within the HSCP shows an increase overall since March 2022 of 21 staff with an overall increase of 23.9 wte staffing. This picture shows that the partnership is working hard to accommodate flexible working for staff with some staff increasing their hours. The overall workforce within EDC is declining with 25 less staff and a reduction of 13.92 wte.

8.2 HSCP Staff by Age profile

The age profile shows that the majority of staff remain aged over 45yrs and that we have a very low number of staff less than 25 yrs. of age (10). This age range is not unexpected within the services that the HSCP provides, although as identified above, this high percentage of older staff might impact on the number of requests for a more flexible employment option.

Age profile at 31 Dec 2022

8.3 Gender Profile

Gender Split as at Dec 22

Male, 140
Female, 833
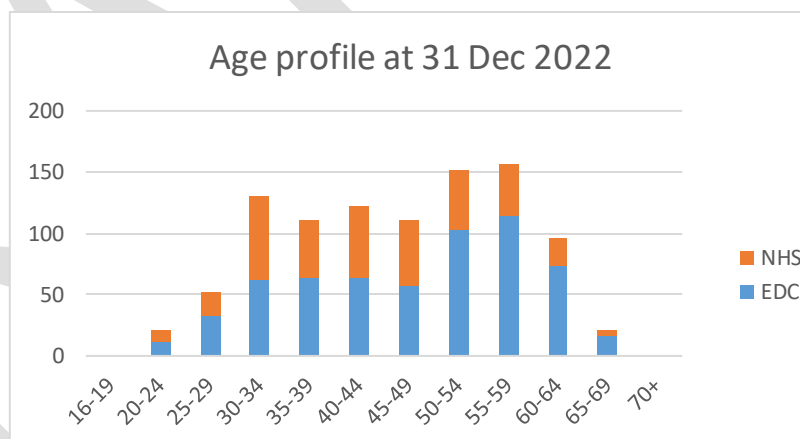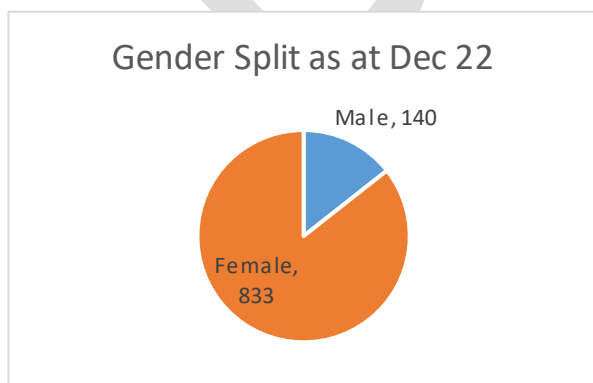
The gender ratio of female to male employed staff has remained constant since the 4th Quarter of 2021-22, with 86% of staff being female.

8.4 Sickness / Absence Health and Social Care Staff

Average sickness absence within HSCP has been increasing over the winter period and remains challenging.

EDC has faced system issues for absence reporting and cannot currently provide monthly figures for percentage absence. Work days lost per full time equivalent has been provided:

Quarter	EDC - WDL per FTE
Q3 21-22	5.13
Q4 21-22	4.67
Q1 22-23	4.69
Q2 22-23	5.37
Q3 22-23	6.53
Average	**5.28**

Sickness / Absence %		
Month	**EDC**	**NHSGGC**
Apr 22	9.61	4.65
May 22	9.52	4.51
Jun 22	unavailable	5.17
Jul 22	unavailable	5.49
Aug 22	unavailable	4.6
Sep 22	unavailable	6.68
Oct-22	unavailable	6.42
Nov-22	unavailable	6.95
Dec-22	unavailable	6.62
Average	**9.82**	**5.68**

The main contributing factor in Health and Social Care for higher absence is aligned with staff moving from short term to longer term absence due to health conditions. There is a notional absence threshold of 4% across both East Dunbartonshire Council and NHSGGC.

All absence is managed in line with policy.

8.5 KSF / PDP / PDR

KSF Activity	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22
Actual	44	44	44	45	45	49.7	55	57	60	57	61	61
Target	80	80	80	80	80	80	80	80	80	80	80	80

KSF (Knowledge & Skills Framework) is the NHS staff review process to ensure that staff are competent to undertake the tasks associated with their role and have the appropriate learning and development planned across the year. Due to Covid-19, progress towards the target figure was paused; whilst progress is being made it is likely to be the final quarter of 2022-23 before we return to target, and we are building it around Wellbeing.

8.6 Performance Development Review (PDR)*

Quarter	% recorded*	Target %
Q4 (21-22)	70.08	85
Q1 (22-23)	14.26	65
Q2	18.06	75
Q3	19.30	80

PDR (Performance Development Review) is East Dunbartonshire Council's process for reviewing staff performance and aligning their learning and development to service objectives.

Covid-19 impacted the number of PDRs undertaken within East Dunbartonshire Council with new ways of working requiring managers to adapt processes. Managers are encouraged to complete and upload PDRs as soon as possible to ensure ongoing work is captured.

* With the focus being on maintaining key service delivery PDR may have not been carried out or recorded as usual. Where formal PDRs have not been completed managers have been encouraged to undertake wellbeing and shorter term objective setting conversations.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE AUDIT & RISK COMMITTEE

DATE OF MEETING:	**21ST MARCH 2023**
REPORT REFERENCE:	**PERF/210323/06**
CONTACT OFFICER:	**DAVID AITKEN, INTERIM HEAD OF ADULT SERVICES, TELEPHONE 0141 232 8218**
SUBJECT TITLE:	**MENTAL WELFARE COMMISSION REPORT 'ENDING THE EXCLUSION'**

1.0 PURPOSE

1.1 The purpose of this report is to update the Committee on the Mental Welfare Commission report 'Ending the Exclusion - Care, Treatment and Support for People with Mental Ill Health and Problem Substance Use in Scotland' and implications and HSCP response to the report.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit and Risk Committee:

2.1 Note the contents of the report

CAROLINE SINCLAIR
CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

3.1 This report was published by the Mental Welfare Commission in September 2022 (attached as **Appendix 1**), and looks at the experience of people living with both mental ill health and problematic drug or/and alcohol use, and reports on how effective and joined-up care and treatment was in their findings.

3.2 Whilst the Commission found evidence of good practice they were concerned that a number of services still did not work sufficiently closely together to meet all of the person's needs, and described how people with lived experience and their families/carers identified a system in which they felt discriminated against, and were often 'bounced' between GP, mental health and alcohol and drug recovery services or excluded due to problem substance use.

3.3 Inconsistency or a lack of joint protocols within services was highlighted in the Commission's report which found that, where established, their application better ensured that needs were met holistically and jointly.

3.4 Concerns were also highlighted that not everyone had a lead professional/care coordinator or had a formal Care Plan in place.

3.5 Medication-Assisted Treatment (MAT) Standards which were introduced in 2022 following the report of the Drugs Death Task Force, were still found to be taking time to embed and drive anticipated improvement across engagement and joined-up working so that people with a substance use problem (drug or alcohol) were able to access mental health care at the point of treatment.

3.6 The Commission also identified the impact of staff shortages on delivering support and treatment and in the continuity of care which resulted in people having to re-tell their stories to multiple professionals, contrary to trauma informed care, and additionally the impact of stigma was reported as continuing to prevent these issues being seen as health related problems; compounding the challenges for individuals and their families and carers.

3.7 The report made a number of recommendations with four recommendations to Health and Social Care Partnerships (supported by health boards and local authorities) for October 2023;

1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use.

2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care coordinator identified.

3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.

4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement.

3.8   **Response/Implications** - In East Dunbartonshire we have Operating procedures for both our Alcohol and Drug Recovery Service and Community Mental Health Team; which are subject to regular review. We also have an existing Joint Interface Procedure which provides a governance framework specifically where there are co-occurring mental health conditions and problem substance misuse. The joint procedure was reviewed in 2022 as part of our response to the National Drugs Mission and locality plan to tackle drug related deaths.

3.9   Additionally we have delivered a number of interface events during 2022, and developed local initiatives to ensure that mental health and addictions services continue to improve joint working arrangements. We have co-located services and streamlined procedures between Multi-Disciplinary Team Meetings and allocation meetings, to ensure that access to our services is as seamless as possible.

3.10   In response to the second recommendation allocated workers and lead professional are in place in East Dunbartonshire across our social work and nursing teams in both the Community Mental Health Team and Alcohol and Drug Recovery Service, and care plans are consistently in place and held within local information systems.

3.11   The third recommendation within the Commission's report is that protocols are in place detailing approaches for people who disengage with services. These protocols are in place as part of NHS Greater Glasgow & Clyde and services in East Dunbartonshire work in accordance with the 'Alcohol & Drug Treatment Services - Did Not Attend (DNA) Minimum Standard Guidelines' which detail risk assessment protocols, further appointment standards, and criteria for assertive outreach. Similar protocols are established within our Mental Health Service with guidance for assertive outreach and DNA protocols.

3.12   The final recommendation is that Psychiatric Emergency Plans are in place and reviewed to ensure protocols for the care and treatment of those individuals presenting intoxicated and that there are robust mechanisms for subsequent engagement. As part NHS Greater Glasgow & Clyde there is a board wide Psychiatric Emergency Plan which is subject to regular review. Crisis services are provided by Mental Health Assessment Units (MHAU) within NHS Greater Glasgow and Clyde which have a clear focus during triage and risk assessment on substance and alcohol presentation and use, with locally agreed arrangements for subsequent engagement.

3.13   Additional measures are in place to ensure more consistent care and follow up for non-fatal overdose in East Dunbartonshire, as part of Turning Point Scotland's Non-Fatal Overdose pathway to ensure more responsive care and support to those at a point of crisis with robust and consistent follow up and engagement.

3.14   **Summary/Conclusion** - In East Dunbartonshire we are well placed to respond positively to the Commission's report. We have established joint working procedures for our mental health and addiction services already in place, which have been reviewed in 2022. Actions have been taken forward to strengthen the integrated work of these teams and we sought to ensure consistent case allocation and provision of care plans. There are additional procedures and protocols established on a board wide basis as part of NHS Greater Glasgow and Clyde which provide further safeguards in terms of our governance in this complex area of our work.

3.15 In response to the Commission's report we were asked to complete a local action plan (**Appendix 2**), and this will be used to take forward actions to develop joint care-planning initiatives and interface practice next year, and I would seek to assure the committee of our continued delivery against the report's recommendations in East Dunbartonshire.

4.0 <u>IMPLICATIONS</u>

The implications for the Board are as undernoted.

4.1 Relevance to HSCP Board Strategic Plan 2022 – 2025 Priorities;- (select those that are relevant)

1. Supporting Carers and Families
2. Improving Mental Health and Recovery
3. Maximising Operational Integration

4.2 Frontline Service to Customers – Enhanced integration of services and joined up service delivery.

4.3 Workforce (including any significant resource implications) – Enhanced joint working arrangements. No resource implications.

4.4 Legal Implications – None.

4.5 Financial Implications – None

4.6 Procurement – None.

4.7 ICT – None.

4.8 Corporate Assets – None.

4.9 Equalities Implications – None

4.10 Sustainability – None

4.11 Other – None.

5.0 <u>MANAGEMENT OF RISK</u>

The risks and control measures relating to this Report are as follows:-

5.1 The risks relate to poorly coordinated care and treatment. Control measures are in place with existing protocols and procedures established as detailed above.

6.0 <u>IMPACT</u>

6.1 STATUTORY DUTY – None

6.2 EAST DUNBARTONSHIRE COUNCIL – Enhanced care, treatment and integrated service provision for people with mental ill health and problem substance use.

6.3 **NHS GREATER GLASGOW & CLYDE** – Enhanced care, treatment and integrated service provision for people with mental ill health and problem substance use.

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** N/A

7.0 **POLICY CHECKLIST**

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 **APPENDICES**
8.1 **Appendix 1** – Mental Welfare Commission Report 'Ending the Exclusion'
8.2 **Appendix 2** – East Dunbartonshire HSCP Action Plan 'Ending the Exclusion'

Ending the exclusion:

Care, treatment and support for people with mental ill health and problem substance use in Scotland

Themed visit report
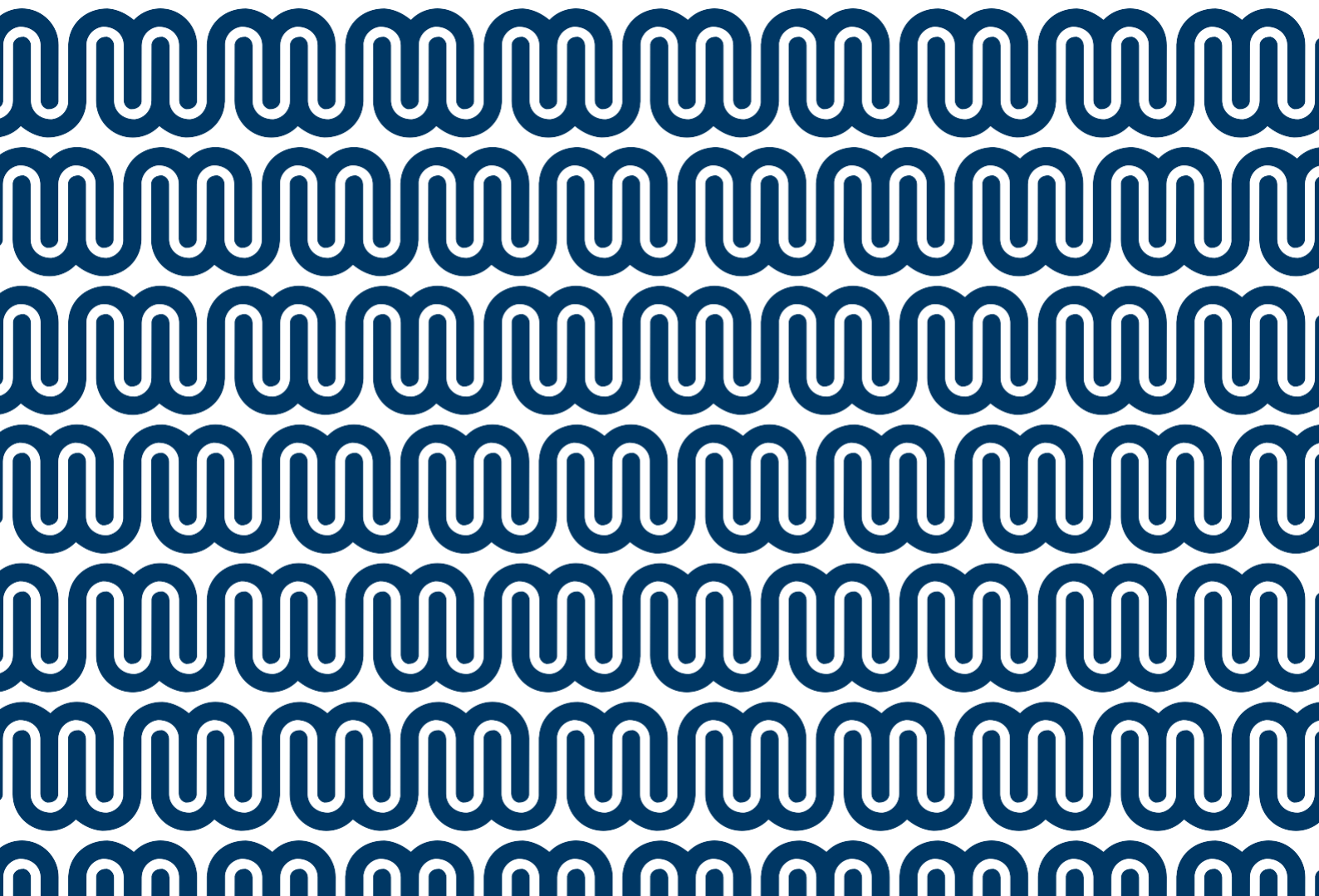
Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

What people told us: a selection of quotes

People living with mental ill health and addiction issues:

> *"I just want to see change. I've lived more than half of my life with this condition...and all I see is people dying or being forgotten about."*

> *"When I asked for sleeping tablets my GP said, 'I'm not your drug dealer'."*

Voices of relatives:

> *"...addiction services and mental health services are complex and outdated. They need reform, they are understaffed and underfunded and very, very neglected."*

> *"I don't have the knowledge or confidence or back up to get help for him."*

> *"Exhausting. Our own mental health has suffered due to the stress of dealing alone with my relative's addiction and mental health problems. We feel totally abandoned by a broken system which refuses to help those most in need. ….The only way out seems through suicide."*

Police officers:

> *"Little/no out of hours support for people, police/ambulance are constant fall back for other services, when neither are the appropriate services to offer meaningful assistance beyond an assessment at A&E."*

GPs:

> *"If the patient has any substance abuse then mainstream psychiatry services will automatically reject any referrals and tell us to refer to the addiction services. Even when the main problem at that time is the mental illness".*

> *"Psychiatry locally give the impression that they do not accept the concept of dual diagnosis- it is common to see substance or alcohol misuse listed as the principle issue and a plan for care by the addictions team, who are distinctly separate from the mental health team, with no mental health team input if substance or alcohol misuse is apparent."*

A housing support worker:

> *"The biggest obstacles we find are from the actual agencies / services themselves, not the clients."*

Foreword - Julie Paterson, chief executive

More people lose their lives to drug misuse in Scotland than in any other European country. Scotland has the highest rate of death due to alcohol in the UK, with the numbers climbing during the pandemic.

It is estimated that alcohol or drug misuse was a factor in something between 48% and 56% of all suicides between 2008 and 2018 in Scotland. These statistics are shocking.

Our report looks at the experience of people who are living with both mental ill health and problematic drug or/and alcohol use. Whether people use alcohol and or drugs to alleviate their mental ill health, or whether mental illness becomes a consequence of alcohol and or drug use, varies. In either situation, lives are devastated. Deprivation has a clear tie to each of these issues.

Our aim

We set out to look across Scotland to determine how we are dealing with this crisis, and whether the measures currently in place for people with both mental ill-health and a substance use problem are effective.

We heard from many individuals and from their families.

We heard from GPs – a critical point of contact – and from secondary health and care professionals. We listened to the experience of third sector organisations, who are often embedded in communities and know the challenges faced by individuals very well.

Failure to follow guidance

What we found was that a huge amount of work has been done to create strategies that should make a difference. Perhaps, given that the problem is so significant, this should not be a surprise.

But we also found that the guidance and standards set out by government are not being followed at a local level. There was a clear failure to implement guidance in most areas of the country. And that failure is having a direct impact on the lives of very vulnerable people and their families, who need joined-up support.

Ninety per cent of the GPs who responded to us said they had experienced difficulties in referring patients to both mental health services and addictions services, including when the person presented in crisis.

We heard about stigma from the very services that should be supporting people.

Individuals and professionals alike all highlighted the issue of staff shortages, and the impact this is having at every stage.

Call for action

Most of our recommendations are for health and social care partnerships (and their respective health boards and local authorities), who must take the lead in ensuring that the guidance already in place is enacted locally. This is absolutely critical.

We also call on NHS Education Scotland to take a key role, and we ask Scottish Government to monitor the delivery of our recommendations and address any barriers to delivery within 12 months.

We ask that all of those organisations read this report closely and work together to reinvigorate Scotland's approach to tackling this pressing issue.

Executive summary

This report looks at the experience of people who are living with both mental ill health and problematic drug or/and alcohol use. It considers how effective and joined-up their care and treatment is; both from the point of view of individuals and from those who work within health and care services in Scotland.

In total, 426 people engaged with us as part of this work through consultations, focus groups and questionnaires. We were keen to focus on their direct experience of services and working within them. We are grateful for their insight and expertise.

Whilst we found pockets of good practice, and a real desire to improve care and treatment we were concerned to find that national guidance and standards that emphasise the need for services to work closely together to meet all the needs of a person have not been realised.

People with lived experience and families/carers describe a system in which they feel discriminated and are often 'bounced' between mental health services and addictions services. The policy ideal that there should be 'No Wrong Door' has not necessarily led to every door being open.

People who are working in services echoed those with lived experience, highlighting a lack of protocols that ensure that needs are met holistically, that people should have care co-ordinators and care plans, are not 'bounced' between services, or excluded from services due to their problem substance use.

Despite guidance on the importance of clear care plans, 77% of professionals said documented care planning did not happen or that they were unware of it.

Despite the Medication-Assisted Treatment (MAT) Standards introduced following the report of the Drugs Death Task Force, we found little awareness of the standards particularly relevant to our report, on engagement and joined-up working so that people with a substance (drug or alcohol) use problem can access mental health care at the point of treatment.

We are concerned that the term 'dual diagnosis' that emphasises the presence of a mental health condition and co-occurring problem substance use may inadvertently reduce the focus on the social and physical health care needs of this already vulnerable group of people. Only 16% of GPs and 13% of other NHS professionals indicated that there is an agreed local protocol for physical healthcare monitoring that they were aware of.

People with lived experience, families/carers, and professionals noted a common theme was the impact of staff shortages on delivering care and treatment and in the continuity of care. People with lived experience and their relatives/carers told us how this is resulting in people having to re-tell their stories to multiple professionals. Many people have experienced past trauma or adverse childhood experiences and it is upsetting to have to recount these experiences repeatedly. This is not trauma-informed psychological care.

The final report of the Drugs Death Taskforce called for an end to stigma as an essential element in Scotland's fight against its high rate of drug-deaths. Our work also confirms that

stigma is preventing these issues being seen as the health problems that they are and is compounding the suffering for individuals and their families and carers.

In summary, current service provision is not good enough. This was confirmed by people who use services, their relatives and 84% of GPs, 77% of NHS secondary care staff and 93% of staff working in non NHS services who engaged with us.

Strategies, policies, standards and guidelines are not being translated into practice to the benefit of individuals and their families. However, like one of our respondents Mr A below, they still retain hope of change. We must listen and we must deliver.

> *"People with dual addictions or coexisting mental health conditions and substance misuse problems can and do recover, I have seen broken people with mental health issues and addiction's achieve this who are now in full time employment, living life, and are out there helping others. With the right care, support, empathy and encouragement people's lives can be transformed or even made easier to live a more fulfilling Life. I have a way to go still, but I have made positive progress, not always easy, but I'm getting there."* (Mr A)

Recommendations

To health and social care partnerships (supported by health boards and local authorities) by October 2023:

1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use (if one does not already exist)*.

2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care-coordinator identified.

3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.

4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement.

To NHS Education for Scotland (NES)

5. NES to consider with relevant stakeholders, and report on how educational and improvement programmes for professionals working in mental health, addiction services and social care might:
   a. Embed a trauma-informed approach to care and treatment of people with mental health conditions and problem substance use;
   b. Address stigmatising attitudes within professionals towards people with mental health conditions and problem substance us.

To The Scottish Government

6. The Scottish Government should monitor the delivery of the above recommendations and work with health and social care partnerships (and associated health boards/local authorities) and NES to support consistency and address any barriers to delivery over the next 12 months.

** In the **absence** of or pending such a written policy/service delivery model for integrated care for this group**, to avoid any inadvertent exclusion now**, the Commission considers that the lead service for this group that require secondary care mental health services and addictions services**,** should be secondary care mental health services (with support from addictions services as needed).*

Chapter 1: Introduction & methodology

Background

It is common for people to experience problems with both their mental health and their use of drugs/alcohol.

The relationship between mental health conditions and problem substance use is complex. For some people, problem substance use might lead to the emergence of a mental health condition. For others, the mental health condition might lead to the problem substance use as people use alcohol or drugs as a way of trying to cope with the distress of a mental health condition. For some people, a traumatic event or period or an adverse childhood experience can lead to these difficulties.

It is difficult however to know exactly how many people are affected by both. One reason is a lack of clarity on definitions.

In this report, the term problem substance use is used to mean the use of alcohol, illegal drugs or prescription drugs that leads to harmful consequences for the individual and their relationships with friends, carers and family.

Some services, professionals and groups representing people who have a diagnosed mental health condition (for example, depression or schizophrenia) and problem substance use refer to the existence of both these conditions at the same time as a 'dual diagnosis'. However we consider this term potentially unhelpful as many people with these difficulties also have multiple needs around their physical healthcare and their social needs. A narrow focus by using certain terms can inadvertently lead to exclusion or a lack of holistic care.

Another reason which makes it difficult to know how many people have both a mental health condition and problem substance use is the double layer of stigma, that is, stigma associated with mental health and stigma associated with substance use:

The Scottish Drugs Forum states that "stigma marginalises people with a substance use problem and makes them more vulnerable". And Scotland's See Me programme confirms 'research we carried out across Scotland found that 56% of people with a mental health condition have experienced stigma and discrimination'.

There is therefore a significant group of people in Scotland being treated unfairly and less likely to reach out for support and more likely to die.

Estimates suggest that between 20-37% of people using mental health services have a difficulty with drugs and alcohol.[1]

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[1] Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. A systematic review - PubMed (nih.gov) (accessed 23 June 2022)

It is estimated that alcohol or drug misuse was a factor in between 48% - 56% of all suicides between 2008 and 2018 in Scotland.[2]

Strategies, Policies, Standards and Guidelines

The Scottish Government's current Mental Health Strategy (2017-2027) has actions that aim to develop better mechanisms for the assessment and referral for people with dual diagnosis and to offer opportunities to pilot improved arrangements for their care (Actions 27& 28).[3]

In 2021, the Scottish Government, following the work of the Drugs Death Taskforce, published ten standards for medication-assisted treatment (MAT) for people with addictions. The standards are to help reduce deaths, promote recovery and ensure a patient-centred approach to the delivery of safe, effective and accessible treatments.[4]

Standard 9 of the MAT standards sets out that all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery. This standard aims to ensure that those receiving treatment for drug use have access to mental health care and do not fall between gaps in service provision. The MAT standards document states that the standards are a guide for service improvement and should be overseen by local improvement teams and that they are not intended for local or national performance management.

In June 2022 a report from Public Health Scotland[5] (PHS) on the implementation of MAT Standards 1-5 across all of Scotland's 29 Alcohol and Drug Partnerships shows that there is unwarranted variation in the implementation of the standards. It identifies risks that partial implementation will not realise the reduction in drug-related deaths. However, perhaps in cognisance of the identified risks of uncertainties around funding, and the concerns it raises about systems being unable to collect the evidence required for intelligence led quality improvement work, whilst PHS recommends full implementation of MAT standards 1-5, it only recommends partial implementation of MAT standards 6-10 by April 2023. The criteria around this standard emphasises the need for local substance use services and mental health services to be able to refer effectively between themselves, for staff working in these services to be competent in assessing problem substance use needs and mental health needs and the need for local protocols around information sharing and joint working arrangements.[6]

[2] NCISH report 2021 display.aspx (manchester.ac.uk) (accessed 23 June 2022)[3] Scottish Government, *"Mental Health Strategy: 2017-2027"* *https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf*

[3] Scottish Government, *"Mental Health Strategy: 2017-2027"* *https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf*

[4] Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot) (accessed 19 June 2022)

[5] National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards - National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards - Publications - Public Health Scotland

[6] Standard 9 Mental Health - Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

In recognition that many people who have problem substance use often have experienced trauma or adverse childhood experiences, Scottish Government published guidance for Commissioners of these services that presented a model of trauma-informed matched care.[7]

This guidance highlights that to engage with psychological work, there must be some degree of stabilisation in substance use although abstinence does not have to have been achieved.

Finally, the "Drug misuse and dependence: UK guidelines on clinical management" (often referred to as the 'Orange Book') from 2017 sets out guidance to health and social care staff who provide drug treatment and support.[8]

This guidance states that for people with 'co-existing mental health and substance use problems':

> *"It is important that individuals are not turned away from either drug and alcohol treatment services or mental health services due to their coexisting illness but rather that such services should aim to be perceived by service users and their carers as supportive with 'no wrong door' through which to enter services."* (p232)

The principles in this 'Orange Book' guidance include strategic collaboration between mental health and addiction services to provide adequate expertise and treatment, identification of patient needs and communication between services, ensuring people can access support and treatment for both conditions and to support the individual in a person centred manner. Where possible, it is suggested that an integrated model of care may be most appropriate, however it is recognised that this model may not always be feasible. The guidance also describes how professionals in addictions services and mental health services should be able to undertake basic assessments about mental health and alcohol and drug use respectively. It states that people with mild to moderate mental health needs in an addictions service can be supported without need for referral to secondary mental health care, however for those with severe mental illness, mental health services should be the lead service.

The National Institute of Health and Care Excellence (NICE) guidelines for people with coexisting severe mental illness and problem substance use set out that services should not exclude people due to their drug use. The guidelines recommend that individuals have care coordinators, that their carers and families join them in setting care plans and that care plans should be holistic, meeting mental health and physical health needs and social supports. Like the 'Orange Book', and the Scottish Government MAT 9 standard they recommend local joint care planning for service delivery.[9],[10]

Although the NICE guidelines refer to people with more severe mental illness and the UK wide 'Orange Book' guidance refers to people with a wider range of mental health conditions, both

[7] [The delivery of psychological interventions in substance misuse services in Scotland: A guide for commissioners, managers, trainers and practitioners](#)
[8] [Drug misuse and dependence: UK guidelines on clinical management - GOV.UK (www.gov.uk)](#)
[9] [https://www.nice.org.uk/guidance/cg120/resources/coexisting-severe-mental-illness-psychosis-and-substance-misuse-assessment-and-management-in-healthcare-settings-pdf-35109443184325](#)
[10] [https://www.nice.org.uk/guidance/ng58/resources/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-pdf-1837520014021](#)

emphasise joint working between services, care coordination, care planning, and meeting holistic needs in a person-centred way.

Despite the existence of multiple guidelines that emphasise not allowing people to fall between services, our initial consultation, as part of this work, suggested that the guidance is not followed; the aspirations are not realised in practice.

Methodology

In early 2020/2021, we met with representatives from twenty organisations and we held a focus group with 15 people with lived experience (through Scottish Families Affected by Alcohol and Drugs) and had meetings with 4 carers.

During these meetings we gathered information about what was perceived to be working well and the issues that we should gather more information about to understand the gaps.

We then created bespoke surveys for people with lived experience, their relatives and carers and for professionals who work with them. We distributed our surveys online through the Commission's twitter account, website and also through a number of collaborating stakeholders. We also visited individuals face to face (when safe and possible) and through online meetings to complete the surveys.

In total, 426 people engaged with us as part of this work. Appendix 1 provides details of those who responded and informed our work.

Our consultation with people with lived experience and other research indicates that there was no common understanding of the commonly used term, 'dual diagnosis' to describe the group of people with a mental health condition with problem substance use. We were aware that many people used this term and so we accepted this as the term we used for our consultation (although during the course of this project we became aware of the term's propensity to exclude). We adopted the definition used by NICE for people with co-existing severe mental illness and substance misuse to clarify what we meant by the term.

> *"Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage)."* NICE[11]

However, it was clear that the people with lived experience who engaged with us determined what the term 'dual diagnosis' meant to them and they often included mental health conditions that would not meet the level of severity that we had defined. In turn, we did not exclude information gathered from and about people who did not meet the NICE definition.

> *"I think we need to take a step back and ask why we are talking about dual diagnosis. It is not about diagnosis. We need services that recognise and work with the complexity of people's lives including the trauma and difficulties they have been through."* (relative/carer)

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[11] [Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE](#) (Accessed 23 June 2022)

Chapter 2: Learning from people with lived experience

Accessing the right supports at the right time, in the right place and provided by the right person is an essential part of recovery. We wanted to know, from those who have experience, who was providing support and whether these supports were holistic and coordinated: meeting mental health, physical health, problem substance use and social support needs as guidelines and policies indicate.

What we expected to find

We expected to find individuals seeking and receiving support from a range of different sources including primary health services (GP), secondary health services (community mental health team, addictions service, psychiatry), local authority, third sector (charity and voluntary organisations), family and friends.

We expected to hear of individuals seeking and receiving a range of types of support including practical (housing, employment, financial, childcare) emotional (counselling, peer support, self-help) and health based (physical and mental health).

We expected to hear about clear, supportive crisis planning for particularly difficult times in a person's life. We also expected to find evidence of clear coordination given the complexities faced by this particularly vulnerable group of individuals.

What we heard

People with lived experience

Sixty five people, who identified themselves as living with both mental health and problem substance use issues, responded to our request for information. They came from 11 different health board areas. Figure 1 shows the breakdown of respondents into age and gender groups.

People described where they lived as a city (26%), town (34%), small town (22%) or rural area (9%) and others did not respond to this question. Ninety percent of respondents felt the area they lived in was accessible, a 30 minute drive from the nearest town.

Figure 1. Age and gender categories of respondents*
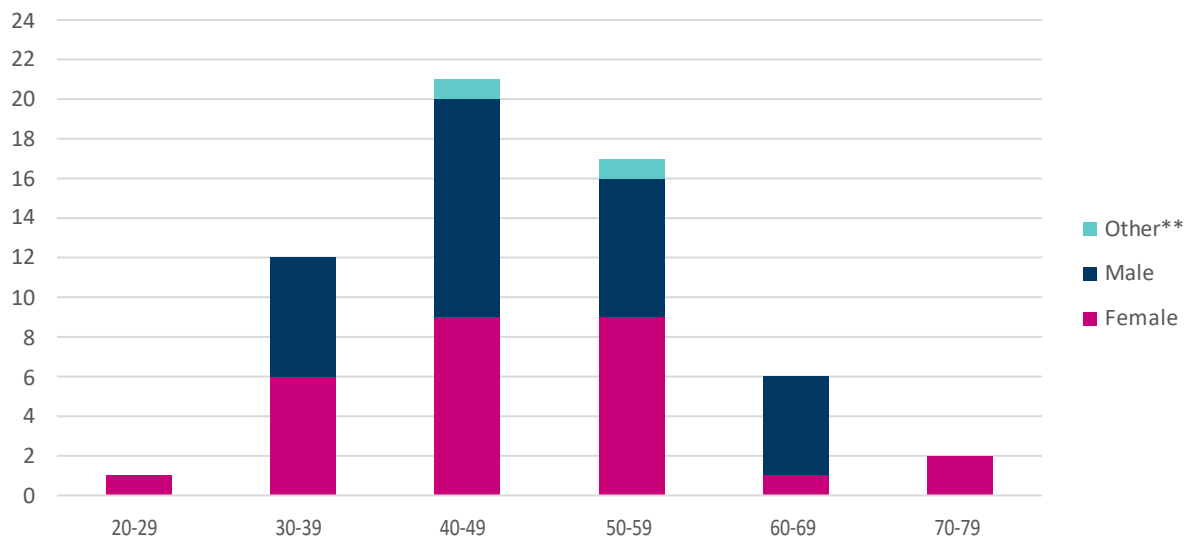
* (n= 65), 6 responses missing; **Other included as gender fluid and non-binary.

The majority of individuals (90%) had received an assessment by an NHS mental health practitioner or psychiatrist. 90% of respondents reported that they had been diagnosed with a mental illness and 85% reported that they had been diagnosed with a dual diagnosis. 10% (n=7) respondents reported that they did not have a diagnosis but felt they should have one.

Diagnoses reported

Figure 2 Mental Illness diagnosis from individuals with lived experience
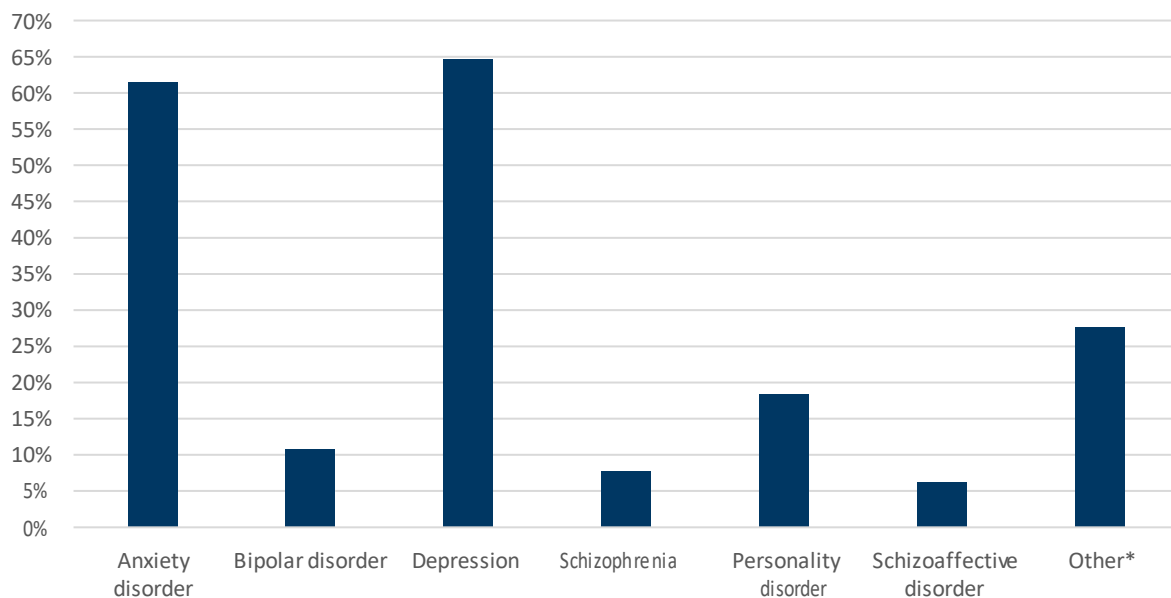
Other diagnoses individuals reported included: obsessional compulsive disorder, foetal alcohol syndrome, post-traumatic stress disorder, autism, post-natal depression, attention deficit hyperactivity disorder and psychosis.

16

We asked individuals what substances they were currently using or had used in the past.

Figure 3 Substance used by individuals with lived experience
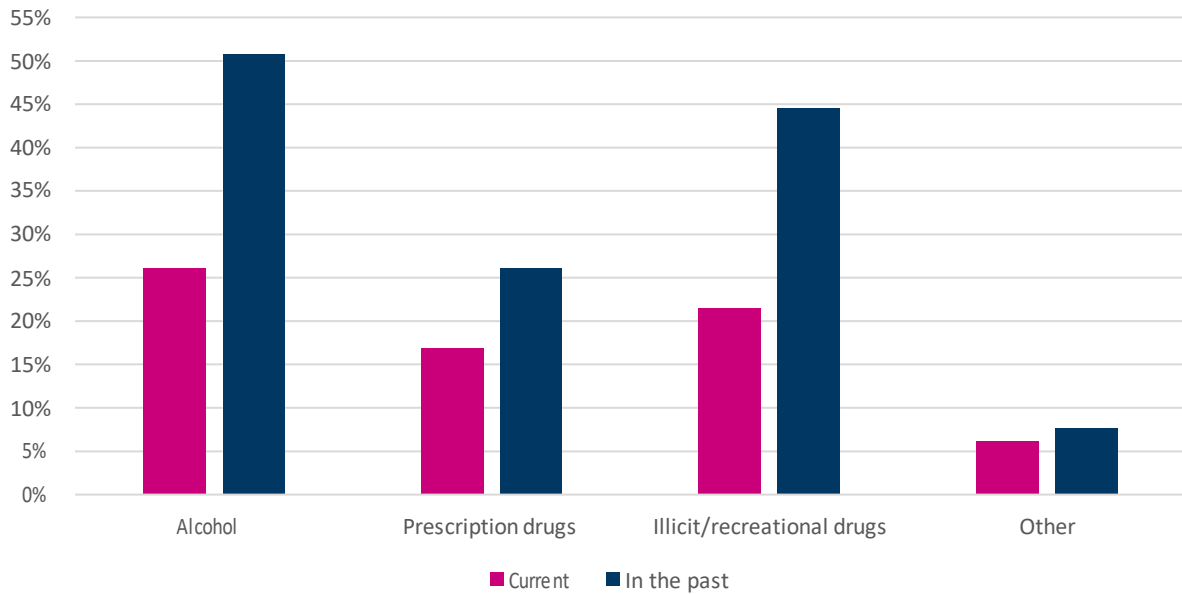
The provision of treatment, as reported by our 65 respondents, is presented in the table below.

Table 1: Provision of treatment for individuals with lived experience

Provision of treatment	%	Number (n=65)
Community addictions team	22%	14
Inpatient services	2%	1
Community mental health team	14%	9
GP	28%	18
Inpatient services	8%	5
Specialist integrated teams supporting people with both mental health and problem substance use issues	5%	5
Other	3%	2
No treatment provided	8%	3
Missing data		8

We asked about sources of support and what type of support was being received. (Table 2). People often described more than one source of support. Most individuals reported that the main type of support they received was emotional support. (See Table 3).

Table 2: Source of support provided for individuals

Support provider	%	Number (n=65)
Local council	12%	8
Social work department	11%	7
NHS	51%	33
Charity or voluntary	34%	22
Private care	2%	1
Volunteers	11%	7
Peer support worker	25%	16
Counsellor	15%	10
Family	40%	26
Friends	25%	16
Other	9%	6
None	8%	5
Not sure	2%	1

Table 3: Type of support provided
Other support included mutual aid and friendship

Types of support provided	%	Number (n=65)
Housing	28%	18
Employment	5%	3
Physical health	32%	21
Self-care	23%	15
Finances	8%	5
Social support	23%	15
Emotional support	58%	38
Counselling	22%	14
Childcare	0%	0
Education	3%	2
Other*	15%	10

We asked if more than one service was providing their care, treatment and support, how they experienced information sharing between these services. Of those who answered this question (n=30) 23% (n=7) stated communication was excellent, 23% stated it was good, and 23% (n=7) stated it was poor (see Figure 4).

Figure 4: Individuals view on communication between services
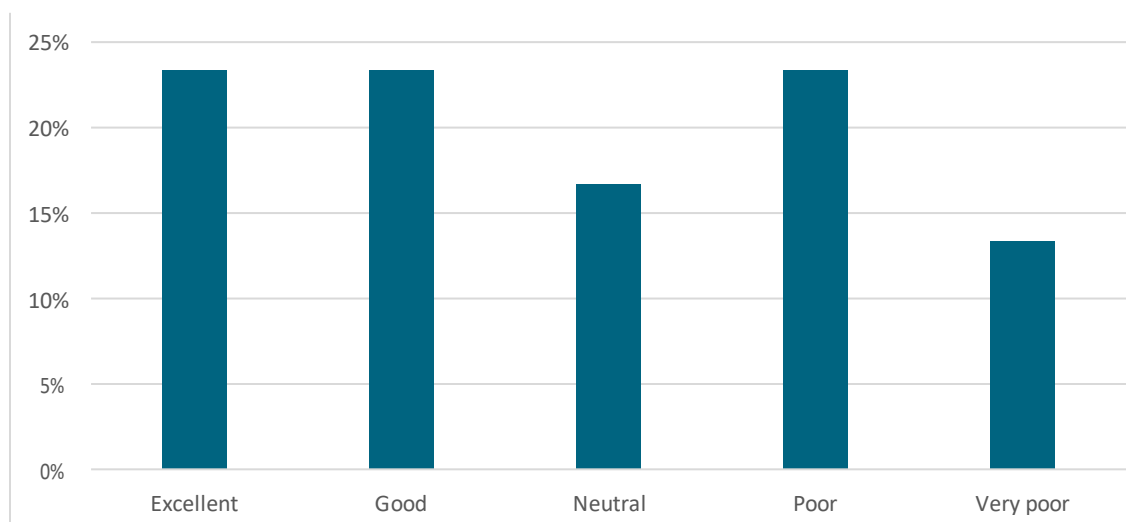
We were keen to understand what worked well. Our respondents told us about various factors that were important to them. We list them below.

Box 1: Common themes of what worked well with current support

- A clear diagnosis
- Medication
- Individual qualities in staff including: trusting, kind, empowering, realistic, caring, helpful, encouraging, non-judgemental, validating problems, good listening skills, honest, empathetic, respectful, approachable
- Staff consistency
- Support available 24/7
- One to one support alongside group therapy
- Support providers keeping in regular contact both over the phone and face to face
- Recovery focused
- Groups to meet others & on-line support groups
- Support to develop self-help strategies
- Peer led support by those with lived experience
- Support providers working well together and communicating with one another
- Self-help, helping others, mutual aid
- Counselling
- Understanding root cause of addiction
- In-patient rehabilitation along with follow up in the community
- Meaningful activity
- Ensuring individuals have the basics like food, heating, financial support
- One person to help with everything
- Phased exit when support has to come to an end
- 12-step recovery programme

Crisis support

In terms of where individuals would go if they were in crisis; the most common responses were their GP and addictions team (see Table 4).

Table 4: Services that individuals might access if in a crisis

Where to go in a crisis	%	Number (n=89)
Community Mental Health Team	25%	16
Addictions team	37%	24
Local psych hospital	3%	2
Crisis centre	6%	4
Charity	9%	6
GP	38%	25
999/111	25%	16
A and E	15%	10
Police	8%	5
Samaritans	12%	8
Breathing space	9%	6
Local council/social work department	8%	5
Friends/family	28%	18
Other (including support workers and recovery groups)	20%	13

Relatives and carers are key supports however 77% of families (60 families) felt they did not know what to do in a crisis.

"I don't have the knowledge or confidence or back up to get help for him."

"No one is interested. He will probably die before he gets any help."

"Only A&E and that scares us due to stigma, reluctant to go."

The impact of the Covid-19 Pandemic

Over half of our respondents 57% (n=37) reported significant impacts on their treatment since the start of the pandemic. We were informed of delays in initial assessments, long waiting lists to start treatment or for consideration of inpatient / residential detox before treatment could be contemplated. We were also made aware of how staff shortages resulted in individuals having to re-tell traumatic stories.

Individuals described the difficulties they experienced getting a face-to-face appointment. There was a recognition from respondents that a 'therapeutic alliance' between the person with living experience and the people who support them is fundamental for recovery or

stabilisation. Some individuals were left with no support or telephone support only. Individuals also told us about support groups being cancelled and feeling socially isolated, depressed and anxious as a result. Individuals missed the support from others with a shared experience. However, we also heard that some individuals preferred support being delivered remotely due to it being more accessible.

Families also felt that the pandemic had had a significant impact on the support available for their relative.

> *"Made it non-existent. Waiting lists are so long seeking help is almost pointless."*

Lockdown often separated people from their families and this, in addition to the reduced support, increased the isolation many individuals experienced. The subsequent deterioration in mental health and increased substance use meant many individuals became increasingly unwell during Covid-19.

> *"Lockdown had a very detrimental effect which led ultimately to his drink/drive charges/losing his job/house and not being able to see his children for a time."*

> *"Disastrous - he has ended up in prison due to poor follow up and service provision".*

What we learned

Beyond the pandemic lockdown experience, we learned from those with experience and their relatives that the current standards and guidelines are not being translated into practice for them.

In many cases, mental health teams and substance misuse teams appear to be working exclusively rather than in tandem.

> *"Each service blames the other and you get poor treatment from both. Require integrated mental/physical/addiction care staff located together and allocated to appropriate staff."*

Accessing these services in order to receive an assessment can often prove challenging. We heard about the difficulties of being assessed (assessment refused) by mental health services when under the influence of drugs/alcohol. There appears to be a widespread expectation of individuals being substance free before their mental health issues can be treated. This is not in keeping with guidelines.

We equally heard that addiction services often refuse to get involved if an individual has mental health difficulties and the individual will be re-directed back to mental health services. In some cases, individuals appear to have to navigate services who respond with 'not my problem' rather than accepting individuals 'whatever their problem'.

We were told that the attitude of service providers can be a problem. People reported being 'labelled' and individuals being made to feel that their problems were a 'life choice' or having 'self-inflicted' their problems.

Stigma associated with the conditions still appears to influence how professionals view people with a difficulty that is a health problem.

> *"When I asked for sleeping tablets my GP said 'I'm not your drug dealer'."*

> *"People look down on me, I've been to a couple of chemists where I get my prescription for methadone. They made me take it in front of other customers, it was humiliating. They have a private room for this type of thing but they don't use it, they keep you waiting and serve other customers before you. It's cruel."*

We also heard about the lack of consistency of staff providing support leading to significant challenges in building a trusting relationship.

We were concerned that despite all the strong arguments for people to have care plans and a care coordinator our sample of respondents reported that they did not have clear care and support plans.

Again, despite Scottish Government guidance around trauma-informed psychological matched care support, our respondents described that staff were not trauma-informed. We were concerned to learn that the staff shortages are resulting in people having to retell their traumas.

We heard about the particular difficulties for certain groups of individuals. These comments were not so frequent that we have included them in the list of common themes above however from an equalities perspective we were made aware of particular difficulties around the additional complexities around care settings when young people have a mental health condition and problem substance use.

Some women reported that they were often asked about whether they were engaged in sex work in order to fund their addiction. They experienced the way in which this was asked as pejorative. Women reported that they are more likely to lose their children to alternative care arrangements.

Finally, in terms of access, services that are based on a Monday-Friday, 9am -5pm model do not work for all and it was suggested there should be a move away from this traditional model of timings of service delivery.

Our respondents told us what was important to them. The list is noted in the box above. Some of what they describe goes beyond the deficit models they are experiencing and speaks to a model of service delivery that seeks to extend a person's capabilities. They have a right to expect this.

> *"I just want to see change, I've lived more than half of my life with this condition...and all I see is people dying or being forgotten about."*

Chapter 3: The voice of relatives/carers of people with mental health conditions and problem substance use

The Carers (Scotland) Act 2016 came into force on the 1 April 2018. The Act provides rights to carers including rights of involvement and a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria.

One of the identified outcomes of the Rights, Respect Recovery report from Scottish Government in 2018[12] was that children and families affected by alcohol and drug use would be safe, included and supported. It stated that "families" includes anyone who is concerned with another person's drug use.

The document acknowledged the far-reaching consequences for families including family breakdown, financial worries, social isolation, stigma and the increased risk of adverse childhood experiences (ACE's) affecting children in later life. Support from friends and family can be a key component of recovery as outlined by people with lived experience in the previous chapter but carers need support in their own right.

The Family Recovery Initiative Fund (FRIF) was set up in 2018 to enable the development of support groups to help families by offering small grants and the government has committed to continuing this.

What we expected to find

In light of the above legislation and policy initiatives we expected to find that families were included in all conversations about an individual's care, where appropriate, and that their input was encouraged and supported. We also expected that they would have access to support and education in their own right and that systems and services are in place to allow this.

What we heard

We received 65 completed online questionnaires and spoke to 12 friends and family face to face or on Zoom. Of the 77 family members/people we had contact with, 67 were female and 9 were men (87/12%), with the majority (60% n=46) being in the 45-64 age group. 40% (n=30) of those supporting someone were parents of the individuals (with 28 of those being mothers (93%)) and 30% (n=20) were children, some of whom, were young carers. We had replies from people who lived across 12 different health board areas with the highest numbers coming from Greater Glasgow and Clyde =19 (25%), Lothian = 11(14%), Grampian = 10(13%), and Forth Valley = 9(12%) .

About half of the families we spoke to said their relative had been diagnosed with both a mental illness and problematic substance use by a doctor.

78% of them said that they felt their relative's substance use was a way of dealing with their mental illness.

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[12] Rights, respect and recovery: alcohol and drug treatment strategy - gov.scot (www.gov.scot)

74% were aware of mental health assessments being carried out but most reported they had had no part in them.

"NO NEVER!"

"Yes. Have been in appointments with him in tears and begging for help to no avail."

The impact of having a parent with a mental health condition and substance use problem was highlighted in the responses too. Young people commented on the overwhelming responsibility they had taking care of their parent, other siblings, running the house and juggling school or college.

"My younger siblings have been in and out of the care system, on at risk registers. I was forced to leave home at 16 with little to no support system and I left school at 14 due to not wanting to leave my mum alone and with my younger siblings which has affected our mental health and future prospects."

The effect on younger children and extended family was also immense.

"My relative has three children under 10 whom she has been unable to care for. The children now live with other family members."

Impact on the family

The impact of supporting a family member with a mental health condition and substance use problem is far-reaching and devastating. We asked families about this and some of their responses are illustrated in the word cloud below.

The mental and emotional stress on families was evident.

> "W*e are done in! We love him, support him but it's been such a struggle to get him any support. When we do it's awful, judgemental, inconsistent and minimal. No support for us. Scottish families only found by ourselves eventually and helped for 8 weeks with CRAFT[13] training".*

> "*This is a cruel destructive illness. I am grieving for my loved one that I have lost although physically he is not dead yet.*"

We were keen to find out what support families had to help them cope while also helping their family member. One of the overriding positives in the responses was the support families had had from family support groups. The many glowing reports regarding Scottish Families Affected by Alcohol and Drugs (SFAD) were testament to that; they were described as "fantastic", "amazing", "brilliant"," great support" and "couldn't do without them." Families Campaign for Change were called "a lifeline".

Several local carer centres were also said to have provided excellent support for the families

In terms of family support from services, 39 respondents of 77 stated they had been offered no support at all and many were finding it increasingly difficult to cope.

> "*No connection with family in same household to support plan and aid open communication Too quick to discharge if struggling with engaging NO HELP WHEN IN CRISIS!!!*"

> "*I feel very alone and scared*".

Others acknowledged that lack of resources and training made the situation worse

> "*…addiction services and mental health services are complex and outdated. They need reform, they are understaffed and underfunded and very, very neglected.*"

Adult support plans
Under the Carers (Scotland) Act 2016 act local authorities have a statutory duty to offer an adult support plan to adult carers or a young carer statement. This is to assess the support needed to allow the carer to continue caring and separate from support provided to the individual. Only six (8%) families had been offered an adult support plan or young carer statement. Eleven (14%) commented that it did not apply to them but did not explain why. Forty eight (62%) said they not been offered one. Thirty one people (40%) said that they had been informed of support but of those, 20 (65%) did not feel they had enough support to help their relative.

Attitudes
The civil rights activist Maya Angelou famously said that 'people will forget what you said, people will forget what you did but people will never forget how you made them feel'. When

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[13] CRAFT is an organisation that offers training in all aspects of managing and strengthening relationships in families. The Commission cannot comment on the training. We have added this footnote to clarify the meaning as presented in this quote only.

we asked families about their experiences of attitudes towards them from services the term "judgemental" was mentioned 25 times in the responses.

Support from friends and family is invaluable but many families faced difficulties maintaining that support. Forty per cent (n=30) commented that even those close to them struggled to understand, and those that did often withdrew as time went on without any resolution.

> *"The general attitude is that they do not matter, they are a drug addict and therefore, in their minds and attitude, a waste of time, effort and energy."*

The impact of this led to families feeling guilty and inadequate. Many admitted to negative feelings about themselves and blamed themselves unnecessarily.

Twenty six per cent (n=20) of our respondents told us about their experience caring for a parent. They were also aware, even as children, of the impact of other people's opinions.

> *"When I was a child this impacted me… as I grew older I became more educated and aware of my mum's condition and became more defensive for her rather than embarrassed."*

Family involvement

Some of the stress on families comes from their exclusion from any plans to help their relative. Services are frequently short sighted when it comes to the valuable information families have on an individual's past history and the support they can provide.

> *"He tells me no one has called him, no letters are received and they won't speak to me due to GDPR[14] even though my son wants me to deal with everything as he can't cope."*

> *"Services must listen to what the families have to say - they know the person before illness, during illness, and on recovery. We have the full picture of the full person - we see them as a whole; not just a list of symptoms and behaviours."*

The daily reality for some families cannot and should not be underestimated.

> *"Exhausting. Our own mental health has suffered due to the stress of dealing alone with my relative's addiction and mental health problems. We feel totally abandoned by a broken system which refuses to help those most in need. ….The only way out seems through suicide".*

What we learned

The overriding message from speaking to families is the lack of support, care and treatment they feel is available to their relative and themselves. They describe patchy, inconsistent services who fail to properly engage. Their own input is frequently dismissed and they are often excluded from any care and treatment plan. The lack of crisis support, advocacy and rehabilitation services were also highlighted.

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[14] GDPR is the General Data Protection Regulation and refers to regulations around how personal data is gathered, used and managed.

Both the NICE guidelines and the 'Orange Book' guidelines specifically mention the involvement of carers and families in the development of care plans. This often starts from the assessment process. Our sample showed that three-quarters of families were not involved. The lack of involvement and the lack of carer support are not due to a lack of policies around this but due to a failure of implementation.

We were also concerned at the way in which families feel judged with regards their relatives developing these conditions, this is in keeping with the stigma that people with lived experience described in the previous chapter.

The final report of the Drugs Death Taskforce called for an end to stigma as an essential element in Scotland's fight against its high rate of drug-deaths. Our work confirms that stigma is preventing these issues being seen as the health problems that they are and is compounding the suffering for individuals and their families and carers.

Chapter 4: The views of professionals

What we expected to find

We expected professionals in primary and secondary care and in non-NHS settings to describe approaches informed by the policies and standards described in our first chapter. That is, services which ensure that individuals are never turned away, or passed from service to service, or told that their treatment is conditional on another treatment.

What we heard

Primary care

Eighty nine GPs from 10 different health boards completed our questionnaire. They worked in a mixture of urban and rural areas as shown in the graph below. 68 of these GPs (77%) worked in areas that were more readily accessible to patients (about 30 minute to drive to an area with a population of 10,000 or more) and a further 10 worked very remotely (more than a 60 minute drive to an area with a population of 10,000 or more).

Figure 5 Areas GPs work in by percentage
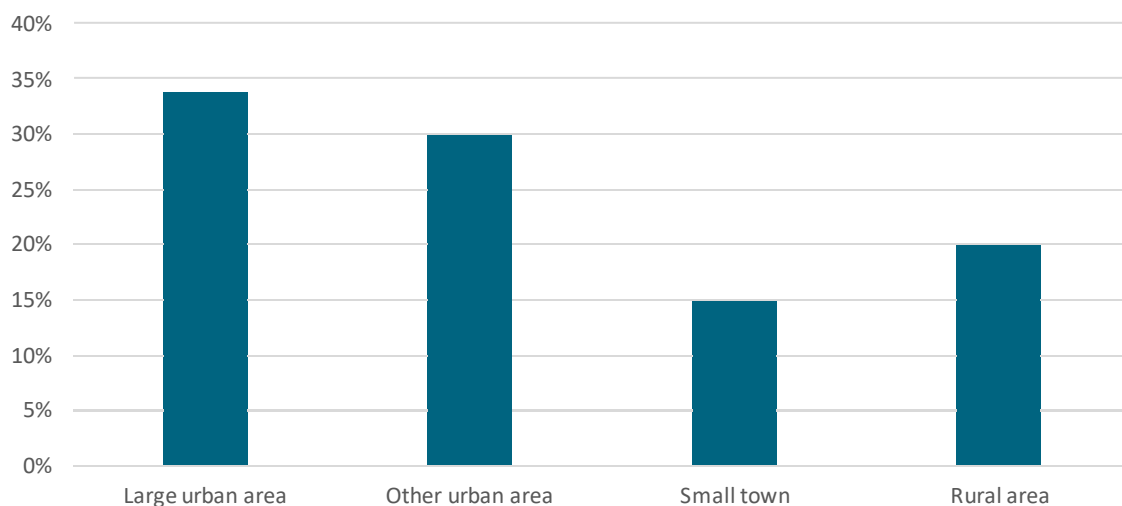
A large urban area was considered as populations of 125,000 or more; other urban area was considered as populations of 10,000 to 124,999; a small town was considered as populations of 3,000 to 9,999; and a rural area was considered as populations less than 3,000.

65 GPs stated that they worked with individuals who experienced both mental health and problem substance use on a weekly basis (75%) with others saying it was less than weekly. Only 1% (n=1) of GPs stated they did not currently work with people with the two conditions diagnosed.

Secondary care professionals

Ninety five secondary care professionals from a variety of disciplines from 12 health board areas completed our questionnaires as below.

Figure 6: Secondary care respondent disciplines by percentage
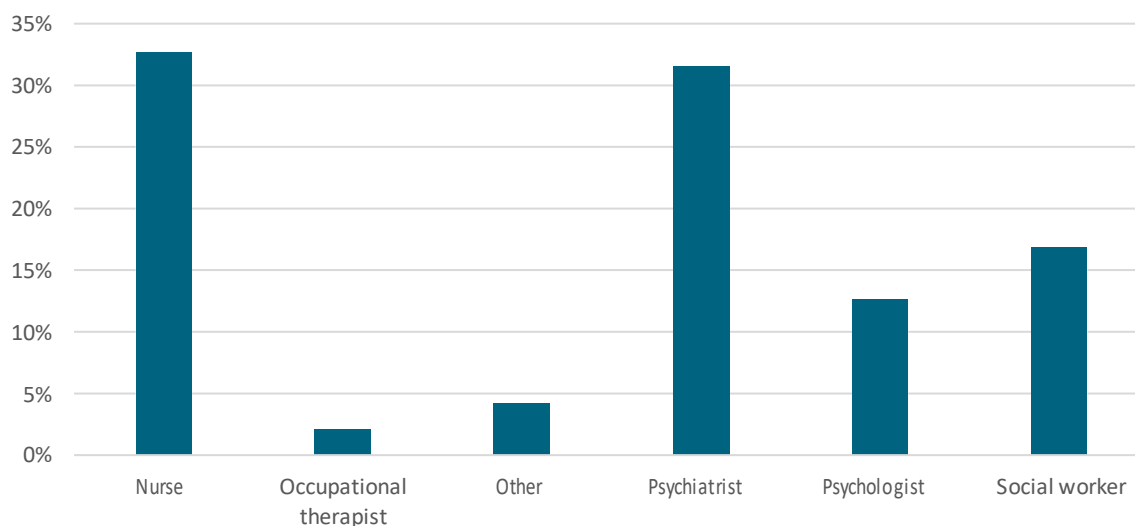
36% (n=34) worked within a community mental health team (CMHT) and 36% (n=34) worked within addiction services. Others worked within inpatient mental health or addiction services and social work, pharmacy, homeless services, liaison psychiatry or forensic services.

52% (n=49) worked within a large urban area (population of 125,000 or more), whilst 28% (n=26) were within other urban area (population of 10,000 to 124,999), 15% (n=14) small town (population of 3,000 to 9,999) and 5% (n=5) in rural areas (population less than 3,000).

77% (n=73) of secondary care staff respondents worked with patients with a mental health condition and problem substance use on a weekly basis,17% (n=16) work with individuals with both mental health conditions and substance use problems less than weekly and 5% (n=5) don't currently work with this group of people.

Non-NHS professionals

There were a total of 61 respondents from 9 different health board areas. 30% worked in a large urban area, 36% in another urban area, 31% in a small town and 23% in rural areas.

Of the 61 respondents, 46% of respondents worked in a local authority, 28% from Police Scotland, 15% were from the third sector,10% were from the voluntary sector and 3% were described as independent. 11% reported that they worked in the NHS (somewhat confusingly, but this may relate to NHS staff working within or being seconded to non-NHS services).

84% of non-NHS respondents stated that they worked with individuals with a coexisting mental health condition and problem substance use on a weekly basis, whilst 10% stated it was less than weekly. The majority of respondents 72% told us they work with those who use drugs and alcohol. 63% work with those with mental illness such as anxiety and depressive disorders and 49% work with those with severe mental illness such as psychosis. They work

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in services that include: home care/housing support service/those who are homeless, all adults (including those with a learning disability, physical disability and mental health difficulties), and adults with a forensic background/offending behaviour, young carers, and those with acquired brain injury. They provide advocacy, counselling, practical support with daily living, welfare, housing, and in the case of the police, immediate emergency response and protection of life.

Current service provision

In relation to current service provision, only 16% (n=14) of GPs and 23% (n=21) of NHS professionals agreed that adequate care and treatment is currently provided. Only 4 of 61 non-NHS professionals agreed that adequate care and treatment is currently provided.

Police officers told us there is:

> "Little/no out of hours support for people, police/ambulance are constant fall back for other services, when neither are the appropriate services to offer meaningful assistance beyond an assessment at A&E."

19% of secondary care staff (n=15) were aware of agreed care arrangements and responsibilities between primary and secondary care. 16% (n=12) were aware of policies outlining how services should work together.

90% (n=79) of GPs felt there were gaps in service provision and had experienced difficulties in referring patients to both mental health services and addictions services, including when the patient presented in crisis.

GPs reported that referrals can be declined from community mental health services due to the person's substance use, without any further assessment or signposting, leaving the GP to re-refer to other supports. A number of GPs felt unsupported in managing substance use, stating that the local addictions team would only see patients for opiate replacement therapy. GPs reported that they were left to manage people who were dependent on benzodiazepines or gabapentinoids.

> "If the patient has any substance abuse then mainstream psychiatry services will automatically reject any referrals and tell us to refer to the addiction services. Even when the main problem at that time is the mental illness".

> "Psychiatry locally give the impression that they do not accept the concept of dual diagnosis- it is common to see substance or alcohol misuse listed as the principle issue and a plan for care by the addictions team, who are distinctly separate from the mental health team, with no mental health team input if substance or alcohol misuse is apparent."

80% (n=79) of GPs identified barriers to referring patients to mental health and/or addition services. In particular primary care reported long waiting times for assessment, difficultly accessing mental health assessments due to patients' ongoing substance use, lack of resource in secondary care services to offer appointments due to staffing levels, patients discharged due to non-attendance at secondary care appointments and under-resourced services using complexity as a reason to decline referral.

Secondary care staff identified that in the majority of areas, people can access support from community addiction services (this is a service primarily designed to meet the needs of people with addictions) and/or the local community mental health team (CMHT). Most respondents (61%) reported that there was no separate 'dual diagnosis' team, 24% did not know if such a team existed and 13% said that there was a 'dual diagnosis' team. Other services/professionals that they were able to access through their own multi-disciplinary team (MDT) or through referral are shown in Figure 7 below.

Figure 7 Teams/professionals secondary care can access.
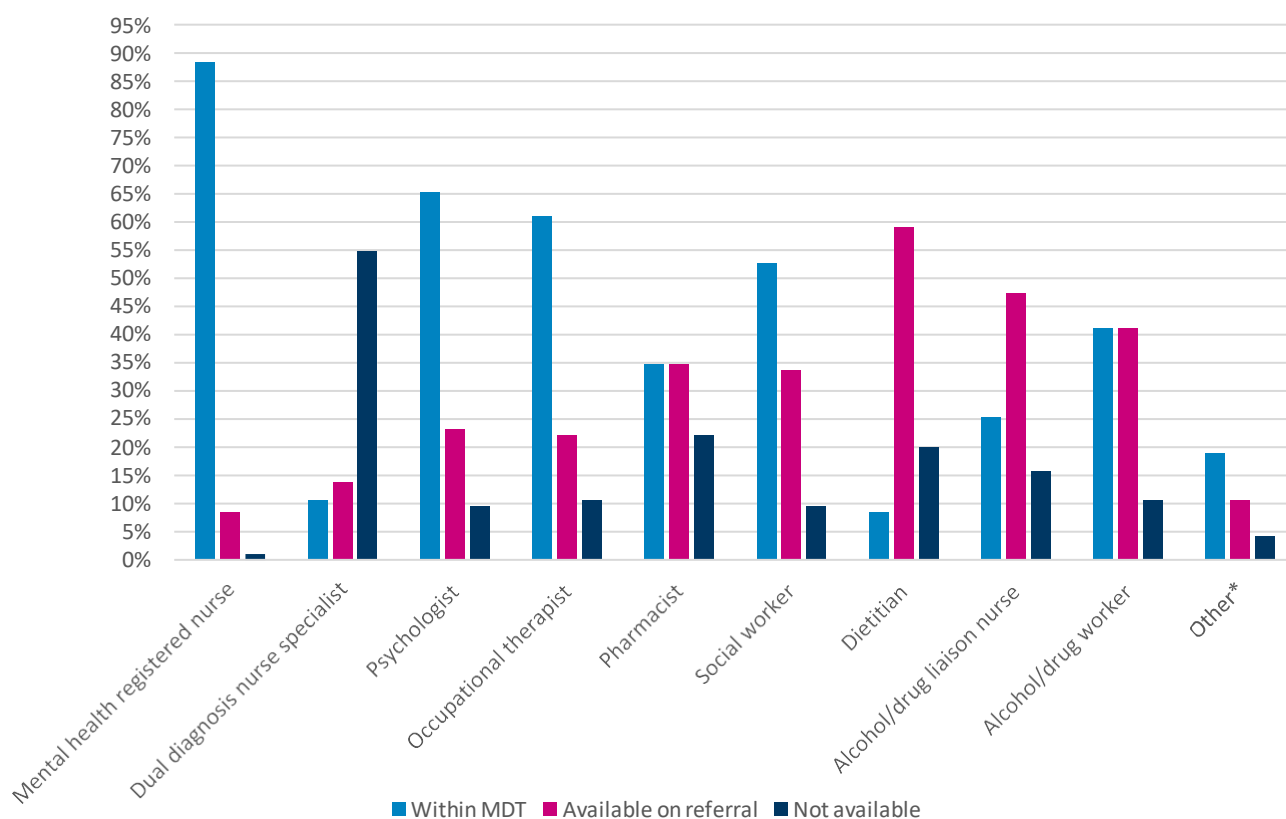
*Other included: Support worker, peer support worker, Psychiatrist, CAAP, Counsellors, Recovery Development workers, and GPs.

Inpatient Services

Sometimes people with mental health conditions and problem substance use will require inpatient admissions. Fifty seven per cent of secondary care professionals (n=53) identified that adult acute mental health wards (these are wards that admit people with mental health conditions) are available for this. 12% (n=12) identified the availability of specialist in-patient addiction service provision and 3% (n=3) stated there was access to a specialist dual diagnosis inpatient service. A quarter reported that there was no in-patient provision or that they were not aware of this. The most common reason for admission was a deterioration in mental health that led to a risk to self or others. The need for inpatient detoxification was

another common reason for inpatient treatment as was failure to respond to community treatment for either condition with consequent risks.

42% of respondents (n=39) were aware that there was a waiting list to be admitted for hospital treatment. This waiting list was mostly for elective inpatient detoxes, as most patients requiring hospital admission for their mental health were admitted on an emergency basis.

Although most professionals reported that pre-discharge planning with community services occurs regularly, only 19% (n=18) report CPA (Care Programme Approach) with its named care coordinator role, being used routinely as part of discharge planning. Although 46% (n=43) of secondary care professionals report responsibilities for ongoing monitoring are made clear, 67% (n=59) of GPs felt that the responsibilities for ongoing monitoring from primary care was not made clear at discharge.

45% (n=40) of GPs indicated that patients are offered physical health monitoring annually, whilst 37% (n=33) said it was not offered and 18% (n=16) were unsure. Only 16% (n=14) of GPs indicated that there is an agreed local protocol for physical health monitoring. 81% (n=66) of GPs noted that the responsibility lies with primary care. In responses to the survey, professionals reported that the lack of agreed local protocols meant that there was often variation in what services people received. At the time of the survey, responses indicated that routine physical health monitoring had stopped in many practices or become a low priority (this was as a consequence of the pandemic).

Only 13% (n=12) of secondary care professionals stated that an agreed local protocol for the medical monitoring of patients with both mental health conditions and substance use issues exists, whilst 36% (n=34) reported there was no such protocol with 51% (n=47) being unsure.

Care plans

Despite guidance that every person should have a documented care plan, 77% (n=72) of secondary care professionals reported that this did not happen or they were unaware of it. Although guidance recommends the use of CPA, only 26% of professionals (n=24) reported the use of CPA, on a discretionary basis in relation to complexity and risk and not as standard practice. In some cases, it was stated that CPA was not thought to be clinically necessary and other professional meetings were held under local shared care arrangements instead.

Medical monitoring

Individuals with mental health conditions and substance use problems often have physical health co-morbidities requiring monitoring. In addition, medications prescribed for the treatment of their mental health and substance use often require monitoring. Only 13% (n=12) of secondary care staff stated that an agreed local protocol for the medical monitoring of patients with coexisting mental health conditions and problematic substance use exists, whilst 36% (n=34) reported there wasn't with 51% (n=47) being unsure.

14% (n=13) of GPs indicated that all patients with known or suspected mental health conditions together with substance use problems receive an assessment of their mental, physical and social care needs in primary care with 56% (n=48) highlighting that they did not and 30 % (n=27) indicating they were unsure if this occurred. 95% (n=84) of GPs were unaware of an Integrated Care Pathway for this group of patients in their local area and equally 95%

(n=77) of secondary care professionals were unaware of any established local protocols for the assessment and management of patients with both diagnoses.

The families we spoke to echoed these opinions with 67% of the 77 families saying the physical health of their relative was not a priority for health services.

Severity of Illness

Guidance directs that severe mental illness should be managed within secondary care mental health services. 75% (n=67) of GPs indicated that all patients with psychosis were referred to secondary mental health care. In the free text responses to our questionnaires, there was a general theme that GPs feel it is difficult to obtain support for patients, regardless of the severity of their mental health diagnosis, when there is a history of problem substance use.

Awareness of MAT 9 and service readiness/response

Following the introduction of the Medication Assisted Treatment (MAT) standards we were interested to explore how these had been implemented in clinical practice, particularly MAT standard 9 that requires that all people with co-occurring drug use and mental health difficulties receive mental health care at the point of MAT delivery.

39% (n=35) of secondary care professionals respondents indicated that it had been implemented, 66% of whom worked in addiction services. 25% (n=23) of respondents indicated that the standard had not been adopted (the majority of whom worked in mental health services). The remaining 36% (n=33) indicated that they were unsure or left this question blank (with the majority being in mental health services).

Retaining patients in treatment

45% (n=41) of secondary care professionals stated that patients are discharged from follow up when they do not 'engage' i.e., miss a defined number of appointments (this is not nationally set). However, this appears to be dependent on the patient's presentation- if there are concerns about risk, then further attempts to engage the patient will be trialled.

Non-NHS based professionals agreed with the sense of current difficulties. Their responses suggested a lack of joined-up working across the sector and they were similarly concerned about the exclusion of people from individual services.

Homelessness was cited as a particular exclusion criterion by non-NHS professionals (working in the third sector) who reported that they had experienced community mental health teams rejecting referrals for individuals who were not living in stable accommodation. For services who support individuals with co-occurring mental health conditions and problem substance use who are without stable or secure accommodation this exclusion criteria felt discriminatory and stigmatising.

> "The biggest obstacles we find are from the actual agencies/services themselves, not the clients" (housing support worker)

For individuals and those who support people who are regarded as homeless they challenged the view of people being hard to reach; instead they shifted the focus to services and the need for them to 'reach out'. For staff who support people who are homeless it seemed a rather

uncomplicated endeavour to 'reach out' and engage with individuals. They further extend this view by suggesting homeless people are in full view of the public and can be located at various predictable places in towns and cities across Scotland.

Lack of accommodation, frequent moves and lack of consistent care poses an increased risk of exploitation; deterioration in mental health, propensity to move towards substance use as a form of self-medicating and concerns that people, young and old, may become 'lost' or 'abandoned' by statutory and non-statutory services were noted. The 'No Wrong Door' approach tells us that it is the responsibility of services to join up and flex support, not the individual to develop and navigate the complexities of their own care plan.

What we learned

Work from the National Confidential Inquiry, the Safer Services Toolkit (updated 1 July 2022) shows that in England, there was a 25% fall in rates of suicide by patients in those NHS Trusts which had put in place a policy on the joint management of patients with co-morbid alcohol and drug misuse.[15]

We didn't find these policies here. Instead we learned that, despite the guidance in Scotland that emphasises the need for clear written protocols on joint working, the absence of, or lack of awareness of protocols for joint working is striking and somewhat hard to believe.

Our work further highlighted that there is even a lack of recognition of the need to address substance use and mental illness concurrently, whilst the substance use may be perpetuating the problem, without treatment of their mental state, it is likely that the person will struggle to stop using substances.

> *"It's the chicken and the egg. They use drugs to help with mental health however this isn't treated as they are using drugs. Mental health support in this team doesn't appear to be taking place and predominately is about the drugs/alcohol issues."*

Supporting individuals through crises

NICE guidance [NG58] states that it is important to:

> "*Ensure practitioners have the resilience and tolerance to help people with coexisting severe mental illness and substance misuse through a relapse or crisis, so they are not discharged before they are fully equipped to cope or excluded from services.*"

The 'Orange Book' highlights the need to act when a patient presents in crisis due to the high risk associated with a deterioration in their mental health, physical health or substance use. This guidance further highlights that most addiction services are designed for the planned management of drug use and are not appropriately resourced to respond to crisis situations. The staffing issues that have been highlighted by individuals, carers and professionals we engaged with prevent the development of the resilience required to make good on the aspirations of the NICE guidance.

There were isolated comments that indicated that there was a shared care protocol in some services that appears to operate in crisis situations. This may be through the Psychiatric

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[15] display.aspx (manchester.ac.uk) (accessed 03 August 2022)

Emergency Plans that Boards are required to maintain although this was not specifically mentioned in responses to our questionnaire.

The implementation of the MAT standards

Standard 9 highlights the expectation and need for mental health services, substance use services and social services to work jointly in a holistic manner to improve access to care for those with co-occurring mental health conditions and problem substance use. The standard further sets out the expectations of each service in delivering this standard. In our reading of the extant policy documents and guidance, MAT 9 is a restatement of what should already be taking place. It is suggested that delivery of this MAT standard centres around a 'no wrong door' approach, as mentioned in the 'Orange Book' and quoted in the introductory chapter. The Royal College of Psychiatrists in Scotland, in setting out its priorities for Scottish parliament in 2021-26, refers to a 'No Wrong Door' approach and describes a public health-led approach to addressing drug and alcohol addictions, including access to care and treatment for those with a dual diagnosis.

Our data shows that professionals in addictions services are more aware of the MAT standards than those in mental health services. The recent (June 2022) Public Health Scotland Benchmarking report[16] that provides detail on the extent to which the first five standards have been implemented shows that there is a real challenge ahead. Whilst we welcome the clarity in the report, that as the Minister for Drugs Policy aptly describes 'pulls no punches' (p5), we look forward to seeing in future updates, the evidence around the implementation of MAT 9, that will ensure that we have a measure of the extent to which services are working together for the individual.

For the moment, we are disappointed that our data shows that only 26% of professionals report the use of the care programme approach (CPA) as a mechanism to ensure shared care, clear care-planning, and a named care-coordinator. This is recommended in the 'Orange Book' and is set out as an example of meeting the criteria in MAT 9.

> *"I do try to do that in practice, suggesting that a drug problem is not a mental health problem is a false dichotomy. Designing services that propagate that dichotomy seems likely to lead to failure."*

> *"Never heard of this and I would be surprised if people engaging in substance use get good access to mental health treatment because most of the specialist services (such as the psychological trauma service) won't see people with substance use problems."*

Similarly, on MAT standard 3 that aims to ensure that people at high risk of drug-death are assertively followed-up and references the need for a multi-service approach to engaging and maintaining people in care and treatment, we note the Public Health Scotland (PHS) report that shows partial implementation of this standard in 69% of the alcohol and drug partnerships.

Our data noted that in some areas, more assertive outreach is carried out than in others and that community mental health teams are more likely to discharge patients due to non-

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[16] National benchmarking report on implementation of the Medication Assisted Treatment (MAT) standards. 2021/22 (publichealthscotland.scot)

engagement than addiction services are. It was noted that unless there is significant risk or the patient requires community supports or use of mental health legislation, then they are likely to be discharged due to non-engagement. There is rarely a co-ordinated approach to non-attendance by all relevant services with decisions based on individual presentation and associated risks.

Given that only 16% (n=14) of GPs and 23% (n=21) of NHS secondary care staff agreed that adequate care and treatment is currently provided, there is much work to be done to implement the existing guidelines. There were suggestions in comments from professionals about creating specialist 'dual diagnosis' teams however we felt that this would set up further barriers rather than reduce them. We were also mindful of recommendations made in NICE guidance NG58 that suggests that services should *'Adapt existing specialist services to meet both a person's coexisting severe mental illness and substance misuse needs and their wider health and social care needs. Do not create a specialist 'dual diagnosis' service."* (1.5.6)

From people with lived experience we had heard about the impact re-telling their story has on reliving past trauma. We had heard of the difficulties around staffing that has compounded this issue as continuity of care is lost. It was therefore very encouraging to hear of the model in North Angus, that has broadened the workforce to include peer-workers and by being a 'one-stop-shop' is consciously trying to avoid people having to re-tell their trauma.

Box 2

North Angus 'Hub': an inclusive model of acceptance into support, treatment and recovery.

This model included mental health nurses, medical staff, social workers, occupational therapists, psychology, third sector staff along with local authority colleagues from housing services. There was also a primary care pathway.

Important to the success of this model was the employment of peer support staff. People with living experience (peers) not only provided support to individuals but due to their specialist background knowledge helped break down barriers to services such as psychological therapies. As a collective service it was recognised peer support workers were in a unique position to really understand the daily challenges individuals' experience with their mental health and the complex nature of substance use and navigate the complexities of the mental health system. They could make referrals to other parts of the service.

From the outset it was agreed that 'no referral would be refused'. While referrals would be 'triaged' this was not undertaken as an inclusion or exclusion criteria only to determine who within the Hub would be the best fit for the individual. To ensure individuals referred into the Hub were met with the right staff, each person would be invited to meet with two members of the team. For example the first appointment may be with a mental health nurse and staff from local housing department. The individual is given a choice, consider their immediate needs and who is best placed to assist.

The 'assessment' in this service is the initial referral or if the individual has 'self-referred' then this will be considered the assessment. By adopting a 'one-stop-shop' approach this reduces the necessity for the individual to re-tell their story as they will be met with a team that is cohesive, communicates effectively and is motivated to keep the individual at the centre of their service. If an individual decides they do wish to have input with a specialist from the Hub for example an occupational therapist, an additional more in-depth assessment will be undertaken

Of the 850 referrals into the Hub none were 'rejected'. Many were supported to consider their mental and physical well-being, harm reduction in terms of risky substance use, housing and income maximisation. There was also support with parenting and relationships and signposting to social supports within communities.

We also heard about North Ayrshire Drug and Alcohol Recovery Service (NADARS). NADARS comprises professionals including nurses, social workers, addiction workers, occupational therapists, GP and pharmacist prescribers and staff with lived experience of alcohol and/or drug issues. In recognition that many individuals present to NADARS with co-occurring mental health conditions and problem substance use, NADARS staff also include psychological therapists, registered mental health nurses and consultant psychiatrists. NADARS continues to evolve, responding to the needs of individuals including responding to physical and sexual health and wider family and social issues. They have one door and it is open for support.

The North Angus Hub and NADARS are evidence that when services take on the responsibility to join up support, it works.

Chapter 5: Conclusions and recommendations

Scotland's problems with alcohol and drug misuse are well known, with recent reports showing shockingly high levels of death due to problem drug use and rising numbers of deaths due to problem alcohol use.

The Mental Welfare Commission's own data, and that of government and health authorities in Scotland, show rising rates of mental ill health.

This report looks at the combination of these issues for our population. It finds that services are not meeting the needs of people who have both mental ill health and problems with alcohol and/or drugs. Those providing the services know this; they told us.

This is not for want of a lack of evidence or guidance on how to tackle it. There is abundant guidance, standards and policies at a national level. We found a failure to implement the guidance at the local level and translate it into coordinated, integrated support for some of the most vulnerable adults and their relatives.

This requires focus on developing the capacity and the resilience of the workforce and measures to retain staff. We heard repeatedly about the lack of staff. Without a skilled, compassionate, committed workforce, it will be increasingly difficult to deliver the care and treatment people rightly expect from public services. This focus on the workforce should include measures to improve skills in assessment of problem substance use and mental health conditions, trauma-informed approaches to care, and reducing stigma towards people who have a complex health problem.

It also requires managers/leaders at the local level to develop clear local protocols and models of delivery that operationalise national guidance and provide clarity to front-line professionals. There is then a need to embed new models and for awareness raising of protocols that emphasise the joined up working, holistic care that existing guidance and standards seek to direct and prevent the 'bouncing' of individuals between services that we were made aware of.

We must ensure that 'No Wrong Door' means that every door is open.

There is hope. The Angus Hub rejected none of their 850 referrals. The NADARS integrated approach works with people, as individuals, holistically addressing whatever is important to them. They show it can be done; there can be no excuses, the exclusion that many individuals and their families and carers experience must end.

Recommendations

To health and social care partnerships (supported by health boards and local authorities) by October 2023:

1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use (if one does not already exist)*.

2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care-coordinator identified.

3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.

4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement.

To NHS Education for Scotland (NES)

5. NES to consider with relevant stakeholders, and report on how educational and improvement programmes for professionals working in mental health, addiction services and social care might:
   a. Embed a trauma-informed approach to care and treatment of people with mental health conditions and problem substance use;
   b. Address stigmatising attitudes within professionals towards people with mental health conditions and problem substance us.

To The Scottish Government

6. The Scottish Government should monitor the delivery of the above recommendations and work with health and social care partnerships (and associated health boards/local authorities) and NES to support consistency and address any barriers to delivery over the next 12 months.

*In the **absence** of or pending such a written policy/service delivery model for integrated care for this group**, to avoid any inadvertent exclusion now**, the Commission considers that the lead service for this group that require secondary care mental health services and addictions services**, should be secondary care mental health services (with support from addictions services as needed).*

Appendix 1: Participants at consultation and questionnaire stages of this project

Stage	Who we consulted	Number of people/ organisations
Consultation	Aberdeenshire HSCP, Clackmannanshire and Stirling HSCP, Scottish Prison Service, National Drugs Death Taskforce, NHS Western Isles, Community Integrated Care (third sector), Glasgow HSCP, Highlands & Islands HSCP, Scottish Recovery Consortium, Mid & East Lothian Drugs, Scottish Government (Alcohol and Drugs Partnership Support Office), Police Scotland, Public Health Scotland, Veterans First Point, Scottish Health Action on Alcohol Problems (SHAAP), Falkirk Council, Scottish Recovery Consortium, Midlothian Substance Misuse Service, Nemo Arts, Social Work Scotland	20 organisations
	Focus group with lived experience: Scottish Families Affected by Alcohol and Drugs	15
	Individuals & Carers	4
Surveys	Individuals with lived experience – face to face	29
	Individuals with lived experience – online responses	36
	Carers/families – face to face visits	12
	Carers/families- online responses	65
	General Practitioners- online responses	89
	NHS Secondary care professionals – online responses	95
	Non NHS professionals- online responses	61

Acknowledgements

national
preventive
mechanism

Recommendation *East Dunbartonshire HSCP*	Self-Evaluation *(where we are at currently in relation to this recommendation)*	Activity *(what do we need to do to meet this recommendation)*	Audit *(how will we know we have met this recommendation)*	Timescale *(when will this identified activity be implemented/ completed)*	Who is responsible *(for driving this improvement activity)*
1. There should be a clear written policy/service delivery model reflecting national standards and guidance, outlining the expectations for the holistic, joined up care of people with a co-occurring mental health condition and problem substance use (if one does not already exist).	In East Dunbartonshire we have Operational Procedures for both our Alcohol and Drug Recovery Service (ADRS) and Community Mental Health Team (CMHT), and additionally an interface procedure and written Protocol where there are co-occurring mental health conditions and problem substance misuse. In response to the National Drugs Mission as part of our locality Drug Death Prevention Action Plan we have undertaken significant local work on our interface practice, culture and procedures during 2022. The existing interface document was reviewed jointly by managers within the CMHT & ADRS.	Recommendations and improvement actions to be agreed and implemented following joint review of East Dunbartonshire CMHT / ADRS Interface Protocols. Approval through locality governance structures.	Implementation of updated joint protocol.	March 2023	Mental Health Operations Manager & Joint Manager Alcohol and Drug Recovery Service
2. Audits should be undertaken to ensure that every person with a co-occurring mental health condition and problem substance use has a documented care plan with a care coordinator identified.	In East Dunbartonshire we have allocated workers and lead professional in place across our nursing and social work teams in both the CMHT and ADRS. Care plans, CRAFT Risk Assessments and Risk Stratification are in place and held within local information systems; Carefirst, EMIS and DAISy.	We have already identified an improvement action to look at the potential for joint care plans across the CMHT & ADRS, with identification of an agreed lead worker for both services where there are a co-occurring mental health and substance use issues. Audit across disciplines to be completed.	Care plan and worker audit to be completed. Review completed re joint care plan and lead professional.	May 2023	Mental Health Operations Manager & Joint Manager Alcohol and Drug Recovery Service
3. Protocols should be in place detailing agreed approaches for people who disengage with services and this includes people with co-occurring mental ill health and problem substance use.	In East Dunbartonshire our Alcohol and Drug Recovery Service work in accordance with the overarching Greater Glasgow and Clyde policy 'Alcohol & Drug Treatment Services - Did Not Attend (DNA) Minimum Standard Guidelines' which sets out risk assessment protocols, further appointment standards, and criteria for assertive outreach to be put in place and our service is fully compliant with this policy which is part of our locality Operational Guidance. Similar protocols are established within our Mental Health Services.	Protocols are already in place. As recommendation (1) locality interface document has been reviewed and any subsequent updates will reflect approaches for people who disengage. .	Implementation of updated locality joint protocol document.	March 2023	Mental Health Manager & Joint Manager Alcohol and Drug Recovery Service

| 4. Psychiatric Emergency Plans should be reviewed to ensure that sections that set protocols for the care and treatment of those individuals presenting intoxicated provide a mechanism for contemporaneous and subsequent engagement. | East Dunbartonshire is part of NHS Greater Glasgow and Clyde where the board wide Psychiatric Emergency Plan is established and regularly reviewed.

Mental Health Assessment Units (MHAU) are established with a focus during triage and risk assessment on substance and alcohol presentation / use as detailed within NHS GGC MHAU Standard Operating Procedures; locally enhanced arrangements for subsequent engagement are established.

Additionally measures to ensure robust and consistent care and follow up for non-fatal overdose are also in place in East Dunbartonshire in partnership with Turning Point Scotland's Non-Fatal Overdose Pathway. | We are currently exploring with a number of other local Health & Social Care Partnerships funding arrangements via our Alcohol and Drug Partnership to extend the Turning Point Scotland NFO Pathway project. | Extended Turning Point Scotland NFO pathway partnership arrangements with East Dunbartonshire. | March 2023 | Alcohol and Drug Partnership Coordinator. |

** In the **absence** of or pending such a written policy/service delivery model for integrated care for this group, **to avoid any inadvertent exclusion now**, the Commission considers that the lead service for this group that require secondary care mental health services and addictions services, should be secondary care mental health services (with support from addictions services as needed).*

Chief Officer
Caroline Sinclair

Agenda Item Number: 10.

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner Meetings September 2022 – September 2023

Updated 20/09/22

Standing items (every meeting)
Minutes of last meeting (JC)
Internal Audit Update (GMcC)
Committee Agenda Planner (JC)
HSCP Annual Delivery Plan Update (JC)
Care Inspectorate Reports as available
Relevant Audit Scotland reports as available
HSCP Committee Agenda Items – October 2022 (Special Meeting to approve Annual Accounts 2021/22)
Final Audited Annual Accounts 2021/22 (JC)
Audit Scotland Annual Audit Report (PL)
HSCP Committee Agenda Items – January 2023
Internal Audit Update (GMcC)
Interim Internal Audit Follow Up Report (GMcC)
Performance Management Update Qtr2 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update

HSCP Committee Agenda Items – March 2023
Internal Audit Plan 2023/24 (GMcC)
Annual Audit Plan – Audit Scotland (PL)
Performance Management Update Qtr3 22/23 (AC / AW)
HSCP Board Agenda Items – June 2023
Annual Internal Audit Report (GMcC)
Final Internal Audit Follow Up Report (GMcC)
Unaudited Annual Accounts 2022/23 (JC)
Performance Management Update Qtr4 22/23 (AC / AW)
HSCP Directions Log Progress Update
Corporate Risk Register Update
HSCP Board Agenda Items – September 2023
Performance Management Update Qtr1 23/24 (AC / AW)
Final Audited Annual Accounts 2022/23 (JC)
Audit Scotland Annual Audit Report (PL)