

**MULTI-AGENCY INSPECTION FOLLOW UP  
SUBSTANCE MISUSE SERVICES IN  
GRAMPIAN 2009**

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## Background

The multi-agency inspection report of substance misuse services in the NHS Grampian area was published in August of 2007. The unit for inspection was the Drug Action Team area. The report had 24 recommendations, some for individual action team areas, some across the three action teams in Grampian, and some Grampian wide, particularly for NHS Grampian. The partner agencies in Grampian drew up an action plan, and reported quarterly on progress against the recommendations. This follow up inspection took place in March and April 2009. Follow up inspections take a proportionate approach, and the following report focuses on how the partners have performed in taking forward the recommendations from the first inspection.

The inspection process consisted of;

- a position statement from the partner agencies identifying action taken to progress each of the recommendations, what still needed to be done, and documents to support these statements;
- the reading of 10 social work files in each of the action team areas, 5 files where there were children living in the household and 5 where no children were involved, to ascertain the level of joint working;
- 2 weeks fieldwork, when we interviewed those involved in planning, commissioning and delivering services.

We also took account of the information in the recent HMIE reports on the joint inspection of services to protect children and young people in both Aberdeen City and Moray. These reports highlighted concerns about the protection of children whose parents misuse substances. We undertook this inspection simultaneously with a joint follow up inspection taking place in Aberdeen City, conducted by Audit Scotland, SWIA and HMIE, to minimise scrutiny activity. They have reported separately.

The original inspection of substance misuse services was a pilot inspection, so we were not able to benchmark the findings of this inspection with other action team areas in Scotland. At present no decision has been made about any future inspection activity in this field.

## **Introduction**

In the last 2 years, the substance misuse field has seen significant changes. In 2008, a new drugs strategy “The Road to Recovery: A new approach to tackling Scotland’s drug problem” was published. In 2009 “Changing Scotland’s Relationship with Alcohol: A framework for action” was published. This set out the Scottish Government’s approach to tackling alcohol misuse. Audit Scotland produced “Drug and Alcohol Services in Scotland”, which looked at funding for services. Also in 2009 the Scottish Government issued “A New Framework for Local Partnerships on Alcohol and Drugs”, creating local Alcohol and Drugs Partnerships (ADPs) in place of Alcohol and Drug Action teams (ADATs). This framework linked drug and alcohol strategies more closely to Community Care Plans and Single Outcome Agreements. The Scottish Government had produced an outcomes toolkit to help local ADPs improve performance management. These developments are considered in our report.

## Summary

It was clear that there had been much activity, and some important improvements across the Grampian area since our first inspection in 2007.

NHS Grampian had increased resources to develop substance misuse strategic planning. The Director of Public health, as strategic lead on substance misuse for the Board, had demonstrated positive leadership in developing groups to take forward some of the issues raised in our original report. NHS Grampian had worked hard to make partners more aware of its strategic intentions. Clinical governance concerns had been addressed in part but needed to be further developed. A range of initiatives had been introduced to involve GPs in services across Grampian. We found that this had helped to improve matters, but the GP service needed coherent planning to take it forward. Mental health and substance misuse colleagues were working together in Moray to improve the joint planning process for people with co-occurring substance misuse and mental health problems, but this joint approach was less evident in the other two areas.

The involvement of pharmacists had been enhanced. Progress had been made in relation to drug-related deaths, and there had been recent actions agreed to improve the take-up of Drug Treatment and Testing Orders (DTTOs). Local authority and health managers had not developed systematic auditing of files by voluntary organisations. The organisations themselves had often taken the lead, and external audit had not taken place.

The three action teams were making efforts to work more closely together. Across all three action teams outcome and performance measures had been slow to develop. The Scottish Government's outcomes toolkit should provide a framework to proceed with this work. User and carer involvement remained under-developed but recent appointments of staff should address this. Work had been going on in Grampian to revise the substance misuse single shared assessment (SSA). This had not been without its challenges. Although a revision of the SSA had been piloted in Drug and Alcohol services in Aberdeen and Aberdeenshire, which aimed to improve risk management, significantly more needed to be done to command the support and confidence of all concerned.

We found a heightened awareness of the importance of joint working to protect children whose parents misuse substances but this awareness needed to be strengthened through further training, improving shared assessment and addressing any barriers to effective collaboration. The issue of when home visits need to be made to assess risk to children needed to be resolved quickly. SSAs should be consistently audited to ensure that policies and guidelines on protecting children whose parents misuse substances are being progressed. Strategic links between the action teams had been improved, and the move to new ADPs should help this process to move forward. Partners were working together better to create a system to allow more effective sharing of information.

**In Aberdeen there had been a substantial commitment of resources and prioritisation of substance misuse by both the council and NHS Grampian. This had resulted in a significant reduction in the number of people waiting for services and a redesign of services to support an integrated care pathway model. Staff we spoke to described a more positive working atmosphere. However, there was a need to ensure that treatment capacity issues were addressed, that there were better links between services, and closer collaboration between social work and health on assessing and meeting the needs of children with substance misusing parents.**

**In Aberdeenshire we found good forward planning, joint working at strategic level and consultation. The integrated working model was reasonably well embedded at service level, but staff recognised the need to continue to work on this. Aberdeenshire should continue and increase its efforts to develop integrated services in the centre and south of the area.**

**Moray had made slow progress in improving its performance management and commissioning to develop appropriate services for the area. The newly agreed Alcohol and Drug Partnership offered Moray the framework to develop integrated services to respond to identified need. This development should include a review of all substance misuse services, including the integrated team.**

## GRAMPIAN-WIDE RECOMMENDATIONS

### Recommendation 17

**NHS Grampian should ensure that action team partners are clear about their strategic intentions.**

Progress on this recommendation was slow to begin with, but a number of developments over the last year had been important in clarifying the strategic priorities of NHS Grampian concerning substance misuse.

One of the clearest priorities to emerge had been reducing waiting times and increasing service capacity in Aberdeen. Senior managers had set out health action plans and invested considerable additional resource in addressing the capacity problems in Aberdeen. These plans had no parallel in Aberdeenshire or Moray. Stakeholders in Aberdeenshire and Moray expressed the view that the Board focused on Aberdeen to the detriment of progress of partnership in their areas. Nevertheless, there was cautious optimism that the improved opportunities to work together as partners, together with a commitment from health to move to an evidence-based model of resource allocation, boded well for the future.

The Board had given substance misuse top priority. Work was underway to produce a substance misuse strategy based on a needs assessment, and a financial baseline had been established.

The chief executive chaired the joint action team in Aberdeen. The director of public health had been given the executive lead for substance misuse in 2008. Since then she had established a number of pan-Grampian substance misuse groups. We found that these groups were increasing confidence that significant developments in substance misuse would be taken forward with the participation of key partners across all three areas.

There was good representation from across the three areas at these groups. In March 2009 the Grampian substance misuse framework for strategic working was agreed. This set out six underpinning principles for collaboration on planning and performance management between the partners. NHS Grampian had also remitted the standing clinical effectiveness group with the responsibility to ensure that all developments were implemented in line with best practice.

There were good examples of NHS Grampian setting a strategic priority but pursuing implementation within a partnership framework. One of these was the commitment in the Grampian health plan 2009/10 to train doctors, nurses and midwives to provide advice to patients who were consuming harmful or hazardous levels of alcohol. The NHS Grampian substance misuse group was taking this forward through a short life alcohol action group. The remit was to develop a Grampian alcohol strategy and brief interventions action plan. National policy developments, which were likely to have a significant impact on health's strategic direction and the deployment of resources, had been discussed at these pan-Grampian forums.

Partners from HMP Aberdeen and other criminal justice stakeholders spoke of the increased communication and collaboration between prison and the community, with

improved opportunities for prisoners to follow through on treatment and support when they were released. NHS Grampian had produced a protocol on prisoner access to methadone and GP services, whilst a pan-Grampian group had been set up to examine total care in relation to through-care. It should also be noted, however, that the experience of prison-based partners of working with the three authorities was quite different. The pan-Grampian group should help to level out the differences, in the service that prisoners could expect, and the pace of progress on policy development.

In developing a strategy which reflected prevalence and mapped needs across the area, there was an acknowledgement from senior managers in health that more needed to be done to build up intelligence, particularly about people with substance misuse problems who were not known to specialist services. NHS Grampian had recently introduced a substance misuse intelligence group and a system of performance reporting on substance misuse. Work had been done by Substance Misuse Service (SMS) and ADP staff on trend data in Aberdeen, which was to be extended to Aberdeenshire and Moray.

We found that NHS Grampian had been making efforts to ensure partners were more aware of its strategic intentions. The pan-Grampian groups were the vehicles for a more inclusive approach to strategic planning for substance misuse. We found that partners in the public sector were positive about recent developments, but it was too early to find evidence of improvement. The process needed to be more inclusive of voluntary and private providers and front-line staff.

### **Recommendation 18**

**NHS Grampian should develop clinical governance arrangements for substance misuse. They should be supported by guidance, standards of performance and reporting requirements.**

NHS Grampian had begun to make progress on this recommendation after a spell where we found little evidence of activity. There were a number of planned developments which were potentially helpful.

We saw evidence that clinical governance arrangements for substance misuse had a clearer focus and higher profile than previously. Practitioners said that this had been helpful to them and the development of their service.

There was good structural support for linking clinical governance in practice to performance management and planning. The clinical effectiveness and reference group for addictions (CERGA) had been re-formatted to provide up-to date information and best practice guidance on clinical treatments. The operational substance misuse service management meetings included consideration of clinical governance issues, whilst the Grampian substance misuse group also included governance as a standing agenda item. Action team substance misuse activity featured on health's corporate risk control plan, which was monitored and up-dated by the Board. NHS Grampian substance misuse service had produced a template of clinical standards for substance misuse.

NHS Grampian had also made attempts to build management capacity and procedural support to ensure sound governance. As well as the recent appointment of a service manager within SMS it had plans to appoint an additional consultant and a substance misuse nurse consultant, who would have complementary responsibilities.

SMS staff told us that risk reporting and other clinical governance issues were reported to senior managers. More work was needed on a process which allowed staff to be assured that their concerns or suggestions had been addressed or considered.

A local document, “clinical governance arrangements for substance misuse services” - based on the national treatment agency template – was still out for consultation at the time of the follow-up inspection. This draft provided a simple overview of how clinical governance arrangements related to primary care service providers.

NHS Grampian SMS in Aberdeen City had taken the proactive step of commissioning Aberdeen University to undertake a quality audit, using the national quality standards for substance misuse services, to evaluate performance. This audit had been completed shortly before our inspection. The report highlighted the need to communicate with staff on their roles and responsibilities in relation to quality standards, the need to move from hand-written records, which made it difficult to extract and extrapolate data, and recommended an urgent review of the impact of parental substance misuse

### **Recommendation 19**

**NHS Grampian should increase their efforts to promote enhanced contracts for GPs and provide support to GPs in order to develop more equitable services across Grampian.**

NHS Grampian had worked to increase the number of GPs who were willing to engage actively in the shared care of patients with substance misuse problems. Only some of its efforts had borne fruit at the time of the inspection, but we found some encouraging developments.

When we first inspected in 2006/07, we found that there were significant gaps in the numbers and spread of GPs who were willing to treat people with substance misuse problems. Some of these GPs had large numbers of such patients on their lists. We also found that there was a significant variation in the level of shared care engagement from GPs. Some were willing to take over the care of stabilised patients from substance misuse nurses (freeing the latter up to take on more people at the “chaotic” or high risk end), while others ‘hosted’ substance misuse clinics, where nursing staff treated and supported patients on an indefinite basis.

While our original inspection found that NHS Grampian lacked the strategic focus and capacity to address these serious problems, the situation had improved since then. NHS Grampian now had 50 GP practices out of the 84 in the area providing an enhanced contract service for substance misuse. At the time of the follow-up, this included 24 out of 32 practices in Aberdeen, 21 out of 36 in Aberdeenshire and 5 out

of 16 in Moray. More recently, regarding the government targets on Alcohol Brief Interventions (ABIs) 79% of practices in the area had signed up to the local enhanced contract to allow this support to be delivered in GP practice.

NHS Grampian recognised that more should be done to encourage those GPs with an enhanced substance misuse contract to play a full part in treatment and rehabilitation.

Managers had taken the following steps to engage more with GPs and to highlight what could be achieved with full participation:

- the deputy medical director had amended the enhanced contracting arrangements to include a lead GP in each practice. The contract included confirmation that the practice would accept stabilised patients back from the substance misuse service;
- payments had been slightly increased;
- meetings had taken place with signed up practices to discuss operational and support issues involving Aberdeen City SMS/ADP;
- peripatetic GPs had been recruited to provide sessions in those parts of Aberdeenshire where it has been particularly challenging to engage GPs;
- support was provided through on-going training opportunities;
- the chief executive of NHS Grampian had hosted a substance misuse development event aimed at GPs in Aberdeen involving substance misuse staff and the Community health partnership
- five of the enhanced contract practices in Aberdeen now had a six monthly recovery plan with broad objectives agreed with the substance misuse and alcohol and drug partnership;
- an electronic survey had also been carried out of GP practices in Aberdeen city.

The survey showed that most GPs were happy with the substance misuse service their practices provided and 52% said that further improvements could be made. Ninety three percent said that support in terms of additional funding, additional support from ancillary services, and training would encourage them to take on more substance misuse patients.

NHS Grampian had also tried to address the funding issue, although the proposal that there should be a tiered payment model depending on the level of GP input had not been agreed. This had left an unsatisfactory situation with GPs being paid a flat rate per patient no matter whether they participated fully in care and treatment or not. NHS Grampian was continuing their negotiations to address this at the time of the inspection.

NHS Grampian had made additional funding available to expand services, particularly in the city. Front-line nursing staff, many of whom had a long history of working with GPs, said that they had noted a positive difference in the willingness of GPs to assume a greater partnership role. This was partly attributed to greater clarity of expectations from the centre, but nursing staff also felt that their efforts to develop their relationship with GPs had contributed to this gradual improvement.

Despite the strong sense from staff that partnership working with GPs was better now than when we first inspected in 2006, they remained concerned about gaps and delays in treatment, and the gaps between treatment and rehabilitative supports. Bottlenecks in nursing services, including criminal justice services, persisted because too few GPs were accepting stabilised patients back.

As well as the continuing efforts to promote enhanced contracts among GPs, NHS Grampian were trialling other options to increase prescribing capacity through pharmacies. They also aimed to reduce the burden on substance misuse nurses by training paraprofessional staff in monitoring and testing procedures. These developments should make access into and through services better.

The efforts made by NHS Grampian in relation to GP involvement were improving the situation. Engaging directly with GPs through performance meetings and development events were yielding encouraging results, but there was still some way to go. The exploration of options to compensate for continued difficulties with GPs was essential. The results of these efforts should be kept under review. NHS Grampian should develop a plan setting out the prescribing and treatment needs across Grampian, and identifying options to respond to gaps in the service

#### **Recommendation 20**

**NHS Grampian should review strategy and service delivery for people with co-occurring substance misuse and mental health problems. Clinical leadership and pathways of care should be clarified.**

We were provided with a draft document “Delivering for Mental Health: Closing the Gaps”, endorsed by health and all three local authorities in July 2008. The document went some way to addressing the key concern behind this recommendation, which was that people with dual diagnosis were not having their needs met.

The project outlined in the document set out the enhanced training, assessment and joint working arrangements which would drive improvements for people with these complex needs. The project team had been meeting on a regular basis since April 2008 and had reported progress to the local committee of the mental health collaborative. A consultancy firm was commissioned to build up a picture of prevalence, practice and experience across Grampian. It was intended that the findings from consultation should come together with the planning function of the project team, to produce a pan-Grampian protocol in 2009. Three pilot training courses on dual diagnosis were also due to take place in the spring of 2009.

While there was evidence that this was progressing in Moray, stakeholders in the City and Aberdeenshire thought that the work had been mainly left to representatives from substance misuse, with colleagues from mental health not attending regularly enough to make a meaningful contribution. If there was to be ownership of the protocol which emerged from the project, mental health services had to be as fully involved as substance misuse services. There should be more evidence of matched clinical leadership between mental health and substance misuse, and the resources within the mental health collaborative should be used to facilitate wider ownership of this commitment.

We found that mixed views persisted about how best to meet the needs of people with mild-to-moderate mental health problems, who were already engaged with substance misuse services. Some front-line clinical staff said that they would try to keep support within the service, particularly if they had established a good trusting relationship with the individual. However, some nursing staff considered that there was a competence or confidence gap which made substance misuse nurses reluctant to engage with mental health problems. All front-line staff said that when problems were more severe it was still difficult to access mental health or ARBD (alcohol related brain damage) services, and they had little sense of an integrated care pathway. Aberdeenshire had recently commissioned SAMH to take forward ARBD-related development work.

### **Recommendation 21**

**Action teams should review pharmacists' representation to ensure that their important role is recognised and their experience contributes to the development of integrated substance misuse services of the best quality.**

We found good evidence that the role of pharmacists had a higher profile in substance misuse plans in each of the three areas. They were also represented at key planning and clinical governance forums which were pan-Grampian.

There had been a number of positive developments since the last inspection:

- The Grampian needle exchange group was chaired by a pharmacist;
- There was pharmacist representation on the pan-Grampian clinical effectiveness group;
- The NHS substance misuse group, chaired by the director of public health, was attended by a senior pharmacist;
- A consultant pharmacist had been commissioned by all three action teams to progress plans to extend supplementary prescribing by pharmacists.

The last was significant. A pilot pharmacy supplementary prescribing service \* was underway at the time of the follow-up. The patient numbers were small and unlikely to impact on waiting list management in the short term. If the pilot was to be successful and the scheme extended, however, this would be potentially very helpful in building additional capacity.

It was also encouraging that the key partners across Grampian had agreed to pilot brief interventions for alcohol use in community pharmacy settings. Reaching and assisting those who would probably not approach services but whose alcohol use might otherwise become increasingly harmful or risky, was worth pursuing. There could be additional benefits in scoping the extent and nature of otherwise hidden problems.

*\*supplementary prescribing describes supervised prescribing by pharmacists in conjunction with a designated medical prescriber, as a means of increasing prescribing capacity.*

## **Recommendation 22**

**NHS Grampian and Grampian Police, in consultation with action team partners, should establish a standing group for the monitoring and prevention of drug-related deaths and should develop formal procedures for the review of drug related deaths where the person was known to services. The three Action teams should agree a definition of alcohol related deaths and include those deaths with drug deaths.**

Some progress had been made on meeting this recommendation. Local progress had, in some respects, been held up by relevant developments at national level.

The Grampian drug related death monitoring group was reconstituted in April 2008, with refreshed terms of reference and wider representation. The group had been meeting on a four monthly cycle. Minutes of the meetings highlighted wide ranging consideration of how to systematically review and learn from drug deaths in Aberdeen. It had covered data sharing and other key issues. It had established processes to enable Grampian to comply with the national data collection requirements.

The group drew up a position statement regarding drug related deaths following the occurrence of 37 drug deaths (and 6 more suspected cases) at the end of 2008. This served to reinforce to the media and the public that action on such deaths was of concern to all the partners represented on the group.

We found that good work had been undertaken on prevention and harm minimisation. Overdose training which aimed to 'train trainers' had been delivered by Scottish Drugs Forum in conjunction with the Scottish Ambulance Service 'heart start' scheme. Trained staff were then expected to cascade this training to others, especially service users and carers.

Increased collaboration between the action teams and the local prison in Aberdeen had been helpful in putting practical steps in place to reduce the heightened risk of overdose to prisoners on release. A national pilot was about to get underway, which included HMP Aberdeen, involving the supply of naloxone to selected prisoners on their release.

The recommendation to the group to include consideration of monitoring and prevention of alcohol related deaths, had not been actioned, the group having taken the decision to await definitive guidance from Scottish Government. In terms of the disparity in numbers, and managing the differentiation between sudden death related to intoxication and death related to alcohol-related harm over a longer period, there were undoubted challenges in combining the two. We considered this delay was therefore reasonable.

The third aspect of the recommendation related to our concern about the death of a person known to a treatment service being reported to the consultant attached to that service, who was also the designated link with the police. NHS Grampian was asked to formalise this process and separate out operational responsibility from that of drug death review. This had been addressed. All deaths of individuals in contact with or waiting for services were reported to the chair of the Clinical Governance

Committee. If there was a need for a critical incident review this would be set up under the auspices of this committee.

### **Recommendation 23**

**Criminal Justice Social Work Services should review the current position of the Drug Treatment and Testing Orders (DTTOs) in order to ensure that offenders and the courts have credible community-based intervention options. Any such review must include strategic partners and other key stakeholders.**

Progress on this recommendation had gathered pace recently. While there was evidence of concerted efforts to bring about positive change, our experience on field work was that there was still confusion about the reasons behind the relatively low numbers of DTTOs.

Aberdeen City took the lead in setting up a short-life working group in 2008 to explore the concerns about DTTOs. The deliberations of this group were informed by a stakeholder event in October 2008. The group produced a Drug Treatment and Testing Order service improvement plan at the end of 2008.

The perspective of the DTTO team at the time of the original inspection was that offenders who should have been referred for DTTO assessment were not, and that this was because court report writers were not considering DTTOs as an alternative to custody. Despite an acknowledged increase in referrals, in the city in particular, we found that the team still had this concern. We were told, for example, that a recent quality assurance exercise had identified that roughly half of those who should have been considered for DTTO had not been referred to the service. A manager said that people who met the criteria for DTTOs were still being sentenced to imprisonment without having been assessed for this disposal.

Staff said that referrals to the DTTO service had never been as low as had been suggested. Workers from both the city and Aberdeenshire spoke of the DTTO team restricting enquiries or referrals. Part of the difficulty throughout had been that neither side were in a position to substantiate their impression as they did not keep relevant data.

The DTTO improvement plan attempted to address the question of blockages in an even-handed and comprehensive way. Quality assurance measures would identify how referrals made to the DTTO team were handled.

The previous target of 60 DTTO orders across Grampian had been reduced by those managing the service to an “interim” target of 40, which was considered by them to be more realistic. At the time of the follow-up, the overall numbers across Grampian stood at 37. There had been an increase in referrals from Aberdeen and Moray, but the number of orders in Aberdeenshire was particularly low at the time of our follow up.

As well as the need to examine why this was the case, we thought the target of 40 orders across Grampian was unhelpfully low. This neither fitted with the prevalence profile, nor appeared to take account of the numbers of offenders who had not been assessed for the DTTO service and should have been afforded this opportunity. We

would encourage a re-examination of this target, as well as greater clarity about the number of assessments likely to be needed in each area. Any such consideration should be canvassed with the Community Justice Authority and with local Sheriffs.

#### **Recommendation 24**

**Voluntary organisation providers in Grampian should conduct an internal audit of all files, focusing on critical areas of parenting assessment, risk assessment and care planning processes. The action teams should put measures in place through contract compliance processes to monitor progress on this.**

There had been mixed progress on this recommendation, although the voluntary sector services themselves had been proactively engaged in improving their capacity to identify and collaborate on child care needs and concerns.

Social work and health were working together in each of the three authorities to achieve clarity and consistency with regard to the Getting our Priorities Right (GOPR) responsibilities of their commissioned partners. Many of these organisations were jointly funded by social work and health under the auspices of commissioning decisions taken through the action teams. In each area service specifications were being re-drawn to include parenting assessment and child care/child protection requirements.

As well as contractual obligations, we saw evidence that there had been a heightened focus on supporting substance misuse workers to develop the confidence and competence to ensure that the needs of children affected by substance misuse were being met. GOPR guidelines had been re-issued to all relevant agencies and each agency has been asked to state how they were embedding GOPR action planning into their procedures and practice.

As stated earlier in this report, progress had been made across Grampian in the roll-out of the SSA to voluntary organisations. This included a parental impact screening section. Concerns identified at this or any later stage were notified to social work child care colleagues, as all three areas had a policy that child care workers undertook SCODA (Standing Conference on Drug Abuse) parental impact assessment. This assessment offers a more comprehensive analysis to provide the basis for care and risk assessment planning. Some staff expressed concern that these SCODA assessments did not always follow when concerns were flagged. Where assessments were completed, these were not routinely shared with voluntary sector colleagues. This was an area for development.

We found evidence of a good level of awareness and acceptance of GOPR among voluntary sector colleagues, an improvement on our previous inspection. Indeed, we heard about attempts to extend this approach to every aspect of their engagement with service users. Turning Point Scotland, for example, was committed to undertaking parental screening assessments on people attending its needle exchange service. Given the anonymous nature of the service, this had been challenging. Staff had tried to communicate the message that it could be a means of increasing support and protection for the family as a whole.

Where file audits had been conducted by voluntary organisations, this had been on their own initiative. None of the organisations we spoke to had been asked to report on the findings from their audit activity as part of any contract compliance exercise. In Aberdeen file auditing had begun, but was being undertaken by social work. Aberdeenshire and Moray had included an audit as a requirement of their commissioned services.

While related to the concerns behind our recommendation, these developments did not fully meet our requirements. The recommendation clearly set out the expectation that the emphasis was on self-evaluation and self-improvement in the first instance. Organisations should be auditing their own files and reporting to commissioners on the findings and improvement actions from these audits. At intervals to be specified in the service level agreement, commissioners should then undertake or organise a robust external audit, establishing a combination of internal continuous improvement and external scrutiny. Social work managers needed to be more proactive in ensuring that files in commissioned services were audited.

## ALL ACTION TEAMS

### Recommendation 1

**All three action teams should continue the work they are doing to develop and agree local outcome and performance measures and develop systems for collecting and analysing information to monitor performance against them. They should do so jointly rather than independently. The Scottish Government should work with action teams to develop appropriate local outcome and performance measures.**

The action teams had only slowly progressed the development of agreed outcome and performance measures. They had worked together to establish forums to monitor and evaluate performance data. They had agreed a standard reporting framework, but the action teams were at different stages of gathering this information. Although these arrangements and reporting mechanisms were in place, there were no final agreed data sets for capturing the information to measure outcomes.

The information gathered by individual teams and services tended to be quantitative, e.g. the Integrated Drug Service (IDS) in Aberdeen gathered information on the number of people drug free for a period and the number of people prepared for work. Information available in each team was patchy. A systematic collection of qualitative performance data would help partners take decisions about the appropriate balance of services needed.

Partners had developed the SSA to capture some performance and outcome information. This had contributed to some difficulties in implementing the SSA (see Recommendation 4, pg 19)

A Grampian-wide group had been established in March 2008 to provide a focal point for decision-making, gathering and sharing in relation to performance data. While this group had not made as much unified progress as might have been expected, they had been proceeding on a systematic basis which augured well for future improvement.

The health intelligence group had commenced work on improving and harmonising performance management data analysis across the three action teams. We saw evidence of how some of these developments had begun to help partners to be clearer about what data should be collected, and come to agreement about how this might be used for planning and development.

The Scottish Government's Alcohol and Drugs Delivery Reform Group had produced an outcomes toolkit that would in future inform the information gathered by the alcohol and drug partnerships. Staff from Aberdeen had been involved in the development group for this and had used their learning from this exercise to help inform practice locally.

## **Recommendation 2**

**NHS Grampian and the three action teams should review the role of users and carers in developing services, and create ways in which they can become more involved. The action teams should review the role of users and carers in the action teams and Forums.**

We found that the action teams were beginning to take practical steps to increase the involvement of service users and carers in service planning and improvement. Managers and stakeholders told us that they had found involving users and carers in local forums “challenging.”

Discussions had taken place between the three action team leaders and Scottish Drugs Forum (SDF) to scope and develop user involvement. Each of the three areas had committed some resource to the appointment of a dedicated staff member, although none were yet in post by the time of the follow-up. Their roles were to be slightly different in each area but broadly covered a combination of information, health improvement and communication.

Service level agreements with providers included a requirement to gather feedback from service users. We met with staff and people who used services. They told us how they had developed processes to gather feedback routinely to inform the future shape of services. Some services such as Turning Point Scotland and the Aberdeen Foyer held service user focus groups and were involving previous users of their services as volunteers to support the delivery of their programmes. Other methods included service user questionnaires and comments boxes at office premises. The pre-treatment team in Aberdeen had revised their approaches following feedback from people accessing the service.

The different localities were slowly building local community understanding and engagement. We heard how staff were actively focused on preventative work and community capacity building through information and advice to school children and parents. However, there was no specific focus on support to carers. Some service user and carer forums in Aberdeen and Aberdeenshire were well-established and continued to provide valued mutual support. In Aberdeenshire links had been made with the carers’ strategy, with a view to an increased focus on carers of people with alcohol and drug problems.

Service user and carer meetings in Moray were poorly attended as a rule. However, the Director of Community Services had chaired a recent public meeting of stakeholders, which had been well-attended by service users and carers. Moray had attempted to build capacity in communities to recognise and respond constructively to substance misuse issues. They had initiated information events for young people and for parents.

Individual services were beginning to involve people to help shape services through their participation in focus groups. The planned employment of information staff would continue these developments. We found more limited examples of the involvement of people who used services in the development of the drug and alcohol strategies. All three areas needed to do more work with stakeholders to develop a

range of involvement options which take account of the geographic and demographic challenges of consulting on substance misuse in Grampian.

#### **Recommendation 4**

**All three action teams and NHS Grampian should ensure that the integrated assessment form for substance misuse is used across Grampian, by all relevant statutory and voluntary staff. Regular auditing of the forms should take place to ensure that the risk assessment section is being effectively utilised.**

We found that the action teams had worked together to develop a comprehensive assessment tool. Aberdeen City and Aberdeenshire had piloted a revised version of the substance misuse SSA which aimed to improve risk assessment and management. This would be available for wider use across Grampian from June 2009. Moray had agreed the integrated SSA would be implemented from June 2009 in their own and externally commissioned services. Training for staff on the new structure of the tool would coincide with the start of the roll-out.

The IDS and IDSCR (Integrated Drug Service Community Rehabilitation) in the Aberdeen, and the substance misuse social work service in the Aberdeenshire, were piloting this at the time of the follow-up. Most staff we met found the revised risk assessment and scoring useful as it helped to show the progress a service user was making. However, we also met providers who thought it needed further work to improve on their own assessment tools.

We met a number of social workers and Community Psychiatric Nurses (CPNs) who were more negative about the use of the single shared assessment tool, including some staff who were of the view that its use was more limited for alcohol services. They described a cumbersome process for completing the whole assessment every three months as a way of collecting data about service users, (see recommendation 1, pg 17) as well as using the form as an aid to assessment. We considered that expecting the assessment to be completed in full every three months for care review purposes was unnecessary. An abbreviated up-date would suffice.

More work was needed by those leading on the pilot, to command the support and confidence of all staff concerned in undertaking these assessments. We understood that those lead officers planned to survey staff to ensure that the revised SSA took account of staff feedback and concerns. This might deal with some continuing staff frustrations around the use of the SSA. It was also important to ensure that all staff were using an agreed and finalised document.

Staff in specialist alcohol services were disappointed by the delay to the development of a specific alcohol referral tool in electronic format, intended to speed up the referral process. Integrated Alcohol Service (IAS) staff in Aberdeen thought this delay had led to them receiving insufficient referral information and contributed to growth in the numbers of people waiting for a service. Managers should set out a timeframe for the delivery of this initiative.

#### **Recommendation 5**

**All three action teams should continue to ensure that staff who work with families where there are children are trained in screening for the impact of parental misuse on children, and in collaborative assessment procedures where this is judged necessary. This should be monitored by senior managers to ensure any risk to children is identified and appropriate action taken.**

We found that there was an increased and improved awareness by staff on the impact of parental substance misuse on children. Staff we met told us that child protection was a high priority. Staff in a range of services told us that they had had increased involvement at child care reviews. They had systems in place to report and share information. Our file reading found that although there was improved screening of impact of parental substance misuse on children, comprehensive assessments were lacking.

Each action team had sent guidelines on GOPR to all statutory and voluntary organisations involved in substance misuse services to increase their awareness of their responsibilities. Each agency was to have an action plan, which they would monitor. We found that most individual agencies had reviewed their action plans but the action teams needed a more consistent approach to their review of them. They were beginning to include this as a requirement of commissioned services along with examining files and file audit processes. The action teams were considering how they gathered, aggregated and evaluated the information from these processes.

In some areas specific funding had been identified to support children and families. This included the employment of dedicated social work staff and the development of family group conferencing in Aberdeenshire.

The action teams had commissioned STRADA (Scottish Training on Drugs and Alcohol) to deliver refresher training on GOPR, and they had delivered half day GOPR briefings to 156 social work, health and voluntary sector staff, predominantly managers, in each of the three local authorities in November 2008. They needed to ensure that front line staff had appropriate GOPR training.

We found that sharing information was improving, but there were still instances where information was not shared timeously. Recent research carried out by Aberdeen University and internal audits conducted by social work found that there was a continued need for improved recording and information sharing. Aberdeen had produced an action plan to progress the recommendations from this report. Other partner agencies should also consider an audit of SSAs to satisfy themselves that staff were adequately assessing the impact of parental substance misuse and information shared between agencies.

Public sector services had a policy of sending completed SSAs to GPs and to health visitors where there were children in the household. However, more needed to be done to involve GP practices in reciprocal sharing of information.

Staff in specialist agencies completed parental impact screening as part of their SSA. However, we were concerned about whether those services that did not carry out home visits as part of the assessment process could adequately assess the impact of parental substance misuse. Senior social work staff in Aberdeen told us

that there was to be a meeting in the near future where this issue would be discussed. We have already identified concern expressed by Her Majesty's Inspectorate of Education (HMIE) in recent reports in relation to Aberdeen and Moray about risks to children with substance misusing parents (see recommendation 9, pg 26). The issue of home visiting in order to complete a comprehensive assessment where children are involved should be resolved quickly across the three action team areas.

### **Recommendation 6**

**All three action teams should continue to work to develop and improve strategic links through relationships between strategic planning groups and the integration of substance misuse issues into appropriate plans. Reporting mechanisms from the action teams to the partner authorities should be agreed.**

At the time of the original inspection, the Scottish Government had instigated a stocktaking exercise, reviewing the effectiveness of all action teams across Scotland. Following this, the Scottish Government set up the delivery reform group to clarify the function and the accountability of the action teams. At the same time the government had set out significant changes to the future shape and direction of alcohol and drug services, with the publication of 'The Road to Recovery' and 'Changing Scotland's Relationship with Alcohol: A Framework for Action'.

Despite the fact that the intervening period had been one of uncertainty for the action teams, as they waited for the delivery reform group to report, we found that the action teams had made progress. The development of strategic links between the action teams and NHS Grampian had moved forward. Action teams were beginning to consider the impact of the changes from the delivery reform group, government policy and structural changes which are to see the new alcohol and drug partnerships embedded in community planning.

Each of the local authorities, and NHS Grampian, had given substance misuse higher priority within their own organisations and in partnership planning. The Grampian Health Plan had additional funding allocated by health services to substance misuse. Aberdeen and Aberdeenshire councils had also committed additional investment.

Both the JADAT (Aberdeen) and AADAT (Aberdeenshire) support teams were involved in the development of substance misuse HEAT targets and collaborated on the inclusion of substance misuse issues in the Single Outcome Agreement (SOA). There was also a better alignment of services with an integrated care pathway model and an underpinning commitment to recovery. The Aberdeenshire alcohol and drugs strategy reflected good engagement with stakeholders and firmly expressed action points which required changes in policy and practice from key partners, which nevertheless had their support. In Moray, there were links into the community planning process to ensure that substance misuse was included as a priority within the SOA.

Within each local authority there had been moves to embed action on substance misuse within the corporate planning process and strategic groups emanating from

this. We saw more cross-referencing on substance misuse between local authority services, in social work and housing plans, or community care and criminal justice plans. The strategic links which had been forged over the last two years will help the action teams make the transition to the new partnerships.

(See recommendation 17, pg 7 for strategic links between NHS Grampian and local authorities)

### **Recommendation 8**

**All three action teams should continue to develop management information systems to enable the appropriate sharing of information and the joint identification of performance information and unmet need. This information should be used to inform key planning and decision-making processes in the action teams.**

Progress on this recommendation was at an early stage. (See also recommendation 1, pg 17). Services were beginning to gather information on the needs and outcomes of people accessing substance misuse services to help target key resources to greatest need or greatest risk in the future.

NHS Grampian had agreed to fund the purchase of a suitable IT system based on an agreed specification of information needs. Scottish Government funding had contributed to the development. Aberdeen City's involvement in a national benchmarking group was useful and in this instance had helped to inform the specification.

The NHS Grampian health intelligence group had developed core data sets in partnership with stakeholder representatives, but these had yet to be finalised. They had appointed an information analyst and Aberdeen would pilot the system before rolling it out across Grampian. The other action teams were in the process of appointing an information officer to improve information gathering and analysis.

Other sources of information being used to inform needs included SMR 25, alcohol brief interventions and information from monitoring service level agreements. It was too early to identify any trends or gaps in service delivery. Continued gaps in information meant that action teams were in a weak position to identify the need for additional or changed resources.

NHS Grampian had identified a wide-ranging data set and planned to use the information gathered to inform their SOAs. Now that resources were being made available for this activity, the partners needed clear strategic collaboration to ensure its success.

### **Recommendation 11**

**All three action teams should continue to review their financial governance and put in place processes to enable them to improve their capacity to monitor and review spending on substance misuse in their areas.**

The Audit Scotland report, "Drug and Alcohol Services in Scotland" was published shortly before our fieldwork. The report stated that NHS and council spend on drug

and alcohol services in Grampian in 2007/8 was £26.8 per head of population compared to a national average of £30. Traditionally central government funds for substance misuse had been allocated to the three action teams by NHS Grampian on 40:40:20% basis, with Moray receiving 20%.

The NHS Grampian Substance Misuse Group agreed a developmental funding allocation arrangement for the funding allocated in 2008/09. NHS Grampian expressed the intention to move to a more sophisticated longer-term formula and proposals in this regard were out for consultation at the time of the inspection.

Senior finance staff were members of the three drug action teams to provide financial advice and guidance including on commissioning and resource allocation decisions. They aimed to deliver a consistent financial governance arrangement. The three chairs of the action teams met regularly to review budget allocation across the 3 areas.

Financial governance had progressed furthest in Aberdeenshire. The ADAT had a financial monitoring subgroup that noted potential financial pressures. The chief executive in Aberdeenshire was confident that the ADAT had robust systems in place to monitor financial information and governance. Moray described openness between partners on finances but this had focussed primarily on action team monies rather than wider substance misuse spend by the services and partner agencies.

It was anticipated that NHS Grampian and the three councils would agree a financial governance framework for funding transfers between the ADPs and CHPs based on that agreed within Aberdeenshire. The development of the commissioning process would feed into these arrangements.

NHS Grampian had a designated account for substance misuse funding from the Scottish Government. At Grampian wide level this was monitored within the public health directorate. They provide quarterly reports on the use of this funding.

We found greater clarity about NHS spend than for other partners, although finance managers did not think that sharing information on council spend would present difficulties for the councils. Current documentation, including the revised protocols, did not specify who should receive financial information or how they should report it. Finances were considered by each organisation and there was limited joint reporting of spend.

Once the joint financial frameworks were in place, the responsibility for finances would rest with each partnership. Partners had not yet agreed their spending priorities. Once agreed, new service level agreements would be put in place to meet these priorities. We thought that work on agreeing financial governance should have progressed more quickly.

## ABERDEEN CITY

### Recommendation 3

**Concerted action should continue to be taken to reduce waiting times and lists. As well as addressing capacity, Aberdeen should further consider redesign of services and set short, medium and long-term targets to reduce waiting lists.**

Through the Joint Alcohol and Drug Action Team (JADAT), managers in Aberdeen had achieved significant reductions in both the numbers of drug misusers waiting for a service and the length of time they had to wait. At the time of our original inspection in 2006/07 the number of people waiting for drug treatment services stood at more than 600. This rose to 800 in January 2008. Steps taken had reduced this number to 325 by the time of our follow-up. Although there had been some fluctuation in the waiting times for drug treatment services, the overall trend had been downward over the last year. 35% of people were being assessed within 14 days of referral while 84% started treatment within 14 days of being assessed.

The JADAT was able to point to actions it had taken to redesign services to achieve these improvements. NHS Grampian and Aberdeen City Council had both invested additional funding in substance misuse services, (£500,000 each in the 2009/10) resulting in the expansion of existing services and the development of new ones.

A pre-treatment team had been established in 2008. It was taking people who had been waiting longest for services off the waiting list and into a treatment and support programme. When the team started it was contacting people who had been waiting since 2004. By the time we met with the team in the follow-up it had worked through the lists to 2007. It was encouraging that the team had persevered in trying to contact people who did not respond to its initial letter. Another positive change since the team started, was that of offering low-threshold prescribing \*early on in the programme. Programme completion was high at 89%, but none of those who had completed the programme had yet been referred back to their GP for follow up support.

The Integrated Drug Service (IDS) brought together nursing, medical, social work and rehabilitation staff to help stabilise people. They were then referred back to GPs for long term support. The team had increased the number of GP practices involved, to 7 from an original 2, (out of 32 practices in the city). Two further practices were keen to become involved at the time of the follow up inspection.

The Integrated Drug Service Community Rehabilitation (IDSCR), comprising voluntary sector staff, had received additional funding. The remit of this service was to offer rehabilitative support and routes out of specialist services. Neither referral levels nor throughput of service uses were as high as intended, and there had been recent management efforts to address this.

*\*low threshold prescribing describes optimising the take up of treatment by service users through minimal entry requirements and liberal compliance obligations.*

Together with the established Substance Misuse Services (SMS) team these teams provided a range of services to help people through the recovery process. This had improved the service considerably but individual services still had improvements to make to work together better, and there was concern within the services themselves about what would happen when they reached capacity. Some were already close to this.

The services will be moving to a new building – the Timmer Market Development - with additional capital invested by the Scottish Government.

The number of people waiting and the length of time they waited for alcohol services had increased in the months leading up to the follow-up. There were over 100 waiting at the time of the inspection and they waited on average 6 months. This was partly a result of staffing difficulties at a time of increasing referrals to the service, but attempts by the service to introduce a more efficient referral system had been held up. The reasons for this delay had not been communicated well. While we heard from managers about the expansion plans for alcohol services in Aberdeen as a result of increased Scottish Government funding, these had not been finalised at the time of the inspection.

#### **Recommendation 7**

**The JADAT should review the balance of services in Aberdeen to make sure they meet the current identified need in the city.**

The initiatives in recommendation 3 above had been part of a process of reviewing and developing the balance of services in the city. Recently, NHS Grampian and Aberdeen City had begun to engage more productively in joint service planning than they had done in the past.

NHS Grampian and Aberdeen City Council had started work to establish a joint service delivery plan for the delivery of drug treatment and rehabilitation services in line with the Single Outcome Agreement. There was also a JADAT alcohol strategy group whose remit was to progress a 10 year alcohol strategy for the city. This group was making slow progress. A needs assessment for alcohol services was completed in December 2008 to inform the future development of services. Aberdeen City had commissioned research from Aberdeen University which had recently been completed on the impact of parental substance misuse on children.

Managers had set up an integrated alcohol service (IAS) in May 2007 to deliver improved personalised care previously delivered by single services across the city. They were intending to recruit a consultant for alcohol services. The Scottish Government had introduced a HEAT (Health Efficiency Access to Treatment) target to increase the number of brief interventions delivered in primary care and by midwives. Grampian was set a target of delivering 3000 brief interventions in 2008/09 but while a good level of GP practices (79%) had signed up, the reports we received suggested that it was unlikely that this target would be met and further work on infrastructure support was needed.

To encourage the recovery of people misusing services, Job Centre Plus had 3 staff attached to the IDSCR team and had set a target to achieve employability outcomes

for 200 people with substance misuse problems per year, double the target of the previous year.

Staff we spoke to generally described improved working between agencies, and said that people were moving through services to recovery. They also spoke of increased GP involvement in the recovery process.

Aberdeen had made significant progress in improving the balance of services across the city. However, staff expressed some concern about the balance of services for substance misusers who had been through the integrated care team process. Joint working with voluntary organisations and particularly with children's social work services (see recommendation 10, pg 27) was an area which we considered needed continued development. It would be helpful if health and social work could each provide a dedicated lead person – in the short and medium term – to further develop integrated services across the city.

### **Recommendation 9**

**The Fulton clinic should review its practice on home visiting by nursing staff to ensure that risk is assessed on an individual basis, and that resources are deployed effectively, based on clear agreed criteria. The assessment tool in use may be helpful.**

At the time of our initial inspection, we recommended that the substance misuse service (SMS) in the Fulton Clinic review its practice on home visiting by nursing staff. On this inspection we were given a copy of the SMS "Home Visiting and Buddy Policy", which clearly stated that "under normal circumstances the Substance Misuse Service does not undertake home visiting". The policy stated that a home visit would only be made after agreement with a line manager, and a home visiting risk assessment was completed. The risk assessment in this instance is of risk to the substance misuse worker. There was no culture of joint visiting with social work staff. Nonetheless, the development of the policy resolved previous inconsistencies regarding practice.

The "Risk Assessment and Risk Management Procedures in Drug and Alcohol Services in Aberdeen City" apply to risk to the substance misuser, risk to others, including children, and risk from others. We had concerns, and the substance misuse services themselves recognised that where children's services were not already involved, there might be unidentified risks to children that were not being properly assessed. Nursing and social work staff were asked to complete parental impact screening assessments as part of the Single Shared Assessment, without having met the children or seen the home environment.

We were told by social work managers that part of the additional funding from the city council might be used for the employment of family support staff. Moreover, work was going on to introduce a policy that at least one home visit be part of a comprehensive assessment process. Discussions about the potential role of family support staff in this process were taking place at the time of the inspection.

The HMle report "Joint Inspection of Services to Protect Children and Young People in the Aberdeen City Council Area" published in November 2008 stated that

“Inspectors were particularly concerned about the numbers of children living in high risk situations with drug abusing parents without adequate support or protection”. Given this, and our concern expressed above, Aberdeen City Social Work Department and NHS Grampian should continue their collaboration to ensure that where there might be risk to children, appropriate shared assessment procedures are in place and any supportive or protective action is also accepted as a shared responsibility. (See Recommendation 5, pg 19)

### **Recommendation 10**

**Aberdeen City Council should review the level and role of its specialist substance misuse social work service in the context of a review of the balance of substance misuse services across the city.**

At the time of the initial inspection, there were two social workers dedicated to substance misuse. Senior staff in Aberdeen agreed that an increase in social work staff was required. At the time of our follow up, they had taken action to increase these numbers.

Reports by Audit Scotland, HMle, and SWIA in 2008 highlighted significant failings in Aberdeen City Council, including social work services. The chief executive of the council had retired, and an interim programme director for social work was appointed in July 2008. Social work services in the city underwent a major restructuring process. This could have had a considerable negative impact on the progress of substance misuse services, and it was important that they continued to focus on the changes needed in substance misuse services.

Aberdeen City Council had prioritised substance misuse, and had agreed to £500,000 per annum recurring funding for the services. Two social work posts had been added in IDS, one of which was a senior post with a supervisory role across substance misuse. There were also 2 social work posts in the IAS, and at the time of the inspection, recruitment for 2 additional IAS social work posts were being initiated. Discussions were on-going regarding the role of family support workers and tenancy support workers. This increase in resources is to be welcomed. Aberdeen City Council staff recognised that further capacity building across council services, social work in particular, would be necessary.

It will be important for Aberdeen City Council and NHS Grampian to work together to plan the number and placement of any future social work resource for substance misuse, along with any increase in health resources. This planning should be part of a joint planning process for all substance misuse services which takes into account the joint commissioning of services from the voluntary and private sectors. This is needed to complement the statutory services to provide an appropriate process for recovery for people with substance misuse problems.

## **ABERDEENSHIRE**

### **Recommendation 12**

**Aberdeenshire should continue to take steps to develop services in the south and central area of the country to the standard of those in the north, based on identified need.**

Managers recognised the weakness of information about need in Aberdeenshire, and services had historically concentrated on the north of the shire, as a result of continuing demand from there. This had continued to a great extent, and Aberdeenshire was still working to identify prevalence and support needs across the whole of the council. Some steps had been taken to strengthen services in the central and south areas.

The Aberdeenshire Alcohol and Other Drug Strategy 2009-11, "Routes to Recovery", set out how Aberdeenshire intended to develop substance misuse services. Partners and stakeholders from across the local authority were positive about the inclusive way this strategy had been developed.

Aberdeenshire had conducted a review of all direct expenditure on drugs and alcohol in their area. This highlighted a disparity between current activity and that identified as a priority during the development of the strategy. The ADAT saw this as giving them a clear agenda for change.

A key priority was to strengthen the gathering of intelligence across Aberdeenshire to inform the ADAT decision making process. This was to be supported by the imminent appointment of an information and performance analyst for Aberdeenshire, and by the work of the NHS Grampian Substance Misuse Health Intelligence Group.

NHS Grampian had employed a GP with special interest in substance misuse to increase the capacity of existing GP practices in the centre and south, which was seen by partners to be an important development and one worth building on. There were regular clinical meetings in Kintore/Inverurie and clinical premises had been identified in Stonehaven.

Additional needle exchanges had been established in Inverurie, Stonehaven and Kenmay, and Turning point Scotland had been commissioned to deliver an exchange in Huntly. The use of non-medical prescribing was developing slowly, with a pharmacist in Peterhead involved. However, the south and central parts of the shire still lacked an integrated model of care similar to the one which exists in the north. This meant, for instance, that social workers had no direct access to SMS services, and had to route their referrals through GPs.

While we recognise the difficulties in finding suitable accommodation in the south and centre, we still consider that priority should be given to strengthening integrated services in these areas.

## MORAY

### Recommendation 13

**The DAAT should put processes in place to ensure that all services have outcome indicators as a priority of delivery and development. This should be clearly reflected in care planning processes and staff should be supported to achieve and sustain this approach.**

While the Moray DAAT had made attempts to ensure that services had outcome indicators, progress had been slow. Some voluntary organisations had their own sets of outcome indicators. A Performance Improvement working group had been set up to develop and implement a performance indicator toolkit. This group reported to the MDAAT Strategy Group in April 2008. The toolkit was not well received as it was generally acknowledged to be over-complicated. There had not been “buy-in” from those taking part and it had resulted in little return. The working group was reformed in late 2008 to take fundamental principles of performance management forward and ensure a reporting tool was designed.

However, this work was overtaken by the Delivery Reform Group producing a national outcomes toolkit, and Moray DAAT agreed to adopt this toolkit. It was expected that the information from this toolkit would feed into the new ADP framework endorsed by Moray Community Planning Partnership in April 2009. The new performance process will also be informed by work done by the Grampian wide NHS led intelligence group.

Moray had begun to include outcomes in the contracts for voluntary organisations funded by Moray Council. However, managers and staff in the integrated substance misuse services told us that there were currently no outcome indicators agreed for these services, and no processes or methodologies in place to promote the development of outcome indicators. A senior official described substance misuse services across the board as being at an “embryonic stage of developing the performance culture”.

While there was evidence that the action team had worked to develop outcome indicators, very little change had been effected since our inspection 2 years ago. The same difficulties in ensuring “buy-in” which affected that initial process should be avoided when the new toolkit is introduced.

### Recommendation 14

**Health and Social work commissioners should examine contractual arrangements with providers to ensure that they include clear statements that they have appropriate access to their files.**

During our inspection in 2007 we were concerned about the local authority’s uncertainty about their access to files held by voluntary organisations that were contracted by them. At the time of our follow up this situation had still not been fully addressed. A new Service Level Agreement (SLA) stipulating access to files had been approved, but was still not signed by the voluntary organisation which had prohibited access to files at the first inspection. Senior managers told us that new

contracts for all voluntary organisations, stipulating that files would be accessed and audited by the council and NHS would come into effect from October 2009.

We were aware that NHS Grampian was not party to this agreement, though they also contracted work from the same voluntary organisation. They gave grants rather than offered a contract. This was an opportunity for the two major commissioners of services to have worked together to agree a joint contract with this agency. We were aware that all substance misuse services would be re-tendered for in 2010-11. The Moray Council had just approved a commissioning strategy for 2008-11 at the time of our visit, but this did not contain proposals for joint commissioning with health. The Moray Council and NHS Grampian should develop joint commissioning arrangements for substance misuse services.

### **Recommendation 15**

**Moray should follow up its review of strategic and operational structures with a fundamental review of service need and develop services and staff accordingly.**

At the time of our original inspection there was a lack of a clear strategy for service development in Moray. This to some extent was still the case. However, more recently there had been promising developments.

The Moray Alcohol and Drug partnership had commissioned a full strategic evaluation of drug and alcohol services, to be undertaken by the Chief Executive's Office, in November 2008. The first draft of this, originally due in February 2009, was delayed and was still not available at the time of our inspection. This review will play an important role in the future commissioning of services. The report on commissioning, and the development of outcomes indicators outlined in recommendation 13, will also have a part to play.

On the 9<sup>th</sup> of April 2009, The Healthier Strategic Group of Moray Council approved the development of an Alcohol and Drug Partnership for Moray, which was embedded in the community planning partnership, as proposed by the alcohol and drugs delivery reform group of the Scottish Government. The community planning board of Moray Council had already agreed that Outcome 6 of the Single Outcome Agreement (SOA) of which substance misuse was a main outcome, would be addressed by the Healthier Strategic Group. Also, within the SOA 2009-10, Moray had decided that alcohol would be one of the ten priority areas for action.

Progress in Moray since our last inspection had been slow, but we considered that the service review, the production of a strategy, to include a commissioning plan, and the re-tendering of services, offered Moray the opportunity, through the new partnership, to develop services in a more structured way.

## **Recommendation 16**

**Roles, responsibilities, and accountability in the integrated team should be clarified as a matter of urgency and joint working policies and procedures put in place.**

Since our initial inspection, Moray had appointed a manager for mental health services in Moray, whose remit included alcohol and drugs. This manager was accountable to the general manager of the Moray Community Health and Social Care Partnership (MCHSCP) and the director of community services. He managed the operations manager for the integrated team

The integrated drug and alcohol team consisted of an operations manager, a clinical nurse manager, a senior social worker and 1.5 full time equivalent (FTE) social workers, a clinical nurse lead post, which was vacant at the time of the inspection and 4 FTE community psychiatric nurses (CPNs). The sickness level among nursing staff in the team was high and the clinical establishment had not been at full complement for some time. The team was supported by a Consultant Psychiatrist for 1 session per week and a GP for 1 session. The team met each week to allocate work, review assessments and follow up issues on individual service users.

Both the health and social work parts of the team had been allocated additional funding to increase staff numbers, including 1 social worker and 1 social work assistant to work with substance misusing parents. This was an important development given the concern expressed about children of substance misusing parents in the HMIE report on child protection services in Moray in February 2009.

NHS Grampian and Moray Council had agreed joint working policies and procedures for the integrated alcohol and drugs team. We saw examples of these policies. We found that these would have benefitted from clarity about partnership working. A manager had been asked to review existing policies and develop new ones to promote joint working within the team and between the team and other related services.

Senior staff recognised that there was further work to be done to fully harmonise and synchronise relationships and operations in this team.

## **Conclusion**

**Although progress had been slow on some of the recommendations, overall we found improvement, and partners had made a considerable commitment of time, energy and resources to improve the position in Grampian. The national developments identified in the introduction to this report all impacted considerably on the work of the action teams.**

**Work to improve the situation further was needed in particular areas. The absence of some management information was continuing to hamper effective planning and targeting of services. Qualitative performance data and data which captured those at risk as a result of the substance misuse of others, whether children or adults needed to be improved. The involvement of users and carers had been slow to progress. All three action teams had to ensure that the processes for protecting children whose parents misuse substances were robustly monitored.**

**The pace of progress had increased over the last year and there was evidence that partnership working was on a better footing to deliver future joint planning and services. All the local authority partners, together with health, had accorded substance misuse higher priority and were showing greater commitment to investment and improvement. There had been important improvements in relation to pan-Grampian planning, the strategic redesign of drug services in Aberdeen, and greater clarity about outcomes. Staff we spoke to said that further improvements in partnership and joint working could be made, but were clear that services had improved since our original inspection in 2006-07.**