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

City Chambers
DUNDEE
DD1 3BY

21st January, 2025

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE PERFORMANCE AND AUDIT COMMITTEE OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
(See Distribution List attached)

Dear Sir or Madam

PERFORMANCE AND AUDIT COMMITTEE

I would like to invite you to attend a meeting of the above Committee which is to be held remotely on Wednesday, 29th January, 2025 at 10.00am.

Members of the Press or Public wishing to join the meeting should contact Committee Services on telephone (01382) 434818 or by email at committee.services@dundeecity.gov.uk by no later than 12 noon on Monday, 27th January, 2025.

Apologies for absence should be intimated to Arlene Hay, Committee Services Officer, on telephone 01382 434818 or by e-mail arlene.hay@dundeecity.gov.uk.

Yours faithfully

DAVE BERRY

Acting Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATION OF INTEREST

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

3 MINUTE OF PREVIOUS MEETING AND ACTION TRACKER

(a) MINUTE **- Page 1**

The minute of previous meeting of the Committee held on 20th November, 2024 is attached for approval.

(b) ACTION TRACKER **- Page 7**

The Action Tracker (PAC1-2025) for meetings of the Performance and Audit Committee is attached for noting and updating accordingly.

4 DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2024-25 QUARTER 2 - Page 9

(Report No PAC4-2025 by the Chief Finance Officer, copy attached).

5 DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE ASSURANCE REPORT - Page 35

(Report No PAC8-2025 by the Clinical Director, copy attached).

6 DRUG AND ALCOHOL SERVICES INDICATORS – 2024/25 QUARTER 2 - Page 63

(Report No PAC2-2025 by the Chief Finance Officer, copy attached).

7 MENTAL HEALTH SERVICES INDICATORS – 2024/25 QUARTER 2 - Page 77

(Report No PAC3-2025 by the Chief Finance Officer, copy attached).

8 UNSCHEDULED CARE - Page 105

(Report No PAC5-2025 by the Chief Finance Officer, copy attached).

9 DHSCP STRATEGIC RISK REGISTER UPDATE - Page 113

(Report No PAC10-2025 by the Chief Finance Officer, copy attached).

10 DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT REPORT – WORKFORCE (D06-24) - Page 127

(Report No PAC7-2025 by the Chief Finance Officer, copy attached).

11 GOVERNANCE ACTION PLAN PROGRESS REPORT - Page 143

(Report No PAC9-2025 by the Chief Finance Officer, copy attached).

12 DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT - Page 163

(Report No PAC6-2025 by the Chief Finance Officer, copy attached).

13 ATTENDANCE LIST - Page 171

(A copy of the Attendance Return (PAC11-2025) for meetings of the Performance and Audit Committee held over 2024 is attached for information and record purposes).

14 DATE OF NEXT MEETING

The next meeting of the Committee will be held remotely on Wednesday 21st May, 2025 at 10.00am.

PERFORMANCE AND AUDIT COMMITTEE
CONTACT LIST
(Updated October 2024)

(a) CONTACTS – PERFORMANCE AND AUDIT COMMITTEE

(* - DENOTES VOTING MEMBER)

Role	**Recipient**
NHS Non Executive Member (Chair)	Bob Benson *
Elected Member	Councillor Dorothy McHugh *
Elected Memer	Councillor Siobhan Tolland *
NHS Non Executive Member	David Cheape *
Acting Chief Officer	Dave Berry
Acting Chief Finance Officer	Christine Jones
Registered medical practitioner employed by the Health Board and not providing primary medical services	Sanjay Pillai
Chief Social Work Officer	Glyn Lloyd
Chief Internal Auditor	Jocelyn Lyall
Staff Partnership Representative	Raymond Marshall
Person providing unpaid care in the area of the local authority	Martyn Sloan

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	**Recipient**
Dundee City Council (Chief Executive)	Greg Colgan
Elected Member – Proxy	Councillor Lynne Short
Elected Member – Proxy	Councillor Roisin Smith
Elected Member – Proxy	Bailie Helen Wright
Dundee City Council (Executive Director of Corporate Services)	Robert Emmott
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
NHS Tayside (Chief Executive)	Nicky Connor
NHS Non Executive Member – Proxy	Andrew Thomson
NHS Tayside (Director of Finance)	Stuart Lyall
Dundee City Council (Members' Support)	Lesley Blyth
Dundee City Council (Members' Support)	Elaine Holmes
Dundee City Council (Members' Support)	Sharron Wright
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership	Kathryn Sharp
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (Communications rep)	Anna Michie
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
NHS (PA to Tony Gaskin)	Carolyn Martin
Audit Scotland (Audit Manager)	Richard Smith
Dundee City Council (Communications rep)	Katie Alexander
Dundee City Council (Communications rep)	Mike Boyle
Dundee City Council (Communications rep)	Lewis Thomson
Dundee Health and Social Care Partnership	Jenny Hill
Dundee Health and Social Care Partnership	Lynsey Webster
Dundee City Council (Legal Manager)	Maureen Moran

Organisation	Recipient
Dundee City Council (Legal rep)	Jackie Bell
Dundee Health and Social Care Partnership	Matthew Kendall
Audit Scotland	Mary O'Connor
Regional Audit Manager	Barry Hudson
Audit Scotland (Audit Director)	Rachel Browne
Health and Social Care Partnership	Angie Smith

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held remotely on 20th November, 2024.

Present:-

Members	Role
Bob BENSON (Chair)	Nominated by Health Board (Non-Executive Member)
David CHEAPE	Nominated by Health Board (Non-Executive Member)
Siobhan TOLLAND	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Dave BERRY	Acting Chief Officer
Barry HUDSON	For Chief Internal Auditor
Christine JONES	Acting Chief Finance Officer
Glyn LLOYD	Chief Social Work Officer
Sanjay PILLAI	Registered Medical Practitioner (not providing primary medical services)

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

Peter ALLAN	Dundee City Council
Suzie BROWN	NHS Tayside
Rachel BROWNE	Audit Scotland
Matthew KENDALL	Health and Social Care Partnership
Clare LEWIS-ROBERTSON	Health and Social Care Partnership
Lynne MORMAN	Health and Social Care Partnership
Shahida NAEEM	Health and Social Care Partnership
Kathryn SHARP	Health and Social Care Partnership
Angie SMITH	Health and Social Care Partnership
Elaine TORRANCE	Independent Chair
Lynsey WEBSTER	Health and Social Care Partnership

Bob BENSON, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

There were apologies for absence submitted on behalf of Jocelyn Lyall, Councillor McHugh and Martyn Sloan.

II DECLARATION OF INTEREST

There were no declarations of interest.

III MINUTE OF PREVIOUS MEETING AND ACTION TRACKER

(a) MINUTE

The minute of meeting of the Committee held on 25th September, 2024 was submitted and approved.

(b) ACTION TRACKER

There was submitted the Action Tracker, PAC39-2024, for meetings of the Performance and Audit Committee for noting and updating accordingly.

IV PROTECTING PEOPLE COMMITTEE ANNUAL REPORT 2023/2024

There was submitted Report No PAC38-2024 by the Protectig People Committee Independent Chairs presenting the annual report published by the Protecting People Committees for the period 2023/2024.

The Committee agreed:-

(i) to note the content of the annual report for the Dundee Protecting People Committees (main report and supporting information) (attached as appendices 1 and 2 of the report);

(ii) to note the progress made in developing an effective partnership response to the needs of at risk children and adults during 2023/2024 (section 4.2 of the report); and

(iii) to note the challenges and priority areas for action identified across the annual reports for focus during 2024/25 and beyond (section 4.3 of the report).

Following questions and answers the Committee further agreed:

(iv) to note that datasets continued to be developed for different groups and would be monitored closely; and

(v) that Kathryn Sharp would share information with Committee members from Women's Aid in relation to what was driving the increase in refuge requests.

V AUDIT SCOTLAND ANNUAL REPORT AND INTEGRATION JOINT BOARD ANNUAL ACCOUNTS 2023/2024

There was submitted Report No PAC45-2024 by the Chief Finance Officer presenting the Integration Joint Board's (IJB) Draft Audited Annual Statement of Accounts for the year to 31st March, 2024 for approval, to note the draft external auditor's report in relation to these accounts and approve the response to this report.

The Committee agreed:-

(i) to note the contents of the attached Audit Scotland cover letter (attached as Appendix 1). and the draft external auditor's 2023/2024 Annual Audit Report (attached as Appendix 2) including the completed action plan outlined on page 20 of the report, and in particular that Audit Scotland had issued an unmodified audit opinion on the IJB's 2023/2024 Annual Accounts;

(ii) to endorse the report as the IJB's formal response to the external auditor's report; and

(iii) to instruct the Chief Finance Officer to provide an update on progress of the action plan noted in Appendix 1 of the external auditor's report by March 2025.

Following questions and answers the Committee further agreed:-

(iv) that the Audited Annual Accounts document would be circulated separately and the following would be agreed remotely by members:

- approval of the Audited Annual Accounts for signature and to instruct the Chief Finance Officer to return these to the external auditor;

- to instruct the Chief Finance Officer to arrange for the above Annual Accounts to be published on the Dundee Health & Social Care Partnership website by no later than 30th November, 2024.

Post-meeting note: the Audited Annual Accounts were approved by Performance and Audit Committee members on 20th and 21st November, 2024.

VI DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2024-25 QUARTER 1

There was submitted Report No PAC42-2025 by the Chief Finance Offficer providing an update on the Performance and Audit Committee on 2024-25 Quarter 1 performance against the National Health and Wellbeing Indicators and 'Measuring Performance Under Integration' indicators. Data was also provided in relation to Social Care – Demand for Care at Home services.

The Committee agreed:-

(i) to note the content of the summary report;

(ii) to note the performance of Dundee Health and Social Care Partnership, at both Dundee and Local Community Planning Partnership (LCPP) levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 (tables 1, 2 and 3);

(iii) to note the performance of Dundee Health and Social Care Partnership against the 'Measuring Performance Under Integration' indicators as summarised in Appendix 1 (table 3); and

(iv) to note the number of people waiting for a social care assessment and care at home package and associated hours of care yet to be provided in Appendix 2.

VII DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE ASSURANCE REPORT

There was submitted Report No PAC44-2024 by the Clinical Director providing assurance to Committee on the business of Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group.

This aligned to the following NHS Scotland quality ambitions:

- Safe
- Effective
- Person-centred

The report provided evidence of the following Best Value Characteristics:

- Equality
- Vision and Leadership
- Effective Partnerships
- Governance and Accountability
- Use of Resources
- Performance Management
- Sustainability

The Committee agreed:-

(i) to provide their view on the level of assurance the report provided and therefore the level of assurance regards clinical and care governance within the Partnership. The timescale for the data within the report was to 30th September, 2024;

(ii) to note that the Lead Officer for Dundee HSCP, Dr David Shaw suggested that the level of assurance provided was:

Reasonable; due to the following factors:

- There was evidence of a sound system of governance throughout the HSCP.
- The identification of risk and subsequent management of risk was articulated well throughout services.
- There was ongoing scope for improvement across a range of services, in relation to the governance processes, although this was inextricably linked to the ongoing difficulties with recruitment and retention of staff.
- There was evidence of noncompliance relating to a fully comprehensive governance system across some teams, i.e. contemporary management of adverse events and risks.

VIII QUARTERLY FEEDBACK REPORT – 1ST QUARTER 2024/2025

There was submitted Report No PAC40-2024 by the Chief Finance Officer summarising feedback received for the Health and Social Care Partnership (HSCP) in the second quarter of 2024/2025. The complaints included complaints handled using the Dundee Health and Social Care Partnership Social Work Complaint Handling Procedure, the NHS Complaint Procedure and the Dundee City Integration Joint Board Complaint Handling Procedure.

The Committee agreed:-

(i) to note the complaints handling performance for health and social work complaints set out within the report;

(ii) to note the work which has been undertaken to address outstanding complaints within the HSCP and to improve complaints handling, monitoring, and reporting;

(iii) to note the recording of Planned Service Improvements following complaints that were upheld or partially upheld; and

(iv) to note the work ongoing to implement Care Opinion as a feedback tool for all services in the Health and Social Care Partnership.

Following questions and answers the Committee further agreed:-

(v) that the HSCP Management Team would consider arranging a presentation from Care Opinion at a future Development Session.

IX DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP STRATEGIC RISK REGISTER UPDATE

There was submitted Report No PAC46-2024 by the Chief Finance Officer providing an update in relation to the Strategic Risk Register and on strategic risk management activities in Dundee Health and Social Care Partnership.

The Committee agreed:-

(i) to note the content of the Strategic Risk Register Update report;

(ii) to note the entry of a new risk on Information Governance (Section 6 of the report); and

(iii) to note the archival of four risks which are now considered to be covered as Operational Risks (Section 7 of the report).

X CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2023/2024

There was submitted Report No PAC37-2024 by the Chief Social Work Officer bringing forward for information the Chief Social Work Officer's Annual Report for 2023/2024.

The Committee agreed to note the content of the report and the Chief Social Work Officer's Annual Report for 2023/2024 attached as Appendix 1 to the report.

Following questions and answers the Committee further agreed:-

(i) that thanks would be expressed to all staff.

XI CITY PLAN FOR DUNDEE 2022-2032 – ANNUAL REPORT FOR 2023/24

There was submitted Report No PAC36-2024 by the Chief Finance Officer submitting the second annual progress report on the City Plan for Dundee 2022-2032 was considered and agreed by the Dundee Partnership on 5th September, 2024. The Dundee Partnership Management Group committed to bring updates to their individual organisations for noting.

The Committee agreed:-

(i) to note the progress made since the first report on the City Plan for Dundee 2022-32 in October 2023 (section 5 and appendix 1 of the report);

(ii) to note that the Strategic Leadership Groups will review performance indicators that had deteriorated and take measures to improve these going forward; and

(iii) to remit the Health and Social Care Partnership Leadership Team and Strategic Planning Advisory Group to monitor Dundee Health and Social Care Partnership's commitment and inputs to delivering actions supporting the plan.

XII GOVERNANCE ACTION PLAN PROGRESS REPORT

There was submitted Report No PAC43-2024 by the Chief Finance Officer providing an update on the progress of the actions set out in the Governance Action Plan.

The Committee agreed to note the content of the report and the progress made against the actions within the Governance Action Plan (contained within appendix 1 of the report).

Following questions and answers the Committee agreed:-

(i) to note that duplicate audit actions would continue to be refined over time; and

(ii) a graphic representation of how the plans, frameworks and strategic groups fit together would be provided in future.

XIII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC41-2024 by the Chief Finance Officer providing an update on the 2023/2024 Internal Audit Plan and progress of the 2024/2025 internal audit plan. The report also included internal audit reports that were commissioned by the partner Audit and Risk Committees, where the outputs were considered relevant for assurance purposes to Dundee IJB.

The Committee agreed to note the progress on the 2023/2024 internal audit plan and work undertaken on the 2024/2025 plan.

Following questions and answers the Committee further agreed:-

(i) to note that an External Quality Assessment of FTF Internal Audit was underway and once the work was completed, a full report would be presented to the PAC.

XIV ATTENDANCE LIST

There was submitted Agenda Note PAC47-2024 providing attendance returns for meetings of the Performance and Audit Committee held over 2024.

The Committee agreed to note the position as outlined.

XV DATE OF NEXT MEETING

To be confirmed.

Bob BENSON, Chairperson.

ITEM No …3(b)……..

PAC1-2025

PERFORMANCE AND AUDIT COMMITTEE – ACTION TRACKER – 20TH NOVEMBER 2024

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
1	31/01/24	IV	REVISED PAC TERMS OF REFERENCE	annual evaluation to be carried out.	Chief Finance Officer	Jan 2025	Complete Updated Terms of Reference approved by IJB in December 2024. This will be prompted on an annual basis via the IJB and PAC agenda planners.
2	31/01/24	V	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2023/2024 QUARTER 2	that, in relation to a query about Table 1 and the West End showing all red although it was one of the least deprived areas, Lynsey would look into the data and report back	Lead Officer, Strategic Services	September 2024 January 2025 May 2025	Patient level data has been supplied by the NHST BSU and clinical expertise identified to assist with the interpretation of the data. However, this has not been able to be progressed due to capacity in relevant posts and other priorities. A revised

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
							timeframe has now been set.
3	25/09/24	X	DRUG AND ALCOHOL SERVICES INDICATORS – 2023/24 QUARTER 4	that consideration would be given to providing data on alcohol related deaths in future reports	Chief Finance Officer	January 2025	Complete Available data has been added to the report.
4	20/11/24	VIII	QUARTERLY FEEDBACK REPORT – 1ST QUARTER 2024/2025	that consideration would be given to arranging a presentation from Care Opinion at a future Development Session	Chief Officer		This has been noted and incorporated within the draft development session schedule for 2025. Confirmed programme of sessions will be issued to IJB members as soon as possible.

ITEM No …4……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE –29 JANUARY 2025**

REPORT ON: **DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2024-25 QUARTER 2**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC4-2025**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Performance and Audit Committee on 2024-25 Quarter 2 performance against the National Health and Wellbeing Indicators and 'Measuring Performance Under Integration' indicators. Data is also provided in relation to Social Care – Demand for Care at Home services.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Note the content of this summary report.

2.2 Note the performance of Dundee Health and Social Care Partnership, at both Dundee and Local Community Planning Partnership (LCPP) levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 (tables 1, 2 and 3).

2.3 Note the performance of Dundee Health and Social Care Partnership against the 'Measuring Performance Under Integration' indicators as summarised in Appendix 1 (table 3).

2.4 Note the number of people waiting for a social care assessment and care at home package and associated hours of care yet to be provided in Appendix 2.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND INFORMATION

4.1 The Quarterly Performance Report analyses performance against the National Health and Wellbeing Indicators. 5 of the 23 National Health and Wellbeing Indicators are monitored quarterly (emergency admissions, emergency bed days, readmissions, falls admissions and delayed discharge bed days lost). The quarterly performance report also summarises performance against indicators in the Measuring Performance Under Integration (MPUI) suite of indicators for four out of six high level service delivery areas – emergency admissions, emergency bed days, accident and emergency and delayed discharges, end of life and balance of care. Further information regarding these indicators and the methodology used to report these indicators can be found in Appendix 3.

4.2 The Public Bodies (Joint Working) (Scotland) Act 2014 and associated regulations and guidance prescribes that Partnerships must compare performance information between the current reporting year and the preceding five reporting years. For Q2 2024-25, quarterly performance reports performance is measured against the 2019-20 baseline year and because 2019-20 performance was affected by the Covid-19 Pandemic, 2018-19 data has also been provided for all indicators as a supplementary baseline.

5.0 QUARTER 2 PERFORMANCE 2024-25 – KEY ANALYTICAL MESSAGES

5.1 Key analytical messages for the Quarter 2 2024-25 period are:

- Significant variation by Local Community Planning Partnership (LCPP) is still apparent, with poorest performance for many of the National Indicators in the most deprived LCPPs.

- Performance is poorer than the 2019-20 baseline and poorer than the 2018-19 baseline for rate of emergency admissions 18+, 28 day readmissions rate 18+, emergency admissions as a rate of all A+E attendances 18+ and rate of hospital admissions due to a fall 65+.

- There was a slightly deterioration in performance compared with the 2019-20 baseline (increase of 0.6%) for the emergency bed day rate 18+, however there was an improvement when compared to the 2018-19 baseline (decrease by 4.4%). This is a positive trend which reflects local improvements in community care to support earlier discharge. 4 LCPPs (West End, Maryfield, Coldside and Lochee) saw a decrease in the rate of emergency bed days against both baseline years.

- The rate of emergency admissions per 100,000 18+ population increased by 17.2% compared with the 2019-20 baseline and increased by 15.5% compared with the 2018-19 baseline and there was an increase across every LCPP. This is a deterioration in performance. The greatest increase compared with both the 2018-19 and 2019-20 baselines was in The Ferry.

- The rate of emergency readmissions within 28 days of any admission increased by 6% between both the 2019-20 and 2018-19 baselines and Q2 2024-25. There was a decrease in East End between both the 2018-19 and the 2019-20 baselines. There was a decrease in the West End between the 2019-20 baseline and Q2 2024-25.

- The rate of hospital admissions due to a fall increased between both the 2018-19 and 2019-20 baselines and Q2 2024-25. Coldside was the only LCPP to show an improvement at Q2 2024-25 compared with the 2019-20 baseline (decrease in the rate by 12%) and Coldside and West End were the only two LCPPs to show an improvement at Q2 2024-25 compared with the 2018-19 baseline (decrease in the rates by 15% and 14% respectively).

- Rate of bed days lost to standard delayed discharge for people aged 75+ is 43% less than the 2019-20 baseline and improved in all LCPP except one, or 23% less than the 2018-19 baseline and improved in 5 LCPPs. At Q2 the LCPP with the highest rate was Mayfield (332 bed days lost per 1,000 people aged 75+) followed by West End and the LCPP with the lowest rate was North East (88 bed days lost per 1,000 people aged 75+).

- Rate of bed days lost to complex (code 9) delayed discharge for people aged 75+ decreased by 30% between the 2019-20 baseline or by 52% against 2018-19 baseline and Q2 2024-25, which is an improvement. There were increases in 5 out of the 8 LCPPs against both baseline years. Lochee had the highest rate, 90 per 1,000 75+(code 9 delays) and Maryfield with the lowest rate, 0 per 1,000 75+.

5.2 Public Health Scotland publishes a report on the number of people who are waiting for a Social Care and Care at Home service provided by the Health and Social Care Partnerships. The information, contained in Appendix 2, shows the number of people waiting for an assessment for a package of care to allow them to live at home or in the community and the number of hours of

care that has been assessed but not yet delivered. The information is presented by people waiting in hospital or waiting at home / in the community for the care at home service to be delivered.

Data published from 15 January 2024 onwards reflects improved definitions and therefore caution should be taken when comparing with figures prior to this date.

In Dundee, as at 02 December 2024:

- 0 people waited in hospital and 118 people waited in the community for a social care assessment. 0 people have waited in hospital each week since 17 October 2022.
- 11 people were assessed and waiting for a care at home package in hospital (163 hours yet to be provided).
- 18 people were assessed and waiting for a care at home package in the community (20 hours yet to be provided).
- For those already in receipt of a care at home package 2 additional hours were required and not provided.

6.0 POLICY IMPLICATIONS

6.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

7.0 RISK ASSESSMENT

Risk 1 Description	Poor performance against national indicators could affect outcomes for individuals and their carers, spend associated with poor performance and the ability of the IJB to deliver fully commitments set out in the Strategic and Commissioning Plan.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (which is an Extreme Risk Level)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance against national and local indicators. - Continue to report data quarterly to the PAC to highlight areas of exceptional performance (poor and excellent). - Continue to support operational managers by providing in-depth analysis regarding areas of poor performance, such as around readmissions to hospital and falls related hospital admissions. - Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data. - Work with operational managers to identify areas of poor performance that result in operational risk and undertake additional analysis as required.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a Moderate Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

8.0 CONSULTATIONS

8.1 The Chief Officer, Heads of Service, Health and Community Care and the Clerk were consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

9.1 None.

Christine Jones
Acting Chief Finance Officer

DATE: 20 December 2024

Shahida Naeem
Senior Officer, Quality, Data and Intelligence

Lynsey Webster
Lead Officer, Quality, Data and Intelligence

Lisa Traynor
Assistant, Quality, Data and Intelligence

APPENDIX 1 – Performance Summary

Table 1a: Performance in Dundee's LCPPs - % change in Q2 2024-25 against baseline year 2019-20

National Indicator	Dundee	Lochee	East End	Coldside	North East	Strathmartine	Maryfield	West End	The Ferry
Emer Admissions rate per 100,000 18+	+17.2%	+18.0%	+10.2%	+16.6%	+12.2%	+20.8%	+19.1%	+10.3%	+31%
Emer Bed Days rate per 100,000 18+	+0.6%	-1.2%	+8.6%	-8.2%	+26.8%	+4.6%	-8.1%	-9.8%	+4.6%
28 Day Readmissions rate per 1,000 Admissions 18+	+6%	+9%	-7%	+10%	+6%	+9%	+13%	-1%	+15%
Hospital admissions due to falls rate per 1,000 65+	+13%	+19%	+33%	-12%	+20%	+7%	+62%	+1%	+12%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Standard)	-43%	-40%	-46%	-47%	-34%	-69%	+83%	-56%	-37%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Code 9)	-30%	-16%	+192%	-71%	-97%	+136%	-100%	-57%	+217%

Source: NHS Tayside BSU and PHS (delayed discharge data)

Note: This table shows the Dundee position alongside the position for the 8 LCPPs. Where the LCPP position is poorer than Dundee this is coded as red (worse than Dundee) and where the LCPP position is better than Dundee this is coded as green.

Key: Improved/Better | Stayed the same | Declined/Worse

Table 1b: Performance in Dundee's LCPPs - % change in Q2 2024-25 against baseline year 2018-19

National Indicator	Dundee	Lochee	East End	Coldside	North East	Strathmartine	Mary field	West End	The Ferry
Emer Admissions rate per 100,000 18+	+15.5%	+14.2%	+13.5%	+10.6%	+10.7%	+23.5%	+22.7%	+3.3%	+25.9%
Emer Bed Days rate per 100,000 18+	-4.4%	-11.8%	-0.5%	-8.4%	+19.8%	+2.6%	-14.2%	-12.6%	+1.5%
28 Day Readmissions rate per 1,000 Admissions 18+	+6%	+13%	-11%	+20%	+3%	+5%	+7%	+13%	+8%
Hospital admissions due to falls rate per 1,000 65+	+14%	+47%	+13%	-15%	+61%	+9%	+67%	-14%	+9%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Standard)	-23%	-47%	-51%	22%	-65%	-47%	+27%	-15%	8%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Code 9)	-52%	-38%	+192%	-71%	-97%	+136%	-100%	-57%	+217%

Source: NHS Tayside BSU and PHS (delayed discharge data)

Note: This table shows the Dundee position alongside the position for the 8 LCPPs. Where the LCPP position is poorer than Dundee this is coded as red (worse than Dundee) and where the LCPP position is better than Dundee this is coded as green.

Key: Improved/Better | Stayed the same | Declined/Worse

Table 2: Performance in Dundee's LCPPs - LCPP Performance in Q2 2024-25 compared to Dundee

National Indicator	Dundee	Lochee	East End	Coldside	North East	Strath martine	Mary field	West End	The Ferry
Emer Admissions rate per 100,000 18+	14,607	17,277	19,100	16,338	13,800	16,346	13,078	9,280	13,609
Emer Bed days rate per 100,000 18+	114,732	139,423	146,902	134,080	108,088	123,015	89,008	71,596	120,879
28 Day Readmissions rate per 1,000 Admissions 18+	149	159	147	153	134	160	159	149	128
Hospital admissions due to falls rate per 1,000 65+	35	37	37	34	30	32	43	31	33
Delayed Discharge bed days lost rate per 1,000 75+ (standard)	213	239	152	257	88	119	332	279	221
Delayed Discharge bed days lost rate per 1,000 75+ (Code 9)	44	90	67	36	2	50	0	17	51

Source: NHS Tayside BSU

Note: This table shows the Dundee position alongside the position for the 8 LCPPs. Where the LCPP position is poorer than Dundee this is coded as red (worse than Dundee) and where the LCPP position is better than Dundee this is coded as green.

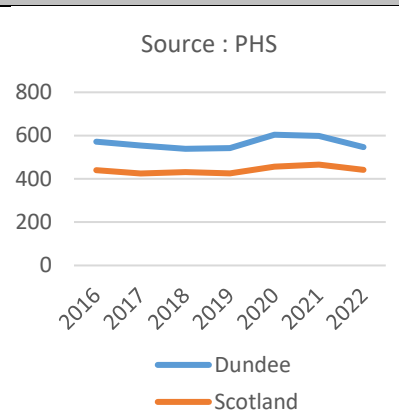
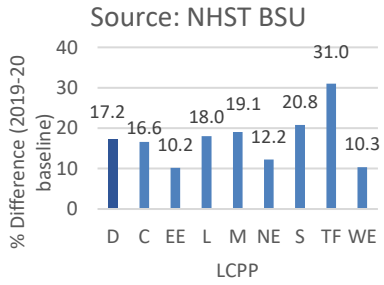
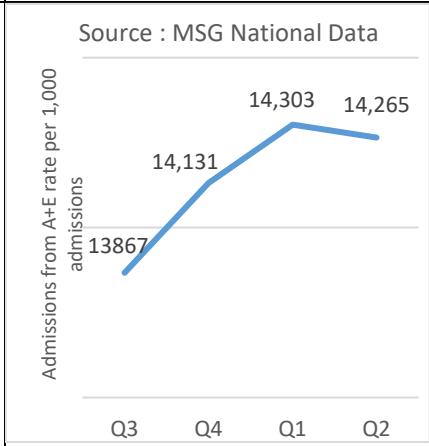
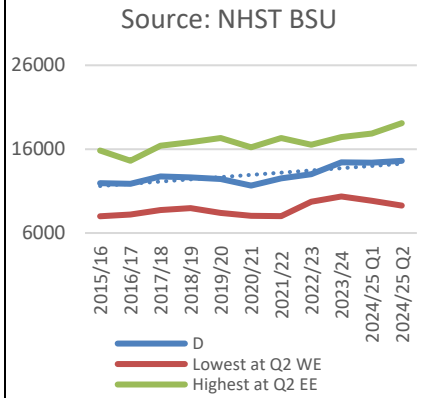
Key: Improved/Better Stayed the same Declined/Worse

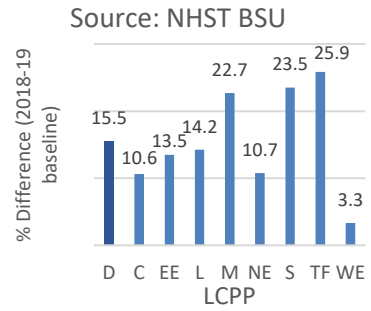
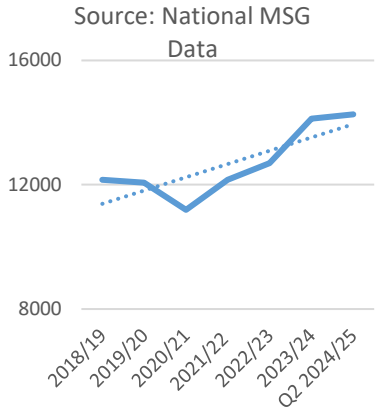
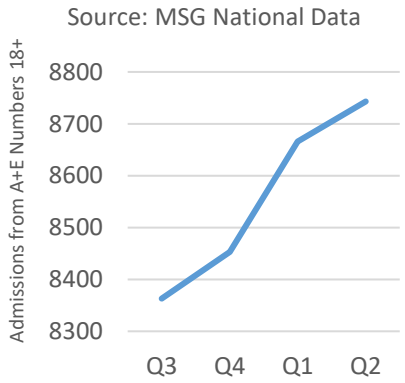
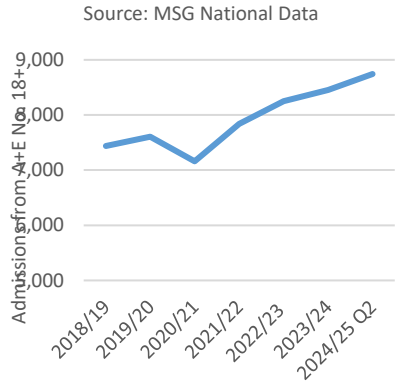
Table 3: Performance in Dundee's LCPPs - LCPP Performance in Q2 2024-25 compared to Dundee

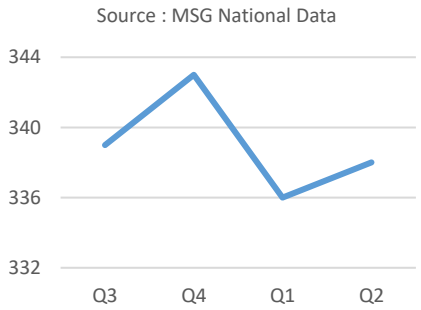
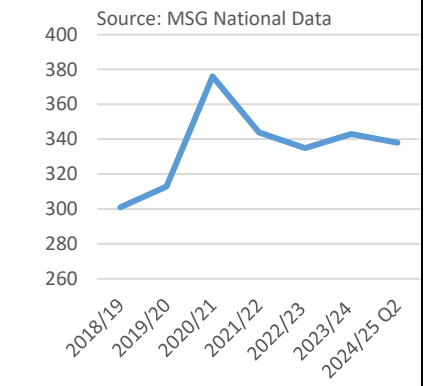
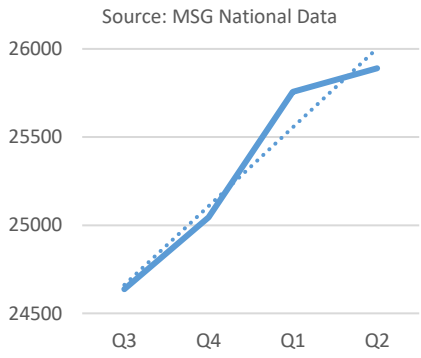
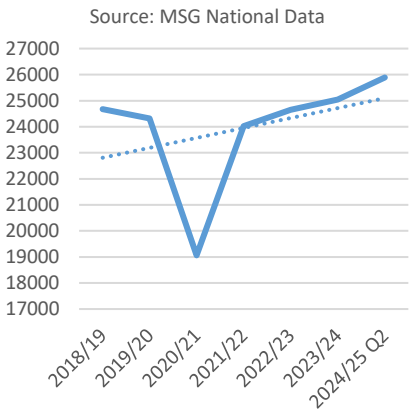
Dundee = D	East End = EE	Coldside = C	West End = WE
Strathmartine = S	North East = NE	Lochee = L	The Ferry = TF

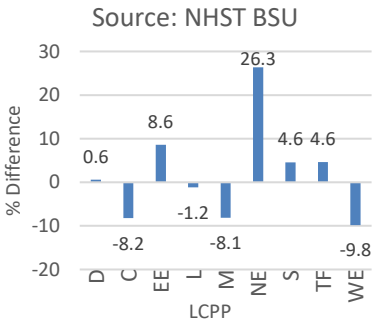
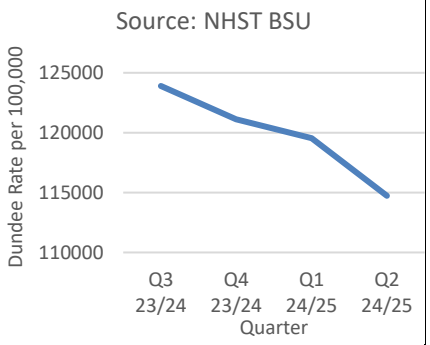
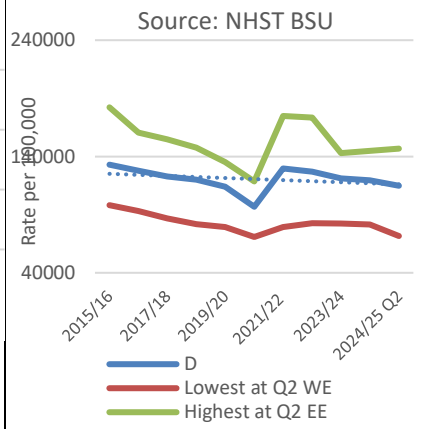
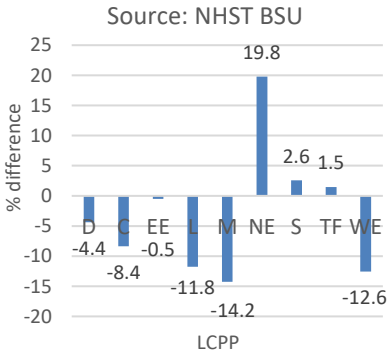
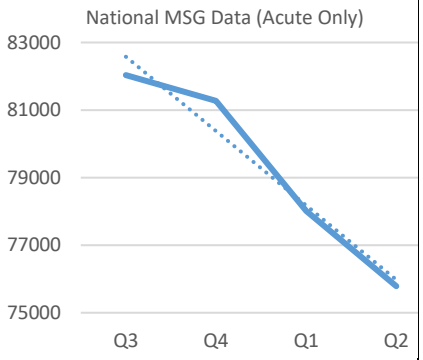
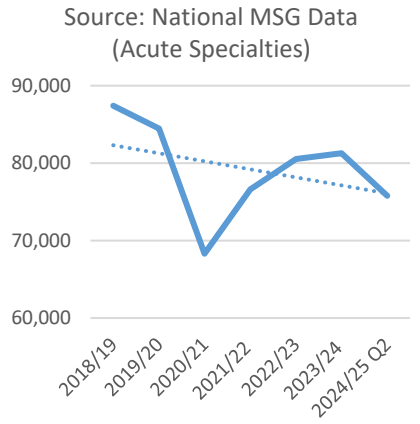
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
1.% of adults able to look after their health very well or quite well*				29th	5th (88%)	3rd
2.% of adults supported at home who agreed that they are supported to live as independently as possible*				10th	3rd (77%)	1st
3.% of adults supported at home who agreed that they had a say in how their help, care, or support was provided*				10th	4th (65%)	2nd
4. % of adults supported at home who agree that their health and social care services seem to be well co-ordinated*				13th	4th (64%)	1st
5.% of adults receiving any care or support who rate it as excellent or good*				22nd	5th (68%)	2nd
6.% of people with positive experience of care at their GP practice*				14th	3rd (71%)	2nd

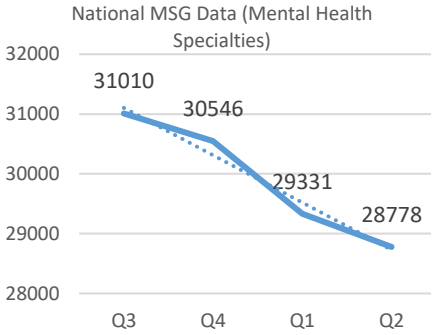
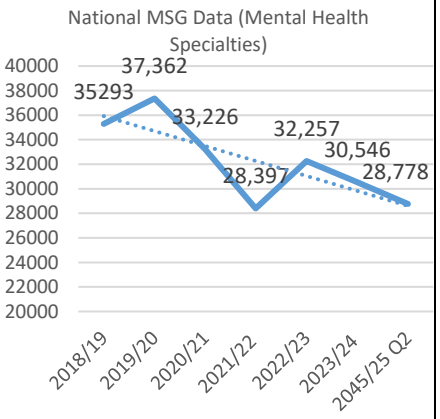
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
7.% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life*				14th	3rd (71%)	2nd
8.% of carers who feel supported to continue in their caring role*				8th	3rd (34%)	1st
9.% of adults supported at home who agreed they felt safe*				11th	1st (77%)	2nd
10. % staff who say they would recommend their workplace as a good place to work	Not Available Nationally iMatter is used to gather feedback from DHSCP staff. For the 2024 survey the response rate was 54%. 76% of staff reported that they would recommend their organisation as a good place to work.	Not Available Nationally	Not Available Nationally			

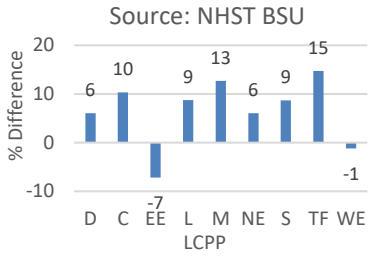
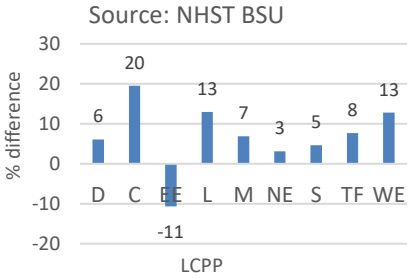
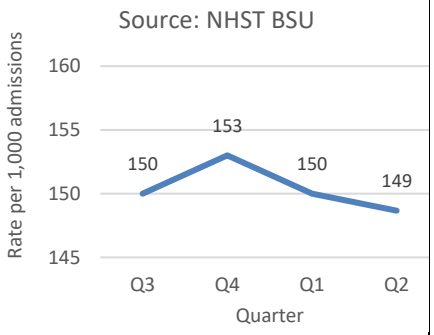
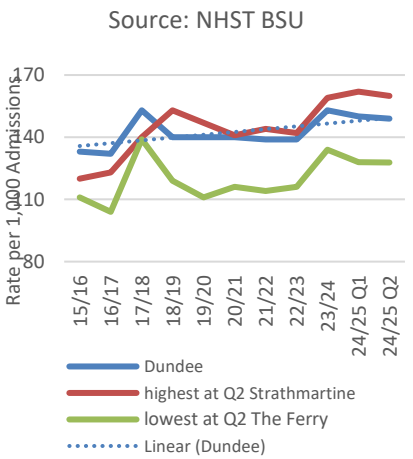
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
11. Premature mortality rate per 100,000 persons	4.5% less in 2022 than 2016 (improvement) 2022 is latest available published data	Not Available		29th	6th	3rd
12. Emer Admissions rate per 100,000 18+	 There was an increase in emergency admissions rate by 17.2% in Q2 2024-25 compared with the 2019-20 baseline. This equates to an increase of 2,147 emergency admissions (deterioration).	 A slight decrease from 14,303 in Q1 to 14,262 in Q2 2024/25	 Note - Linear (D) is the trendline for Dundee	28th	7th	3rd

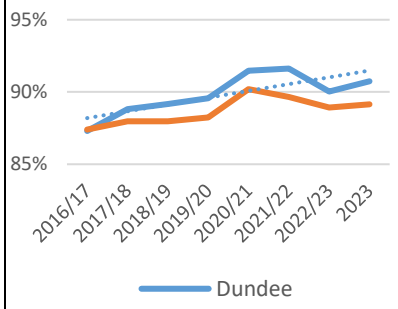
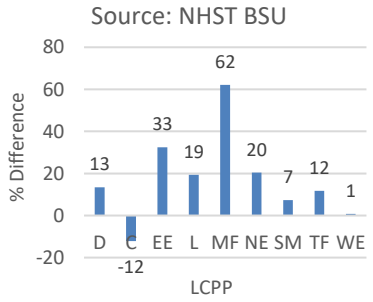
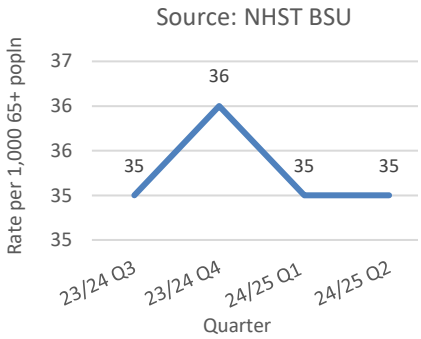
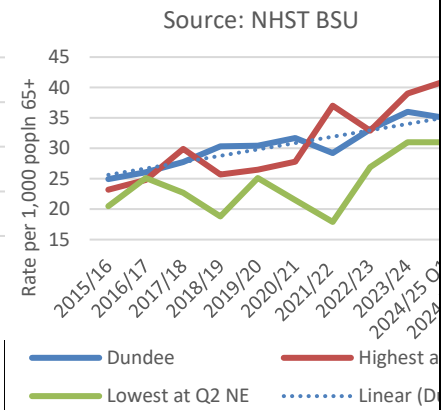
	 There was an increase in the emergency admissions rate by 15.5% in Q2 2024-25 compared with the 2018-19 baseline. This equates to an increase of 1,959 emergency admissions (deterioration).		 Increase since 2020/21 as we moved out of the Pandemic emergency response.			
Emergency Admissions Numbers from A&E (MSG)	1,138 more emergency admissions from A+E in Q2 2024/25 compared with the 2019/20 baseline. 1,303 more emergency admissions from A+E in Q2 24/25 compared with the 2018/19 baseline.	 An increasing trend since Q3 2023/24	 Increase since 2020/21	NA as number and not rate	NA as number and not rate	NA as number and not rate

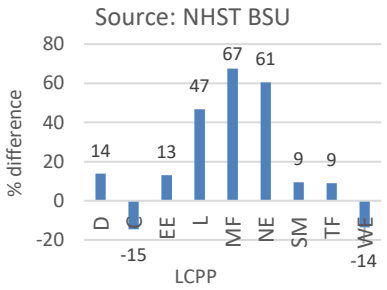
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
Emergency Admissions as a Rate per 1,000 of all Accident &Emergency Attendances (MSG)	Rate has increased by 25, from 313 at the 2019/20 baseline to 338 at Q2 2024/25. This is an increase of 8%. Rate has increased by 37, from 301 at the 2018/19 baseline to 338 at Q2 2024/25. This is an increase of 12%.	 Rate increased from 336 at Q1 24/25 to 338 at Q2 24/25, which is a deterioration although the Q2 rate is lower than is was at Q3 and Q4 2023/24.	 A small decrease in Q2 2024/25 compared with 2023/24.	Not Avail	Not Avail	Not Avail
Number of Accident & Emergency Attendances (MSG)	1572 (6% increase) more A&E attendances in Q2 2024/25 than the 2019/20 baseline. 1210 (5% increase) more A&E attendances in Q2 2024/25 than the 2018/19 baseline.	 Increase in attendance since Q3		NA as number and not rate	NA as number and not rate	NA as number and not rate

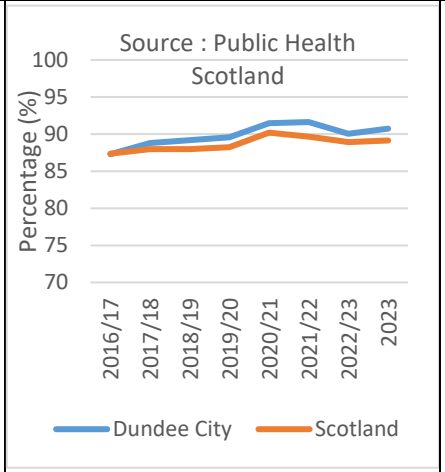
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
13.Emer Bed days rate per 100,000 18+	 There was an increase in the emergency bed days rate by 0.6% between the 2019-20 baseline and Q2 2024-25. This equates to an increase of 870 emergency bed days (slight deterioration).	 The emergency bed days rate is showing a consistently decreasing trend over the past 4 quarters.		15th	1st	2nd
	 There was a decrease in the emergency bed days rate by 4.4% between the 2018-19 baseline and					

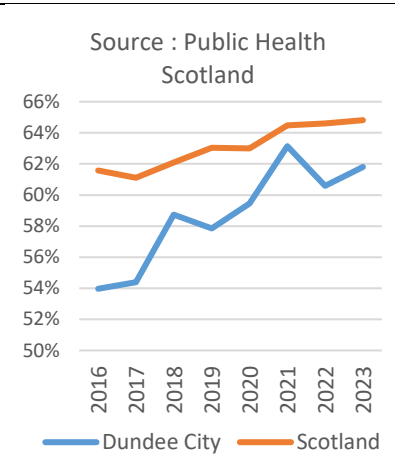
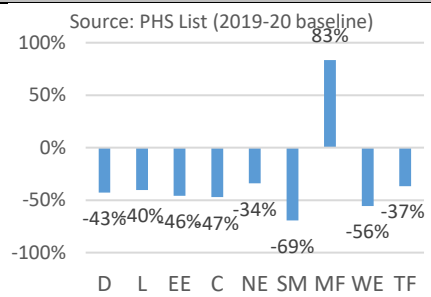
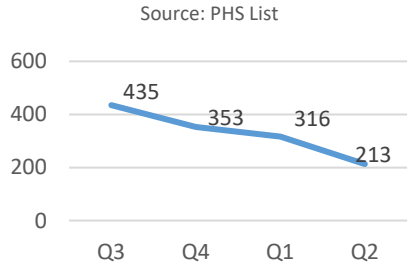
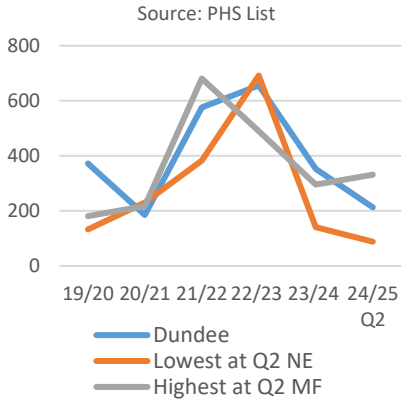
	Q2 2024-25. This equates to a decrease of 6,359 emergency bed days (improvement). 6515 (18%) less mental health bed days in Q2 2024-25 compared with the 2018-19 baseline (improvement) (source: MSG) 8584 (23%) less mental health bed days in Q2 2024-25 compared with the 2019-20 baseline (improvement) (source: MSG)	 A decrease in the rate of mental health emergency bed days since Q3 (improvement)	 An overall decrease in the rate of mental health emergency bed days since 2022-23 (improvement)			

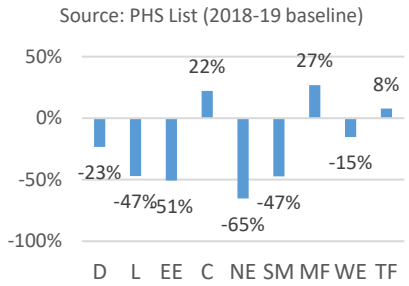
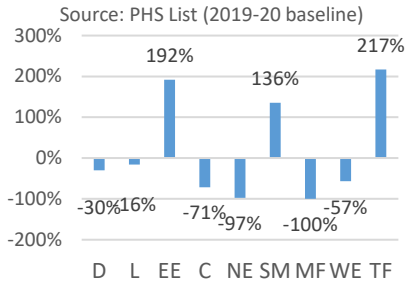
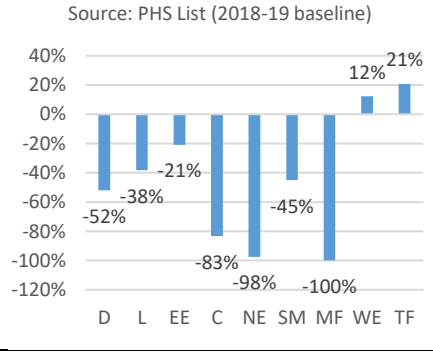
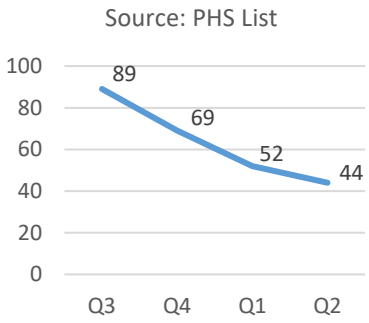
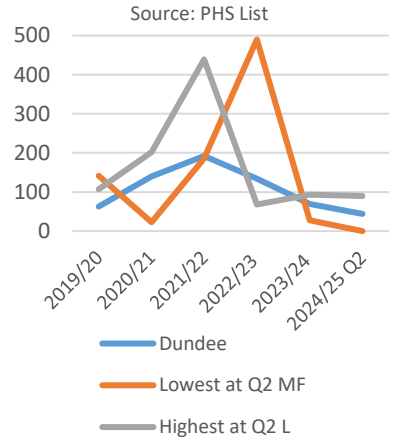
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
14. Emergency Readmissions rate per 1,000 Admissions 18+	 The rate is 6% higher at Q2 2024-25 than 2019-20. The number of readmissions (numerator) increased by 879 readmissions between the 2019-20 baseline and Q2 2024-25.  The rate is 6% higher at Q2 2024-25 compared with the 2018-19 baseline. The number of readmissions (numerator) increased by 896 readmissions between the 2018-19 baseline and Q2 2024-25.	 There has been a slight decrease from Q4 2023-24 and Q2 2024-25.		31st	8th	3rd

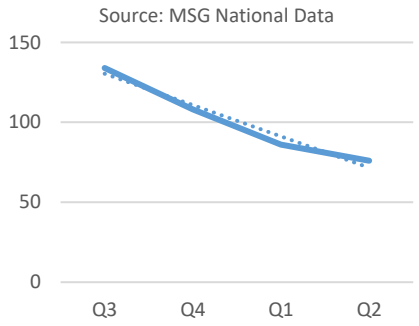
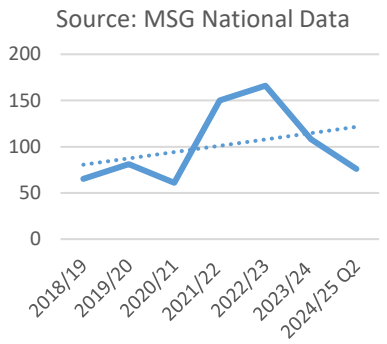
National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
15. % of last 6 months of life spent at home or in a community setting	Up from 89.2% in 2018/19 to 90.7% in 2023 (improvement)	Not Available		5th	2nd	2nd
16. Hospital admissions due to falls rate per 1,000 65+ population	 The rate of admissions has increased by 13% in Q2 24-25 from the 2019-20 baseline. This equates to an increase of 138 fall related hospital admissions. The greatest increase (deterioration) in the number of falls was in Maryfield with a 62% increase (43 fall related admissions) (deterioration).	 The rate has remained consistent at 35 per 1,000 population with a slight increase in 2023-24 Q4.		31st	8th	3rd

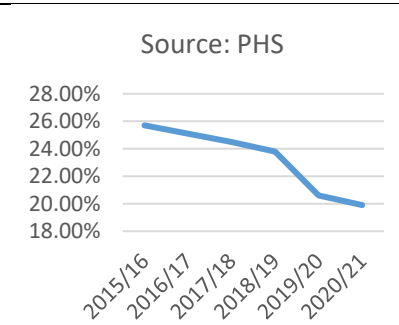
	Maryfield was 2nd lowest LCPP in 2019/20.  The rate of admissions has increased by 14% in Q2 24-25 from the 2018-19 baseline. This equates to an increase of 141 fall related hospital admissions. The greatest increase (deterioration) in the number of falls was in Maryfield with a 67% increase (43 fall related admissions) (deterioration). Maryfield was 3rd lowest LCPP in 2018/19.					

National Indicator	Difference From Baselines (2018-19 and 2019-20)	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 31 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
17. % care services graded 'good' (4) or better in Care Inspectorate inspections	Dropped from 86.2% in 2018/19 to 77.5% in 2023 (deterioration)	Not Available		19th	7th	1st

18. % adults with intensive care needs receiving care at home	7.4% (155 people) more in 2023 than 2017 (improvement) (note calendar year)	Not Available		24th	6th	3rd
National Indicator	**Difference From Baselines (2018-19 and 2019-20)**	**Dundee Short Term Trend (last 4 quarters)**	**Long Term Trend**	**Scotland Position 1= best, 31 = worst**	**Family Group Position 1= best, 8 = worst**	**Tayside Group Position 1= best, 3 = worst**
19.1 Delayed Discharge bed days lost rate per 1,000 75+ (standard)	 43% decrease (improvement) since the 2019/20 baseline.	 Decline (Improving trend) in the last 4 quarters	 Decline in standard delays since 2022/23. This is an improving trend..	NA	NA	NA

	 23% decrease (improvement) since the 2018/19 baseline.					
19.2 Delayed Discharge bed days lost rate per 1,000 75+ (Code 9)	 30% decrease (improvement) since 2019-20 and decrease (improvement) in 5 LCPPs. 	 Downward trend for delayed discharges	 Downward trend since 2021/22, an improvement in performance.	NA	NA	NA

	52% decrease (improvement) since 2018-19 and decrease (improvement) in 6 LCPPs.					
National Indicator	**Difference From Baselines (2018-19 and 2019-20)**	**Dundee Short Term Trend (last 4 quarters)**	**Long Term Trend**	**Scotland Position 1= best, 31 = worst**	**Family Group Position 1= best, 8 = worst**	**Tayside Group Position 1= best, 3 = worst**
Delayed Discharge bed days lost rate per 1,000 18+ (All Reasons) (MSG)	Bed days have decreased since the 2019-20 baseline. In 2019-20 there were 9,861 bed days lost and this decreased to 9,219 at Q2 2024-25. Bed days have decreased since the 2018-19 baseline. In 2018-19 there were 9,376 bed days lost and this decreased to 9,219 at Q2 2024-25.	 Reduction (improvement) since Q3.	 A decrease in bed days lost rate since 2022/23.	NA	NA	NA

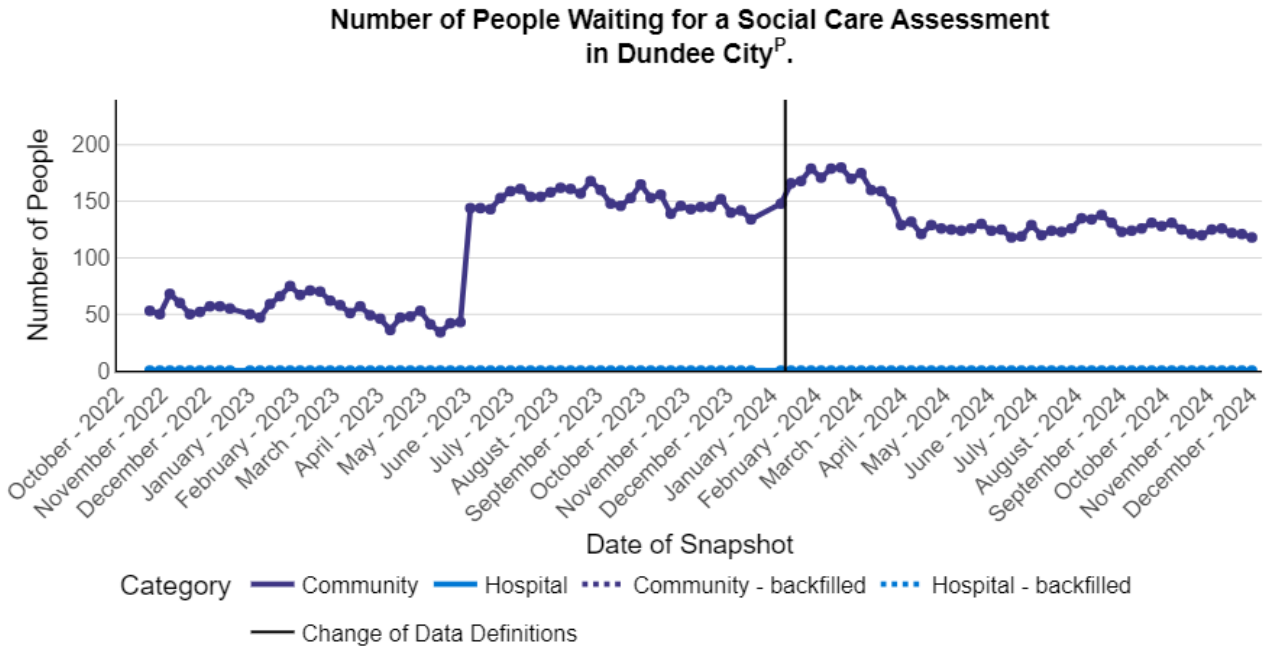
20. % of health and social care resource spent on hospital stays where the patient was admitted as an emergency	5.8% less in 2020/21* than 2015/16 (improvement) *latest data available	Not Available		18th	3rd	3rd

APPENDIX 2 SUMMARY OF SOCIAL CARE – DEMAND FOR CARE AT HOME SERVICES DUNDEE

This report is an assessment of the demand for Care at Home services provided by Health and Social Care Partnerships. The information shows the number of people waiting for an assessment for a package of care to allow them to live at home or in the community and the number of hours of care that has been assessed but not yet delivered. The information is presented by people waiting in hospital or waiting at home/community for the care at home services to be delivered.

The data items submitted from 15 January 2024 onwards reflects improved definitions and therefore comparing figures before this date should be done with caution.

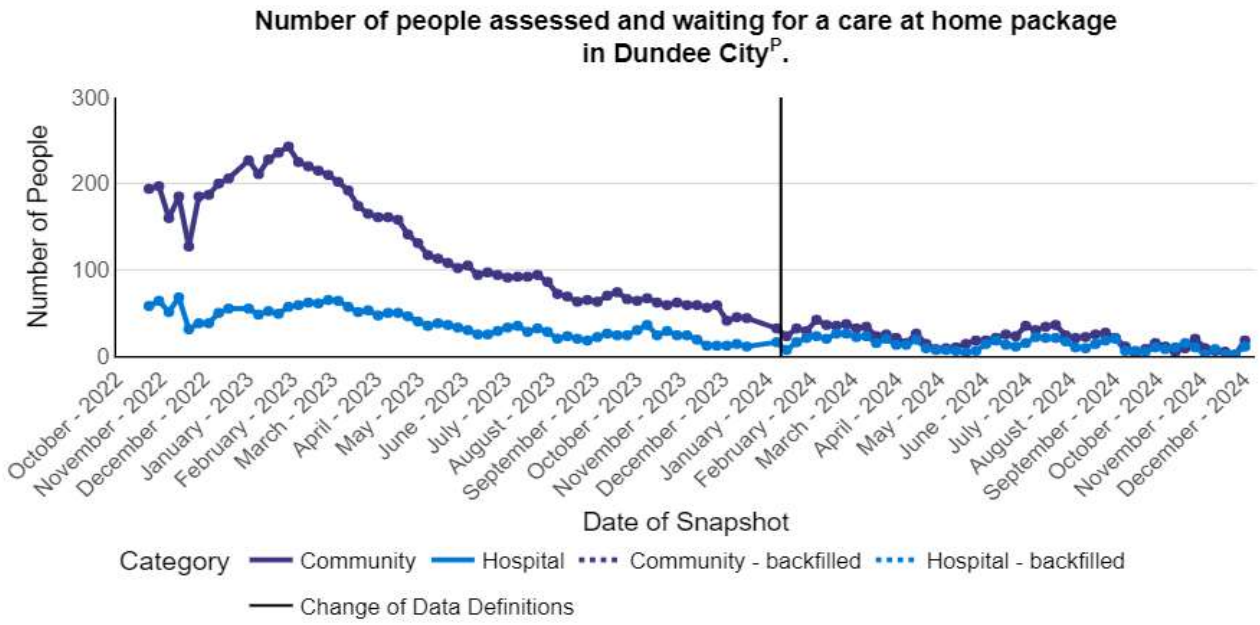
Chart 1



In Dundee as at 02 December 2024:

- 0 people waited in hospital and 118 people waited in the community for a social care assessment.
- 0 people have waited in hospital each week since 17 October 2022.

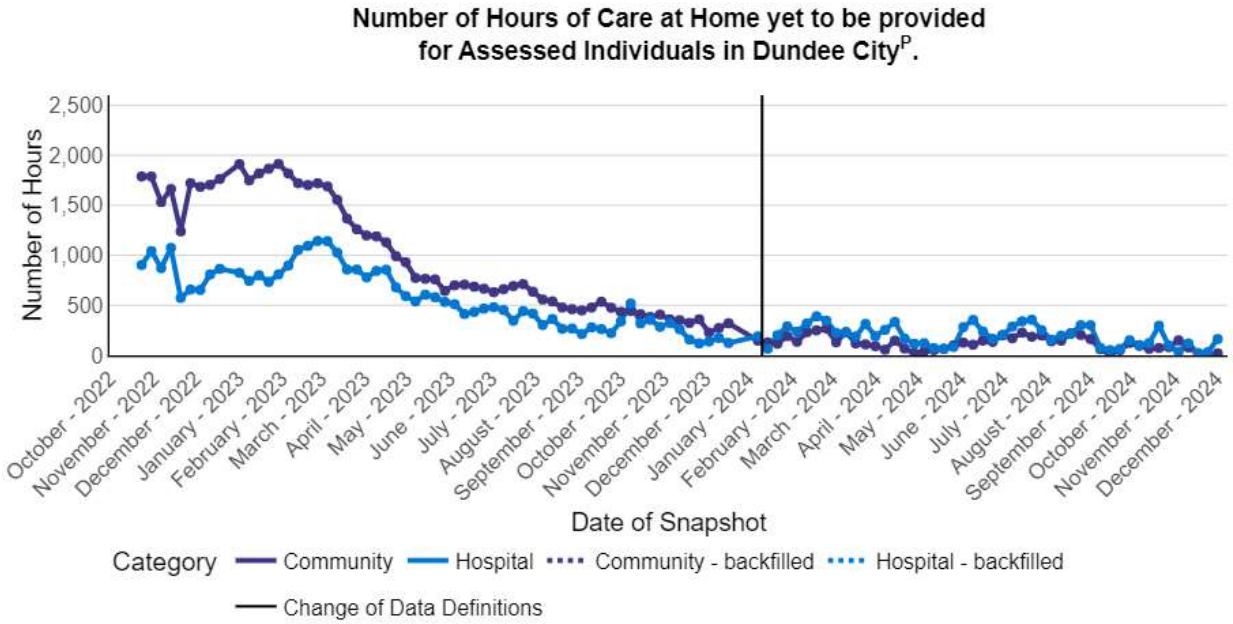
Chart 2



In Dundee as at 02 December 2024:

- 11 people were assessed and were waiting in hospital for a care at home package.
- 18 people were assessed and were waiting in the community for a care at home package.

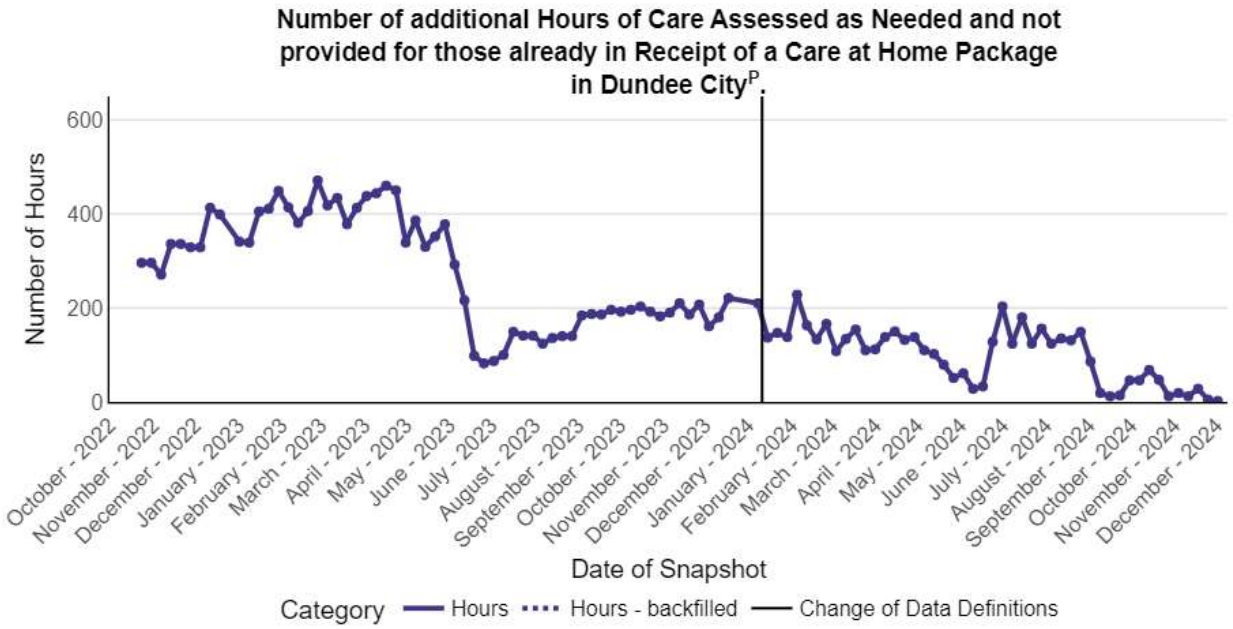
Chart 3



In Dundee as at 02 December 2024:

- 11 people were assessed and waiting for a care at home package in hospital (163 hours yet to be provided).
- 18 people were assessed and waiting for a care at home package in the community (20 hours yet to be provided).

Chart 4



In Dundee as at 02 December 2024:

- For those already in receipt of a care at home package 2 additional hours were required and not provided.

APPENDIX 3 – DATA SOURCES USED FOR MEASURING PERFORMANCE

The Quarterly Performance Report analyses performance against National Health and Wellbeing Indicators 1-23 and Measuring Performance Under Integration (MPUI) indicators. 5 of the 23 National Health and Wellbeing Indicators are monitored quarterly (emergency admissions, emergency bed days, readmissions, falls admissions and delayed discharge bed days lost. Data is provided both at Dundee and Local Community Planning Partnership (LCPP) level (where available). Data is currently not available for eight out of the 13 National Indicators which are not reported using The Health and Social Care Experience Survey (see section 4.3). The Scottish Government and Public Health Scotland are working on the development of definitions and datasets to calculate these indicators nationally.

The National Health and Wellbeing Indicators 1-9 are reported from The Health and Social Care Experience Survey administered by the Scottish Government which is conducted biennially. Full details were provided to the PAC in February 2021 (Article V of the minute of the Dundee Performance and Audit Committee held on 3 February 2021 refers). The Scottish Government changed the methodology used to filter responses to reflect people who receive services from the Partnership and therefore it is not possible to longitudinally compare results for National Indicators 1-7 and 9.

The quarterly performance report also summarises performance against indicators in the Measuring Performance Under Integration (MPUI) suite of indicators for four out of six high level service delivery areas – emergency admissions, emergency bed days, accident and emergency and delayed discharges, end of life and balance of care. In November 2020 the Performance and Audit Committee agreed that targets should not be set for 2020/21 for these indicators, however that the indicators should continue to be monitored in quarterly performance reports submitted to the PAC (Article VI of the minute of the Dundee Performance and Audit Committee held on 24 November 2020 refers).

National data is provided to all partnerships, by Public Health Scotland. This data shows rolling[1] monthly performance for emergency admissions, emergency admissions from accident and emergency, accident and emergency attendances, emergency bed days and delayed discharges. Previously Public Health Scotland were only able to provide data for all ages, however following feedback from Dundee and other Partnerships they have now provided data for people age 18+.

It was agreed at the PAC held on 19 July 2017 (Article VIII of the minute of the meeting refers) that local data, provided by the NHS Tayside Business Unit will be used to produce more timeous quarterly performance reports against the National Health and Wellbeing Indicators. NHS Tayside Business Unit has provided data for emergency admissions, emergency bed days, readmissions, delayed discharges and falls.

Data provided by NHS Tayside differs from data provided by Public Health Scotland (PHS); the main differences being that NHS Tayside uses 'board of treatment' and PHS uses 'board of residence' and NHS Tayside uses an admissions based dataset whereas PHS uses a discharge based dataset (NHS Tayside records are more complete but less accurate as PHS data goes through a validation process). As PHS data is discharge based, numbers for one quarter will have been updated the following quarter as records get submitted for those admitted one quarter and discharged a subsequent quarter. By the time PHS release their data, records are (in most cases) 99% complete. The data provided by NHS Tayside Business Unit is provisional and figures should be treated with caution.

[1] For Q2 the data is for the period October 2023 to September 2024

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE ASSURANCE REPORT**

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC8-2025**

1.0 PURPOSE OF REPORT

1.1 This is presented to the Performance and Audit Committee for:

- Assurance

This report relates to:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambitions:

- Safe
- Effective
- Person-centred

This report provides evidence of the following Best Value Characteristics:

- Equality
- Vision and Leadership
- Effective Partnerships
- Governance and Accountability
- Use of Resources
- Performance Management
- Sustainability

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Provide their view on the level of assurance this report provides and therefore the level of assurance regards clinical and care governance within the Partnership. The timescale for the data within this report is to 30 November 2024.

2.2 As Lead Officer for Dundee HSCP I would suggest that the level of assurance provided is: Reasonable; due to the following factors:

- There is evidence of a sound system of governance throughout the HSCP.
- The identification of risk and subsequent management of risk is articulated well throughout services.
- There is ongoing scope for improvement across a range of services, in relation to the governance processes, although this is inextricably linked to the ongoing difficulties with recruitment and retention of staff.

- There is evidence of noncompliance relating to a fully comprehensive governance system across some teams, i.e. contemporary management of adverse events and risks.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND

The role of the Dundee HSCP Governance Group is to provide assurance to the Dundee Integration Joint Board (IJB), NHS Tayside Board (through the Clinical Governance Committee) and Dundee City Council, that there are effective and embedded systems for Clinical, Care and Professional Governance in all services within Dundee HSCP.

The GIRFE Framework is an agreed tool used by all three HSCPs to ensure consistency of approach between Local Authorities, Tayside NHS Board and the IJBs for the three HSCPs; quality assurance is assessed against an agreed, prioritised common data set for each of the governance domains as detailed below.

The six domains continue to evolve over time and must be adaptable and responsive to the changes in legislation and external support and monitoring. The domains reflect the principles set out in the Health and Social Care Standards, My support, My life; Scottish Government, 2018 and the Quality of Care Approach, HIS and Care Inspectorate, September 2018. The domains are:

Information Governance
Professional Regulation and Workforce Development
Patient / Service User / Carer and Staff Safety
Patient / Service User / Carer and Staff Experience
Quality and Effectiveness of Care
Promotion of Equality and Social Justice

5.0 ASSESSMENT

a. Clinical and Care Risk Management

a.1 Lack of resource to deliver the benzodiazepine dependence pathway compliant with guideline, DDARS

Datix Ref	**Risk Exposure - No Controls**			**Current Risk Exposure Rating** *Please include data from previous **four** reporting periods*												**Planned Risk Exposure**			**Risk Trend (↑/→/↓)**
				16/2/24			**26/6/24**			**17/10/24**			**16/12/2024**						
	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	
1129	5	4	20	4	4	16	4	4	16	4	4	16	4	4	16	3	3	9	→

L = Likelihood C = Consequence RER = Risk Exposure Rating

Insufficient number of DDARS staff with prescribing competencies

Datix Ref	Risk Exposure - No Controls			Current Risk Exposure Rating *Please include data from previous **four** reporting periods*												Planned Risk Exposure			Risk Trend (↑/→/↓)
				16/2/24			26/6/24			17/10/24			16/12/2024						
	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	
612	5	5	25	4	4	16	3	5	15	3	5	15	3	5	15	3	3	9	→

L = Likelihood C = Consequence RER = Risk Exposure Rating

Increasing patient demand in excess of resources – DDARS

Datix Ref	Risk Exposure - No Controls			Current Risk Exposure Rating *Please include data from previous **four** reporting periods*												Planned Risk Exposure			Risk Trend (↑/→/↓)
				26/6/24			17/10/24			17/10/24			16/12/2024						
	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	
233	4	5	20	5	5	25	3	5	15	3	5	15	3	5	15	3	4	12	→

L = Likelihood C = Consequence RER = Risk Exposure Rating

a.2 Three of the top 5 risks sit with the Dundee Drug and Alcohol Recovery Service (DDARS). There are ongoing service pressures due to staff turnover that affect all of the key risks identified although it is noted this has slowed considerably and the team are approaching a full complement of staff.

This increase in staffing has helped however we recognise that the people using the service have an increasingly high level of complex needs and due to the Medication Assisted Treatment (MAT) programme we have had to commit significant resources to new interventions such as two Buvidal® clinics that run all day 5 days a week. Dundee continues to be one of the best performing HSCPs in Scotland in relation to the MAT Standards.

a.3 Risk 233 had shown a current risk score in excess of the inherent risk score since April 2023. This was primarily due to ongoing challenges relating to recruitment and retention into the DDARS service. This is starting to ease as noted above.

Acuity and dependence levels continue to intensify within the patient group requiring intensive input from staff including adult support and protection concerns. Housing and homelessness are proving to be an issue for our most complex patient group where mainstream housing is not adequate for their needs.

While this is not within DDARS complement of staffing, the absence of hospital liaison staff is resulting in risks attached to the management of the patients for drugs and alcohol use in acute care results in additional demands for nursing staff.

Two locums remain in post and plans to advertise for substantive posts are progressing. These posts are required to maintain safe clinical services, same day prescribing, Buvidal® prescribing, support for non-medical prescribers and advanced nurse practitioners, medical trainees, GPs with special interest and the specialty doctor.

There has been a significant amount of work achieved over recent years to increase the diversity of the nursing role. This has resulted in the increase of non-medical prescribing and advanced nurse practitioner roles.

DDARS has seen growth in the staff group who have prescribing competencies. At this time there are 7.4wte nursing staff who can prescribe (two previous NMPs promoted within the service to non-clinical roles) and seven trainees, which include the primary care project staff and child and family nurses.

Training is ongoing: two staff will complete training within next four months, one additional staff member within ten months with four staff currently planning start dates.

The longer-term workforce plan is to have three non-medical prescribing staff for each team. This would result in an additional 3.6 staff (18 in total) with prescribing competencies to achieve this, based on current need.

There are currently two Advanced Nurse Practitioners (ANPs) and one trainee ANP, who have been providing intensive support to individuals where there are co-occurring physical conditions. This intensive input has been integral in ensuring people access the right care at the right time ensuring positive outcomes.

The benzodiazepine dependence pathway is currently being considered via a National Taskforce who are considering the possible models of practice. There is no update on progress of this since the last committee meeting.

a.4 Capacity issue due to vacancy and new staff – Dietetic Diabetes Team

Datix Ref	**Risk Exposure - No Controls**			**Current Risk Exposure Rating** *Please include data from previous **four** reporting periods*												**Planned Risk Exposure**			**Risk Trend (↑/→/↓)**
							09/03/2024			**17/10/2024**			**16/12/2024**						
	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	
1434	5	4	20				4	4	16	4	3	12	4	3	12	3	2	6	→

L = Likelihood C = Consequence RER = Risk Exposure Rating

The dietetic diabetes team comprises four staff (3.2wte). There has been rapid turnover of staff within the team which has led to a reduction in knowledge and skills which is being addressed through comprehensive induction and educational processes. There is only one full time member of staff with the knowledge and skill to comprehensively induct and educate the two new starts which is prolonging the process. A number of mitigations have been explored including:

- Successful international recruitment.
- Requests have been made to other health boards to support education and training. Currently there have been no offers to support due to capacity issues across Scotland.
- Investigation of clinical support from within and out with NHS Tayside.
- Following robust dietetic risk assessment has been undertaken to identify priority patient groups.
- Following robust dietetic risk assessment specific groups of patients have been identified who can self-manage with support from written or video information with minimal risk.
- Where appropriate, patient education groups are used as an alternative to one to one appointments.
- Clinical admin processes have been reviewed and streamlined to protect direct patient care.
- All videos and leaflets have been uploaded to the Diabetes MCN website to enable easier access for patients and clinicians.

a.5 Capacity to Exercise Guardianship Duties (Learning Disabilities)

Datix Ref	Risk Exposure - No Controls			Current Risk Exposure Rating *Please include data from previous **four** reporting periods*												Planned Risk Exposure			Risk Trend (↑/→/↓)
							10/06/2024			17/10/2024			16/12/2024						
	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	L	C	RER	
1343	5	3	15				5	3	15	4	3	12	4	3	12	3	2	6	→

L = Likelihood C = Consequence RER = Risk Exposure Rating

As a result of the limited capacity of the learning disability team to undertake Guardianship duties, there is a risk that people under family Guardianship scrutiny may not receive a suitable level of support and those awaiting allocation of a Local Authority Guardianship will experience delays in care.

The team have established a process for the prioritisation of renewals to ensure there are no lapses in orders and this is closely monitored by the team manager. Appropriately trained mental health officer staff are able to work additional hours on an ad hoc basis to support.

New Risks

No new risks have been added to the system in this reporting period.

b. Workforce Risks

b.1 There are a number of risks (13, increased from 12) pertaining to workforce availability across a wide spectrum of professions, including nurses, medical staff, allied health professions and social care staff. The vast majority of teams are affected to some degree, often with mitigations impacting on those teams who are able to recruit staff. Work continues to enhance recruitment and retention, with international recruits now being widely employed. Staff wellbeing remains a focus for the HSCP.

Primary Care (PC) Sustainability Risk – Strategic Risk 1374

b.2 The Sustainability Primary Care Services Risk current rating remains at 20 (Red / Very High), having been reduced in 2023 from 25 following the implementation of some of the more strategic and leadership actions across Tayside. This risk is categorised as a Quality (of Care) Clinical risk. There are currently 21 GP practices in Dundee.

This risk recognises that a failure to maintain sustainable Primary Care Services in localities and across Tayside will result in a failure to meet both the National Clinical Strategy and will have a negative impact on both patients and staff. The risk arises as a result of an inability to:

- Reliably recruit, train and retain workforce;
- Have appropriate premises arrangements to deliver clinical and support services, and
- Have in place adequate digital systems to support clinical care and communication between teams, patients and across the services. This risk encompasses all Primary Care contractors; Dental, Optometry, General Practice and Community Pharmacy.

A second sustainability survey was undertaken with GP practices across Tayside in February 2024 which gathered more data on workforce and general information on other issues impacting on a practice's sustainability. The preliminary analysis of the second survey indicates that 20% of Dundee practices consider their future sustainability to be a risk. The factors contributing to this included GP partner leaving/retirement, increased patient demand versus capacity and independent contractor practices noting some or significant impact on sustainability risk arising from leasing/ownership of premises. An interim survey focussing on workforce was issued in September 2024 to monitor the position.

Local actions and controls have been, and continue to be, developed, and reviewed. These actions seek to increase capacity, manage demand and address barriers by taking forward actions within the control of the HSCP.

The workstreams linked to the Primary Care Improvement Plan are mostly fully recruited to, except for the pharmacy team which has ongoing challenges, despite innovative approaches to increasing skill mix. There is the potential to further develop these teams but there is no resource to do so.

However, the increasing demand for GP and the wider Primary Care team is such that any improvement or shift of clinical workload has been offset by that demand. Dundee is therefore in a position of having had three practices closing in a three year period. Numerous practices have had periods with closed lists and being unable to accept new registrations.

Dundee has a Premises Strategy and a wider GP strategy agreed and is working to progress this. The removal of the burden of ownership, or leasing of premises is critical to the recruitment of new GPs partners and there has been limited progress regionally and nationally for this but at 30 September 2024 there has been no progress regionally with leases transferring to NHS Tayside. In total three Dundee practices have received a GP sustainability loan (as at April 2024). However, the loan scheme for 2023/24 had been oversubscribed and Scottish Government needed to fund the completed loans before accepting any further tranche one agreements. Scottish Government are not yet in a position to say when tranche two applications would be opened.

Resource had been identified locally to support the GP career start programme which is key to supporting some practices remain stable, but longer term funding is still not in place.

The local development and further integration of urgent care teams and the development of roles in other primary care-based teams, will continue to contribute positively, such as the advanced district nurse role.

Treated/Archived Risks

b.3 Treated/Archived Risks are those that have all planned/proposed control in place, and the risk has been mitigated to the lowest possible level.

There has been no risk treated/archived with the time period.

Closed Risks

b.4 Closed Risks are risks that have been replaced or superseded and are therefore no longer required to be managed.

There have been no risks closed in this reporting period.

Clinical & Care Governance Arrangements

b.5 The arrangements for clinical, care & professional governance (CCPG) in the Dundee HSCP are outlined in Appendix 1: Dundee HSCP Governance Structure.

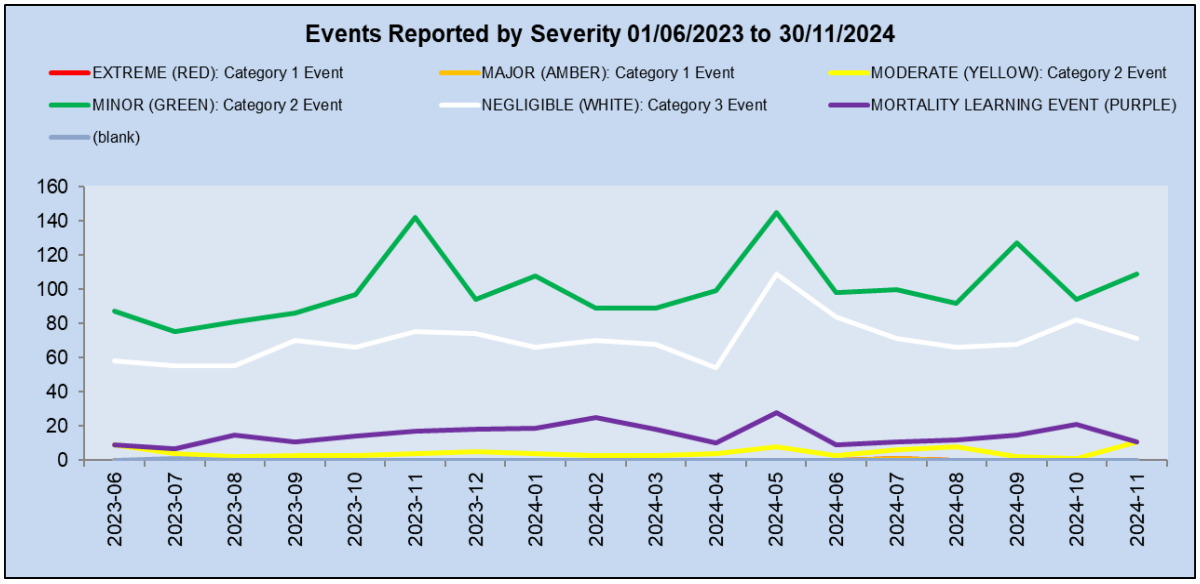
During this reporting period exception reports were presented to the CCPG Group from the following services as outlined in the table below.

To support enhanced compliance and to meet internal audit recommendations, the production and presentation of exception reports is being more closely monitored. The Clinical, Care and Professional Governance Group are also reviewing frequency of annual reports and exception reports to support management capacity. The following table details where assurance reports have been submitted and if a member of the service was present to speak to the report or provide a verbal update.

MEETING DATE	24 Apr 2024		20 Jun 2024		14 Aug 2024		9 Oct 24		4 Dec 24	
EXCEPTION REPORT	Report	Speaker	Report	Speaker	Report	Speaker	Report	Speaker	Report	Speaker
Learning Disability & Mental Health	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Psychology	Y	N	N	N	Y	Y	Y	Y	N	Y
DDARS & Sexual Health	N	Y	N	Y	Y	Y	N	N	Y	Y
Nutrition & Dietetics	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Community Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Acute & Urgent Care	N	N	N	N	Y	Y	Y	Y	Y	Y
Inpatients & Day Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Older People MH & Care Homes	Y	Y	N	Y	Y	N	N	Y	Y	N
Primary Care	N	Y	Y	Y	Y	Y	Y	Y	Y	Y

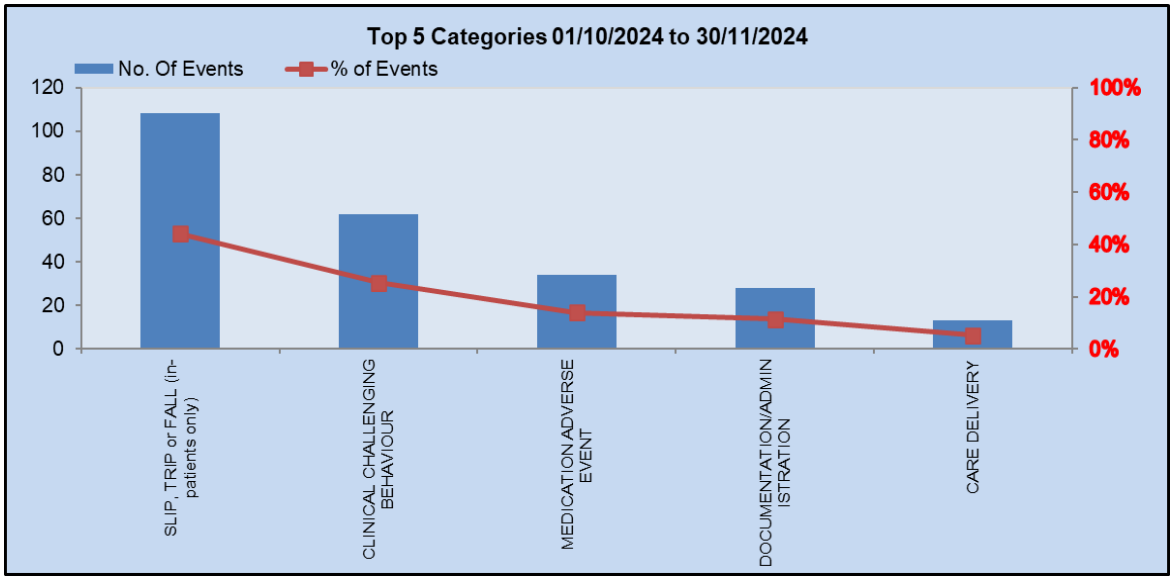
c. Adverse Event Management

c.1 The following graph shows the impact of the reported adverse events by month over the past 18 months. There were 400 adverse events reported in this time period (01/10/2024-30/11/2024). There is an increase in minor events with a small rise in mortality learning events, the majority of these are reported through Expected Death categories (20 of 32 reported adverse events).



The ratio of events with harm to events with no harm is 1 to 3.8. This is a decrease from the previous report.

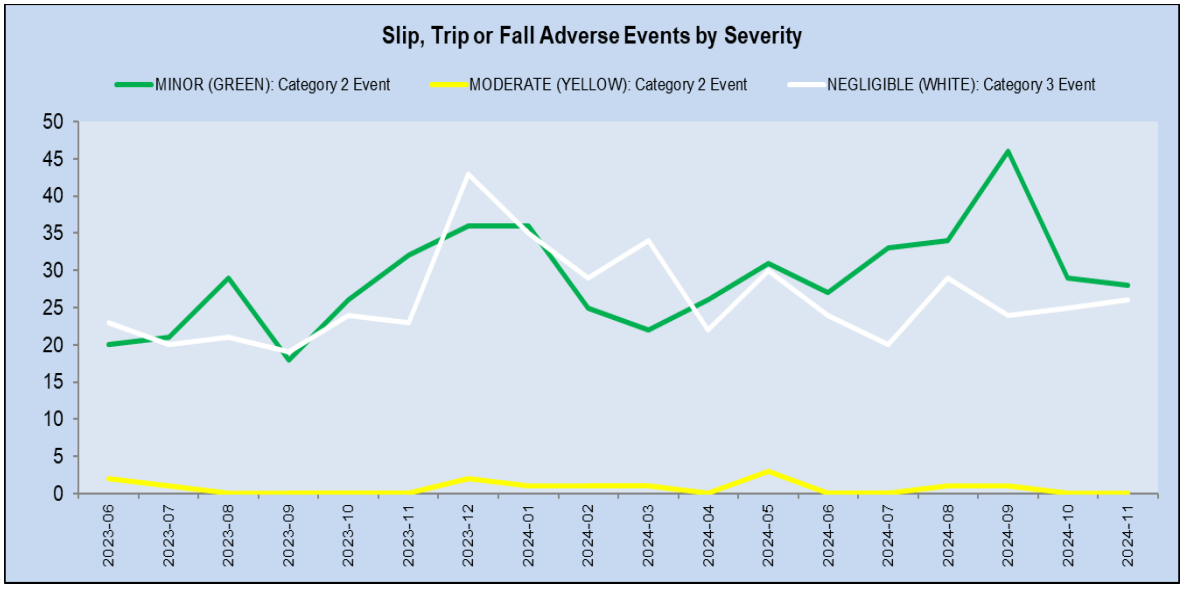
c.2 The following graph shows the Top Five Categories reported between 01/10/2024 and 30/11/2024.



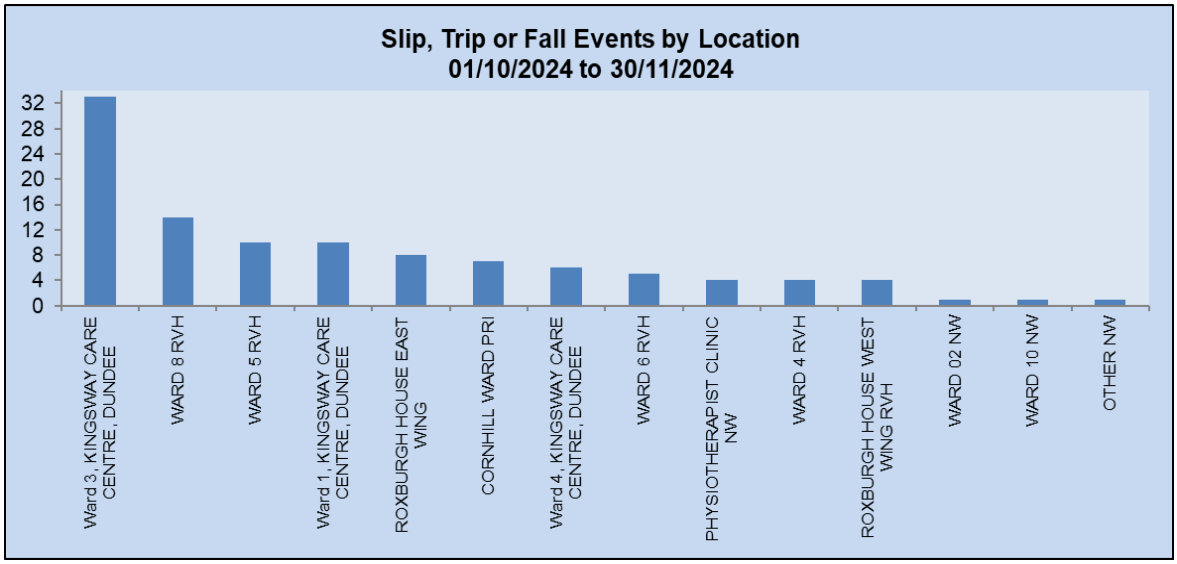
These categories account for 245 of the 400 events (61%) reported within the time period.

Slips, Trips and Falls

c.3 There were 108 events reported between 01/10/2024 and 30/11/2024. This is a decrease of 27 from the last reporting period. The following table shows slips, trips and falls by severity over the past 18 months:



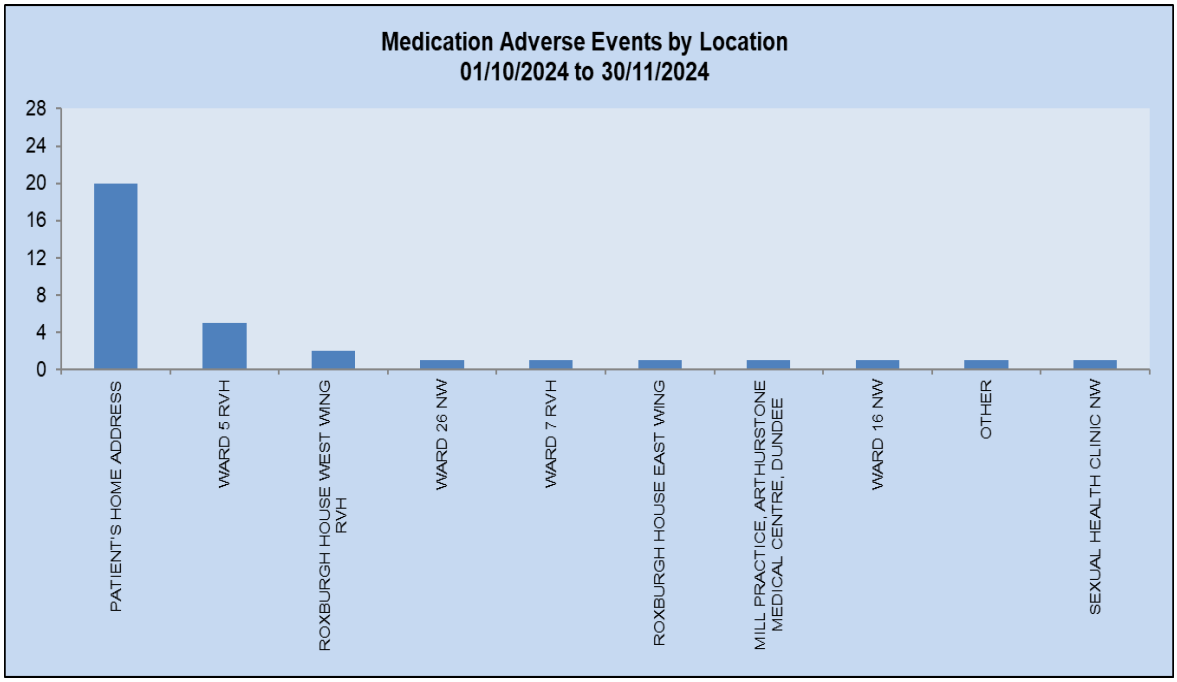
c.4 The following chart shows the number of slips, trips and falls (In-patients only) by location, with the highest number of falls being across Psychiatry of Old Age. Inpatient teams continue to review all falls to ensure all preventative measures are in place and that post-falls reviews are undertaken. The level of harm resulting from a fall remains low.



c.5 The above graph (*c.4*) shows an increase of 3 in inpatient falls over this reporting period. A review of the adverse events shows a number of individuals were responsible for multiple events across a number of ward areas. The severity of these adverse events remains low with minimal harm to patients (bruising, skin flaps) and no harm to staff.

Medication Adverse Events

c.6 There were 34 events reported between 01/10/2024 and 30/11/2024. This is an increase of 2 from the last reporting period. Within this there were 16 separate subcategories reported across ten different clinical teams. There are no clear themes or patterns identified within teams or across the HSCP. The majority of these events occur in the patients' homes (19) with the most commonly occurring subcategory being Missed Dose by Staff (6), with four within District Nursing.

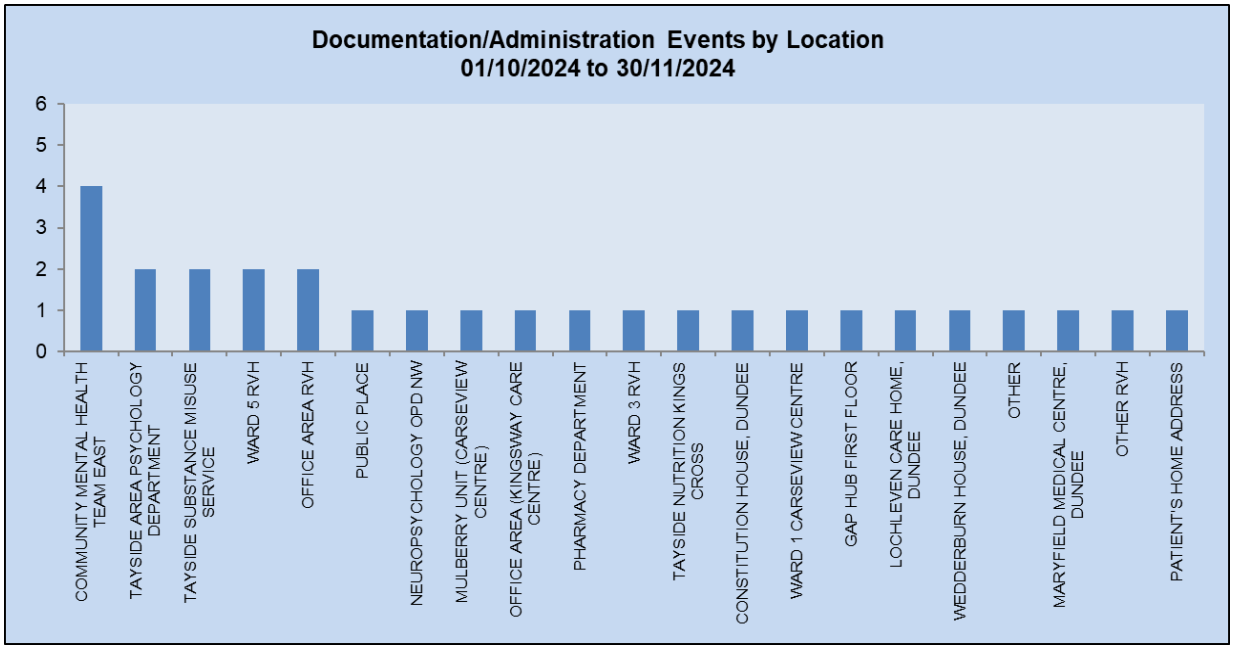


Each adverse event is followed up within the team to identify learning and any required improvements with those involved undertaking reflection. This frequently includes working closely with our pharmacy colleagues.

A number of these incidents identified adverse events in other parts of the system that were identified via HSCP teams, e.g. discharged without correct medicine. Follow up discussions are held with teams to support learning and management of risk.

Documentation/Administration

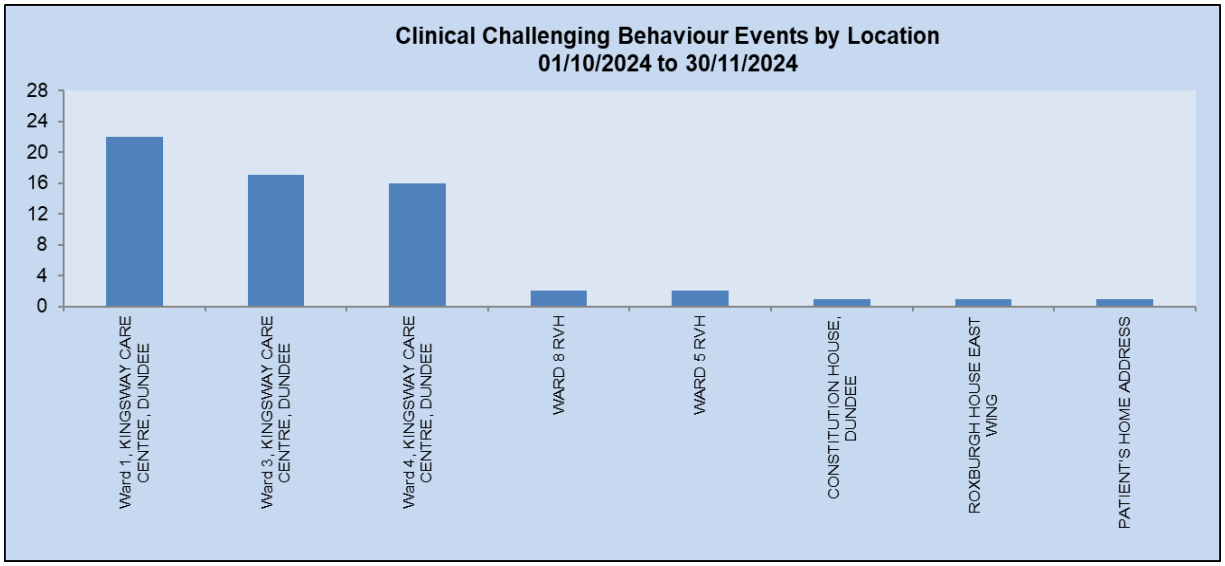
c.7 There were 28 events reported between 01/10/2024 and 30/11/2024. This shows an increase of 9 from the last reporting period. The chart below shows the documentation/administration events by location.



The high number of incidents reported this period was primarily due to failed communications errors (8). They all occurred over five different clinical teams with no clear themes.

Clinical Challenging Behaviour

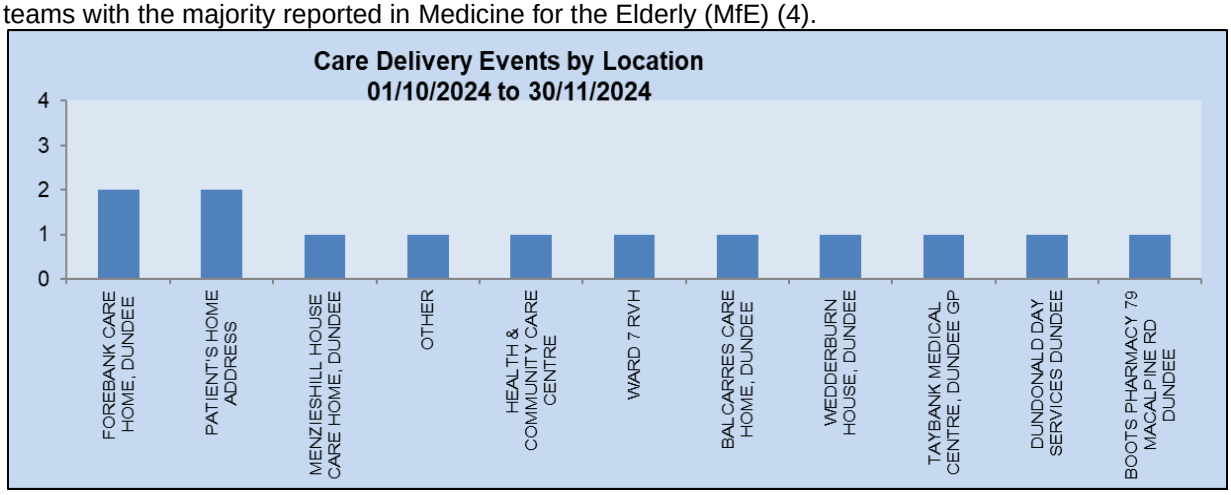
c.8 There were 62 events reported between 01/10/2024 and 30/11/2024. This is an increase of 27 from the last report. The chart below shows the clinical challenging behaviour adverse events by location.



The majority of these events occur in our Psychiatry of Old Age service. There are an increasing number of patients being admitted with high levels of stress and distress. There is very positive evidence of these incidents being well managed with staff being well supported as outlined in the post incident reviews that are carried out.

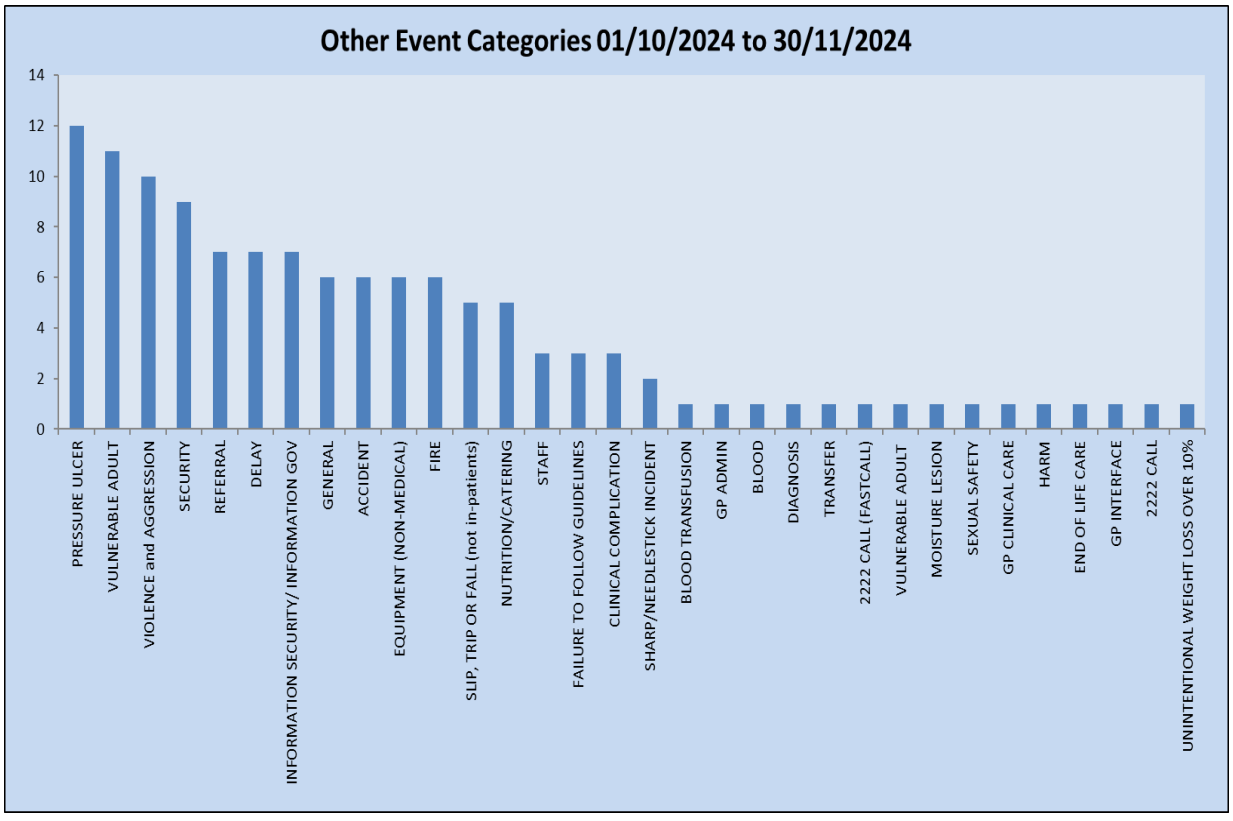
Care Delivery

c.9 There were 13 events reported in this reporting period. The high number of incidents reported this period was primarily due to discharge problems (6). They all occurred over 3 different clinical teams with the majority reported in Medicine for the Elderly (MfE) (4).



Other Event Categories

c.10 There were 123 events reported outwith the top five events and Mortality events reported. These are listed in the chart below.

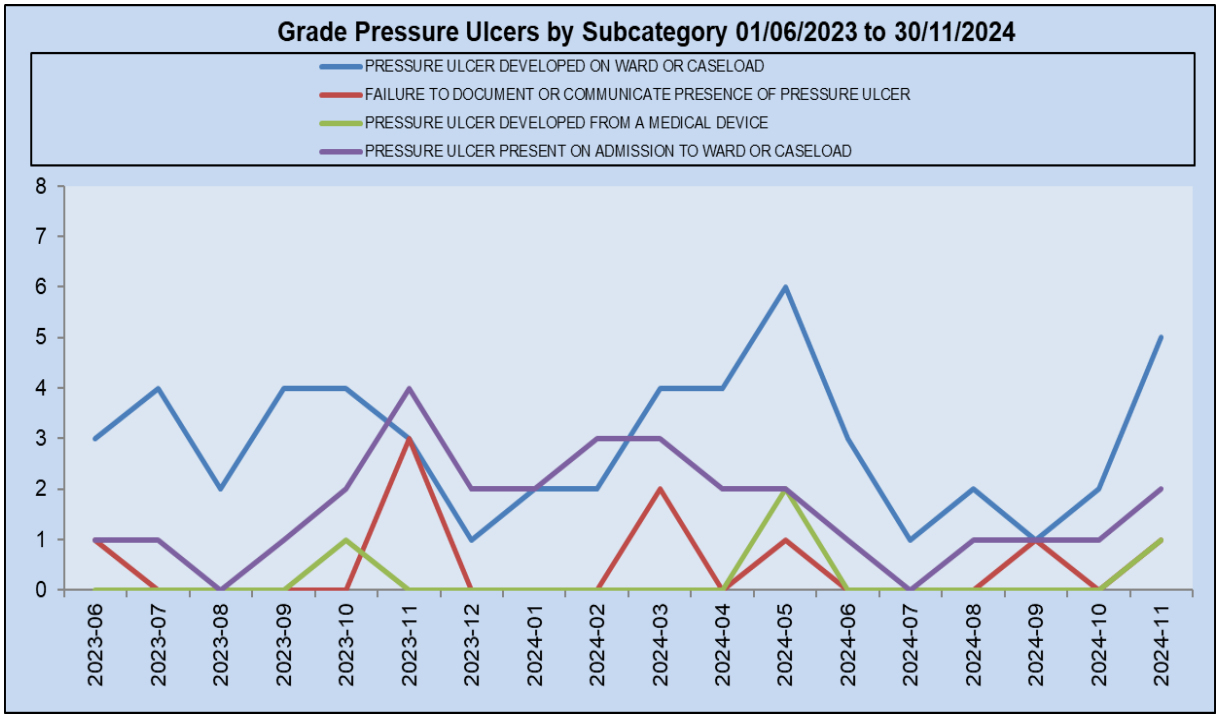


Significant Adverse Event Reviews

c.11 There are currently two active Significant Adverse Event Reviews in Dundee HSCP. One of these is now ready to be signed off. Once complete, a learning summary will be shared with the committee.

Pressure Ulcers & Falls

c.12 There have been 12 pressure ulcer events reported between 01/10/2024 and 30/11/2024. This is an increase of 6 on last reporting period. The number of pressure ulcers reported over the past 18 months is shown in the following graph, by subcategory.



Where pressure ulcers develop on a ward or caseload this is consistently reviewed and within community services is predominantly as a result of patients and families not following the clinical advice provided by the nursing team. The team will work with families and patients to educate and support as much as possible in these situations, ensuring patient-centred care, particularly during palliative and end of life care.

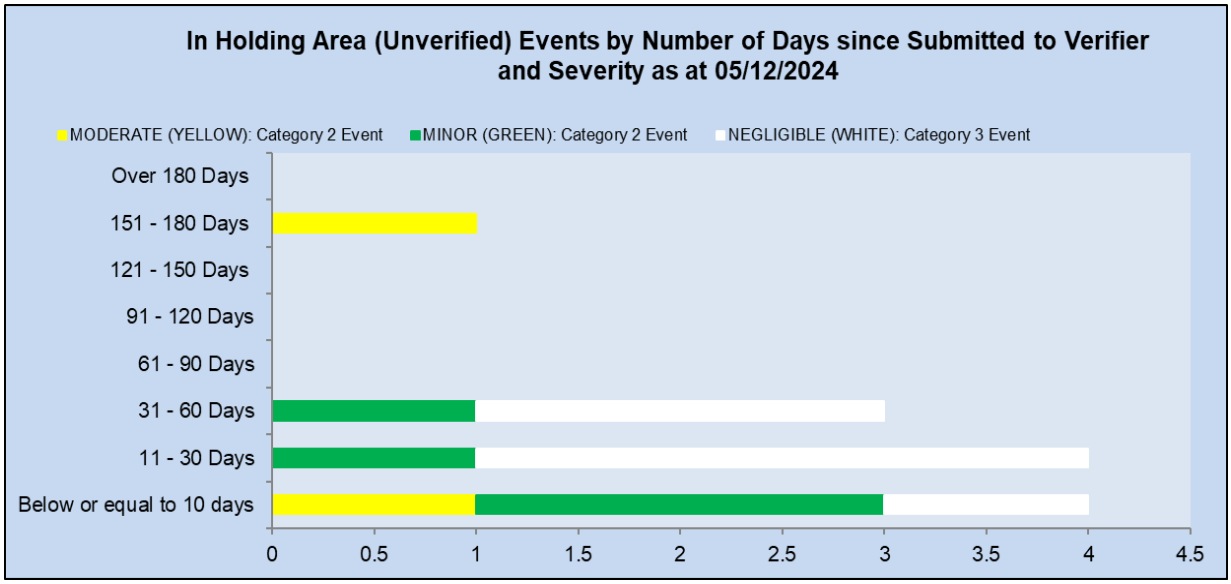
Where pressure ulcers are noted on admission to a caseload or ward, work investigations are commenced to ensure all preventative steps have been taken, with all relevant services collaborating.

Adverse events management – Systems and Processes

c.13 Overdue Unverified Events

At the time of data extraction, there were 12 unverified events. This is a decrease of 23 since last reporting period. Of these unverified events, 12 had exceeded the timescale of 72 hours for verification.

The following graph shows the unverified events by the severity and the number of days overdue.

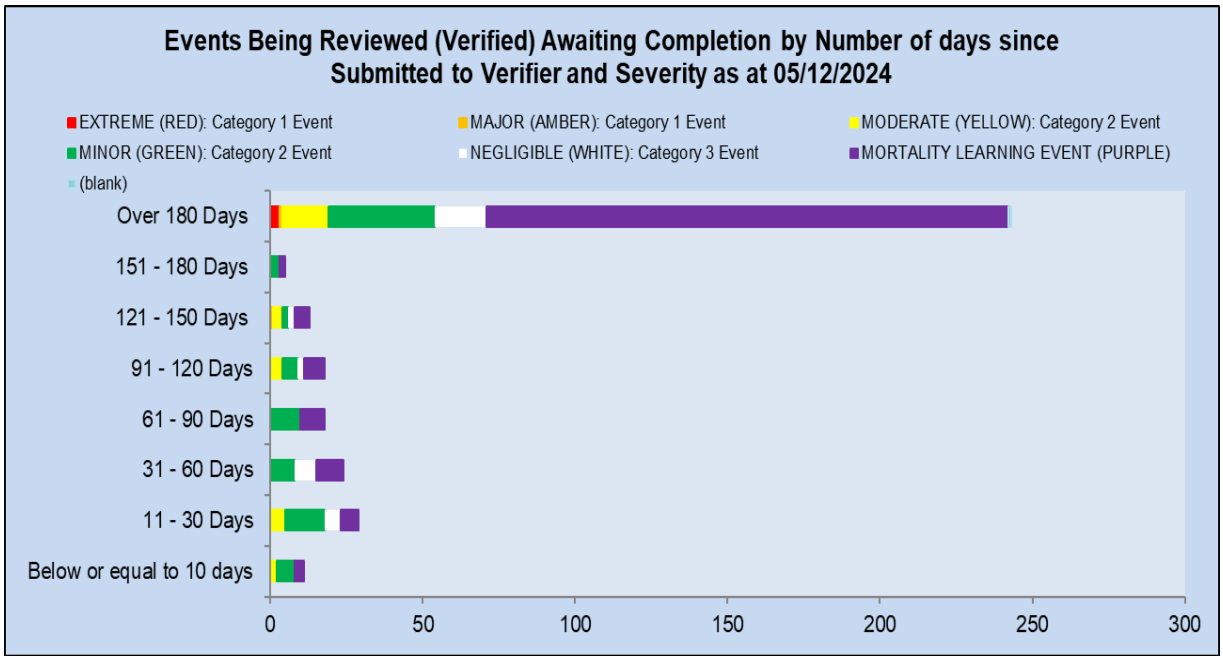


The Dundee HSCP Governance Huddle meets weekly and will review unverified adverse events and provide prompts to managers to take action for outstanding events. If an adverse event might need immediate action, the huddle will escalate to other members of the team for action and review.

c.14 Overdue Verified Events

There are 361 (346 last reporting period) events that are verified but overdue for completion within Datix.

The following graph shows the length of time that has elapsed since the reporting of the events at the time of data extraction by severity for those events that are overdue for completion.



c.15 The table below shows the number of overdue events by the year and department.

Department	2019	2020	2021	2022	2023	2024	Total*	Change**
Community Mental Health Services	2	4	6	22	33	30	97(95)	↑
Central (DDARS)	0	0	2	4	18	22	46(52)	↓
East (DDARS)	0	1	8	4	5	21	39(37)	↑
Primary Care (DDARS)	0	0	1	6	14	8	29(27)	↑
West (DDARS)	0	0	1	4	10	12	27(26)	↑
Community Learning Disabilities	0	1	0	4	6	7	18(23)	↓
Other - Mental Health (Dundee)	0	0	1	5	3	6	15(12)	↑
Psychiatry of Old Age	0	0	0	1	2	6	12(10)	↑
Area Psychological Therapy Service	0	0	0	0	6	6	10(11)	↓
Allied Health Professions (Dundee HSCP)	0	0	0	0	0	8	9(5)	↑
District Nursing (Dundee HSCP)	0	0	1	0	1	8	8(10)	↓
MFE (Medicine for the Elderly)	0	0	0	0	0	3	8(2)	↑
General Practice - Dundee	0	0	0	0	0	8	5(7)	↓
Other (DDARS)	0	0	0	0	0	5	5(4)	↑
Nutrition and Dietetics (Dundee HSCP)	0	0	0	0	1	2	5(2)	↑
General Practice - Dundee HSCP	0	0	0	1	0	2	4(3)	↑
Other - Specialist Palliative Care	0	0	0	0	0	1	3(1)	↑
Adult Psychotherapy Service	0	0	0	0	0	5	3(3)	↔
Palliative Medicine	0	0	1	1	1	1	3(3)	↔
Physiotherapy (AHP Dundee HSCP)	0	0	0	0	1	1	2(2)	↔
Stroke and Neuro Rehab unit RVH	0	0	0	0	0	5	1(3)	↓
Specialist Community Nursing (Dundee HSCP)	0	0	0	0	0	1	2(1)	↑
Tayside Sexual and Reproductive Health	0	0	0	0	0	2	1(2)	↓
(Risk Only) System-Wide Mental Health Risk - Dundee HSCP	0	0	0	0	0	1	1(1)	↔
CMHT - Social Work - DHSCP	0	1	0	0	0	0	1(1)	↔
(blank)	0	0	0	0	0	1	1(1)	↔
Health (DDARS)	0	0	0	0	0	1	1(1)	↔
Adults and Older People	0	0	0	0	1	0	1(0)	↑
Learning Disability - Social Work - DHSCP	0	0	0	0	0	0	1(0)	↑
Sources of Support	0	0	0	0	0	0	1(0)	↑
Speech and Language Therapy (Ahp, Dundee HSCP)	0	0	0	0	0	0	1(0)	↑
Connect Early Intervention in Psychosis	0	0	0	0	0	1	1(0)	↑
Keep Well	0	0	0	0	0	1	0(0)	↔
Occupational Therapy - AHP(Dundee HSCP)	0	0	0	0	0	1	0(1)	↓
Other – Older People Services (Dundee)	0	0	0	0	0	1	0(0)	↔
Total	**2**	**7**	**21**	**52**	**102**	**177**	**361(346)**	↑

* Figures in brackets relate to the October 2024 report
** Since October 2024 report

There has been a longstanding concern regards the overdue verified events. The focus for teams is very much on contemporary adverse events rather than historical adverse events due to the current longstanding issues with workforce availability. Other factors also contribute to these adverse events not being progressed including: awaiting toxicology results, Procurator Fiscal involvement, awaiting information from other agencies (e.g. Police Scotland) and awaiting responses from other services in NHS Tayside.

There has been a renewed focus on these through our Clinical, Care & Professional Governance Group. Mental Health & Learning Disability Services and Dundee Drug and Alcohol Recovery Services have established adverse incident review groups to further support this work.

Event Severity	2019	2020	2021	2022	2023	2024
EXTREME (RED): Category 1 Event	0(0)	1(1)	0(0)	1(1)	1(1)	0(2)
MAJOR (AMBER): Category 1 Event	0(0)	0(0)	0(0)	1(2)	0(0)	1(1)
MODERATE (YELLOW): Category 2 Event	0(0)	0(0)	0(0)	1(1)	8(9)	20(15)
MINOR (GREEN): Category 2 Event	0(0)	0(0)	2(2)	5(5)	14(14)	61(42)
NEGLIGIBLE (WHITE): Category 3 Event	0(0)	1(1)	1(1)	6(6)	7(7)	18(16)
MORTALITY LEARNING EVENT (PURPLE)	2(3)	5(6)	18(18)	38(53)	71(77)	77(61)
(blank)	0(0)	0(0)	0(0)	0(0)	1(1)	0(0)
Total	2	7	21	52	102	177

d. Feedback

d.1 Complaints

The table below shows the number of complaints by service area and how long they have been open:

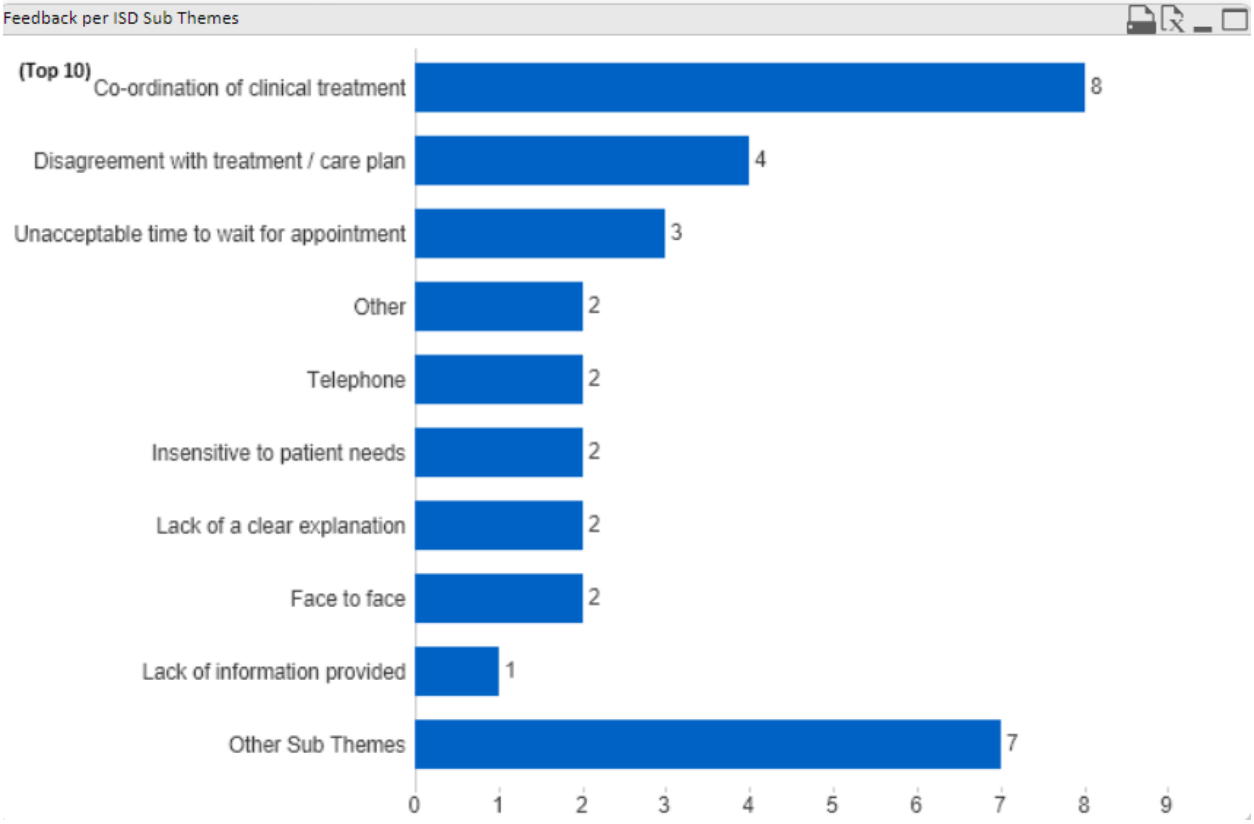
Current complaints as at 13/12/2024

Clinical Care Group/Department	Days_Band	0-5 Days	6-10 Days	16-20 Days	>20 Days	>40 Days	Total
Mental Health (Dundee)		1	1	-	3	1	**6**
Physiotherapy (Dundee HSCP)		-	-	1	-	-	**1**
General Practice - Dundee HSCP		-	1	-	-	-	**1**
Corporate (Dundee HSCP)		-	1	-	-	-	**1**
Older People Services (Dundee)		-	-	-	-	1	**1**
Total		**1**	**3**	**1**	**3**	**2**	**10**

Complaints management continues to perform moderately well across the partnership. Ongoing collaboration with the Patient Experience Team to continue to improve this position will remain in place.

Key Themes

d.2 The key themes and sub themes for complaints are shown in the chart below.



Every complaint is reviewed to understand what did happen, what should have happened and, where a difference exists, what measures can be taken to reduce the likelihood of a similar incident occurring again.

All teams are asked to report on their complaints through the CCPG Group and Forum to ensure the sharing of learning across the Health and Social Care Partnership.

Learning from Complaints

d.3 There is an emerging issue for patients who wish to be prescribed Glucagon-Like Peptide-1 agonist medications (GLP-1s) which have been approved by Scottish Medicines Consortium but patient pathways are still to be agreed in Tayside. A short life working group to consider patients pathways in Tayside is planned. Weight Management services will monitor further complaints. Information relating to GLP-1s has been added to our patient letters and website. Communication has also been circulated to the primary care advising that referrals for anti-obesity medications will not be accepted.

d.4 Positive feedback

The development of the Care Opinion feedback system continues across the HSCP. This will provide additional direct patient feedback for teams to reflect upon.

Scottish Public Services Ombudsman Reports

d.5 There are currently three cases with the ombudsman under investigation. These are across Psychiatry of Old Age, Medicine for the Elderly and Mental Health services.

External Reports & Inspections

d.6 There have been no external inspections during this reporting period.

e. Mental Health

Mental Health Key Performance Indicators

e.1 The suite of mental health measures for Dundee is intended to provide assurance and allow for scrutiny of mental health services delegated to Dundee IJB. The indicators have been developed in tandem with a suite of substance use measures being developed for the purpose of presenting information regarding performance within NHS Tayside functions. The suite of indicators is dynamic and can be improved and enhanced. Collaborative work with both Perth & Kinross and Angus HSCPs is ongoing to determine the final position for mental health key performance indicators.

Community Mental Health Team (CMHT) Activity

e.2 The following series of graphs relate to the demand, activity and waiting lists across the East and West Community Mental Health Teams. This data demonstrates that the demand on CMHT services has increased from pre-COVID levels and appears to be remaining at those increased levels.

CMHTs remain entirely dependent on Locum Consultant staffing and the differences between East and West Teams are largely resultant from a difference in stability across that staff group, as well as a historic difference in baseline staffing levels (for medics).

CMHT West's list shows an upward trend in new additions to outpatient waiting list and new referral numbers. New outpatient attendance remains steady.

High level of sickness absence and vacancies are impacting on ability to reduce waiting list due to staff absorbing caseloads where individuals are absent or there are vacant post. The focus is on safe and effective care of existing patients. Consultant cover remains steady.

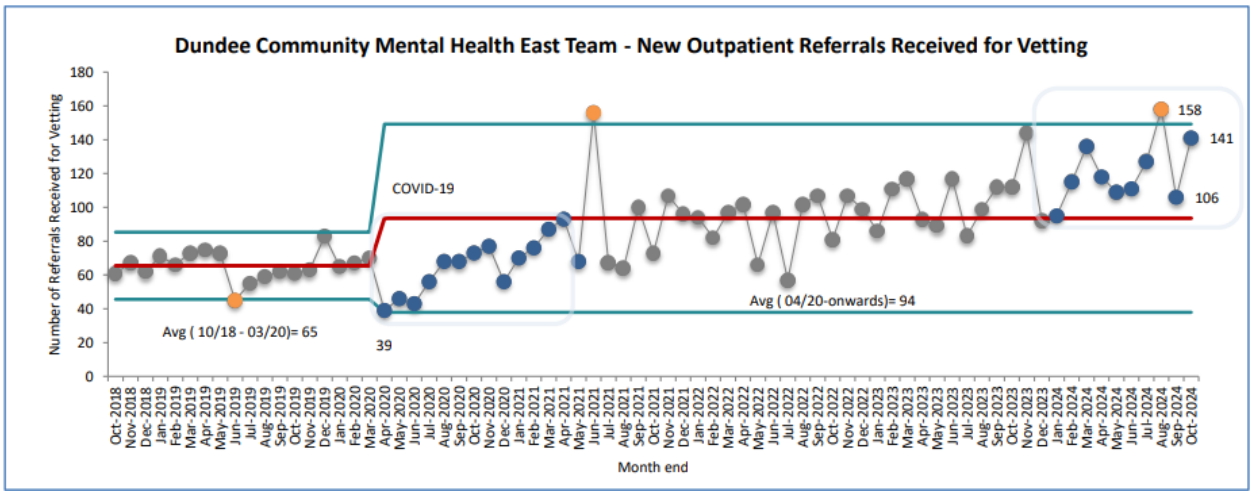
Financial challenges have impacted on ability to recruit to vacant posts however detailed planning is underway to ensure risk-based approach in place to support recruitment decisions.

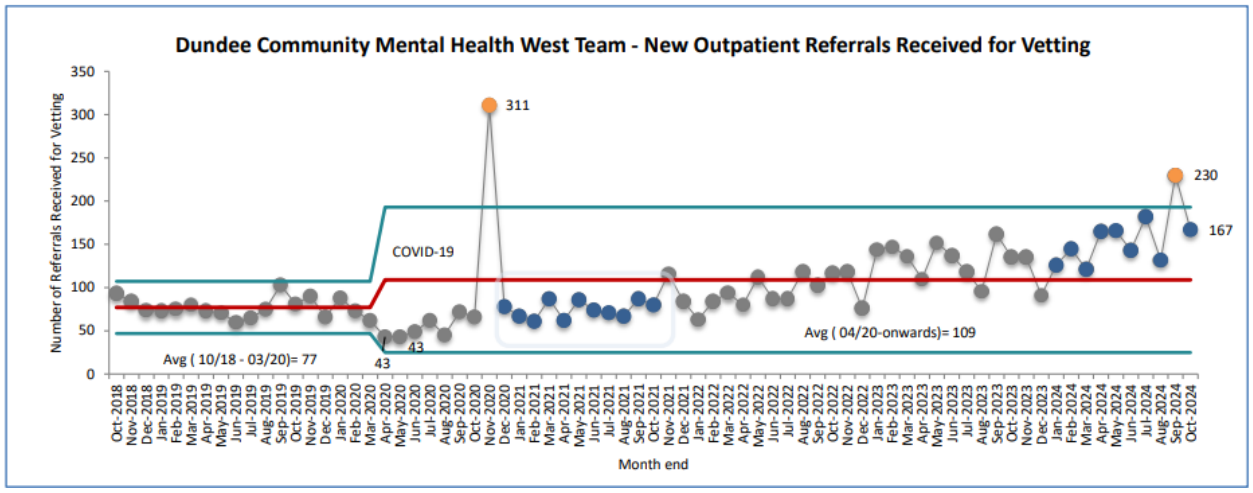
East Team continues to offer Near Me as a platform to engage with service users.

CMHT West's waiting list continues in an upward trend and may be linked with the allocation of GP practices aligned to each CMHT. West have a higher number of practices aligned to their service and demographically there are a higher number of students registered in a practice in the West. West continues to push towards seeing more new patients to reduce the waiting list number. The consultation is ongoing around review of GP allocation for CMHTs.

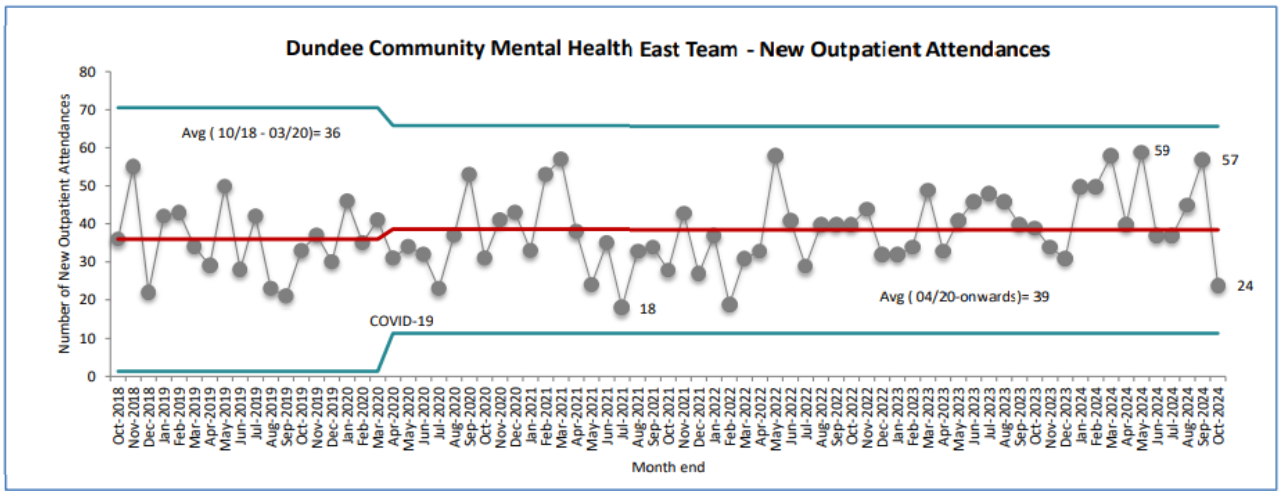
A third Locum Consultant commenced on 3 May 2024 and discussions around an additional consultant to offer remote sessions are ongoing.

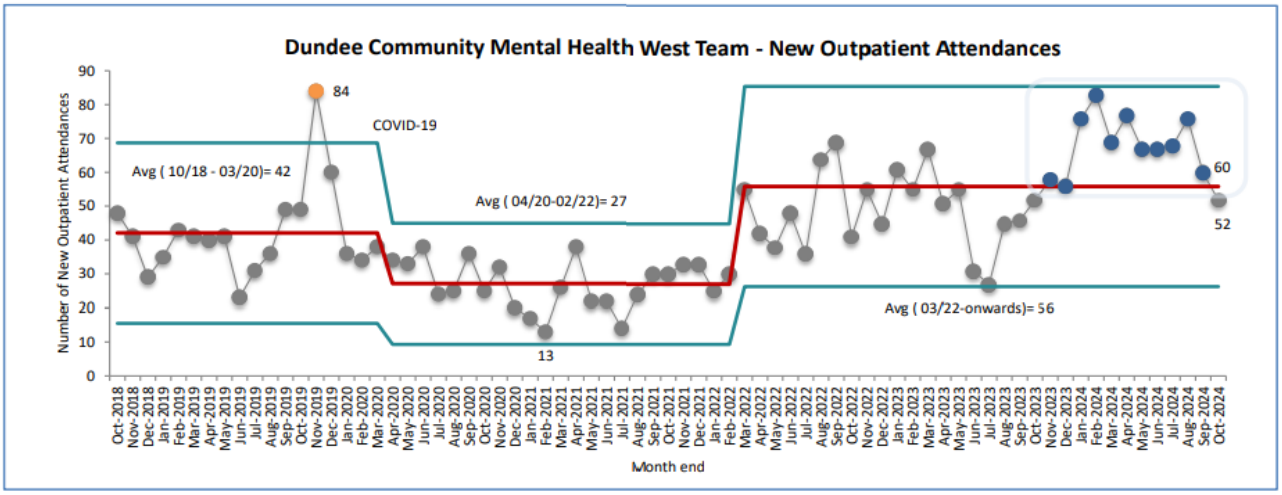
e.3 Volume of referrals received for vetting, including those vetted and returned, grouped by referral received month:



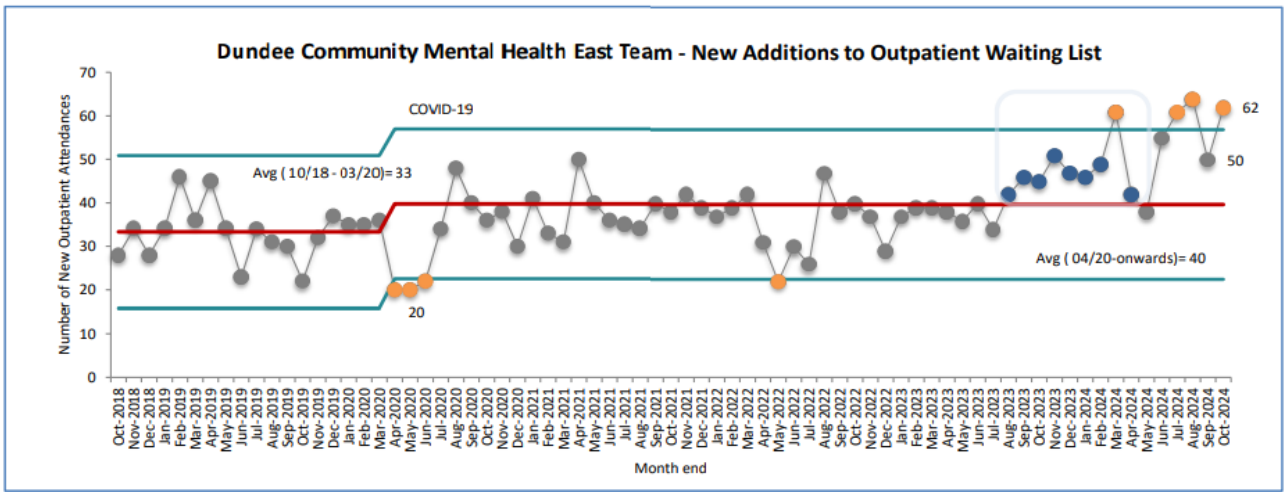


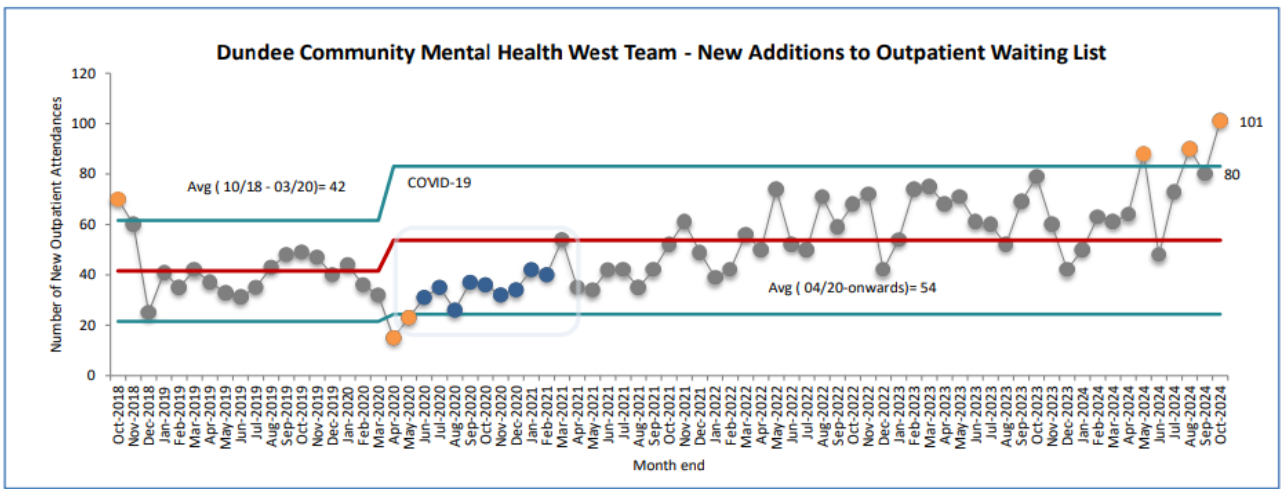
e.4 Volume of new outpatient attendances, excluding did not attends, grouped by attendance month:



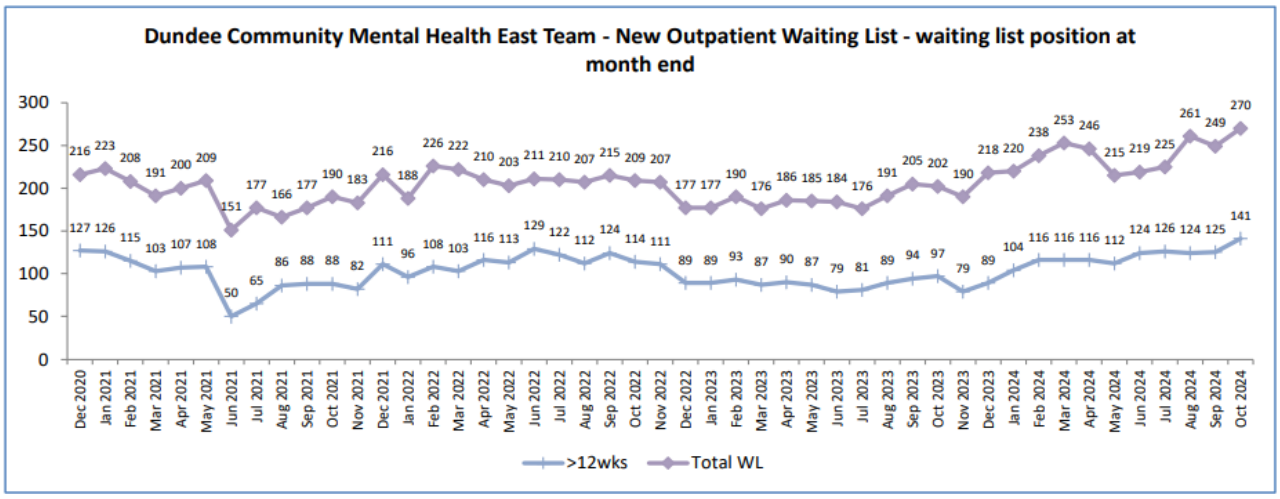


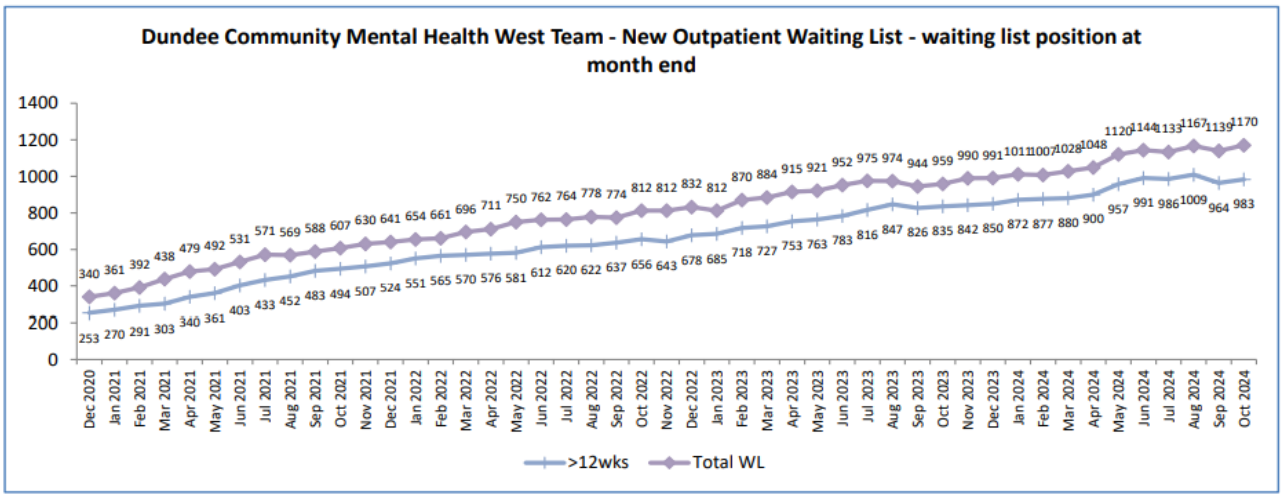
e.5 Volume of referrals added to the waiting list for a new appointment, grouped by referral month:





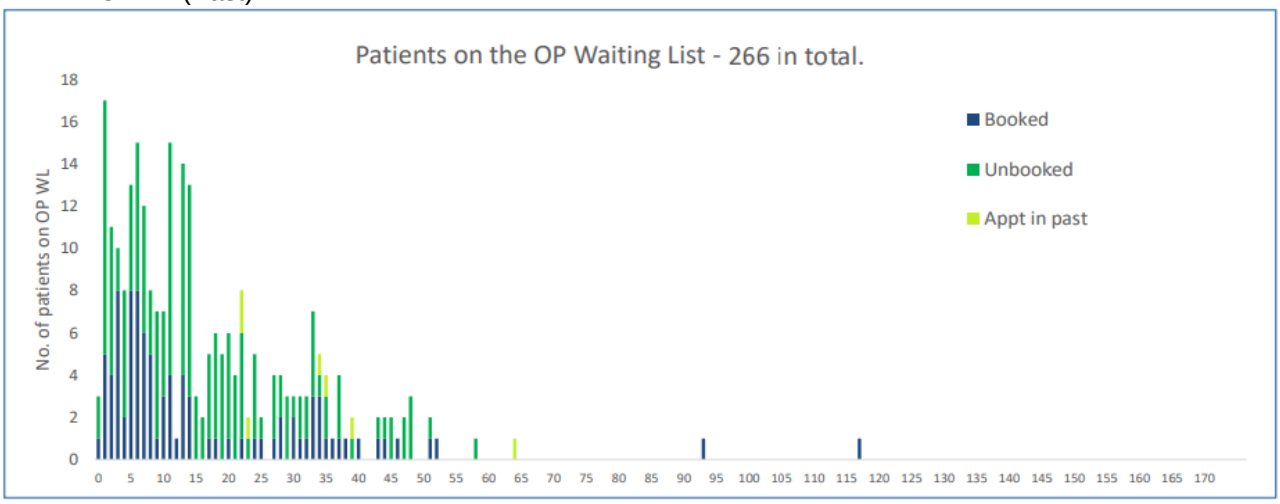
e.6 Snapshot of waiting list position at month end; total volume on waiting list and volume waiting over 12 weeks:



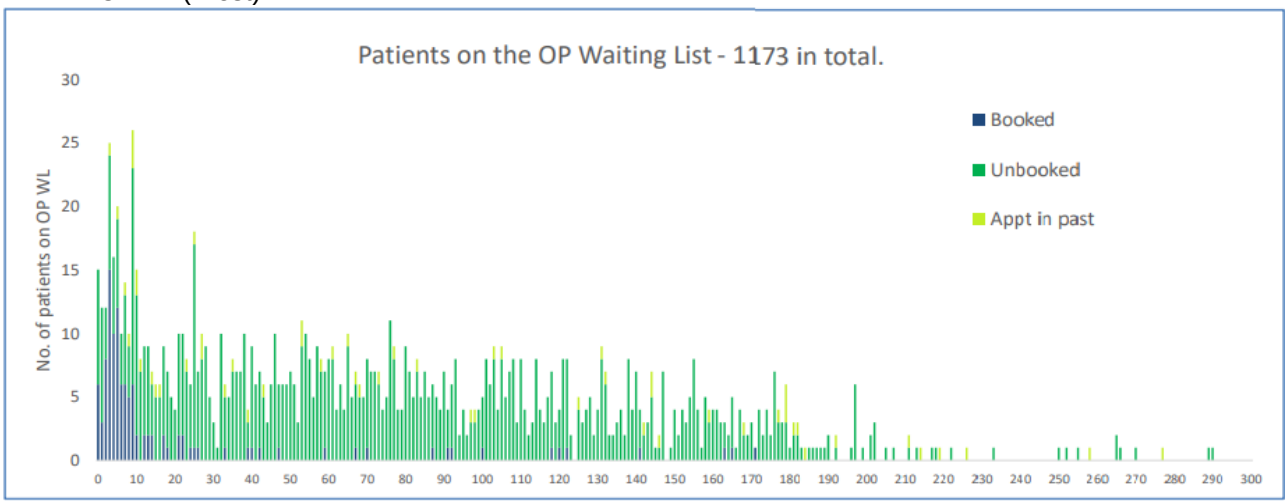


e.7 Snapshot waiting list distribution by weeks waiting at a point in time (05/06/2024) – Waiting List Type – True WL

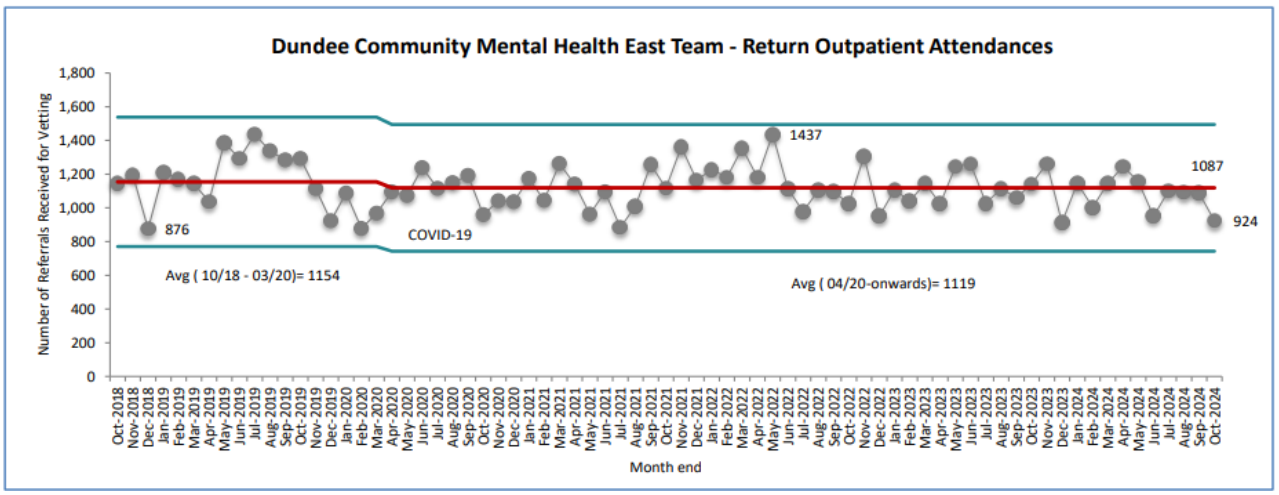
CMHT (East)

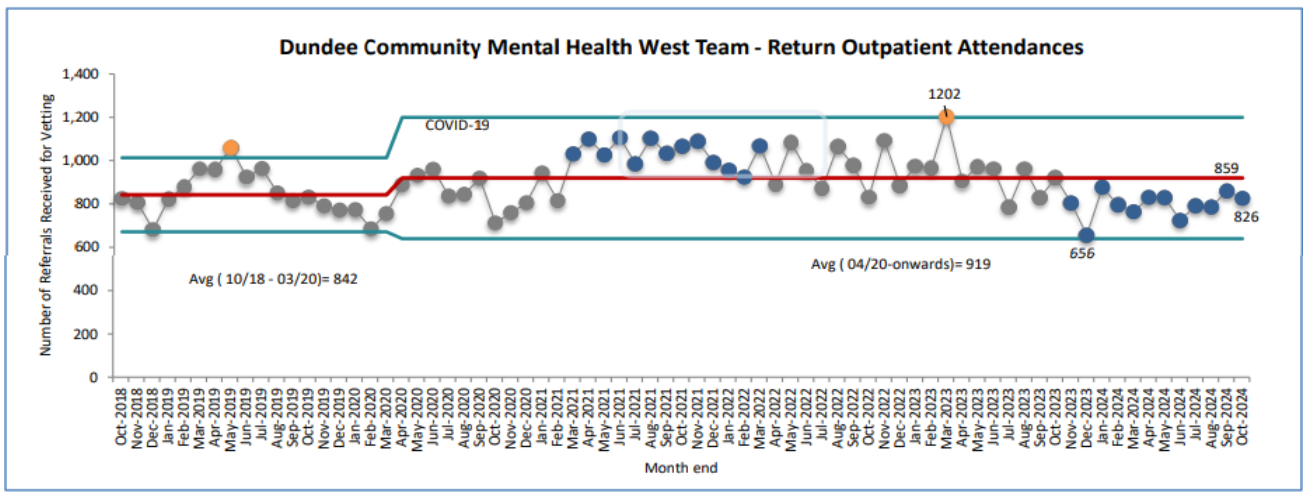


CMHT (West)



e.8 Volume of return outpatient attendances, excluding did not attends, grouped by attendance month:





6.0 POLICY IMPLICATIONS

6.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

7.0 RISK ASSESSMENT

Risk 1 Description	The risk of not providing sufficient assurance through governance assurance routes will reduce confidence in the ability of the HSCP to deliver safe, quality care.
Risk Category	Governance
Inherent Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Mitigating Actions (including timescales and resources)	Systems in place for all operational teams to provide exception reports to the clinical, care and professional governance group. 'Getting It Right' Group established to support development of reporting framework for HSCP.
Residual Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Planned Risk Level	Likelihood (1) x Impact (3) = Risk Scoring (3)
Approval Recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

8.0 CONSULTATIONS

8.1 The Chief Finance Officer, Chief Officer, Locality Managers and the Clerk were consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

9.1 Appendix 1: Dundee HSCP Governance Structure

Dr David Shaw
Clinical Director

DATE: 15 January 2025

Jenny Hill
Head of Service

Angela Smith
Interim Head of Health and Community Care

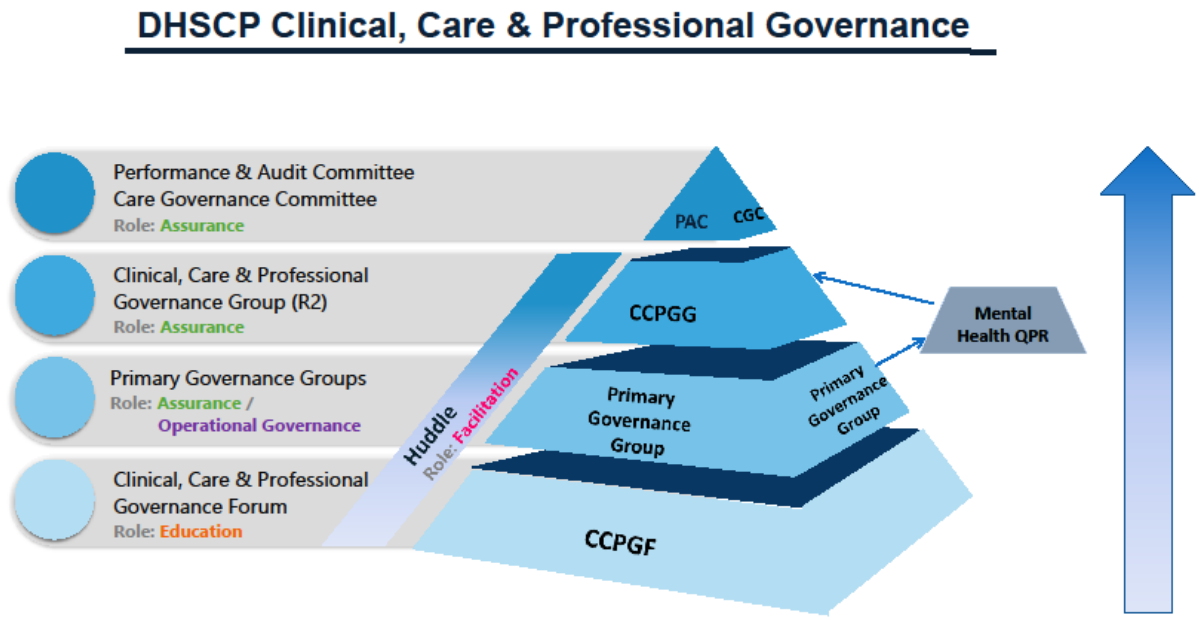
Matthew Kendall
Allied Health Professions Lead

Niki Walker
Clinical Governance Facilitator

Level of Assurance		System Adequacy	Controls	□
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited	Controls are applied continuously or with only minor lapses.	
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.	☑
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.	
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.	

Dundee HSCP Governance Structure

Dundee HSCP governance structures are outlined in the diagram below. The following narrative explains how each of the aspects functions to provide assurance to NHS Tayside and the Dundee IJB.



Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group is responsible for directing, collating and monitoring governance arrangements and ensuring that there are effective and embedded systems for Clinical, Care & Professional Governance in all services within Dundee Health and Social Care Partnership. It is chaired by the Clinical Director, and membership, as referenced in the terms of reference, extends to Head of Health and Community Care Services, Associate Nurse Director, Associate Medical Director, Associate Locality Managers, Lead Allied Health Professional, Lead Nurse, Lead Pharmacist, Clinical Governance Lead, Senior Officer – Business Planning and Information Governance, NHS Business Support Representative.

Management structures across Dundee HSCP have been redesigned over the past three months and the members of the CCPG Group will be updated to reflect this and the Primary Governance Group Structure which sits beneath the CCPG Group.

At each CCPG Group meeting each Primary Governance Group will present an exception report highlighting key areas of concern across the six domains listed in GIRFE. They will also reference exceptional pieces of work undertaken, current challenges and future potential issues identified through triangulation of data reviewed through Primary Governance Group meetings.

Each Primary Governance Group will produce an annual report in line with the reporting programme.

A range of additional reports are also reviewed at the CCPG Group, which includes DHSCP Analysis Report (Adverse events and Risks), Complaints, Infection Prevention and Control and Inspection Reports.

Further assurance is sought with a range of reports/discussions relating to topics such as professional registration, GDPR, SPSO, contemporaneous issues for example Dundee Drugs Commission review and Trust and Respect Report.

Primary Governance Groups (PGG)

There are currently nine PGGs:

- In Patient & Day Care Services (MfE, Stroke and Neurology, Palliative)
- Adult Community Services
- Acute and Urgent Care
- Mental Health & Learning Disabilities
- Psychological Therapies
- Primary Care & Health Inclusion
- Nutrition and Dietetics
- Dundee Drugs and Alcohol Recovery & Tayside Sexual and Reproductive Health Services
- Older People's mental Health and Care Homes

Each Primary Governance Group will meet monthly and the remit of the Primary Governance Group is to:

- Provide assurance to the Clinical, Care and Professional Governance Group on the systems and processes for clinical, care and professional governance activities.
- Develop, prioritise, implement, monitor and review the annual work plan for clinical, care and professional governance activities.
- To create the learning environment and conditions within Services by dedicating time to allow staff to share learning, tools and other resources and encourage the dissemination of good practice.
- Ensure that clinical and care leadership underpins Service assurance processes and that clinical and care leaders are supported to share tools and resources to spread good practice.
- Encourage an integrated approach to quality improvement across Services.
- Ensure appropriate actions in relation to clinical, care and professional governance and quality activities are taken in response to internal reports and external reports from bodies such as NHS Healthcare Improvement Scotland, Care Inspectorate, Audit Scotland, Mental Welfare Commission and Scottish Public Services Ombudsman.

- Ensuring that there is a robust reporting and assurance mechanism for services which are hosted within the partnership but do not solely operate within Dundee Health and Social Care Partnership.
- Undertake the management, escalation or cascading of issues/risks/concerns as appropriate.
- Collate, review and analyse core and service specific datasets to inform exception report to the CCPGG, reflecting the six domains described in the Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework.
- The exception report should include, but is not limited to:

    - Emergent issues of concern identified
    - Adverse Events:
        - Recurring themes, Major and Extreme Incidents
        - Incidents that trigger Statutory Duty Of Candour
    - All Red Adverse Events
    - Adverse Event Reviews, Significant Case Reviews
    - Complaints
    - Risks
    - Inspection Reports and Outcomes
    - Changes to standards, legislation and guidelines
    - Outcomes of care
    - Adherence to standards
    - Sharing of learning

A representative from each PGG will represent the group at the Dundee HSCP CCPG Group and present and talk to the exception report and, where required, the annual report. The representative will act as a conduit between the PGG and CCPGG ensuring effective communication between groups.

Due to the recent redesign of the management structure, there have been changes in the organisation of the PGGs. The Governance team, alongside the professional leads in the HSCP are working closely with the new chairs of these PGGs to support development of these groups.

<u>Governance Huddle</u>

There is a weekly governance huddle attended by the professional leads and the governance team. A high level review of all adverse events is undertaken with the intention of identifying themes or patterns and triangulating knowledge of service pressures, governance scorecards and service data to identify services who may be struggling, who require support to manage adverse events or who may display a change in their current performance in relation to managing adverse events. This allows for early support to be provided to teams from both a governance and managerial perspective to undertake early management of developing potential risks.

The huddle is open to managers to attend to gain an enhanced overview of the governance arrangements across the HSCP. Managers can also attend to discuss specific aspects of clinical, care and professional governance as required.

The huddle will also undertake work to review risk management, complaints process and quality and any other governance-related theme as required.

Clinical, Care and Professional Governance Forum

The forum is used as an education forum for managers and lead governance staff across the HSCP. The format allows for review of scorecard data, encouraging discussion around works of excellence and challenging areas, with managers peer-reviewing one another and sharing learning across a range of themes.

Each forum will also have a dedicated educational element to improve knowledge and understanding of governance systems and processes across the HSCP. Subjects to date have included: Qlikview, Risk Management System, Datix system report building and scorecard development.

ITEM No …6……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **DRUG AND ALCOHOL SERVICES INDICATORS – 2024/25 QUARTER 2**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC2-2025**

1.0 PURPOSE OF REPORT

The purpose of this report is to update the Performance and Audit Committee on the performance of Drug and Alcohol Services.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Note the data presented in this report, including the improvements in key indicators relating to access to drug treatment services during 2024/25 (section 6 and appendix 1).

2.2 Note the range of ongoing improvement activity (section 7).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND INFORMATION

4.1 Deprivation is high in Dundee, combined with one of the lowest employment rates and highest rates of people who are economically inactive in Scotland. Approximately 24,000 (25.5%) people in Dundee are recorded as economically inactive, this is 2% higher than the Scotland percentage of 23.5%. Health and wellbeing is known to vary by deprivation. Lifestyles that include smoking, unhealthy diet, the consumption of excess alcohol and recreational drugs are more prevalent in the most deprived localities. In general, people whose lifestyles include all or some of these factors have or will have poorer health and can experience a range of other risks to their wellbeing or safety.

4.2 Dundee has the second lowest life expectancy in Scotland. In Dundee life expectancy is 76.7 years, whereas it is 79.1 years in Scotland as a whole. Life expectancy varies substantially by deprivation level and the occurrence of morbidity including drug and alcohol use and mental illness. A significant proportion of the difference in life expectancy between Dundee and many other Partnerships can be accounted for by deaths at a young age from drugs, alcohol and suicide. Drug and alcohol use disproportionately affects the most vulnerable and socio-economically deprived people in Dundee's communities and is associated with other health and social problems, including poor mental health, crime, domestic abuse and child neglect and abuse. Drug and alcohol use is recognised both at a national and local level as a major public health and health equity issue.

4.3 In Dundee City, drug and alcohol services are provided by a range of organisations, including the Dundee Drug and Alcohol Recovery Service (DDARS), offering a mixed-model approach delivered by a multidisciplinary team in collaboration with social work, community justice and third sector services. The aim of this service model is to offer the right care, in the right place, at the right time for every person. It consists of both drop-in and appointment-based services

alongside an assertive outreach component and additional services for children, families and intensive input for expectant mothers. All elements of the service seek to provide same day access to treatment (Medication Assisted Treatment (MAT) Standard 1) and assertive outreach to those at the most risk of harm (MAT Standard 3).

5.0 DRUG AND ALCOHOL SUITE OF INDICATORS

5.1 The aim of this dataset is to provide oversight and assurance regarding activity and performance in drug and alcohol services. It contains a summary of data, alongside accompanying analytical narrative. In all data reports with public accessibility, content and disaggregation is assessed in order to comply with General Data Protection Regulation and ultimately to ensure that individuals cannot be identified.

5.2 Data for indicators 1 – 14 presents rolling averages for each quarter. This includes the reporting quarter plus the previous 3 quarters, to give an annual pattern based on the reporting quarter. For example, Q2 24/25 also includes data for Q1 24/25, Q4 23/24 and Q3 23/24. Reporting in this way allows for longitudinal comparison between the reporting quarter and previous years data.

6.0 WHAT THE DATA IS TELLING US

6.1 The number of suspected non-fatal overdose incidents reported by Scottish Ambulance Service and Police Scotland remained almost the same between Q2 2023/24 (201) and Q2 2024/25 (206).

6.2 The proportion of people who started treatment within 21 days of referral has remained high however decreased by 2% from 91% at Q2 2023/24 to 89% at Q2 24/25.

6.3 The number of referrals for alcohol treatment decreased from 616 at Q2 23/24 to 453 at Q2 24/25. There was an increase in the number of individuals starting alcohol treatment from 219 at Q2 2023/24 to 475 at Q2 2024/25. Statutory services are working to improve waiting times, and they have experienced above average numbers of people disengaging prior to treatment.

6.4 The number of referrals for drug treatment services increased from 546 at Q2 23/24 to 606 at Q2 24/25. The number of people starting drug treatment services decreased slightly during the same period (from 474 at Q2 2023/24 to 464 at Q2 2024/25)

6.5 The number of Alcohol Brief Interventions (ABIs) increased by 9% between Q2 23/24 (1210 ABIs) and Q2 2024/25 (1322).

6.6 The number of unplanned discharges where the service user disengaged increased by 42% between Q2 23/24 and Q2 24/25 (from 193 to 272).

6.7 In addition to the suite of indicators contained in appendix 1, the National Records of Scotland published their statistical report on drug-related deaths in Scotland in 2023 (report available in full at: Drug-related Deaths in Scotland in 2023 | National Records of Scotland (nrscotland.gov.uk)). In 2023 there were 1,272 deaths due to drug misuse in Scotland; this is 221 more deaths than in 2022. In 2023 in Dundee, there were a total of 46 deaths; this is an increase of 8 deaths in 2022. After adjusting for age, Dundee City had the second highest rate of drug misuse deaths in Scotland, behind Glasgow which has the highest rate (please note this is calculated over the five-year period 2019-2023).

6.8 The National Records of Scotland published their statistical report on deaths which are known to be a direct consequence of alcohol use. (report available in full at Alcohol-specific deaths 2023, Report) In 2023 there were 1,277 deaths which were a direct consequence of alcohol use in Scotland; this is 1 more death than in 2022. In 2023 in Dundee there were 36 deaths in 2023 which was a reduction of 1, compared with 2022 when it was reported to be 37. There was a peak during 2021 and 2022 when there were 43 and 46 deaths respectively. After adjusting for age, Dundee was in the top 3 in Scotland for alcohol-specific mortality rate and was higher than the Scottish average (the other areas in the top 3 were Glasgow City and North Lanarkshire.

7.0 SERVICE IMPROVEMENT AND PRIORITIES

7.1 During 2023-24 there was significant progress with the implementation of MAT standards 1-5, and good progress with the implementation of MATs 6-10. At the 2024 national benchmarking assessment, Dundee scored the maximum points possible (at this stage) for the implementation of all the 10 standards. The focus for the second quarter of 2024-25 was on maintaining the achievements made with the implementation of MAT standards, identifying and responding to gaps and expanding the implementation of the standards to all drugs and alcohol. Guidance from the national MAT Implementation Support Team on the extension of the standards is expected and in the meanwhile local plans for the extension of the standards to fit local needs are being implemented.

People in Dundee continue to have fast access to treatment, they have a choice as to the medication prescribed to them, with increasing numbers opting to receive Buvidal as their preferred medication and are supported to remain in treatment for as long as required. Independent Advocates (provided through DIAS and funded by the ADP) support individuals during the period they receive MAT and beyond. DDARS has established an assertive outreach team to support those at risk of disengagement from services.

Harm reduction support continues to be provided as part of the implementation of MAT, and during quarter 2 focused on increasing BBV and STI testing, as well as immunisation. The implementation of MAT standards is psychologically and trauma informed, with progress made to ensure the process follows a gendered approach. Frontline staff receive training to ensure they are skilled and supported to deliver the standards. The Multi-agency Consultation Hub (substance use and mental health) continues to progress and work is underway to establish this process as core business and ensure close links with other high risk review processes are established.

7.2 The Non-Fatal Overdose (NFOD) multi-agency rapid response team continues to meet on a daily basis and provide support to people who have experienced an overdose. There is now formal joint working with A&E with information provided by A&E to the NFOD Co-ordinator. During quarter 2 there has been a slight rise in the complexity of the needs of the people experiencing non-fatal overdoses, requiring the involvement of more services (in addition to the specialist substance use services). The three Tayside ADPs has jointly agreed to continue funding the Tayside NFOD co-ordinator until end March 2026.

7.3 There has been a significant increase in people from Dundee accessing residential rehab. All of these people are supported through the dedicated pathway to enter the residential treatment, during their stay and on their return to the community. More women have accessed residential rehabilitation than ever before, and most of those embarking on residential support completed the full treatment. Third sector partners continue to manage the residential rehabilitation pathway, preparing individuals prior to accessing the residential establishment, supporting them and their family during their time at the establishment and providing support back to the community.

7.4 The Drug Service Redesign Project continues to test ways of working to provide holistic shared care with general practice for those on Opioid Substitution Therapy (OST). Following a low uptake for this option, there was an increase of people opting for this option in 2023-24. During quarter 2 one more Primary Care practice joined the scheme. Community Pharmacies continue to be liaised with, to support their role and identify any additional support that they require. Key workers managed by the 3rd sector, as well as DDARS staff, continue to support participating GPs and other Primary Care staff to provide the care. Dundee Independent Advocacy Service (DIAS) are also key partners supporting this project.

Dundee received confirmation from the Scottish Government that the project can utilise the accrued underspend and extend for a further financial year. It is now planned that during the current financial year, the Career Start GP and the Project Nurses will continue their training. In the next financial year (2025-26), the project will aim to deliver its ambition of a Primary Care Team to support General Practices and the community pharmacies that are currently testing models, to continue exploring and improving models of care.

7.5 A short life group was established in response to reports of increased ketamine related harm in local areas. Through the group, there has been awareness raising amongst Primary Care colleagues across Tayside regarding possible clinical presentations that might indicate ketamine use and prompt enquiry. Opportunities for additional training of relevant staff are being explored with Scottish Drugs Forum, and the group is exploring options for school-based education around ketamine with a view to improving the consistency and impact of the messages. The group is also considering options for local work to explore young people's awareness of ketamine related risks and develop harm reduction messaging.

7.6 The Alcohol and Drug Partnership (ADP) has contracted additional support (managed by the third sector) to progress the development of non-opioid and alcohol pathways. Following a scoping process, models for both pathways have been developed and a series of tests of change are currently running to establish and implement best practice.

7.7 The ADP has commenced early discussions with the Scottish Government to explore options for developing a Safer Consumption Facility (SCF) in Dundee. An application to the Lord Advocate will be required, based on a needs assessment and other key evidence. There are several models for such a facility which need to be assessed, including an option for a mobile SCF.

8.0 RISK ASSESSMENT

Risk 1 Description	Risk of IJB not being sufficiently sighted on performance related to alcohol or drug services in Dundee.
Risk Category	Governance, Political
Inherent Risk Level	Likelihood 3 X Impact 3 = Risk Score 9 (High)
Mitigating Actions (including timescales and resources)	- Develop a dataset which will provide a suitable level of detail. - Agree on the frequency of reporting. - Liaise with the information and pharmacy colleagues in the ADP to ensure timeous reporting. - Liaise with operational managers to inform analysis and contribute improvement information.
Residual Risk Level	Unlikely 2 x Minor 2 = Risk Score 4 (Moderate)
Planned Risk Level	Unlikely 2 x Minor 2 = Risk Score 4 (Moderate)
Approval recommendation	The PAC is recommended to accept the risk levels with the expectation that the mitigating actions are taken forward.

9.0 POLICY IMPLICATIONS

9.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

10.0 CONSULTATIONS

10.1 The Chief Officer, Heads of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

11.0 BACKGROUND PAPERS

None.

Christine Jones
Chief Finance Officer

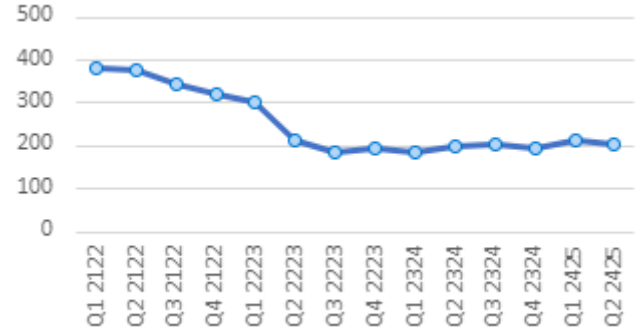
DATE: 17 December 2024

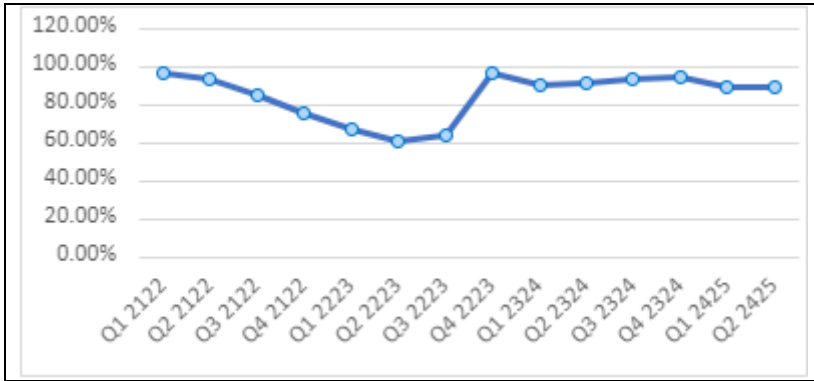
Lynsey Webster
Lead Officer: Quality, Data and Intelligence

Shahida Naeem
Senior Officer, Quality, Data and Intelligence

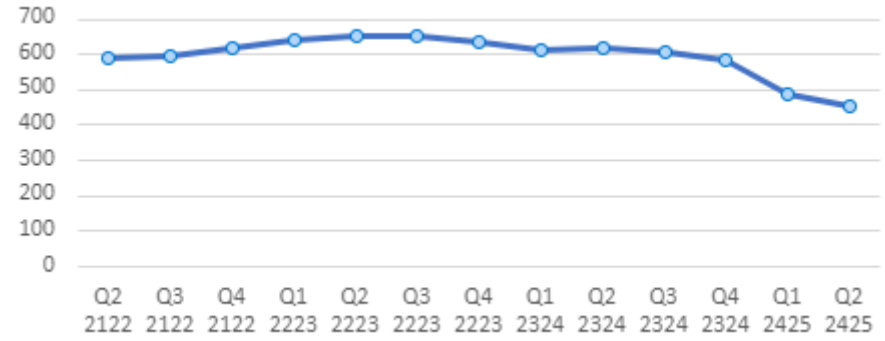
Vered Hopkins
Lead Officer, Protecting People

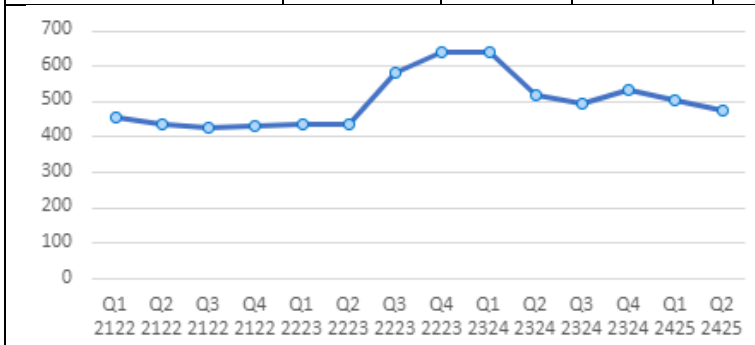
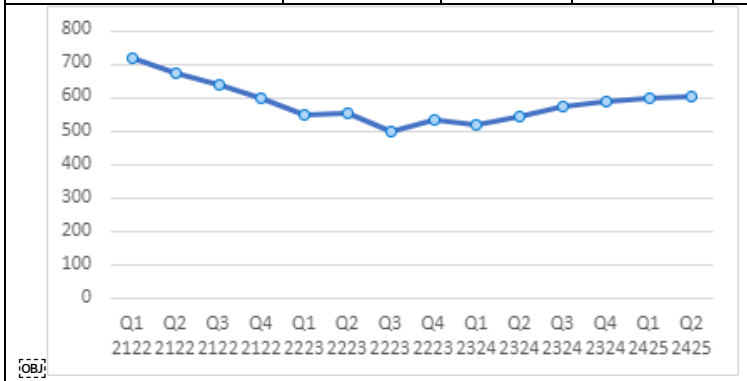
Appendix 1
Drug and Alcohol Services Indicators – Q2 2024/25

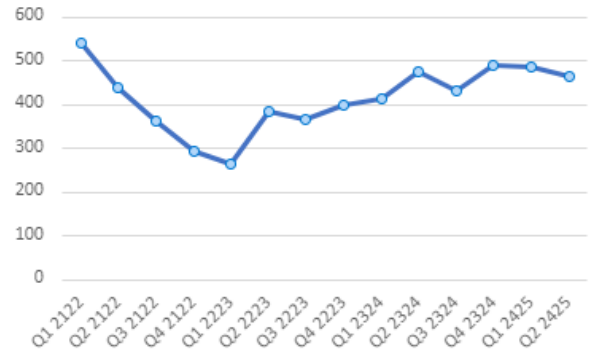
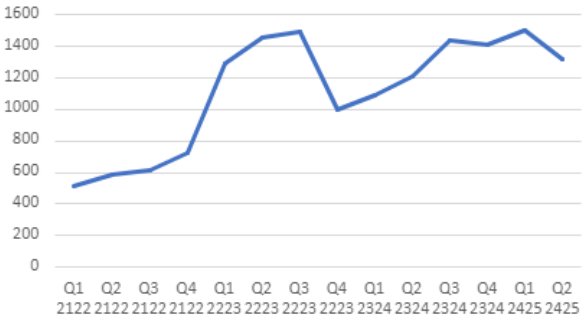
Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Comments/ Analysis
1. The number of suspected non- fatal overdose incidents reported by Scottish Ambulance Service (and Police)	319	302	212	187	192	187	201	202	192	214	206	No notable change in the last year A new referral route of direct notification from Ninewells has been incorporated.
												
2. Percentage of people referred to services who begin treatment within 21 days of referral	75.7%	66.8%	61%	64%	96%	90%	91%	93%	94%	89%	89%	The waiting time standard is 90%. Q4 23/24 - Q1 24/25 saw some waiting time delays and an analysis paper was presented to the ADP in August. Q2 24/25 was 97% so we expect this to return to above compliance.

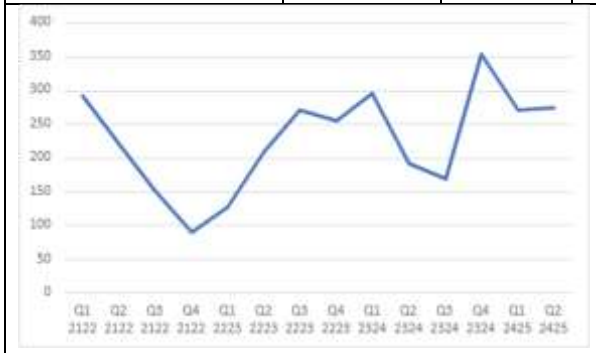


Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Comments/Analysis
3. Number of referrals to alcohol treatment	619	639	654	653	638	612	616	606	583	489	453	Q1 24/25 was a large reduction in the number of referrals which rose again to expected levels in Q2.



Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Comments/Analysis
4. Number of individuals starting alcohol treatment per quarter	430	435	437	583	638	638	519	493	535	505	475	This is remaining low relative to the large numbers of treatment starts at the end of 22/23.
												
5. Number of referrals to drug treatment	601	551	555	500	537	520	546	572	589	600	606	There continues to be a steady number of new referrals.
												

Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Comments/Analysis
6. Number of individuals starting drug treatment per quarter	294	265	384`	366	399	412	474	432	491	485	464	This is remaining relatively consistent.
												
7. Number of alcohol brief interventions (ABI's) provided in Dundee	727	1289	1459	1489	996	1087	1210	1434	1415	1500	1322	There is an ongoing training programme for ABI's.
												

Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Comments/Analysis
8. Number of unplanned discharges (service user disengaged) recorded in DAISY	91	128	210	272	255	295	193	169	353	271	275	
												
9. Number (rate per 1,000 18+ population) of emergency admissions where reason for admission was due to drug use		466 (3.8)	456 (3.8)	438 (3.6)	422 (3.5)	462 (3.8)	488 (4.0)	472 (3.9)	487 (4.0)	461 (3.8)	452 (3.7)	Stable trend
10. Number (rate per 1,000 18+ population) of emergency admissions where reason for admission was due to alcohol use		356 (2.9)	287 (2.4)	260 (2.1)	256 (2.1)	260 (2.1)	288 (2.4)	282 (2.3)	274 (2.3)	274 (2.3)	279 (2.3)	Stable trend

Indicator	Rolling 21/22 Q4	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2
11. Naloxone Spend in Dundee	£67,417	£64,098	£70,622	£80,675	£77,134	£82,549	£68,927	£55,818	£43,240	£35,343	£42,886 An overpayment was identified which was refunded to DHSCP in February 2024.
12. Naloxone – Resupply Used	195	353	388	398	410	323	293	268	255	243	238 All repeats have been consistently reported as it is accepted some may not disclose 'used' as the reason for repeat supply.
13. Total number of Naloxone Kits Issued	1569	1944	1715	1602	1630	1528	1548	1456	1222	1303	1274 Naloxone kits supplied in Dundee (report from Tayside Take Home Naloxone Programme PHS submissions) Naloxone spend does fluctuate across the year depending on when orders for stock are placed. Nyxoid intranasal kits were introduced around Q4 21/22 and a lot of services ordered stock of these kits for the first time, hence an increase in charges that quarter. There is a time lag for when we then see these kits appearing in supply figures. First supplies are starting to decrease as saturation point is reached. This means replacement kits will start to

											increase and first supplies decrease. Kits last for 2 years so it is likely a dip in supply will be observed for a short period before starting to issue replacement kits.
Indicator	**Rolling 21/22 Q4**	**Rolling 22/23 Q1**	**Rolling 22/23 Q2**	**Rolling 22/23 Q3**	**Rolling 22/23 Q4**	**Rolling 23/24 Q1**	**23/24 Q2 (Not rolling)**	**23/24 Q3 (Not Rolling)**	**23/24 Q3 (Not Rolling)**	**Rolling 24/25 Q1**	**Rolling 24/25 Q2**
14. Total Spend on prescriptions generated by Dundee Drug and Alcohol Recovery Service (DDARS(and Dundee Drug Treatment Service (DDT)	£616,692	£589,455	£531,573	£492,637	£426,306	Data for Q1 23/24 not available	£204,204.64	£196,178.98	£238,702.33	Not available	Not available Prescription data for prescriptions generated by DDARS and DTTO, dispensed in community pharmacy (report from prescribing support unit). Please note that this data describes prescription costs for methadone and oral formulations of buprenorphine. DDARS now holds stock of Buvidal (long acting subcutaneous buprenorphine). The cost of this stock is not included in prescription data. The number of people choosing Buvidal as OST has increased.

ITEM No …7……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **MENTAL HEALTH SERVICES INDICATORS – 2024/25 QUARTER 2**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC3-2025**

1.0 PURPOSE OF REPORT

1.1 The purpose of this paper is to report a suite of measurement relating to the activity of mental health services for scrutiny and assurance.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Note the content of this report, including current performance against the suite of mental health service indicators (section 6 and appendix 1).

2.2 Note the operational and strategic supporting narrative in the context of the trends in performance and activity (section 7).

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND INFORMATION

4.1 The suite of mental health measures (Appendix 1) for Dundee is intended to provide assurance and allow for scrutiny of mental health functions delegated to Dundee Integration Joint Board. The suite of indicators is dynamic and can be revised and enhanced based on feedback from PAC members and other stakeholders.

4.2 In all data reports with public accessibility, content and disaggregation has been reviewed in order to comply with General Data Protection Regulation and ultimately to ensure that individuals cannot be identified.

5.0 LOCAL CONTEXT

5.1 Dundee has the 2nd highest rate in Scotland of adults (aged 16+) who reported in the 2022 Census that they lived with a mental health condition. Dundee has a rate of 162 people per 1,000 population compared to 131 per 1,000 population for Scotland. Dundee has 20,242 people in the 16+ age group who identified themselves as having a mental health condition; this equates to 16% of the 16+ population. The highest rate per 1,000 population was for the 16-34 age group. 17% of all females (16+) reported they had a mental health condition and 11% males. In the 2022 Census, Maryfield and Coldside had the highest rate per 1,000 population (16+ age group) and The Ferry had the lowest rate per 1,000 population. Maryfield had more than double the rate of people with a mental health condition, compared with The Ferry.

5.2 In the 2022 Census 24% of people with mental health conditions in Dundee rated their health as bad or very bad. This compares with 7% for the general Dundee population who rated their health as bad or very bad. There is variation between LCPP areas in terms of self-reported mental health conditions, ranging from 30% in the East End to 14% in the West End, of people who rated their health as bad or very bad.

5.3 In Dundee life expectancy is ten years lower for people with a mental health condition (66.8 years) compared with the general Dundee population (76.8 years).

5.4 The Kings Fund review of long-term conditions and mental health reported that those with long-term conditions and co-morbid mental health problems disproportionately lived in deprived areas with access to fewer resources. It is estimated from Scottish Health Survey data that around a third (33%) of all adults age 16+ in Dundee have a limiting long-term physical or mental health condition. Results from the Scottish Burden of Disease study suggest that the population of Dundee experiences a higher rate of burden of disease (a combined effect of early deaths, and years impacted by living with a health condition) compared with Scotland, for a number of health conditions, including cardiovascular disease, COPD, mental health and substance use disorders, and diabetes.

5.5 The effects of COVID-19 on the population has further widened the social and health inequalities gap and many people are finding it more difficult than ever to cope across many aspects of their life. Engage Dundee found that the most common difficulties reported by respondents during the pandemic were regarding mental health (37%).

5.6 In the past academic reporting year (Aug 23 to July 24) there has been on average 60 children on the child protection register. Over that time, half of the registrations have been with parent/carers mental health as a reason for registration.

5.7 In August 2024, the National Records of Scotland published its statistics for probable deaths by suicide in 2023. Across Scotland there was an increase in probable suicides (30 deaths) from the 2022 figures, with a total of 792 deaths in 2023. In Dundee specifically, in 2023, 30 people died by probable suicide, 22 males and 8 females, this is an increase of one person from 2022 (for comparison 2022=29, 2021=25, 2020=34). At council level, the rate was higher (statistically significant) than the Scottish average in Dundee City, Highland, and East Ayrshire. In Scotland, male suicides increased by 34 to 590 deaths in 2023, while female suicide deaths decreased by 4 to 202 deaths in the latest year. The rate of suicide mortality in the most deprived areas in Scotland was 2.5 times as high as in the least deprived areas in Scotland.

6.0 WHAT THE DATA IS TELLING US

6.1 Although the rate of mental health admissions for the 18-64 age group has increasing trends in comparison to Q1 2022/23, numbers have begun to stabilise across all hospital admissions and emergency admissions. The rate of mental health admissions for the age 65+ age group also shows stabilisation across all hospital admissions and emergency admissions. For both age groups, there is substantial variation by LCPP, with the most deprived localities having the highest rates of admissions.

6.2 The rate of mental health bed days for the under 65 and 65+ age groups has decreased which is an improvement across all hospital admissions and emergency admissions. For both age groups, there is substantial variation by LCPP, with the most deprived localities having the highest rate of admissions.

6.3 When benchmarked across the 8 Family Group Partnerships and compared with Scotland, Dundee had the 2nd highest rate of mental health emergency bed days for ages 18-64 and for ages 65+.

6.4 There has been an increasing trend in referrals for Psychological Therapies since Q1 2022/23, with a fall in since Q4 2023/24. Most new referrals were from West End and Lochee. There has been a slight fall in the proportion of patients referred to Psychological Therapies who commenced their treatment within 18 weeks of referral (completed waits). This has fallen from 75% in Q1 22/23 to 70% in Q2 2024/25.

6.5 The number of community-based mental health appointments from Dundee Crisis Team has decreased, however when all Community Mental Teams are combined the overall number of appointments has increased. The proportion of referrals accepted is just over 60%. The number of people discharged without being seen has a downward trend, with 431 not seen for Q2 2024/25. At Q2 2024/25 the number of community-based mental health return appointments for every new patient seen was an average of 10.

6.6 There is an increasing trend in the number of new referrals to Psychiatry of Old Age with numbers beginning to stabilise since Q1 2023/24. The proportion of referrals accepted has remained steady at just over 60%. At Q2 24/25, the highest number of new referrals came from The Ferry and the lowest number were from Maryfield. At Q2 2024/25, the average number of return appointments for every patient seen was 12. There was an increasing trend in the number of people discharged without being seen from Q1 2023/24 to Q2 2024/25.

6.7 The number of new referrals to Learning Disabilities services is showing an upward trend with 464 referrals in Q2 2024/25. The highest number of new referrals were from Coldside and West End, with the lowest number from The Ferry. The proportion of referrals accepted has increased from 56% in Q2 2023/24 to 75% in Q2 2024/25. The average number of return appointments for every new patient seen at Q2 24/25 was 11, and there was an increase in the number of people discharged without being seen from Q1 2022/23 to Q2 2024/25.

6.8 There is a downward trend in the number of referrals to Mental Health Officers since Q1 2022/23 teams, with numbers now beginning to stabilise. Whilst for the Community Mental Health Team for younger people has seen a drop in referrals, there has been little change in the caseloads for all Social Work Mental Health teams.

6.9 There has been an increase in the number of local authority and private guardianship applications. There has also been an increasing trend in Short Term Detentions between 2023/24 Q1 to Q2 2024/25.

7.0 OPERATIONAL CONTEXT / ACHIEVEMENTS / AREAS FOR FURTHER DEVELOPMENT

7.1 Tayside Psychological Therapies Service, along with six other Mainland Health Board areas, has been placed in Enhanced Support by Scottish Government. This is resultant of not meeting the 18-week referral to treatment waiting times standard (where 90% of people given first appointments should have waited less than 18 weeks). This does not attract any additional resource for the service and, in the first instance, has meant additional analyst time to further examine locally held and used data.

7.2 An Improvement Plan has been provided to the Chief Officer and shared with Scottish Government colleagues. Tayside currently has an above average accepted referral rate but the third lowest level of Clinical and other Doctorate level staff in Scotland. This has been offset somewhat by enhanced skill mix but, overall, remains below average. An 'immediately realistic recruitment plan" and a "further required investment plan" has been shared with the total required extra investment (to meet the 90% target) approximating £1.5M. This is not currently affordable and a small increase in resource (in the Region of 7 additional posts) has been agreed in the first instance. This recruitment will take place in January 2025.

7.3 There continues to be significant challenges with Community Mental Health Teams, with rising referral rates. Staff absence has decreased. The Transformation finance approved for use to improve processes around ADHD assessment and treatment is not yet being utilised but will be a priority development in January 2025.

8.0 POLICY IMPLICATIONS

8.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

9.0 RISK ASSESSMENT

Risk 1 Description	Poor performance could affect outcomes for individuals and their carers, spend associated with poor performance and the ability of the IJB to deliver fully commitments set out in the Strategic and Commissioning Plan.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (which is an Extreme Risk Level)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance and activity. - Continue to report data to the PAC to highlight performance and activity. - Support operational managers by providing in depth analysis regarding areas of poor performance. - Ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a Moderate Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

9.0 CONSULTATIONS

9.1 The Chief Officer, Heads of Service, Health and Community Care and the Clerk were consulted in the preparation of this report.

10.0 BACKGROUND PAPERS

10.1 None.

Christine Jones
Acting Chief Finance Officer

DATE: 20 December 2024

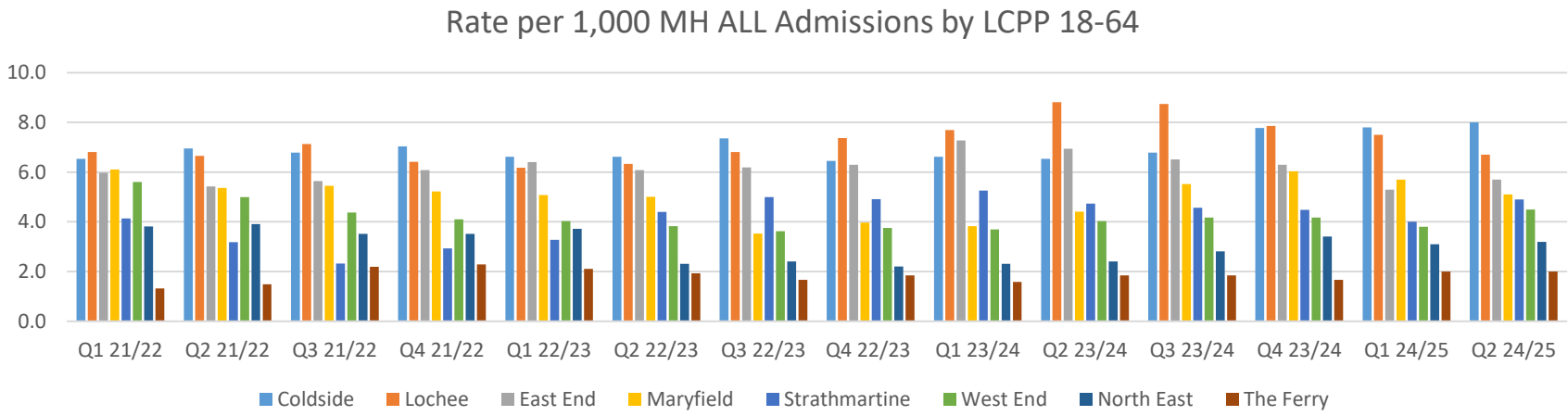
Lynsey Webster
Lead Officer: Quality, Data and Intelligence

Shahida Naeem
Senior Officer, Quality, Data and Intelligence

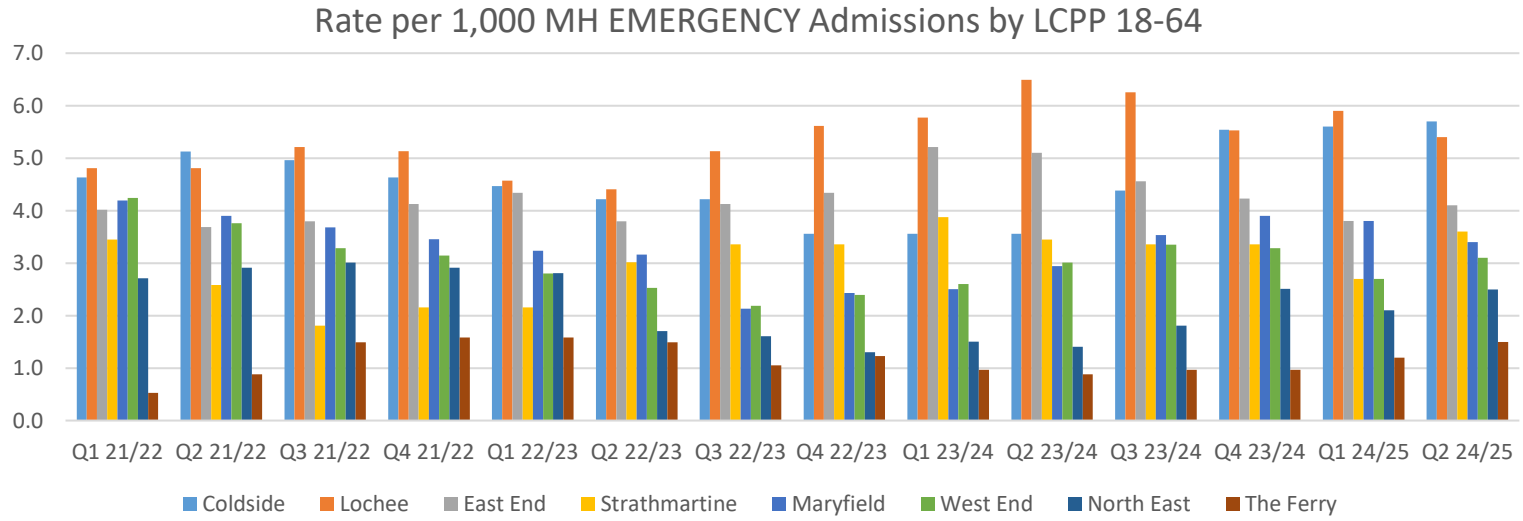
Linda Graham
Clinical Lead for Mental Health and Learning Disabilities

APPENDIX 1 – MENTAL HEALTH SERVICES INDICATORS

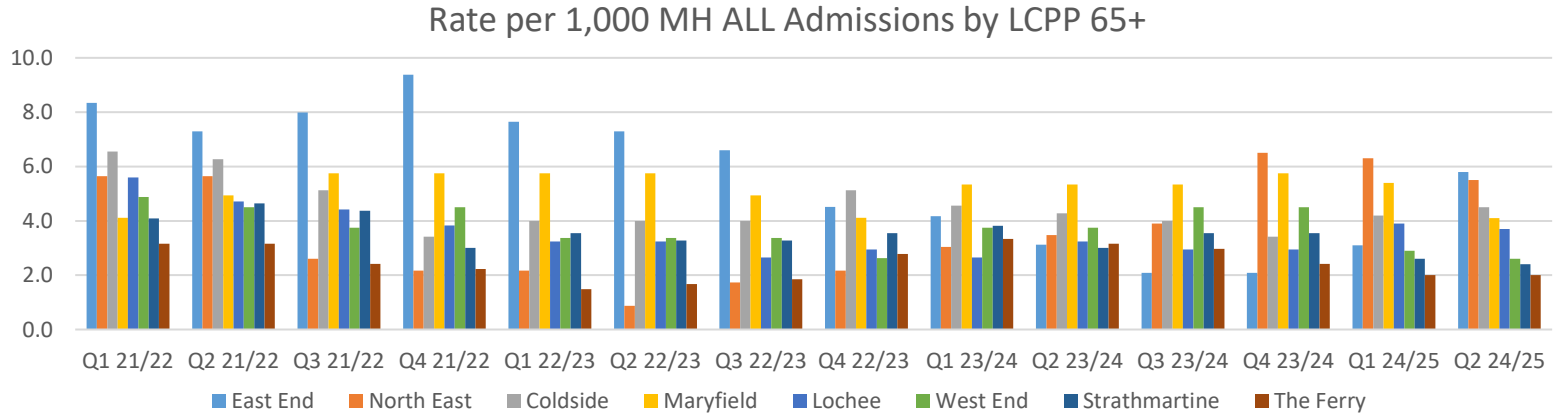
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Admission Summary for People Age 18-64													
Number of Mental Health ALL Admissions for people aged 18-64	443	435	433	437	451	472	489	498	471	481			An increasing trend in the number of admissions in comparison to Q1 2022/23.
Rate per 1,000 Mental Health ALL Admissions for people aged 18-64	4.7	4.6	4.6	4.6	4.8	5.0	5.2	5.2	4.9	5.1			Rates per 1,000 population have increased from Q1 2022/23 to Q2 24/25. There are variations by LCPP, note that rates are not standardised. Highest rates in Coldside, followed by Lochee and lowest rates in The Ferry.



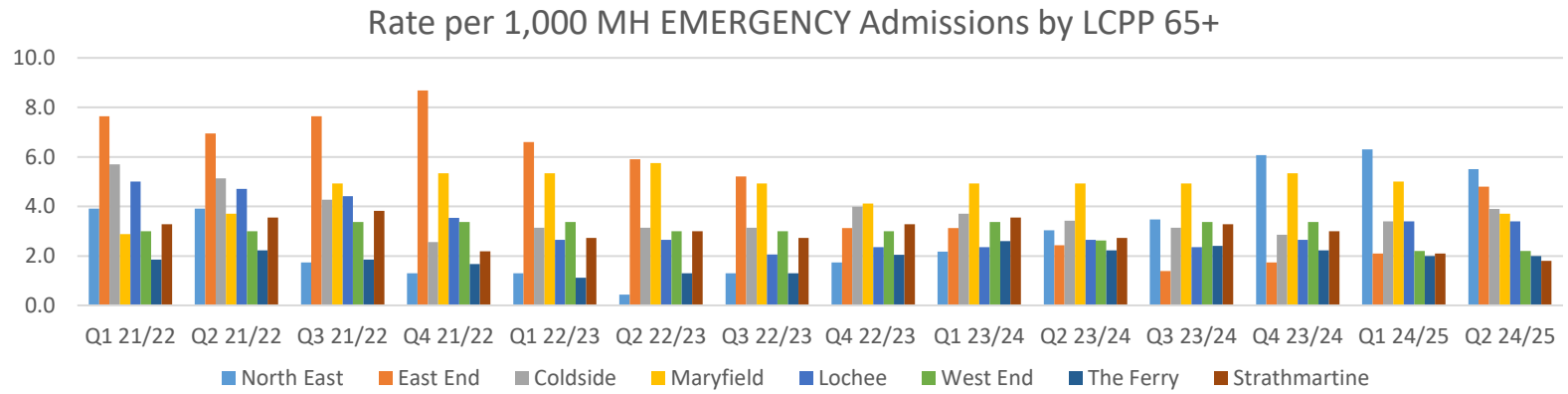
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Admission Summary for People Age 18-64													
Number of Mental Health EMERGENCY Admissions for people aged 18-64	307	290	281	287	306	319	338	351	334	349			An increasing trend between Q1 2022/23 to Q2 2024/25.
Rate per 1,000 Mental Health EMERGENCY Admissions for people aged 18-64	3.2	3.1	3.0	3.0	3.2	3.4	3.6	3.7	3.5	3.7			Increase in rate per 1,000 from Q1 2022/23 to Q2 2024/25. Highest rate in Coldside (5.7 rate per 1,000) and Lochee (5.4 rate per 1,000) Lowest rate in The Ferry with a rate of 1.5 per 1,000 population.



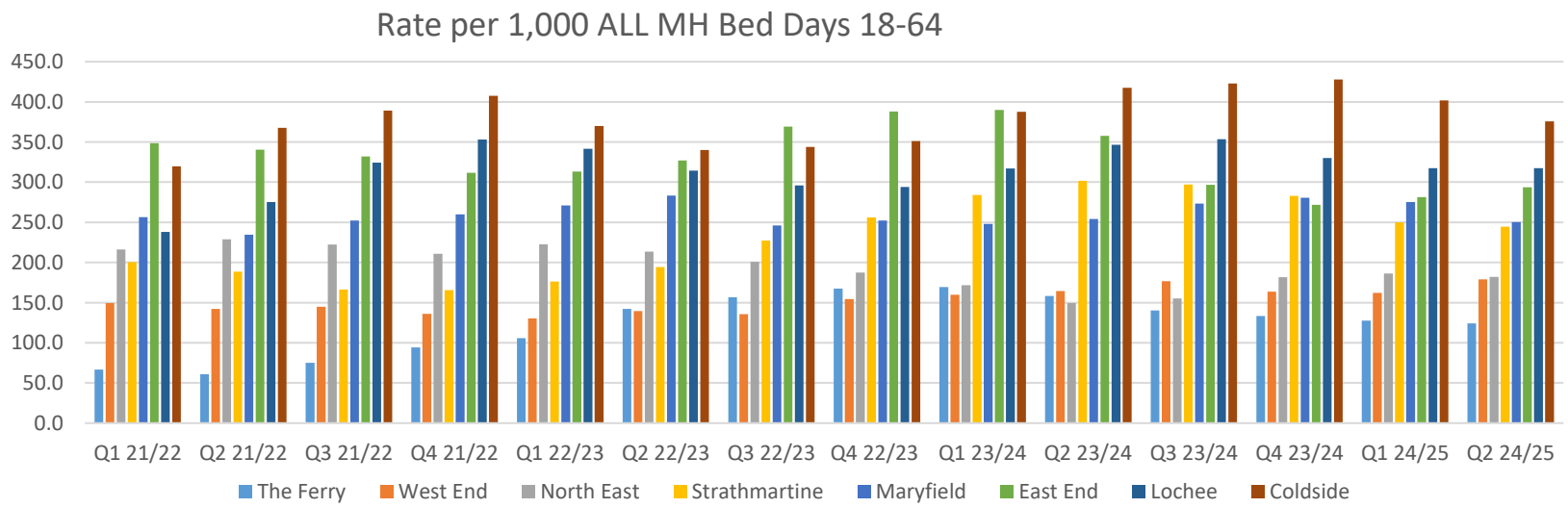
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Admission Summary for People Age 65+													
Number of Mental Health ALL Admissions for people aged 65+	96	92	89	91	99	94	93	95	95	96			Fairly consistent numbers in few quarters. There has been variation from Q3 2022/23 and Q1 23/24 before stabilising.
Rate per 1,000 Mental Health ALL Admissions for people aged 65+	3.7	3.5	3.4	3.5	3.8	3.6	3.5	3.6	3.5	3.6			Similar rates to previous quarters. Variation by LCPP although note that rates are not standardised. Highest rates in East End, followed by North East and lowest rate in The Ferry.



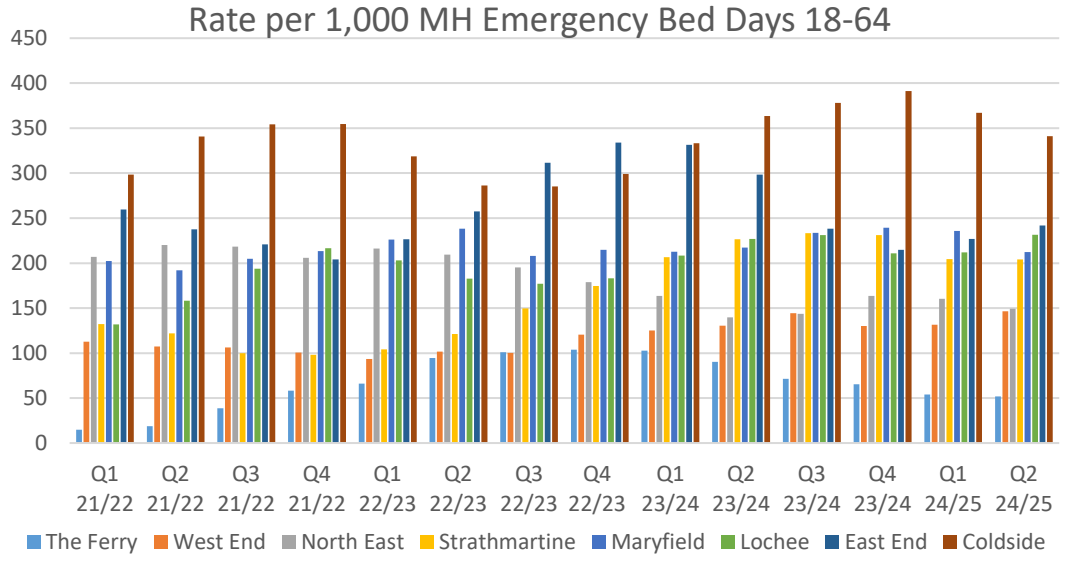
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Admission Summary for People Age 65+													
Number of Mental Health EMERGENCY Admissions for people aged 65+	80	79	74	75	83	76	78	83	82	86			Slight increase in Q2 2024/25 in comparison to previous quarters.
Rate per 1,000 Mental Health EMERGENCY Admissions for people aged 65+	3.0	3.0	2.8	2.9	3.2	2.9	3.0	3.2	3.0	3.2			Slight increase in rate per 1,000 in Q2 2024/25 in comparison to Q2 2023/24. Variation by LCPP Highest rates in North East, followed by East End and lowest rate in Strathmartine. Although note these are small numbers.

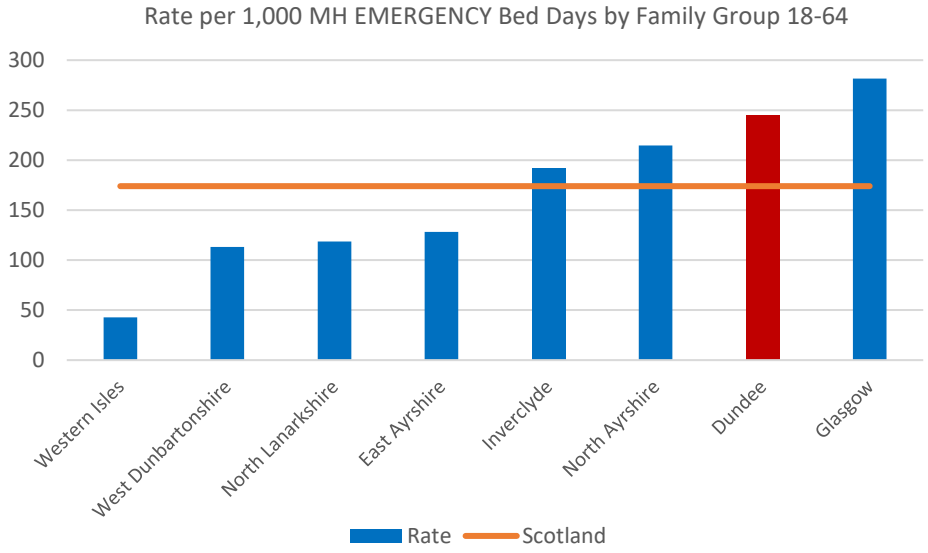


Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Bed Days for People Aged 18-64													
Number of Mental Health ALL Bed Days for people aged 18-64	22683	22935	23009	23926	24800	25326	25146	24614	23722	23303			Decreasing trend since Q2 23/24.
Rate per 1,000 Mental Health ALL Bed Days for people aged 18-64	238.9	241.6	242.3	252	262	266.7	264.8	259.2	249.3	244.9			Decreasing trend since Q2 2023/24 with the highest rate in Coldside (375.7 rate per 1,000) and the lowest in The Ferry (124.2 rate per 1,000).

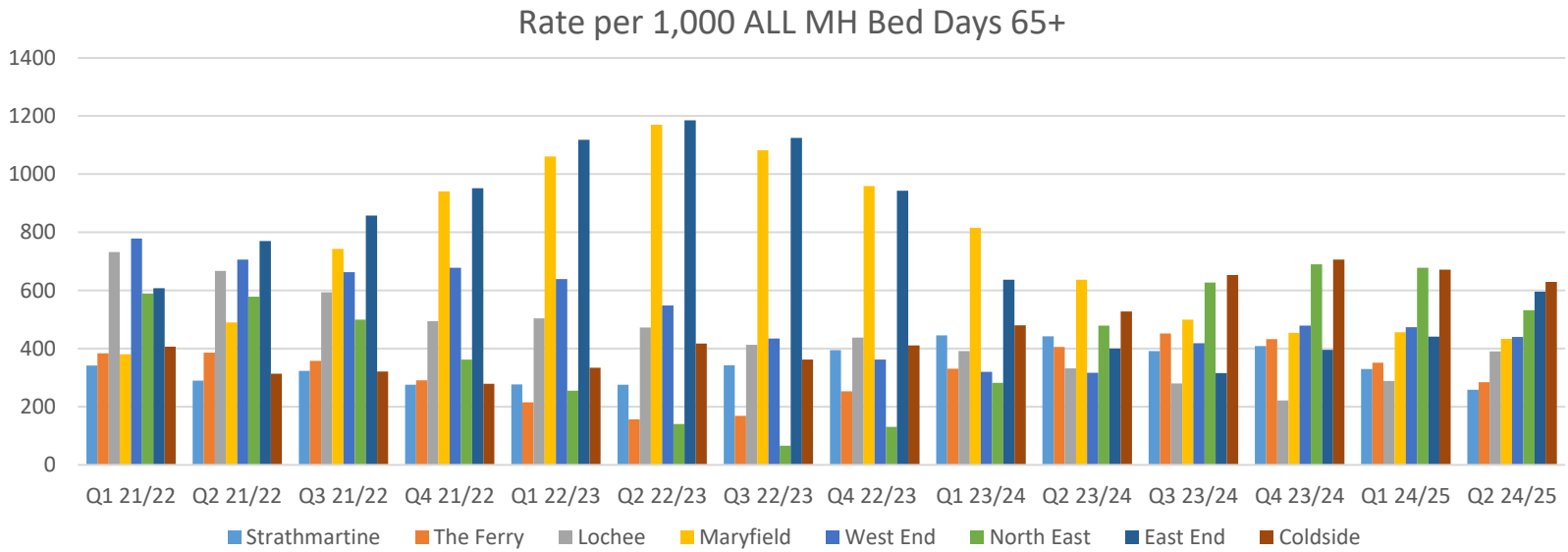


Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 23/24 Q4	Comments/ Analysis
Bed Days for People Aged 18-64													
Number of Mental Health EMERGENCY Bed Days for people aged 18-64	17020	17401	17652	18650	19601	19874	19888	19547	18922	18768			Increasing trend for emergency bed days.
Rate per 1,000 Mental Health EMERGENCY Bed Days for people aged 18-64	179.3	183.3	185.9	196.4	206.4	209.3	209.5	205.9	198.8	197.2			Decreasing trend from Q2 2023/24 to Q2 2024/25. Coldside had the highest rate per 1,000 and The Ferry had the lowest rate.

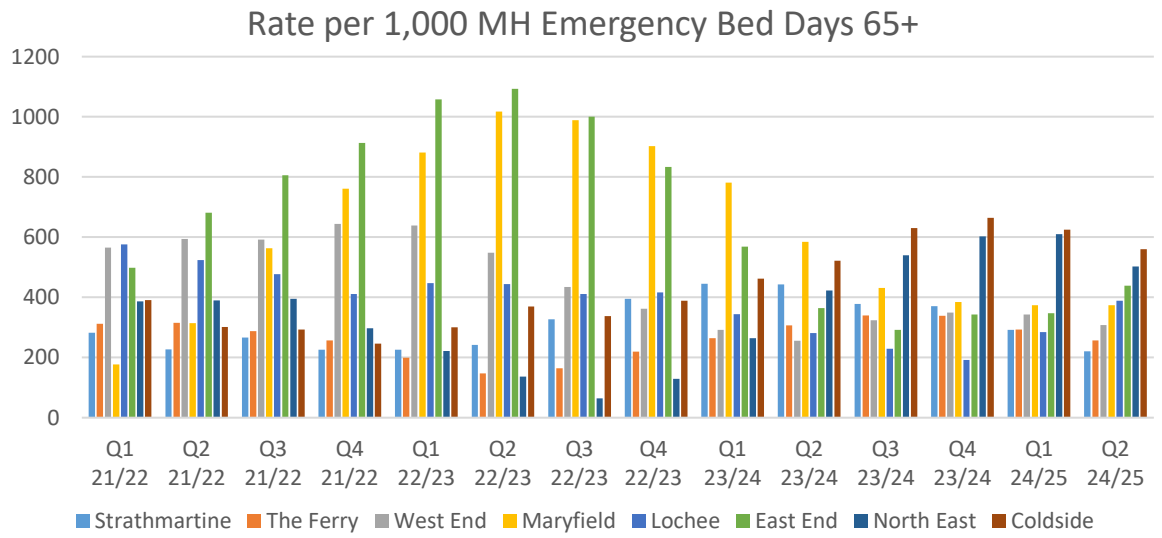


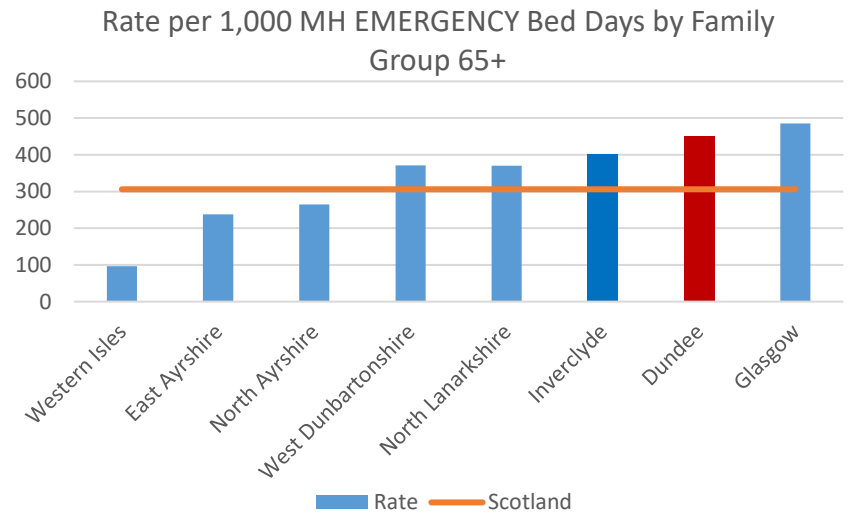


Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling2 3/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/Analysis
Bed Days for People Aged 65+													
Number of Mental Health ALL Bed Days for people aged 65+	13148	12971	12019	12052	11754	11438	11806	12173	11930	11451			Downward trend since Q1 22/23.
Rate per 1,000 Mental Health ALL Bed Days for people aged 65+	501	494.3	458	459.2	447.9	435.8	449.9	463.9	443.2	425.4			Downward trend since Q1 22/23. The highest rate is in Coldside and the lowest is in Strathmartine.

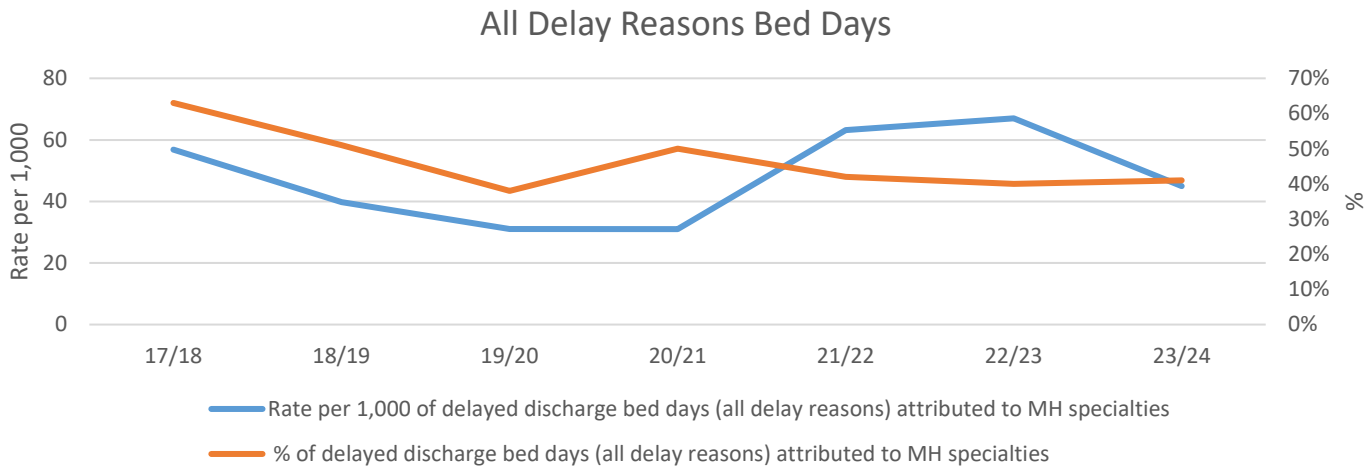


Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling2 3/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/Analysis
Bed Days for People Aged 65+													
Number of Mental Health EMERGENCY Bed Days for people aged 65+	11882	11881	11257	11268	10769	10188	10202	10407	10284	9863			A downward trend in emergency bed days from Q1 22/23 to Q2 24/25.
Rate per 1,000 Mental Health EMERGENCY Bed Days for people aged 65+	452.8	452.7	429	429.4	410.4	388.2	388.8	396.6	382.0	366.4			A downward trend with the highest rate in Coldside and the lowest in Strathmartine.





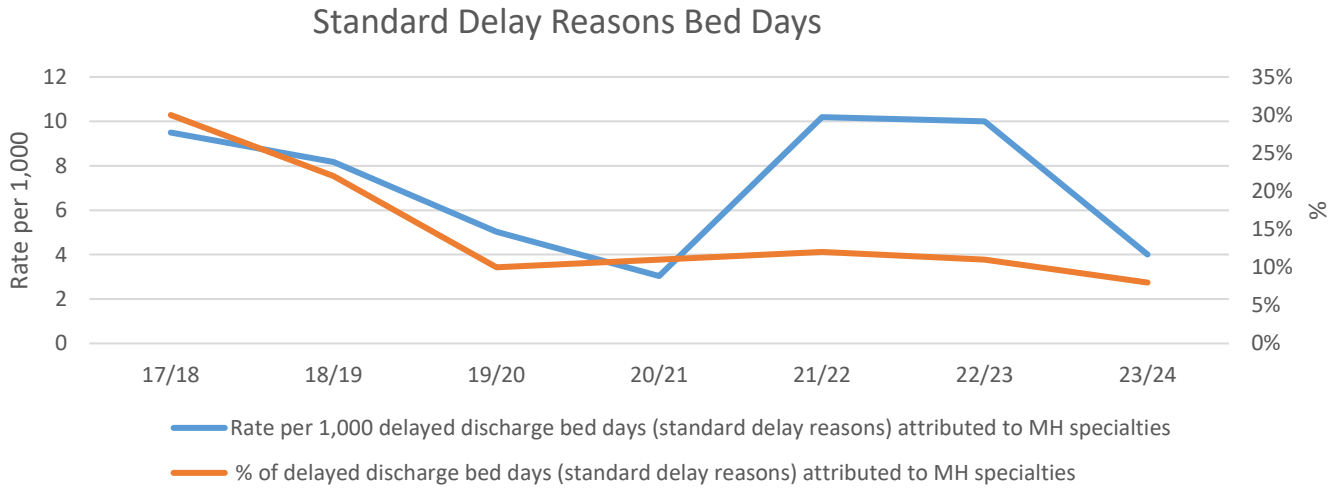
Delayed Discharge for Mental Health Specialities



Source: PHS Publication June 2024, Delayed discharges in NHS Scotland annual

This data in available annually and not available by LCPP level

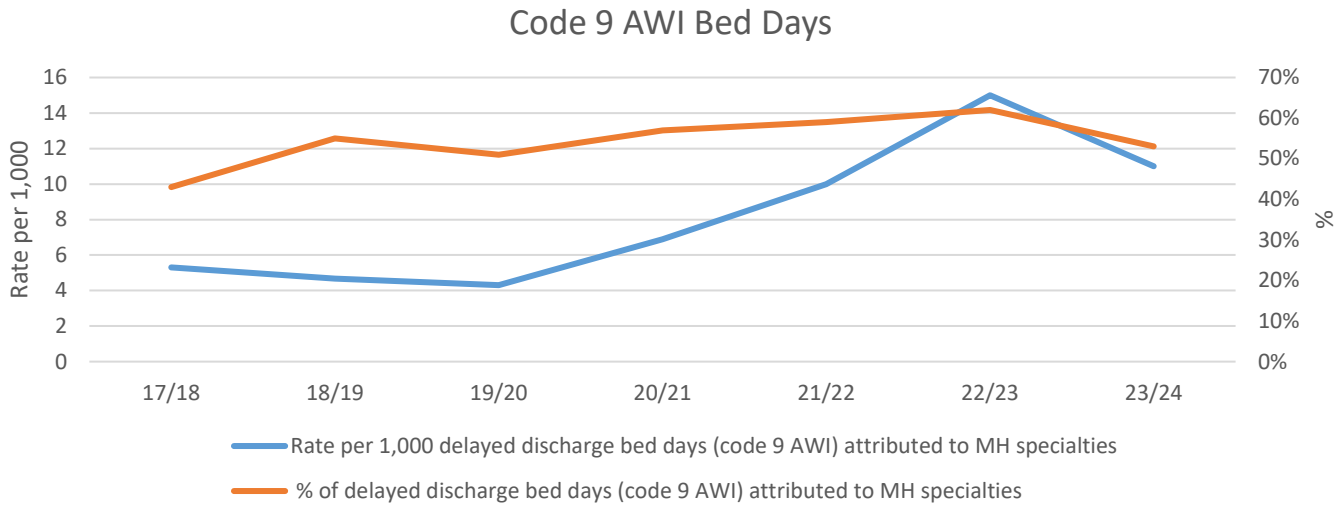
Rate per 1,000 delayed discharge bed days (all reasons) attributed to MH specialties increased between 2021/22 and 2022/23 was higher than previous years but had come down for 2023/24.
% of delayed discharge bed day (all delay reasons) attributed to MH specialities has been steady in the past few years.



Source: PHS Publication June 2024, Delayed discharges in NHSScotland annual

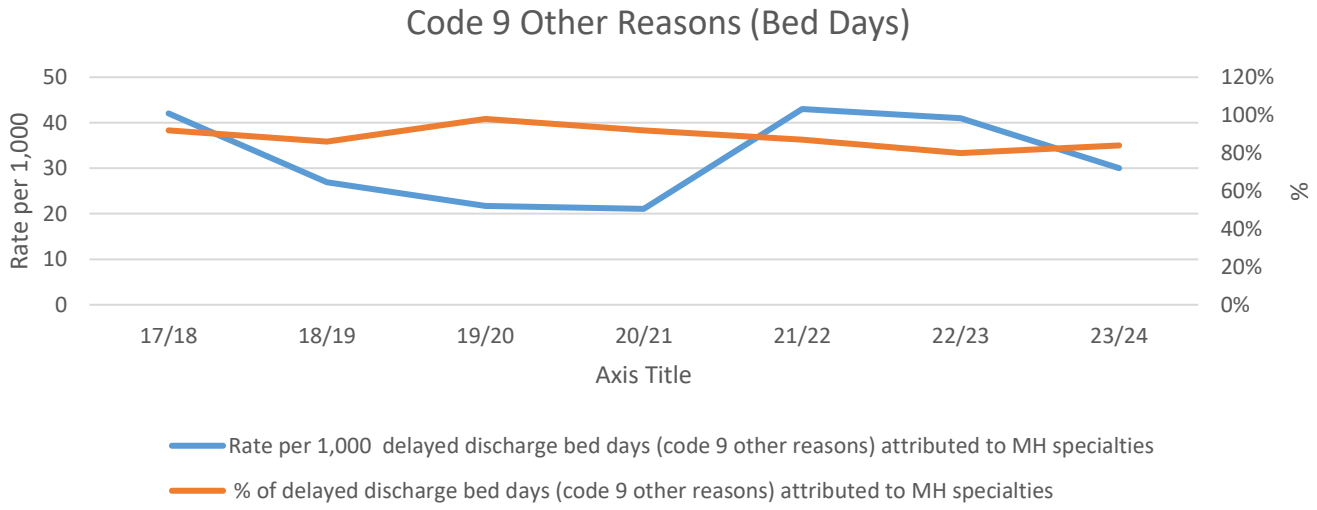
This data in available annually and not available by LCPP level

Rate per 1,000 delayed discharge bed days (standard delay reasons) attributed to MH specialties has fallen since 2022/23.
% of delayed discharge bed days (standard delay reasons) attributed to MH specialties has a decreasing trend.



Source: PHS Publication June 2024, Delayed discharges in NHS Scotland annual
This data in available annually and not available by LCPP level

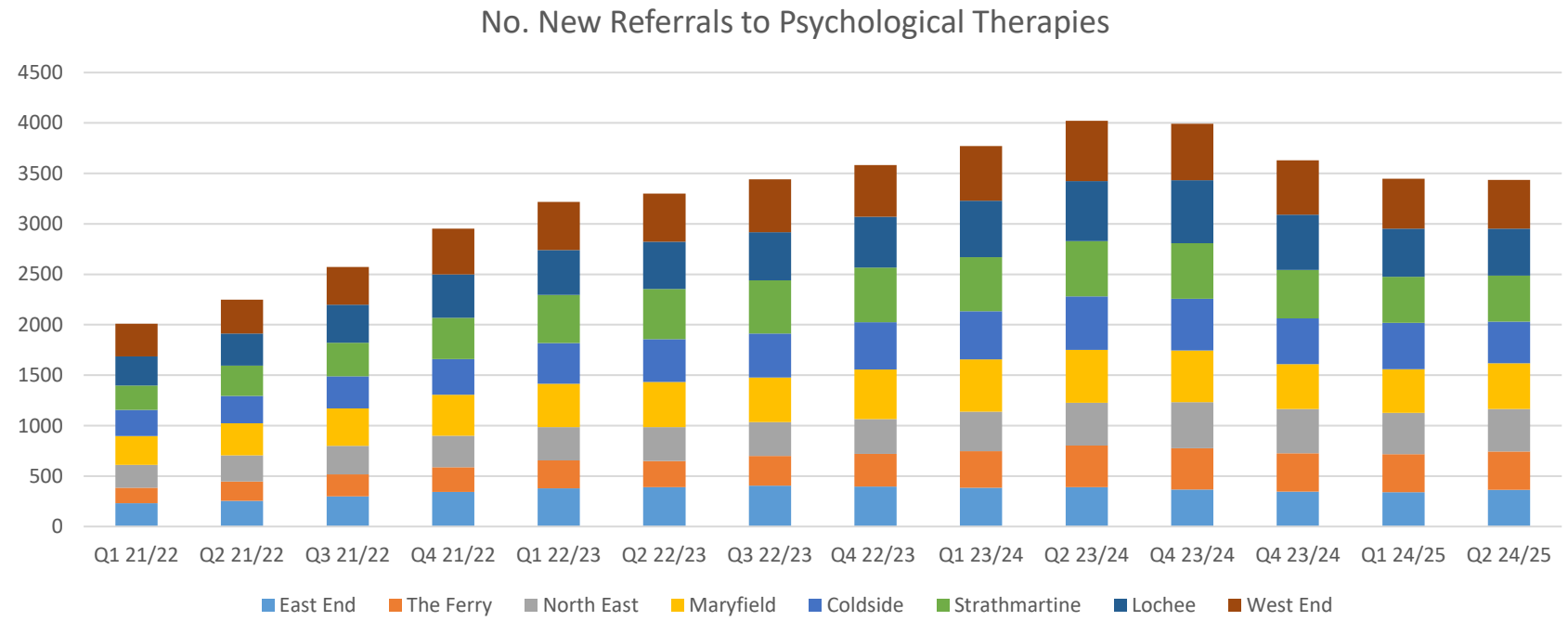
Rate per 1,000 delayed discharge bed days (code 9 AWI) attributed to MH specialties has fallen in 2023/24 after an increase in the previous reporting year.
% of delayed discharge bed days (code 9 AWI) attributed to MH specialties has decreased in 2023/24.



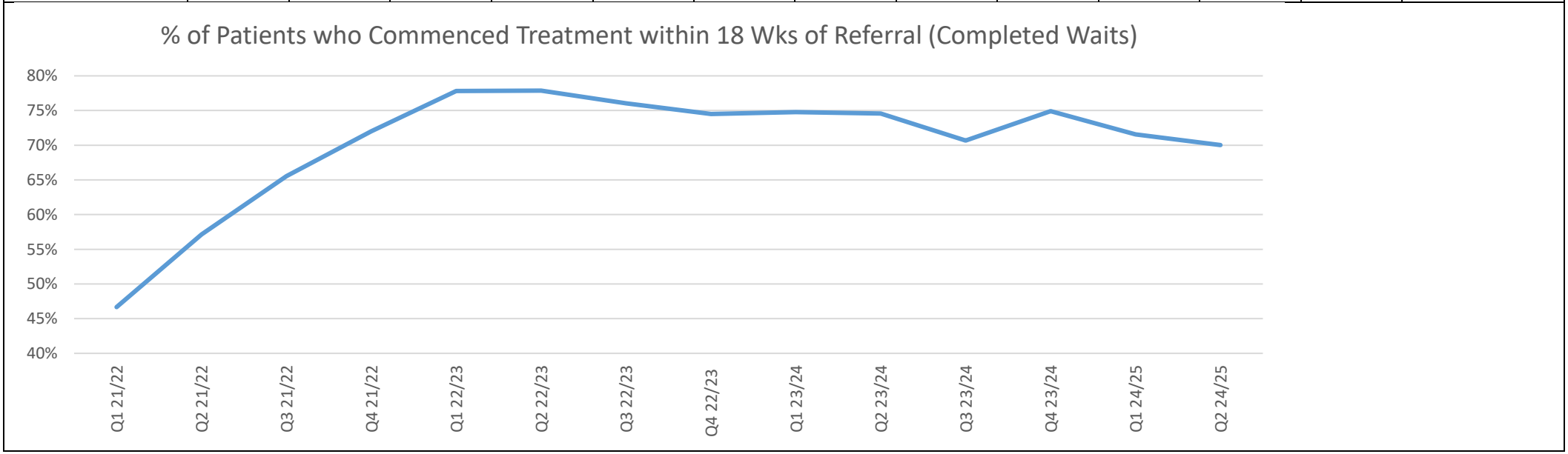
Source: PHS Publication June 2024, Delayed discharges in NHS Scotland annual
This data in available annually and not available by LCPP level

Rate per 1,000 delayed discharge bed days (code 9 other reasons) attributed to MH specialties decreased from 41 in 2022/23 to 30 in 2023/24.
% of delayed discharge bed days (code 9 other reasons) attributed to MH specialties increased from 80% in 2022/23 to 84% in 2023/24.

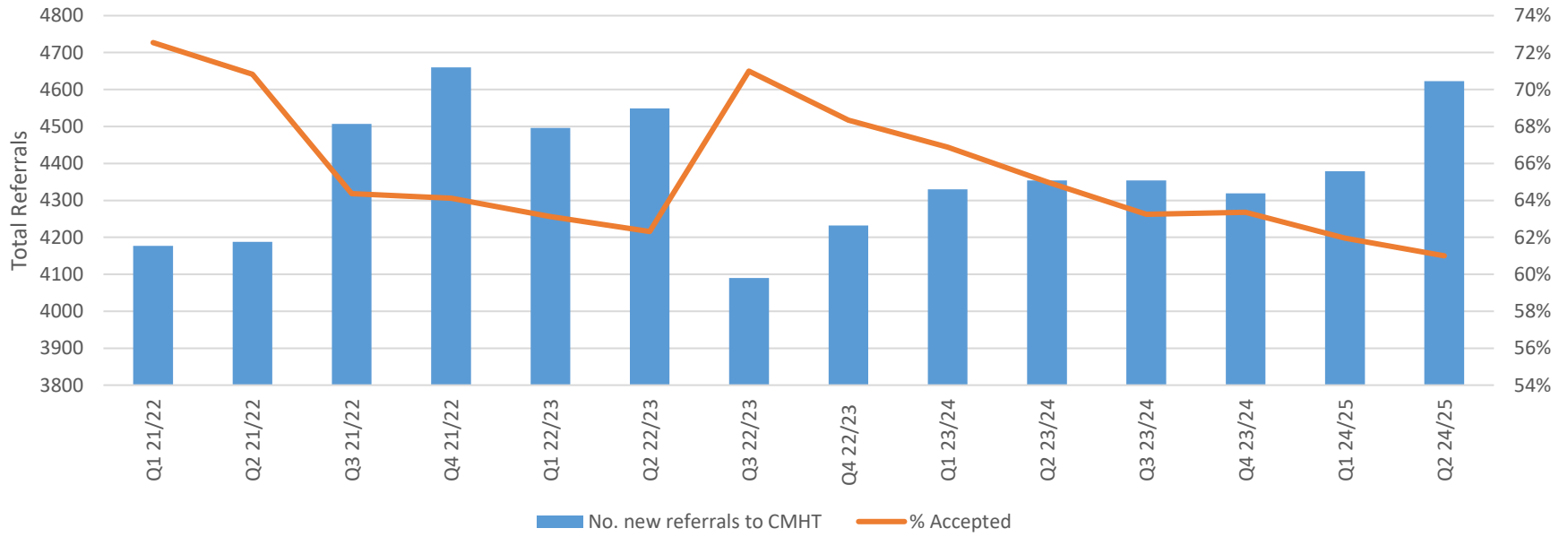
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Psychological Therapies													
Number of NEW referrals to psychological therapies (ALL)	2383	2514	2735	2926	3152	3423	3520	3631	3448	3436			An upward trend since Q1 2022/23 with a slight fall in Q2 2024/25. West End had the highest number with 484 referrals.



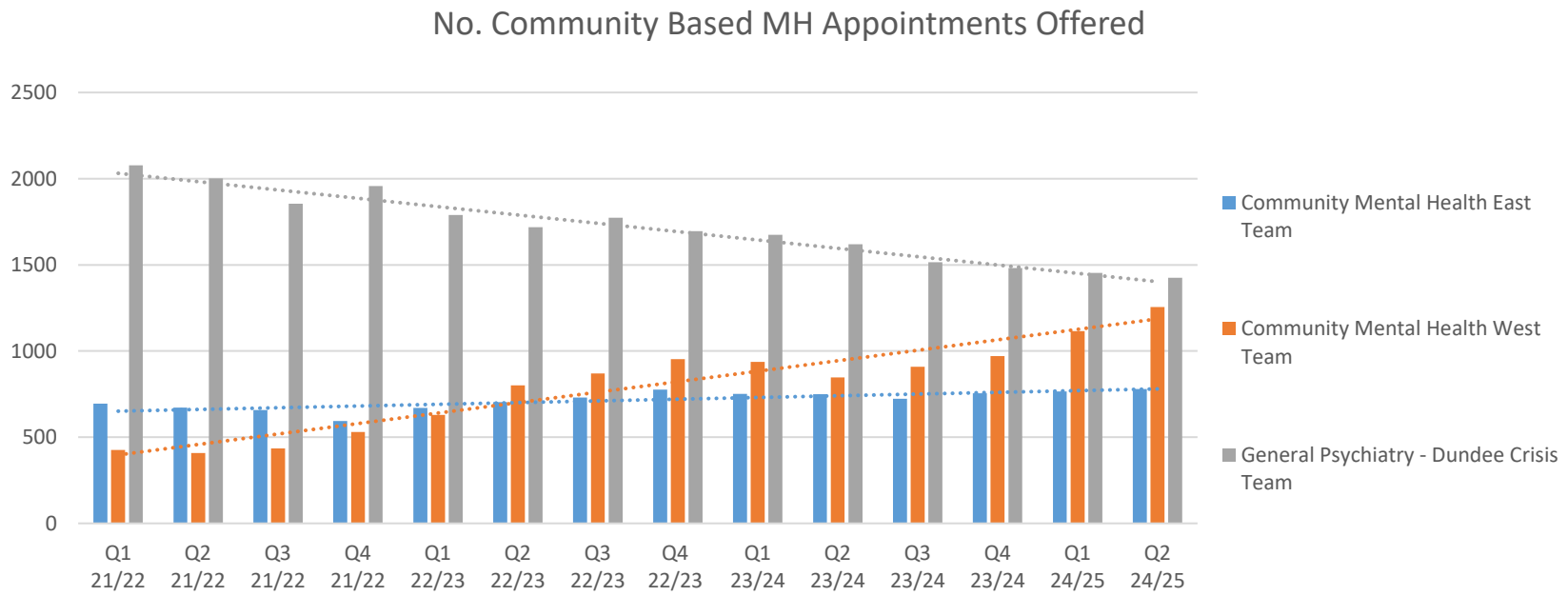
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Psychological Therapies													
% of patients referred who commenced their treatment within 18 weeks of referral (completed waits)	75%	75%	73%	71%	71%	71%	71%	71%	72%	70%			Slight fall in the % of people who were seen within 18 weeks from Q1 2022/23 to Q2 2024/25.



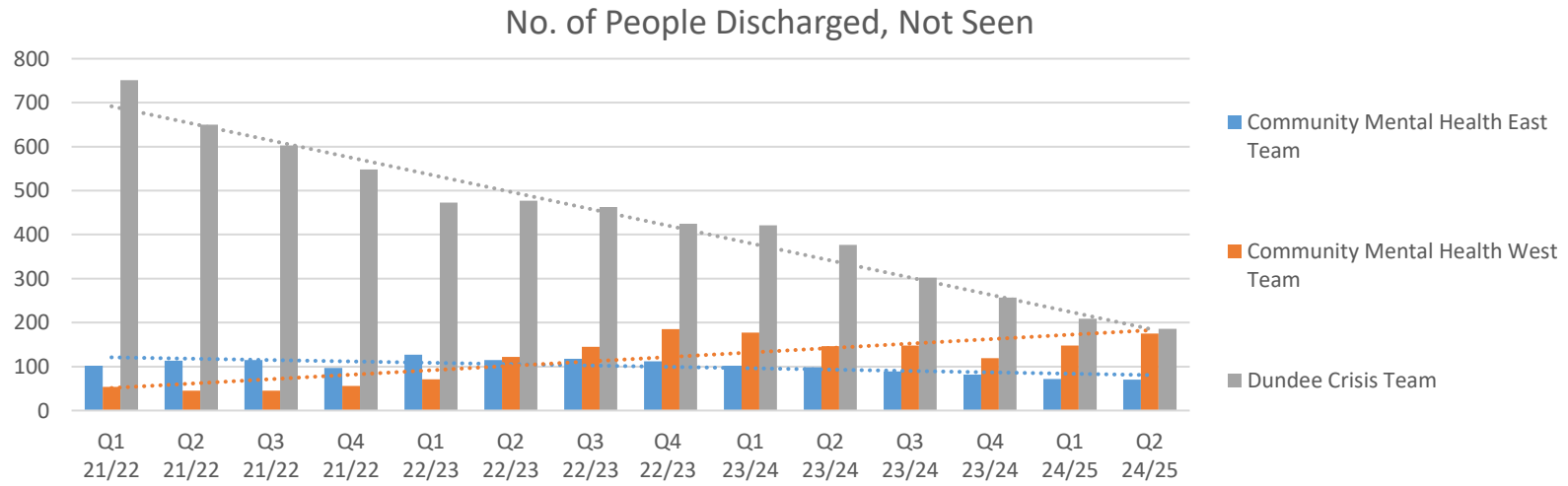
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
CMHT teams (*Includes a combination of General Psychiatry – Dundee Crisis Team, Dundee Community Mental Health East Team and Dundee Community Mental Health West Team)*													
Number of new referrals to CMHT (and % accepted) .	4496 (63%)	4549 (62%)	4090 (71%)	4232 (68%)	4330 (67%)	4354 (65%)	4354 (63%)	4319 (63%)	4379 (62%)	4623 (61%)			An increasing trend in number of new referrals from Q3 2022/23 and Q2 2024/25. % accepted remains steady and sitting between 61% and 63% over the last 3 quarters.



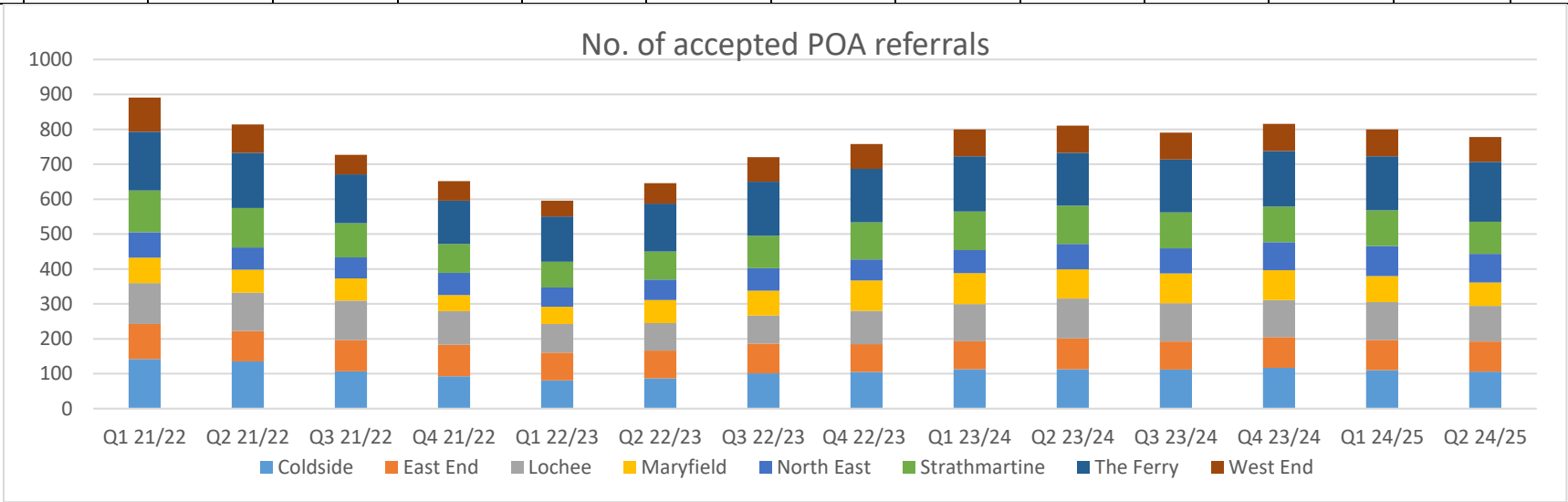
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
CMHT teams (*Includes a combination of General Psychiatry – Dundee Crisis Team, Dundee Community Mental Health East Team and Dundee Community Mental Health West Team)*													
Number of community based mental health appointments offered (included attended and DNA)	3083	3216	3365	3414	3362	3214	3147	3207	3334	3459			An increase in number of appointments offered from Q1 2022/23 to Q2 2024/25. The largest increase in the CMHT West Team.



Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
CMHT teams (*Includes a combination of General Psychiatry – Dundee Crisis Team, Dundee Community Mental Health East Team and Dundee Community Mental Health West Team)*													
No. of return appointments for every new patient seen. (average per month over the previous 12 months)	13	13	12	11	11	11	12	11	11	10			On average 10 return appointments over the past 12 months.
Number of people discharged without being seen	665	706	720	712	700	621	539	458	429	431			Reduction in number of people discharged without being seen from Dundee Crisis Team - this has been decreasing consistently since Q1 2021/22.

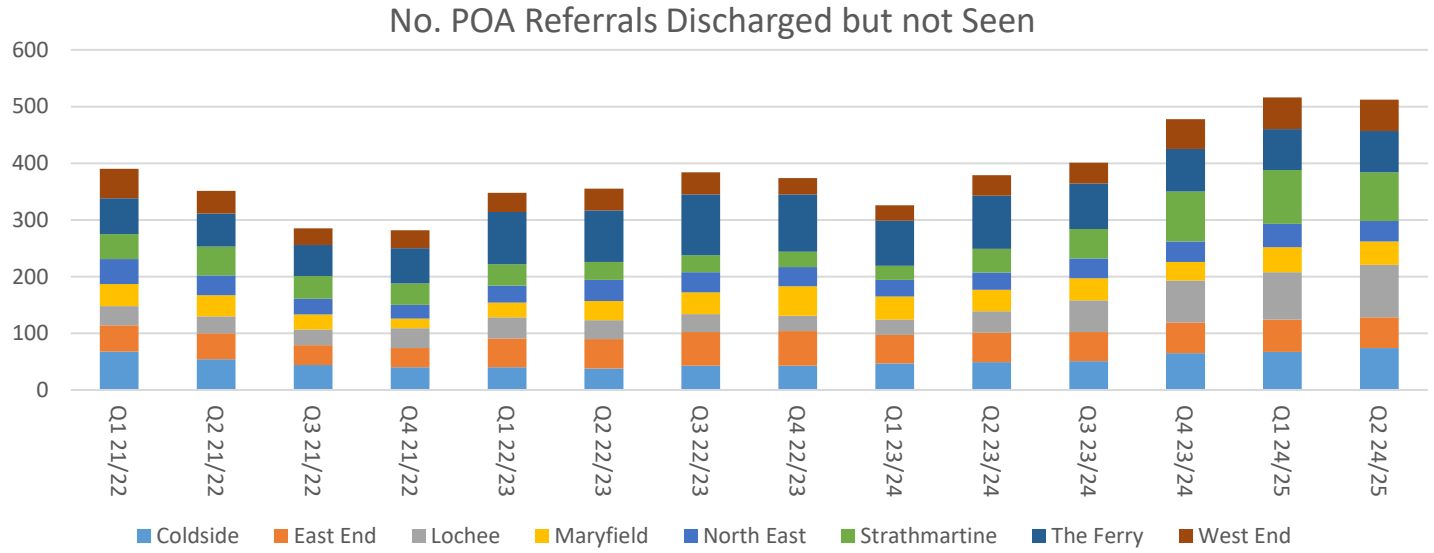


Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Psychiatry of Old Age													
Number of accepted referrals to Psychiatry of Old Age (and % accepted)	596 (70%)	646 (72%)	720 (72%)	758 (64%)	800 (63%)	811 (60%)	791 (58%)	816 (61%)	800 (61%)	778 (61%)			

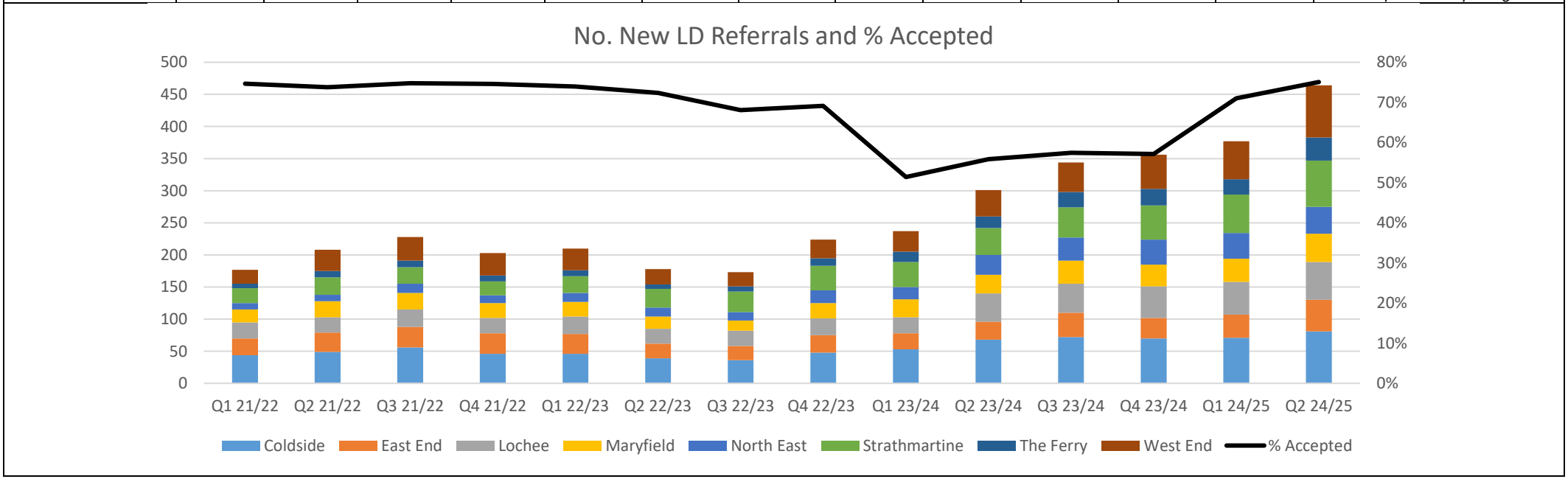


Increasing trend in the number of referrals since Q1 2022/23. For Q2 24/25, the highest number of new referrals came from The Ferry (172) and the lowest number came from Maryfield (67). % accepted remains steady at 61%. *Please note: There has been a change in the way referrals are counted in 2023/24 reporting period*

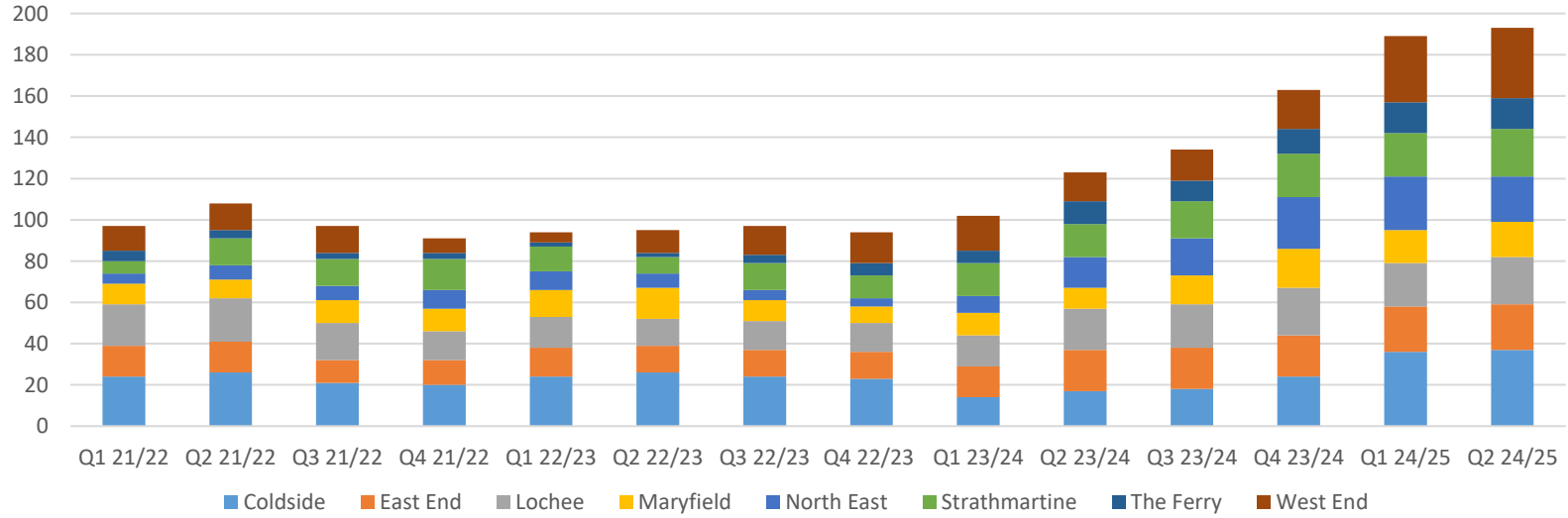
Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Number of return appointments for every new patient seen.	9	9	9	9	11	11	12	12	12	12			Average number of return appointments remains the same in the past 12 months.
Number of people discharged without being seen	348	355	384	370	322	375	401	478	516	512			Increasing trend. The largest number of people discharged without being seen are from Strathmartine (88) and the lowest number are from Maryfield (33).



Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Learning Disability													
Number of new referrals to LD (and % accepted)	210 (74%)	178 (72%)	173 (68%)	224 (69%)	237 (51%)	301 (56%)	344 (57%)	356 (57%)	377 (71%)	464 (75%)			Increasing trend in the number of new referrals since Q1 2022/23. The highest number of new referrals were from Coldside and West End (71) and the lowest number was from The Ferry (36). % accepted has increased since Q4 23/24. *Please note: There has been a change in the way referrals are counted so these numbers are different previous reporting*



Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/Analysis
Learning Disability													
Number of return appointments for every new patient seen.	14	14	14	13	12	12	11	11	11	11			Reducing trend from Q1 2022/23 to Q2 2024/25.
Number of people discharged without being seen	94	95	97	94	102	123	134	163	189	193			Increasing trend since Q1 2022/23. Highest numbers were in Coldside and lowest was in The Ferry.



Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Social Work Demand Information													
MHO new referrals and Assessment	337	321	298	292	292	283	264	265	260	272			Decreasing trend since Q1 2022/23.
CMHT (SW team) new referrals	149	136	151	145	134	121	78	66	57	66			A decreasing trend since Q1 2022/23.
CMHT older people new referrasl(SW team)	136	140	159	165	174	190	186	189	158	136			A decreasing trend over the last 4 quarters.
LA Guardianship applications	41	48	49	40	52	54	55	60	60	70			An increasing trend in the number of guardianship applications.
Private Guardianship application	58	59	64	63	64	70	69	73	80	88			An increasing trend in the number of guardianship applications
Emergency detention in hospital (up to 72 hours) (s36)	102	103	107	95	101	97	103	117	105	104			Numbers have fluctuated between 95 and 107 since Q1 2022/23, except for a peak at Q4 2023/24 when there were 17.

Indicator	Rolling 22/23 Q1	Rolling 22/23 Q2	Rolling 22/23 Q3	Rolling 22/23 Q4	Rolling 23/24 Q1	Rolling 23/24 Q2	Rolling 23/24 Q3	Rolling 23/24 Q4	Rolling 24/25 Q1	Rolling 24/25 Q2	Rolling 24/25 Q3	Rolling 24/25 Q4	Comments/ Analysis
Short term detention in hospital (up to 28 days) (s44)	164	166	169	169	181	179	209	205	197	205			Increasing trend since Q1 2022/23.
Compulsory Treatment Orders (s64)	52	47	52	55	58	59	63	60	54	45			Decrease over the last 2 quarters.
No. of S44 with Social Circumstance report was considered	56	51	52	56	61	69	73	73	63	57			
No. of SCR that were prepared	41	35	34	32	35	38	42	46	41	44			
MHO team caseload at period end	265	251	265	273	264	263	255	251	250	251			Caseload numbers have remained fairly consistent.
MHO unallocated at end of quarter	49	46	53	44	37	36	51	42	52	40			
% MHO unallocated out of all cases	18%	18%	20%	16%	14%	14%	20%	17%	21%	16%			A reduction in % unallocated in past quarter.
CMHT (SW team) caseloads at period end	456	412	410	429	474	491	471	467	492	506			Increasing trend since Q1 2022/23.
CMHT (SW teams) unallocated at end of quarter	4	0	2	11	57	38	42	45	28	19			A reduction in numbers since Q1 23/24.
% CMHT (SW teams) unallocated out of all cases	1%	0%	0%	3%	12%	8%	9%	10%	6%	4%			A reduction in % unallocated cases in the

													past two quarters.
CMHT older people (SW team) caseloads at period end	269	254	262	253	280	267	258	269	275	268			Caseload numbers have remained fairly consistent.
CMHT older people (SW team) unallocated at end of quarter	0	0	0	0	0	0	0	0	0	0			
% CMHT older people (SW team) unallocated out of all cases	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			

ITEM No …8……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **UNSCHEDULED CARE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC5-2025**

1.0 PURPOSE OF REPORT

1.1 To provide an update to the Performance and Audit Committee on Unscheduled Care Services and Discharge Management performance in Dundee.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Note the current position in relation to complex and standard delays as outlined in sections 5-8.

2.2 Note the improvement actions planned to respond to areas of pressure as outlined in section 9.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Background to Discharge Management

4.1.1 A delayed discharge refers to a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date (Public Health Scotland Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and associated indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged; and,
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 Within Dundee key staff work collaboratively with the Tayside Urgent and Unscheduled Care Board in order to deliver on the strategic plan as set out by the National Urgent and Unscheduled Care Collaborative. The focus of this work is to deliver care closer to home for citizens of Dundee and to minimize hospital inpatient stays wherever appropriate.

4.1.4 The Tayside Urgent and Unscheduled Care Board is chaired jointly by the Associate Locality Manager for Acute and Urgent Care in Dundee Health and Social Care Partnership and the Associate Director for Medicine in NHS Tayside. Membership of the Board is made up of senior staff from key clinical areas. The Dundee position is represented by the Associate Locality

Manager for Acute and Urgent Care. Liaison between the local Board and the national team is undertaken by a Programme Manager within the NHS Tayside Improvement Team alongside the Programme Leadership Team.

4.1.5 This year, the programme of work is split across 4 key workstreams:

1. Optimising Access - Aimed at creating clear and seamless communication and referral pathways between community urgent services in order to create alternatives to hospital admission where appropriate.

2. Performance 95 - Improving the flow through the Emergency Department in order to ensure the 4-hour national target is achieved.

3. Community Urgent Care - Linked closely to the Optimising Access workstream, this focuses on improving and expanding the role of Urgent Care services in the community setting. In Dundee this specifically relates to improvement work ongoing within the Dundee Enhanced Care at Home Team (DECAHT).

4. Optimising Flow - A continuation of the Discharge Without Delay work undertaken last year, focussing on supporting every ward area in Tayside to achieve upper quartile length of stay in relation to the national benchmarking data.

4.1.6 These workstreams are closely linked to the aims contained within the NHS Tayside Annual Delivery Plan. As part of the collaborative working relating to this, each Health and Social Care Partnership in Tayside has agreed to work towards specific targets: achieving and maintaining GREEN RAG (red / amber / green) status for delayed discharges against the locally set targets; and contributing to a 5% reduction in admissions.

4.1.7 Various reporting mechanisms are in place as well as datasets which supports the ongoing understanding of performance against the agreed targets.

This includes:

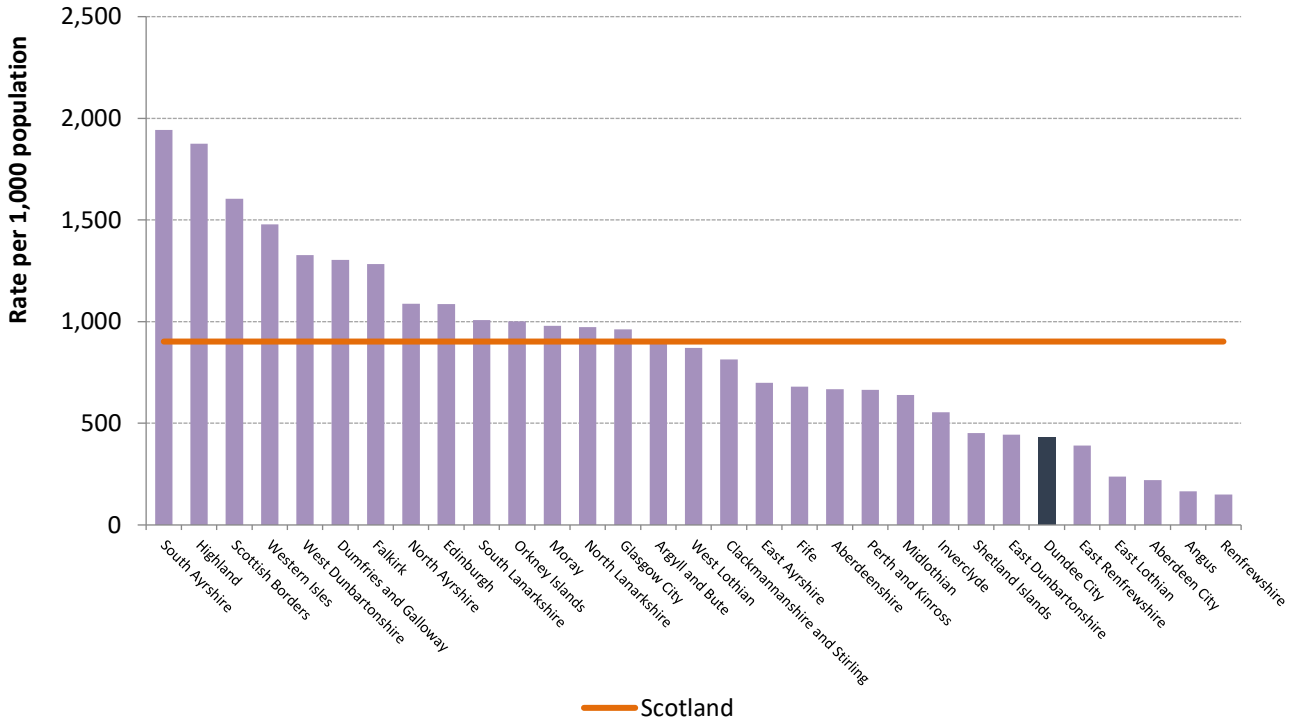
- Daily management and reporting of 'RAG' status across all sites;
- Weekly Dundee Oversight Report detailing performance across Partnership services including delayed discharge;
- Weekly Tayside level 'Discharge Without Delay' key measurement;
- DECAHT performance report; and,
- Community hospital length of stay data pack monthly.

In addition, on a weekly basis a snapshot report of the delayed discharge position in Dundee is provided to the Dundee Health and Social Care Partnership Chief Officer, the NHS Tayside Chief Operating Officer and other key senior staff across Dundee Health and Social Care Partnership and NHS Tayside. This information is used to maintain an ongoing focus on enabling patients to be discharged from hospital when they are ready as well as to inform improvements.

5.0 CURRENT PERFORMANCE TOWARDS NATIONAL INDICATORS

5.1 The National Indicator is 'Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population' and the chart below presents the 2023 annual performance for every HSCP.

Chart 1 Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population 2023



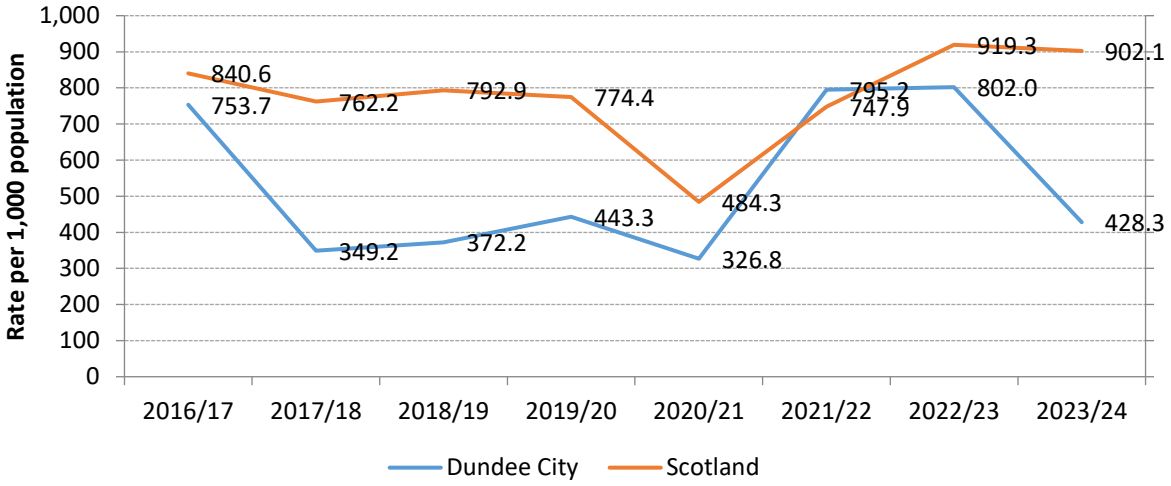
5.2 Dundee performs well against the National Indicator and is 6th best in Scotland with a rate of 428 per 1,000 population compared with the Scotland rate of 902 per 1,000 population.

5.3 Longitudinally, Dundee performance has fluctuated but for every year except 2021/22 performance has been better than Scotland.

5.4 Dundee's performance broken down by LCPPs and complex and non-complex delays is monitored quarterly and included in the PAC Quarterly Performance Reports.

5.5 In addition to the National Indicator, HSCPs are monitored against an Indicator agreed by the Ministerial Strategic Group and this monitors the rate of bed days lost per 1,000 of the 18+ population. This data is also monitored quarterly and included in the PAC Quarterly Performance Report.

Chart 2 Delayed Discharge Bed Days Lost per 1,000 18+ population



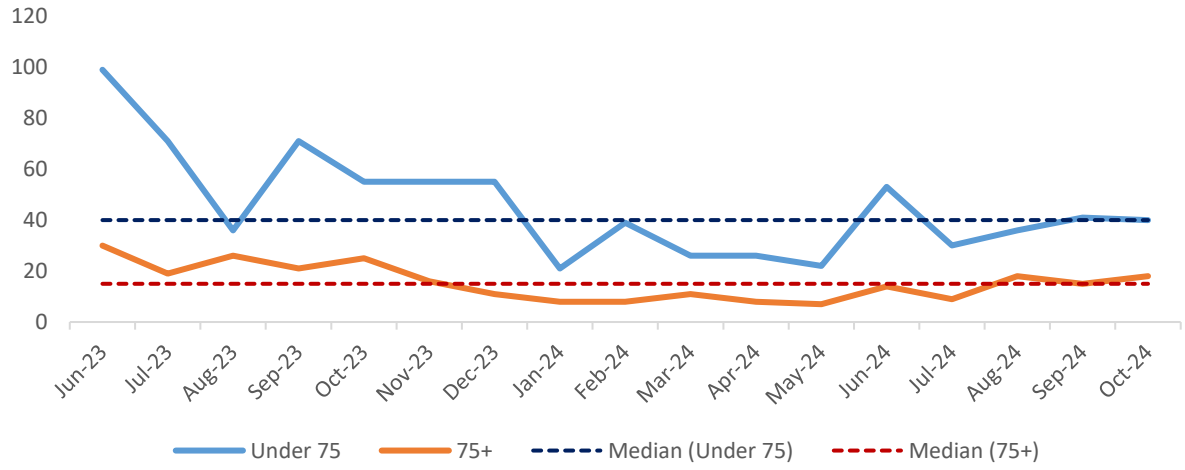
Source: PHS Scotland

5.6 Comparing 2023/24 performance with the 2019/20 baseline shows an improved performance in Dundee whereas a poorer performance for Scotland as a whole.

6.0 Average Duration of Delay

6.1 As part of the further development of monitoring and reporting data, current analysis is focusing on the average duration of delay based on type, age group and location.

Chart 3 Average Duration of Delay by Age Group in Days



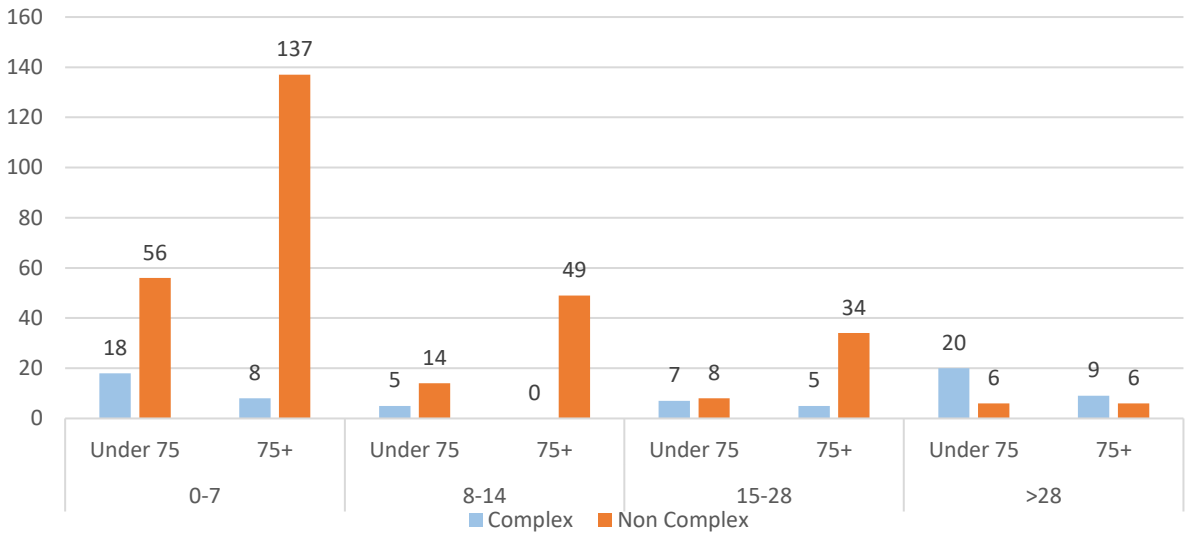
Source: Health and Business Intelligence Unit NHS Tayside

6.2 Chart 3 illustrates the average length of delay per month. Using the data available between January 2024 and October 2024, the median length of delay for people under 75 is 40 days, reducing from 52 days in the last quarter. This reflects the complexity often associated in the younger adult inpatient population, particularly within General Adult Psychiatry and Learning Disability. Of note there also is an increase in younger adults in the acute hospital who have more complex needs and therefore longer delay.

6.3 The median length of delay for people over 75 is 15 days, reducing by 1 day in the last quarter, reflecting the improvement work which has taken place to maximise capacity within social care services which largely supports discharge of older adults within the acute hospital.

6.4 Chart 4 illustrates that the majority of delays greater than 28 days are within the complex delay category, whereas non-complex delays tend to be shorter.

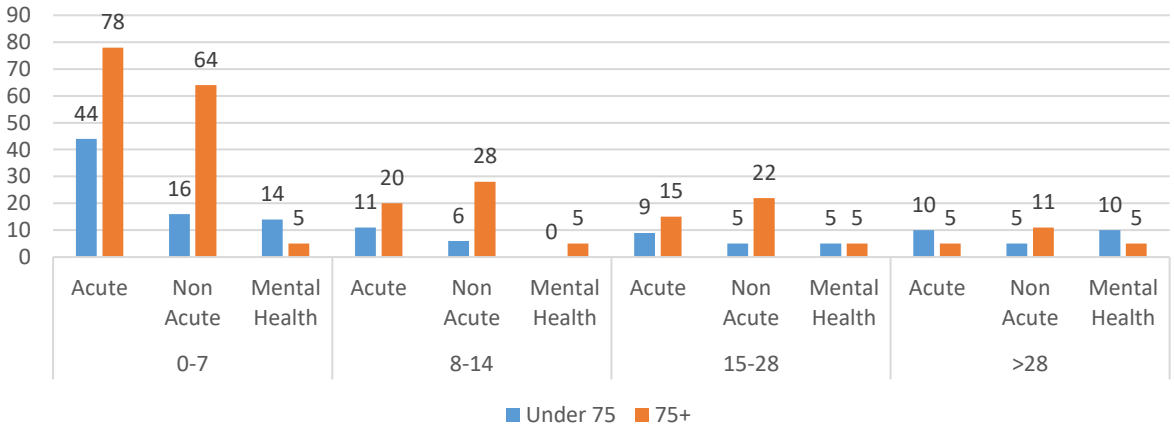
Chart 4 Average Duration of Delay by Type and Age Group January 2024 – November 2024



Source: Health And Business Intelligence Unit NHS Tayside

Note: the 8-14 day delays for under 75 complex delays has been rounded up to 5 to comply with GDPR.

6.5 **Chart 5 Average Duration of Delay by Age and Location**

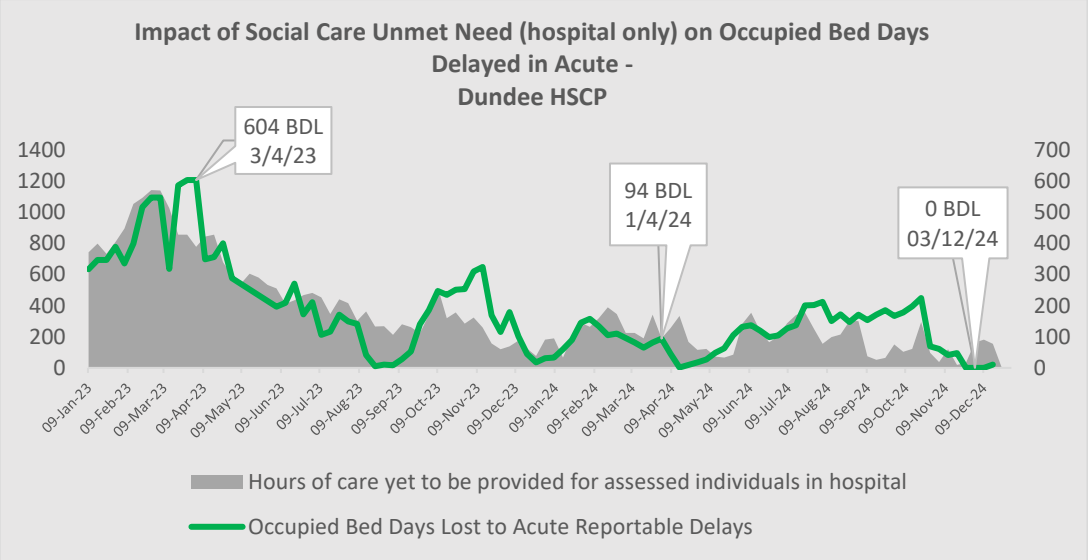


Source: Health and Business Intelligence Unit NHS Tayside

Note: Where a value is recorded as 5, this includes all values of 5 and less as values less than 5 have been rounded up to 5 to comply with GDPR.

7.0 As a result of the ongoing improvement work within DHSCP Care at Home services, the bed days lost to delay has gradually reduced over the year. In April 2023, 604 acute bed days were lost due to reportable delays, compared to 94 in April 2024. This performance has continued to improve with zero bed days lost in the acute hospital in early December 2024.

Chart 6 Impact of Social Care Unmet Need on Bed Days Lost Delayed in Acute Hospital - Dundee HSCP

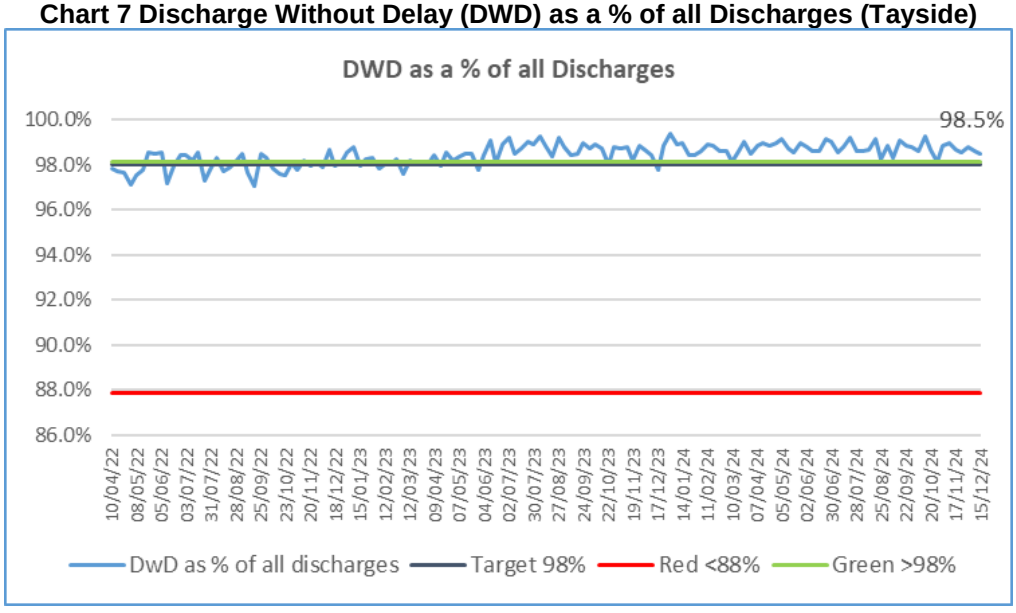


7.1 An increase in unmet need resulted in an increase in bed days lost in June, showing the impact social care unmet need has on delays within the hospital system.

8.0 Discharge Without Delay

8.1 The majority of discharges across the whole system take place without delay. Chart 7 illustrates that Tayside has consistently performed at or above the 98% national performance target.

Chart 7 Discharge Without Delay (DWD) as a % of all Discharges (Tayside)



9.0 Key Outcome Focussed Actions

9.1 Partnership services are continuing to focus on the following areas to support further improvement:

- Continue to implement agreed actions identified within the Strategic Commissioning Plan.
- Continue to develop Community Urgent Care service as part of the Urgent and Unscheduled Care (UUC) Board Optimising Access workstream aimed at reducing hospital presentations by 5%.
- Continue to maintain and sustain GREEN RAG status for delayed discharge performance towards the suite of improvement measures across urgent and unscheduled care.
- Now that the Medicine for the Elderly Medical Team is aligned to GP clusters and Dundee Enhanced Care at Home Team (DECAHT), there is a suite of improvement measures targeted at reducing harm caused by polypharmacy and creating 'virtual wards' to support primary care.
- Targeted work to reinvigorate GP cluster meetings as a means of returning to 'early intervention and prevention' approach.
- Royal Victoria Hospital improvement plan in place and target of upper quartile length of stay set in all Medicine for the Elderly wards.
- Allied Health Professional Consultant appointed to lead the developing Stroke and Neuro Rehabilitation Unit (SNRU).
- Target Operating Model for SNRU further developed and at testing stage.
- Plan to undertake whole system stroke/neuro work across the acute and step-down bed base in 2025
- Senior Nurse UUC leads clinically on Optimising Flow workstream targeted at achieving upper quartile length of stay in all ward areas in Tayside.
- Evaluation of flow coordinator role has been successful and new Integrated Discharge Hub management structure being tested.
- AME West now open, affording all frail patients the opportunity for a comprehensive geriatric assessment supported by the Acute Frailty Team.
- Commissioned social care service (D2A) working with multidisciplinary team in Frailty Unit with aim of supporting early discharge and achieving zero delays in this area.
- Reinvigoration of Discharge to Assess model across the wider hospital as a means of minimising care home admissions and maximising social care efficiency/outcomes for people.
- Redesign of AHP services across whole system patient pathways

10.0 POLICY IMPLICATIONS

10.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

11.0 RISK ASSESSMENT

Risk 1 Description	Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Mitigating Actions (including timescales and resources)	- daily review of all delays. - Range of improvement actions underway to reduce risk of delays.
Residual Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Planned Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk)
Approval recommendation	The PAC is recommended to accept the risk levels with the expectation that the mitigating actions are taken forward.

12.0 CONSULTATIONS

12.1 The Chief Officer, Head of Health and Community Care and the Clerk were consulted in the preparation of this report.

13.0 BACKGROUND PAPERS

13.1 None.

Christine Jones
Acting Chief Finance Officer

DATE: 17 December 2024

Lynne Morman
Associate Locality Manager, Acute and Urgent Care

Lynsey Webster
Lead Officer, Quality, Data and Intelligence

Joanna Henderson
Project Manager, Acute and Urgent Care

ITEM No …9……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **DHSCP STRATEGIC RISK REGISTER UPDATE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC10-2025**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Performance and Audit Committee in relation to the Strategic Risk Register and on strategic risk management activities in Dundee Health and Social Care Partnership

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Note the content of this Strategic Risk Register Update report.

2.2 Note the entry of a new risk on Increase in National Insurance. (See Section 6).

2.3 Note the extract from the Strategic Risk register attached at Appendix 1 to this report.

3.0 FINANCIAL IMPLICATIONS

3.1 None

4.0 MAIN TEXT

4.1 The Dundee HSCP Strategic Risk Register is available to Dundee City Council Risk and Assurance Board through the Ideagen Risk Management system.

4.2 Operational Risks are reviewed by the Clinical Care and Professional Governance forum with any significant areas of concern which may impact on the ability of the IJB to deliver its Strategic and Commissioning Plan reported to the PAC through the Clinical Care and Professional Governance Group's Chairs Assurance Report.

4.3 Operational Risks which should be escalated are identified through Senior Management meetings, the Clinical Care and Professional Governance Risk forum and are reported through reports to the PAC or IJB as appropriate.

5.0 STRATEGIC RISK REGISTER UPDATE

5.1 There are currently six risks scoring at 20 or 25, which are High Risk Categories.

5.2 There are four risks which score at the maximum score of 25 are Staff Resource; Lack of Capital Investment in H&SC Integrated Community Facilities (including Primary Care); Unable to Maintain IJB Spend; and Restrictions on Public Sector Funding.

5.3 Restrictions on Public Sector Funding has increased in score to 25. This is due to the scale of the cost pressure gap and public sector financial position.

5.4 The Unable to Maintain IJB Spend risk has remained at a score of 25 as the IJB has approved the Financial Recovery Plan.

5.5 The Staff Resource risk has remained at the highest score since 2021. The latest risk update highlights how staff resource impacts on the ability to progress the strategic plan actions. The implementation of the Safe Staffing Act is also demonstrating areas where staff resource is less than the standard. The impact of the half hour reduction of NHS workforce for Agenda for Change will also mean that across services available working week hours will reduce.

5.6 Lack of Capital Investment in H&SC Integrated Community Facilities (including Primary Care) remains at the maximum of 25. The Scottish Government 2024/25 Capital Investment Resources available to LAs and NHS Boards has been severely restricted leading to minimal likelihood of resources being made available for community facilities.

5.7 The Primary Care Sustainability risk remains at a score of 20. The most recent update highlights the pressure on general practice due to increasing demand and complexity of health needs together with the increase in GP vacancies, and premises leasing.

5.8 A new Strategic Risk around the National Insurance Increase has been entered on the Strategic Risk Register. The risk is primarily around the impact on third sector providers. Control factors are being developed.

5.9 Capacity of Leadership Team remains at a score of 16. This reflects the retirement of the Chief Officer. Control factors include response from partner bodies, review of team structure and sharing of management team duties.

5.10 Data Quality risk remains at a score of 16. The Strategy and Performance team are working with operational staff to improve data quality. Forthcoming changes to IT systems include the move from Oracle to SQL for hosting Mosaic and the change from DCC IT system Citrix which will impact on reporting mechanisms. Quality, Data, and Intelligence team are working with IT to improve reporting mechanisms and decide on most efficient and resilient reporting systems (e.g. Power BI, Crystal).

5.11 Increased Bureaucracy risk remains at a score of 16. This is due to the potential for additional bureaucracy through the Scottish Government Covid Enquiry and National Care Service development.

5.12 National Care Service risk remains at a score of 20 (Impact 4 x Likelihood 5). We are still not able to assess the impact of the National Care Service on the IJB's ability to carry out its Strategic Plan. The latest update highlights the withdrawal of Council Leaders support for the Scottish Government's revised National Care Service Bill.

5.13 The Viability of External providers risk remains at a score of 16 and the most recent update highlights the development of improved robust monitoring when risk is identified.

5.14 The Cost of Living Crisis risk remains at a score of 16. The latest update highlights the sub-analyses of Engage Dundee for a range of at risk groups.

5.15 Changes to IT Systems remains at a score of 16. The latest update highlights the risks caused by the implementation of O365 and the discrepancies between NHS and DCC implementation; the implementation of Morse and the lifespan of a software system used for prescribing in DDARS.

6.0 NEW RISKS

6.1 A new Strategic Risk around the National Insurance Increase has been entered on the Strategic Risk Register. The risk is primarily around the impact on third sector providers. Control factors are being developed.

7.0 ARCHIVED RISKS

7.1 No risks have been archived since the last report.

8.0 POLICY IMPLICATIONS

8.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services, or funding and so

has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

9.0 RISK ASSESSMENT

9.1 No risk assessment is necessary for this report.

10.0 CONSULTATIONS

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

11.0 BACKGROUND PAPERS

11.1 None

Christine Jones
Acting Chief Finance Officer

DATE: 27 December 2024

Clare Lewis-Robertson
Lead Officer (Strategic Planning and Business Support)

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP – STRATEGIC RISK JANUARY 2025

Description	Lead Director/Owner	Current Assessment			Status	Date Last Reviewed
		L	C	Exp		
Unable to maintain IJB Spend IJB is unable to maintain spend within allocated resources which could lead to being unable to deliver on the Strategic & Commissioning Plan. **Latest update** An update of the financial recovery plan for delegated health and social care services for 2024/25 was presented to the IJB on the 11.12.2024 **Control factors** • Financial monitoring systems • Increase in reserves • Management of vacancies and discretionary spend • MSG and external audit recommendations • Savings and Transformation Plan • Financial Recovery Plan	Dundee HSCP Chief Finance Officer	**5**	**5**	**25**	→	12.12.2024
Restrictions on Public Sector Funding Continuing restrictions on public sector funding will impact on Local Authority and NHS budget settlements in the medium term impacting on the ability to provide sufficient funding required to support services delivered by the IJB. This could lead to the IJB failing to meet its aims within anticipated timescales as set out in its Strategic and Commissioning Plan. **Latest Update** Budget Outlook paper was presented to the IJB on the 11.12.24. Given the scale of the cost pressure gap and public sector financial position, the risk has been escalated to a score of 25 Control factors • Budgeting Arrangements • MSG and external audit recommendations • Savings and Transformation Plan Financial Recovery Plan	Dundee HSCP Chief Finance Officer	**5**	**5**	**25**	↑	12.12.2024
Staff Resource The volume of staff resource required to develop effective integrated arrangements while continuing to undertake existing roles / responsibilities / workload of key individuals may impact on organisational	Dundee HSCP Chief Officer	**5**	**5**	**25**	→	12.12.2024

priorities, operational delivery to support delivery of effective integrated services. Corporate processes in partner bodies can lead to delays in recruitment. Market conditions can impact on ability to appoint suitable staff in a timely way. Impact on levels of staff absence impact on staff resource. **Latest update** Ability to progress strategic plan actions are impacted by staff resource available and proposed future budget reductions will exacerbate this. Implementation of safe staffing act is demonstrating the levels of staffing operationally. Impact of half hour reduction of NHS workforce for Agenda for Change will mean that across services available working week hours will reduce. **Control factors** • Additional focus on Absence Management • Development of new models of care • Organisational Development Strategy • Recruitment • Safe Staffing Act recording tools • Service Redesign • Workforce plan • Workforce wellbeing actions.						
Lack of Capital Investment in Community Facilities (including Primary Care) Restrictions in access to capital funding from the statutory partner bodies and Scottish Government to invest in existing and potential new developments to enhance community-based health and social care services. Latest update This continues to be an extreme risk. Scottish Government 2024/25 Capital Investment Resources available to LAs and NHS Boards has been severely restricted leading to minimal likelihood of resources being made available for community facilities **Control factors**	Dundee HSCP Chief Officer and Chief Finance Officer	**5**	**5**	**25**	→	12.12.2024

Development of IJB Property Strategy Joint working with Partner Bodies over alternative opportunities Reshaping non-acute care project						
National Care Service The recent legislation published on the establishment of the National Care Service sets out plans to introduce Local Care Boards with the abolition of Integration Joint Boards **Latest update** National Care Service (Scotland) Bill - draft Stage 2 amendments were posted in June 2024 with a 'Call for Views'. There is recognition by Scottish Government that work is needed to confirm which legislative approach would best deliver the intended changes. COSLA issued a statement on 27th September 2024 to advise that Council Leaders have withdrawn support for the Scottish Government's revised National Care Service Bill. It is currently anticipated that Integration Joint Boards will reform to become local Care Boards. The degree of uncertainty about future arrangements and timing for implementation of planned changes means there is a significant level of risk for IJB's	Dundee HSCP Chief Officer	**4**	**5**	**20**	→	12.12.24
Primary Care Sustainability Continued challenges around the sustained primary care services, arising from recruitment, inadequate infrastructure including IT and location, and inadequate funding to fully implement the Primary Care improvement plan. **Latest update** **Sustainability of General Practice:** If there continues to be huge pressure on general practice due to increasing demand and complexity of health needs together with the increase in GP vacancies due to retirement and recruitment and retention issues then we will be unable to meet the health needs of the population. **Current Controls: I**mplementation of MOU under GMS 2018. Programme of work around sustainability encompassing GP strategy and GP premises strategy. Improved access to other services within primary care that support general practice. Informing patients about those services. Informing Reception Teams on service availability and access, further developing care navigation across all practices. Monitoring position through sustainability survey. Planned Controls: There is further work to be done to understand critical components of this risk including premises, funding, other services and staff groups (e.g. ANPs, nurses).	Dundee HSCP Chief Officer	**4**	**5**	**20**	→	12.12.2024

If GP practices requests for lease assignation cannot be considered as a result of a lack of an agreed processes for practices, HSCPs and NHS Tayside regarding leases acquisition, including defining the necessary governance arrangements, then this will have a negative impact on GP partner recruitment and retention. **Current Controls**: GP Premises Strategy developed. Process in place in Dundee HSCP to consider local requests in the context of the property strategy. RAG process defined. Planned Controls: Draft process developed. Draft paper for submission to ELT (proposed Nov 2024) to be agreed across all four parties for consideration and approval of lease acquisition						
National Insurance Increase The increase in National Insurance contributions poses a financial risk particularly to third sector organisations. These organisations which often operate on tight budgets and limited funding streams face additional financial strain. This could lead to reduced capacity to deliver essential services, weakening the partnership's ability to meet its strategic objectives and compromising care delivery to vulnerable populations. Control Factors are being developed	Dundee HSCP Chief Officer and Chief Finance Officer	**4**	**4**	**16**	↑	12.12.24
Cost of Living Crisis Cost of living and inflation will impact on both service users and staff, in addition to the economic consequences on availability of financial resources. This is likely to have a significant impact on population health and the challenge this will present to the IJB in delivering its strategic priorities. Latest update Sub-analyses of Engage Dundee have been undertaken for a range of at-risk groups including carers and long-term sick and disabled. Findings have been fed into a range of SPGs to identify appropriate actions. Developments include a new mental health and wellbeing section on the NHST website linking people to a service directory, including money/benefits advice, and self-help materials. Public Health has led on the production of a mental health promotion leaflet, which is being co-produced with partners, communities and	Dundee HSCP Chief Officer and Chief Finance Officer	**4**	**4**	**16**	→	12.12.2024

services users. This will be targeted at the digitally excluded, linking in with local community centres and foodbanks/ larders. A multi-agency Engine Room has been formed to develop interim indicators to link work at a local and service level to the city's strategic objective of reducing inequalities in health, and assess whether services are being provided in an equitable manner. The HSCP is involved in the city's Local Fairness Initiatives and Employability Pathfinder. Tests of change are being explored with GP practices in the North-East and East End to raise awareness of community supports. Control Factors • Engage Dundee • Fairness and Equality Workstreams • Focus of Services identifying those most vulnerable						
Viability of External Providers Financial instability / potential collapse of key providers leading to difficulty in ensuring short / medium term service provision. * Inability to source essential services * Financial expectations of third sector cannot be met * Increased cost of service provision * Additional burden on internal services * Quality of service reduces Latest update Contracts Team are currently looking at improved interface with contract/finance teams to ensure more robust monitoring when risk is identified - this part of internal audit recommendations. **Control factors** • Consistent engagement with service providers • Internal audit review to partnership's approach to viability of external providers • Potential Local or Scottish Government Intervention • Robust Contract Monitoring • Co-ordination to provider services	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	12.12.2024

Escalation of Property Safety Issues The Health and Social Care Partnership faces a significant strategic risk due to the due to the ability of the partner bodies to effectively repair and maintain critical health and social care infrastructure, crucial for the safe delivery of care and other essential support services Latest update Current areas of concern highlighted are at Kingsway Care Centre and RVH. Control factors include Property Rationalisation programme and escalation of these issues by Chief Officer.	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	12.12.2024
Capacity of Leadership Team Capacity of management team Latest update Several factors have contributed to the increase in likelihood for this risk, including the retirement of the Chief Officer. The leadership team continue to be impacted by workload pressures of the wider workforce recruitment challenges. This is likely to be exacerbated as preparations for the intro of the NCS develop over the coming period. The implementation of the new Leadership structure on a permanent basis will consolidate and provide clarity to roles. Control factors • Response from Partner bodies • Review of Senior Management Team Structure • Sharing of Management Team duties	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	12.12.2024
Data Quality Data Quality of information on Mosaic case recording system is not accurate leading to difficulties in providing statutory government returns and accurate billing for billable services delivered. Latest Update Strategy and Performance research team are working with operational staff to improve data quality.	Senior Manager	**4**	**4**	**16**	→	12.12.2024

Forthcoming changes to IT systems include the move from Oracle to sql for hosting Mosaic and the change from DCC IT system Citrix which will impact on reporting mechanisms. Quality, Data and Intelligence team are working with IT to improve reporting mechanisms and decide on most efficient and resilient reporting systems (e.g. Power BI, Crystal.						
Increased Bureaucracy Governance mechanisms between the IJB and partners could lead to increased bureaucracy in order to satisfy the assurance arrangements required to be put in place. Latest update Potential for additional bureaucracy through Scot Gov Covid enquiry and National Care Service development. **Control factors** • Support and roles • Work with partner bodies to streamline report requirements for respective accountabilities	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	12.12.2024
Changes to IT Systems There are significant changes coming to IT systems across DHSCP. These include move from Citrix to AWS. There are also moves from hosting Mosaic, Case Management system from Oracle to sql and issues arising from changes to reporting. There are also difficulties in ensuring access to information on Sharepoint between DCC and NHST. Hybrid working is being affected by these challenges. Morse is being implemented in NHST. Latest Update Changes to IT Systems remain to cause challenges for DHSCP workforce. This includes differences in implementation of O365 across DCC and NHST. Implementation of Morse in NHST is also ongoing. The IT system used by DDARS for prescribing is coming to its end of life and another solution is yet to be identified. The company that owns Vision, used by NHS, i going into administration, and there is uncertainty around this.	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	12.12.2024
Information Governance Capacity and ability to comply with increasing number of Subject Access Requests in DCC leading to potential action from Information Commissioner		**3**	**4**	**12**	→	12.12.2024

Latest Update A year-on-year increase in Subject Access Requests has meant that this is causing a significant impact on staff who undertake this task. In addition, changes to IT mean that manual redaction is no longer secure and must be undertaken by a specific software that only certain staff have access to. The move away from Sharefile to o365 file sharing has caused issues for securely sharing large amounts of electronic documents with external requesters. Risk that we will not comply with Data Protection rules and face action from Information Commission. Control factors • Posts identified in Strategy and Performance section to undertake these tasks. Recruitment processes to begin in next six months.						
Category One Responder Additional responsibilities associated with Category 1 responder status are not supported by additional resources from Scottish Government and existing resources are not sufficient to meet statutory duties. Latest update Risk to remain on register due to finalisation of list of available DHSCP senior staff to manage rest centres, and to include Category One Responder duties in the next revision of the IJB Standing Orders in 2025. It is anticipated that once these actions are completed this risk will be able to be deactivated.	Head of Health and Community Care	**2**	**4**	**8**	→	12.12.2024
Employment Terms Differing employment terms could expose the partnership to equality claims and impact on staff morale. Latest Update Management continue to have an overview of where issues arise within integrated teams with differing employment terms, and continue to assess and review within integrated teams.	Dundee HSCP Chief Officer	**3**	**3**	**9**	→	12.12.2024
Governance Arrangements being Established fail to Discharge Duties Clinical, Care & Professional Governance arrangements being established fail to discharge the duties required. The IJB's Governance arrangements were assessed as weak/unsatisfactory. Latest update	Dundee HSCP Chief Officer	**2**	**4**	**8**	→	12.12.2024

Reports from CCPG to the PAC consistently provide a level of reasonable assurance of good and sound governance. leading to a reduction in the likelihood of this risk occurring. This risk will be revisited when we receive the Internal and External Audit governance report conclusions, with a view to potentially archiving. Control factors • Development of IJB Member Governance development sessions • Implement Governance Action Plan • Review of processes established						

New Risks for entry

None						

Archived

None						

Risk Status	
↑	Increased level of risk exposure
→	Same level of risk exposure
↓	Reduction in level of risk exposure
x	Treated/Archived or Closed

ITEM No …10……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT REPORT – WORKFORCE (D06-24)**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC7-2025**

1.0 PURPOSE OF REPORT

1.1 This paper presents the findings of the Internal Audit Review of Workforce arrangements in place within Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Notes the content and recommendations of the Internal Audit Report on Workforce as set out in Appendix 1 to this report.

2.2 Notes the audit opinion of limited assurance, and management action plan to address the weaknesses identified.

2.3 Instructs the Chief Finance Officer to implement the recommendations of the report and provide an update on progress through the internal audit actions reporting process.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Dundee Integration Joint Board (DIJB) approved the Dundee Health and Social Care Partnership Workforce plan 2022-2025 in June 2022, following the publication of National Workforce Strategy for Health and Social Care in Scotland in March 2022 and Scottish Government issued DL (2022) 09 in April 2022 providing guidance on the completion of the 3 Year Workforce plan 2022-25.

4.2 The Internal Audit review remit was to consider the design and operation of the controls related to the development of the Workforce plan and specifically considered:

- Whether the format and content of the Workforce Plan is based on appropriate evidence in compliance with DL (2022) 09, including validation of the self-assessment against the Appendix 1 checklist and whether Scottish Government feedback was addressed
- Whether the Workforce Plan is informed by, and informs, strategic workforce risk(s), and both identifies and provides mitigations, sufficient to manage risks to target levels by agreed timescales
- The adequacy and effectiveness of monitoring and assurance arrangements to ensure the delivery of the Workforce Plan, including relevant reliable and sufficient data to measure success

4.3 The audit opinion from the review is that limited assurance can be placed on the arrangements in place. This means that significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited. Controls were applied but with some significant lapses.

4.4 The review identified the following main findings:

- The HSCP has not yet developed an approach to modelling Service demand to a level of detail which supports effective planning for future workforce requirements. In the absence of an understanding of the way in which future workforce requirements are likely to develop, there is a risk that workforce planning interventions may not be applied in the areas of highest risk.

- The Workforce Strategic Risk Register in its current state of development does not support management in determining the most pressing workforce issues facing the HSCP, or assessing the control framework in terms of the impact of the controls which are in place or the controls which would be required to mitigate risk to an acceptable degree.

- The articulation of actions in the Workforce action plan is overly broad and not clearly linked to any approach to prioritisation. As a consequence, progress is difficult to assess, and the action plan provides limited assurance that actions are addressing the areas in which the greatest impact can be realised with the resources available.

- The Workforce Planning Group does not have formal terms of reference, although its role and responsibilities have changed since the convening of the short life working group from which it developed.

- There is no clear and explicit link between the information which is formally reported to the Workforce Planning Group and relevant risks and controls. As such, the reporting may not provide assurance over the effectiveness of the mitigation of workforce risks.

4.5 An action plan has been agreed with Health and Social Care Partnership management to address the identified weaknesses and findings. These are detailed in Section 2 of the attached report.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

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

7.0 CONSULTATIONS

7.1 The Chief Officer, Regional Audit Manager, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Christine Jones
Acting Chief Finance Officer

Date: 23 December 2024

FTF Internal Audit Service

Dundee IJB Workforce

Report No. D06/24

Issued To: D Berry, Acting Chief Officer
C Jones, Acting Chief Finance Officer
K Sharp, Acting Head of Service, Strategic Services

J Hill, Head of Health and Community Care
A Smith, Head of Health and Community Care
L Webster, Lead Officer (Quality, Data, and Intelligence)

Performance and Audit Committee
External Audit

Contents

Draft Report Issued	12 November 2024
Management Responses Received	11 December 2024
Target Audit & Risk Committee Date	29 January 2024
Final Report Issued	**06 January 2025**

CONTEXT AND SCOPE

1. The Dundee Health and Social Care Partnership (HSCP) Strategic Risk Profile describes the following risk which could threaten the achievement of its strategic objectives – *'HSCR00b1 Staff Resource - The volume of staff resource required to develop effective integrated arrangements while continuing to undertake existing roles / responsibilities / workload of key individuals may impact on organisational priorities, operational delivery to support delivery of effective integrated services. Corporate processes in partner bodies can lead to delays in recruitment. Market conditions can impact on ability to appoint suitable staff in a timely way. Impact on levels of staff absence impact on staff resource.' The risk is currently rated at 5x5 (Red) with a target risk score of 3x3 (Yellow).*

2. The current actions recorded in the Strategic Risk register to mitigate this risk include:

    - *Development of new models of Care*
    - *Organisational Development Strategy*
    - *Service Redesign*
    - *Workforce Plan*

3. The National Workforce Strategy for Health and Social Care in Scotland was published in March 2022 and on 1 April 2022, the Scottish Government issued DL (2022) 09, which provides guidance on the completion of the 3 Year Workforce plan 2022-25, with a deadline for submission of 31 July 2022.

4. The June 2022 meeting of the IJB approved the Dundee Health and Social Care Partnership Workforce Plan 2022/2025.

5. Our audit evaluated the design and operation of the controls related to the development of the Workforce plan and specifically considered:

    - Whether the format and content of the Workforce Plan is based on appropriate evidence in compliance with DL (2022) 09, including validation of the self-assessment against the Appendix 1 checklist and whether Scottish Government feedback was addressed.
    - Whether the Workforce Plan is informed by, and informs, strategic workforce risk(s), and both identifies and provides mitigations, sufficient to manage risks to target levels by agreed timescales;
    - The adequacy and effectiveness of monitoring and assurance arrangements to ensure the delivery of the Workforce Plan, including relevant reliable and sufficient data to measure success

AUDIT OPINION

6. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

7. Our main findings are:

   - The HSCP has not yet developed an approach to modelling Service demand to a level of detail which supports effective planning for future workforce requirements. In the absence of an understanding of the way in which future workforce requirements are likely to develop, there is a risk that workforce planning interventions may not be applied in the areas of highest risk.
   - The Workforce Strategic Risk Register in its current state of development does not support management in determining the most pressing workforce issues facing the HSCP, or assessing the control framework in terms of the impact of the controls which are in place or the controls which would be required to mitigate risk to an acceptable degree.
   - The articulation of actions in the Workforce action plan is overly broad and not clearly linked to any approach to prioritisation. As a consequence, progress is difficult to assess, and the action plan provides limited assurance that actions are addressing the areas in which the greatest impact can be realised with the resources available.
   - The Workforce Planning Group does not have formal terms of reference, although its role and responsibilities have changed since the convening of the short life working group from which it developed.
   - There is no clear and explicit link between the information which is formally reported to the Workforce Planning Group and relevant risks and controls. As such, the reporting may not provide assurance over the effectiveness of the mitigation of workforce risks.

8. Detailed findings are included at Section 3.

ACTION

9. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

10. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1	
Finding:	
The HSCP has not yet developed an approach to modelling Service demand to a level of detail which supports effective planning for future workforce requirements. In the absence of an understanding of the way in which future workforce requirements are likely to develop, there is a risk that workforce planning interventions may not be applied in the areas of highest risk. While there are a number of actions related to understanding Service demand and modelling staff requirement reflected in the Workforce Planning action plan, these are expressed as open ended ambitions and, as a consequence, it is difficult to gain assurance over the extent to which progress has been made towards implementation.	
Audit Recommendation:	
The Workforce Planning subgroup should establish an approach to modelling future service demand and therefore workforce requirements which can be implemented within its currently available resources. This approach should be predicated on the basis of data already available and documented assumptions where data is not available. SMART Actions within the action plan should be refined such that they set out specific deliverables which can be used to update and refine the initial assessment of future service demand, ideally with expected timescales.	
Assessment of Risk:	
Significant 	Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**
Management Response/Action:	
The Workforce Planning Data Sub-Group will be asked to review the approach to service demand and related workforce modelling and to make proposals to the Workforce Planning Group for a realistic and proportionate approach. This will be based on use of currently available local HSCP data, alongside workforce planning data from the corporate bodies and relevant national data. It is known that NHS Tayside will be undertaking further modelling work to inform their next workforce planning submission to Scottish Government due in June 2026, close links will be made to this activity via the Workforce Planning Group representative. The Workforce Planning action plan will subsequently be updated to reflect the agreed approach. It is recognised that such an approach will have limitations in terms of scale, scope and accuracy but is necessary given the lack of specialist modelling expertise and capacity within local systems.	
Action by:	**Date of expected completion:**
Acting Head of Service, Strategic Services	**30 April 2025**

Action Point Reference 2	
Finding:	
The Workforce Strategic Risk Register is not yet fully developed and currently does not support management in determining the most pressing workforce issues facing the HSCP, or in assessing the control framework in terms of the impact of the controls which are in place or the controls which would be required to mitigate risk to an acceptable degree. Register Scoring indicates that the majority of identified workforce risks are unmitigated. Internal controls for all risks have not yet been identified.	
Audit Recommendation:	
The Workforce Strategic Risk Register should be developed such that it provides at least: • Risk Scoring to a level of detail and consistency that allows management to distinguish the most severe risks from the those which are less critical. • An assessment of the internal controls which are already in place, and those which are not in place but would be required to reduce the level of risk to within tolerance. Ideally such an assessment would be based on an analysis which quantifies the impacts and likelihood of the risks identified, to ensure objective risk scoring. However, in the context of the HSCP's current resource constraints, it is likely that in the medium term this will require a number of assumptions to be made on the basis of management knowledge and experience. Where they are required, assumptions should be recorded so that their effect on the analysis is clear and can be updated if and when other information becomes available.	
Assessment of Risk:	
Significant 	Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**
Management Response/Action:	
The Workforce Strategic Risk Register will be revised and updated, including incorporating risk scoring and current/planned mitigating controls. A format will be adopted consistent with that already utilised within the IJB Strategic Risk Register.	
Action by:	**Date of expected completion:**
Head of Health and Community Care	**31 March 2025**

Action Point Reference 3	
Finding:	
The Workforce Planning Group does not have a formal terms of reference, although its role and responsibilities have changed since the short life working group from which it developed was originally convened.	
Audit Recommendation:	
Terms of Reference for the Workforce Planning Group should be prepared and agreed. This should include consideration of whether there are areas of overlap with the work of other management groups. If so, these should be similarly reflected in the terms of reference of those groups.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
A draft terms of reference has been developed and discussed by the Workforce Planning Group. This will be submitted to the HSCP Senior Management Team for approval at their next meeting.	
Action by:	**Date of expected completion:**
Head of Health and Community Care	**31 January 2025**

Action Point Reference 4	
Finding:	
The articulation of actions in the Workforce action plan is overly broad and not clearly linked to any approach to prioritisation. As a consequence, progress is difficult to assess, and the action plan provides limited assurance that it addresses the areas in which management action can have the greatest impact.	
Audit Recommendation:	
HSCP Management should refine the action plan with a focus on identifying specific deliverables and realistic timescales. This will likely involve breaking down some of the existing high level actions into a number of sub tasks. The elements of the action plan should reflect the required internal controls which are identified within the Workforce Strategic Risk Register. As this may result in a plan containing more actions than are realistically achievable, management should identify and pursue those actions which will deliver the maximum impact within the resource available, supported by the risk register scoring.	
Assessment of Risk:	
Significant 	Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**
Management Response/Action:	
The Workforce action plan will be revised and updated, including identifying deliverables and timescales. The review of the action plan will also incorporate any outstanding feedback from the Scottish Government regarding the Workforce Plan.	
Action by:	**Date of expected completion:**
Head of Health and Community Care	**31 March 2025**

Action Point Reference 5	
Finding:	
There is no clear and explicit link between the information which is formally reported to the Workforce Planning Group and relevant risks and controls. As such, the reporting does not provide assurance over the effectiveness of arrangements to mitigate workforce risks.	
Audit Recommendation:	
As part of the development of the Workforce Strategic Risk Register and the identification of internal controls, management should consider the extent to which reporting can provide assurance over the effectiveness of those controls, or provide a control in and of itself. Based on this, management should consider whether the information that they currently receive fulfils those needs and refine their reporting requirements if it does not.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
Agendas for the Workforce Planning Group for 2025 will be aligned to ensure reporting against the revised action plan and risk register. Following review of those documents an agenda planner will be produced for the year to ensure a robust schedule of reporting.	
Action by:	**Date of expected completion:**
Head of Health and Community Care	**31 March 2025**

DETAILED FINDINGS

Consistency of Workforce Plan with Guidance

11. The Scottish Government issued guidance relating to the preparation of Three Year Workforce Plans to NHS Boards and HSCPs in April of 2022. The guidance included a self assessment framework intended to enable Boards and HSCPs to determine their own compliance with the guidance, in advance of submission of draft Plans to the Scottish Government in August 2022.

12. We were not able to determine whether the HSCP carried out such a self assessment at the time the initial Workforce Plan was prepared. In carrying out our own assessment, we observed that fully meeting all expectations of the guidance required a capability to forecast service demand and assumed a level of data availability that were not in place for Dundee HSCP. As a consequence, the existing Workforce Plan and its updates do not fully meet the criteria set out in the Workforce Planning Guidance. In particular, the Plan and its updates do not include detailed projections or modelling for the required future workforce, and as a result the Plan is not able to quantify the expected future establishment gap.

13. The Plan does however clearly set out an intention to put in place the necessary planning infrastructure to be able to perform such modelling. The Plan is supported by an underpinning Action plan which includes (among others) open actions to:

    - Model medical staffing;
    - Analyse the General Practice position;
    - Analyse third/independent sector demographics; and
    - Complete a gap analysis comparing demand with workforce numbers and skills

14. Demographic analysis included in the plan and in its updates indicate that service demand can, in general, be expected to increase. However, these broader demographic trends have not been translated into expected impacts on individual HSCP services or the requirement for particular specialisms.

Strategic Workforce Risks

15. The IJB Risk Register includes a Workforce category, with a general risk relating to Staff Resource. Some Internal Controls have been identified and recorded, however there is limited detail on the extent to which these contribute to risk mitigation. At time of review, the risk score against Staff Resource remained 5x5, indicating that management's assessment is that the existing internal controls do not mitigate the risk.

16. The Workforce Plan is recorded as one of these internal controls, and there is in turn a Workforce Strategic Risk Register which contains risks related to demand, staffing pressures, and workforce planning. The development of the register has been impacted by a lack of available resource.

17. The Workforce Strategic Risk Register has been developed from the assessment of risks included in the first iteration of the Workforce Plan in October 2022. This first iteration also included a high level action plan, and both the Workforce Plan and high level action plan are formally updated annually. We compared the risks and internal controls set out in the current iteration of the Workforce Plan with the Internal Controls identified within the Workforce Strategic Risk Register, and the actions laid out in the Workforce action plan.

18. Although we found that these are generally consistent, the parallel development of the action plan and the risk register means that these are not explicitly linked. This makes it difficult to determine the extent to which the actions in the action plan represent mitigations for particular risks, and/or the implementation of internal controls that have been determined to be required. Similarly, the risk register in its present state of development does not provide a comprehensive assessment of the controls that are in place or which are required to be implemented to reduce risks to a level acceptable to management.

Monitoring and Assurance arrangements

19. The development of the Workforce Plan, as well as monitoring of workforce issues more generally, is carried out by a Workforce Planning Group which was originally convened as a short life working group. This group developed the initial iteration of the Workforce Plan for submission to the Scottish Government, but ultimately became responsible for implementation of the plan and its ongoing review and update.

20. Despite the development of its role, the Workforce Planning Group is not convened according to formal terms of reference. Its role is articulated to an extent within the Workforce Plan, however there are aspects of the plan which depend on work undertaken by others, both inside and outside the HSCP. In particular, the HSCP is dependent on partners and external bodies for the provision of certain data, and aspects of workforce planning, such as forecasting future workforce requirements, are influenced by service redesign work taking place under the direction of other management groups and committees.

21. There is a risk that the Workforce Planning Group is perceived or understood to have responsibilities over aspects of workforce planning which are beyond its control. Where these responsibilities are not clearly articulated or allocated, this ambiguity could result in inadequate management attention towards significant issues.

22. Each iteration of the annually updated Workforce Plan has included a list of actions, although the Plan presents these at a relatively high level. This is supported by a more detailed action plan and tracker document which is considered as a standing agenda item of the Workforce Planning Group.

23. In reviewing the plan, we observed that a number of actions are not well-formed, in the sense that they appear to represent aspirations or longer term objectives as opposed to specific, time-bound tasks with clear criteria for assessment of their completion. For instance, a number of actions are expressed as “Undertake further work to…” or “Further develop our ability to…” without articulating what further work or development is required. The reporting presented to the Workforce Planning Group does, however, include summary updates that show the completion of sub-tasks which contribute towards the overall objective.

24. The consequence is that, while there is clear evidence of significant activity being undertaken, the plan and its tracker do not provide strong assurance that planned actions are progressing as they should, or that the progress that is being made contributes effectively to the mitigation of workforce risks.

25. There is a risk that management time and resource is not directed towards the actions that will have the greatest impact in mitigating workforce risks. Where actions have a very broad scope it becomes difficult to assess the level of time and resource required to implement them, and therefore the extent to which the plan is realistic and deliverable.

26. The Workforce Planning Group receives and considers a number of reports breaking down workforce data. In particular, reports summarising vacancies, and reports separately summarising absence statistics for staff employed by Dundee City Council and NHS Tayside.

27. Where the Workforce Strategic Risk Register identifies internal controls, these do not include any reporting controls. As such, there is no explicit link between the information which is reported to, and scrutinised by, the Workforce Planning Group and the mitigation of workforce risks.

28. While there is a clear subjective link between vacancy and absence data and workforce risks related to recruitment and wellbeing, clearly determining the purpose for which information is reported would enhance the effectiveness of reporting. This should be in terms of either the controls over which it provides assurance, or the events for which it provides notification or early warning.

Data

29. The Workforce Planning Group has convened a data subgroup with a remit to coordinate and collate information across the Tayside region, agree a common dataset across theHSCPs, and agree on a common reporting approach. The data subgroup includes representation from the three Tayside HSCPs and NHS Tayside.

30. The work of the data subgroup is complicated by differences in data recording and reporting formats between Council and NHS bodies, as well as differences in recording systems, however the data subgroup has achieved good progress in agreeing a common set of definitions and reporting conventions that can underpin further development.

Section 4 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Section 4 Definition of Assurance and Recommendation Priorities

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	**Three**
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	**Two**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**None**

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **GOVERNANCE ACTION PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC9-2025**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Performance and Audit Committee with an update on the progress of the actions set out in the Governance Action Plan.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the content of the report and the progress made against the actions within the Governance Action Plan (contained within appendix 1).

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 In November 2024, following the completion of an exercise to reprioritise outstanding recommendations within the Governance Action Plan (GAP), routine reporting the PAC recommenced (Article XI of the minute of the meeting of the Performance and Audit Committee held on 20 November 2024 refers). This included an overview of actions removed from the GAP following completion or because they had been abandoned. As at 20 November 2024 there were 29 actions that remained live within the GAP.

4.2 Appendix 1 contains an overview report detailing the current status of the actions within the Governance Action Plan. Since November 2024, a further 3 actions have been completed, no additional actions have been added and 26 remain ongoing.

4.3 Of the 26 ongoing actions there has been no further progress towards implementation for 20 actions since the last update was provided to PAC. This reflects the relatively short period of time that has elapsed since the last PAC meeting, end of year holiday period and prioritisation of all available resources to support both winter pressures and the 2025/26 budget development process. However, significant progress (25%) has been achieved in actions relating to IJB member involvement in development of the organisation's risk profile and in relation to arrangements for financial monitoring of external providers.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

Risk 1 Description	Lack of progress toward completion of actions within the Governance Action Plan may undermine the sustainability of governance arrangements and assurances within the IJB.
Risk Category	Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (which is an Moderate Risk Level)
Mitigating Actions (including timescales and resources)	• All actions have now been uploaded to Ideagen system to support efficient and effective monitoring arrangements. • The process of updating the progress against each action currently being undertaken by officers across the Partnership. • Governance Action Plan updates are now being routinely reported to PAC. • A process is being established for new actions to be added to GAP, for example recommendations from audit reports.
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

7.0 CONSULTATIONS

7.1 The Chief Officer, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Christine Jones
Acting Chief Finance Officer

DATE: 23 December 2024

Clare Lewis-Robertson
Lead Officer, Strategic Planning and Business Support

IJB Outstanding Actions – Governance Action Plan

Completed since last update

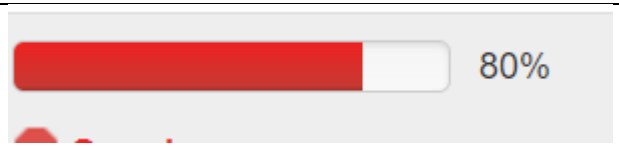
		Title and Description	Due Date	Ownership	Latest Update
1	✓	DHSCPGAPEA20221123 **Governance changes following revision of Integration Scheme** Management should identify the governance changes needed following ministerial approval of the Joints Boards revised integration scheme, alongside its existing governance action plan's outstanding actions. As part of this process management should review actions: for their currency; against strategic priorities and risk profile; and against its capacity to deliver.	31 Mar 2023	Chief Officer Chief Finance Officer Head of Service, Strategic Services	10.12.24 Review of Governance Action Plan now completed and routine update reporting to the IJB reinstated.
2	✓	DHSCPGAPIA20200825-1 **Proper monitoring and escalation of agreed governance improvement actions** Alongside proper monitoring of agreed governance improvement actions, we would recommend that a clearer escalation route of such issues encountered is needed to prompt the IJB to determine any remedial actions to be taken. Barriers to achievement and solutions to address these should be clearly identified and the Chair's Assurance report should clearly identify these key governance issues so that the IJB understands their importance, impact and is able to take appropriate action The discussion should include how to address issues involving Partners, with further escalation to the Working Together Forum, where the Chairs, Council Leaders, Chief Executives and Chief Officers from all partner bodies meet.	31 Oct 2020	Chief Officer Head of Service, Strategic Services	10.12.2024 Review of Governance Action Plan is now complete and routine reporting to IJB has been reinstated.

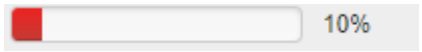
3		DHSCPGAPIA20230524-1 **GAP -reprioritisation of outstanding recommendations** The current GAP does not make it easy to identify if all the recommendations from a specific report/source have been completed. Areas of enhancement to the reporting could include:· Chart showing total number of action points due broken down into complete, in progress, due date extended, no longer relevant· Link to risk (and/or area of governance) –updates should clearly identify risks of non-delivery of actions and these should be summarised in the risk assessment section of the cover paper, which should link to relevant strategic risks. · a RAG rating for outstanding actions Consider drafting a Follow Up Protocol to clarify roles and responsibilities, monitoring and escalation arrangements over the process. The PAC Terms of Reference will require updating to reflect the arrangements going forward, along with related protocols.	30 Sept 2023	Chief Finance Officer	10.12.24 Review of the Governance Action Plan is now completed, and routine reporting has been reinstated at every PAC meeting.

In progress

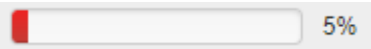
		Title and Abbreviated Description	Due Date	Ownership	Most Recent Update
4		DHSCPGAPAIAR20190212 **Improved hosted services arrangements** Development of improved Lead Authority Services arrangements around risk and performance management for lead authority services	31 Oct 2020	Chief Officer Chief Finance Officer	24.12.24 Bi-monthly meetings in place to discuss key risks and strategic priorities. Financial summary of Lead Partner services included in monthly finance report to HSCP managers as well as finance report to IJB. Internal Audit of Lead Partner arrangements scheduled for 2025.

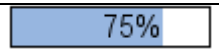
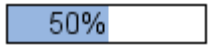
		50% **No change in % achieved**			
5		DHSCPGAPEA20201124 **Regular reporting against savings and transformation proposals** Updates on the IJB's transformation programme and efficiency savings are not reported to the Board on a regular basis. The position on the achievement of savings proposals and transformation should be clearly and regularly reported to members. 50% **No change in % achieved**	31 Aug 2021	Chief Officer Chief Finance Officer Head of Service, Strategic Services	23.10.24 Financial monitoring reports contain information regarding financial implications of savings and transformation. This will be further strengthened through the ongoing financial recovery plan and forthcoming 25/26 budget setting process. There will also be additional opportunities to enhance reporting as the Delivery Plan is implemented and reported through the Senior Management Team and Strategic Planning Advisory Group, with exception reports to the IJB.
6		DHSCPGAPEA20211124 **Reporting against risk management improvement actions and strategic risk register** Further improvement actions remain to be progressed associated with the IJBs risk management arrangements, including reviewing the IJB's risk management policy and developing further an understanding of the IJBs risk appetite. The Board and PAC should continue to be updated on progress on the delivery against the remaining risk management improvement actions and updates to the Strategic Risk Register.	31 Oct 2022	Chief Officer Head of Service, Strategic Services	10.12.24 Risk appetite survey of IJB members currently being developed and to be finalised for issuing in January 2025.

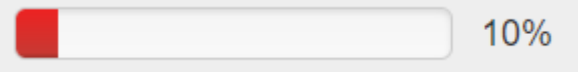
		 **No change in % achieved**			
7		DHSCPGAPIA20210623-6 **Compliance from Partner Bodies** There is currently no direct reporting to the IJB on its risk profile; nor direct, overt assurance on each of its strategic risks with risk monitoring occurring at the CCPG and the PAC receiving assurance on the overall system of risk management as above. Where controls sit within the partner bodies, the IJB receives only a general annual assurance through the year end processes. To further develop good governance arrangements, an IJB assurance plan could be implemented to ensure assurance on all risks is provided to the IJB, including where necessary assurances from partner organisation.  **No change in % achieved**	31 Dec 2021	Chief Finance Officer	23.10.24 Findings of internal audit reports conducted by the Council and NHS Tayside with relevance to the IJB are now summarised and reported to PAC. Further work is to be progressed in relation to FTF Governance Assurance Principles over the next 12 months.
8		DHSCPGAPIA20211124-1.1 **Revision of Integration Scheme**	30 Jun 2022	Head of Service, Strategic Services	10.09.24 Scoping work for the Performance Framework required within the Integration Scheme has been undertaken. Further development of the framework

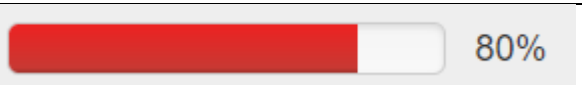
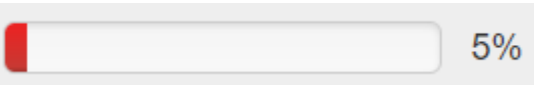
		As set out in the Integration Scheme, 'a list of targets and measures, which relate to the non-integrated functions of the partners that will have to be taken into account by the Integration Joint Board when preparing their Strategic Plan' should be included  **No change in % achieved**			will be a priority within the Partnership Delivery Plan for 2024-2026.
9		DHSCPGAPIA20211124-1.2 **Enhanced Performance Reporting** Further developments of the performance management arrangements should include the following: Assurance and performance reports should be related to specific risks and should contain an overt conclusion on whether the performance reports indicate that controls are operating effectively to mitigate the risk as intended.  **No change in % achieved**	30 Jun 2022	Head of Service, Strategic Services	10.09.24 All performance and assurance reports contain a risk assessment section to ensure that they are clearly linked to relevant strategic and operational risks. The development and submission of performance reports has been further evolved since 2021 - including the development of distinct suites of indicators and regular reporting against these for areas of service which are considered to be strategic risks (this includes mental health, drugs and alcohol and unscheduled care). Within the new Strategic Services structure there is further scope for refinement of performance reporting, including interface with risk and finance, which will be explored further by colleagues over the next year.
10		DHSCPGAPIA20211124-1.3 **Finance & Performance Group**	30 Jun 2022	Head of Service, Strategic Services	10.09.24 The role of a Finance and Performance Group is being considered as part of ongoing discussions

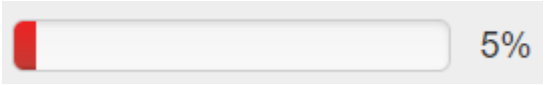
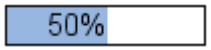
		The combined Finance & Performance Group, when constituted, should consider both finance and performance in the context of the IJB's strategic risks and both inform and be informed by the Strategic Commissioning Plan. 5% **No change in % achieved**			within the Senior Leadership Team regarding the structure and focus of leadership and management meetings.
11		DHSCPGAPIA20211124-1.4 **Process for analytical Reports** Management should agree a process for what triggers deep dive/ analytical reports which should prioritise relevance to strategic IJB risks. Actions agreed should be monitored to ensure the desired effect is achieved. 50% **No change in % achieved**	31 Mar 2024	Head of Service, Strategic Services	10.09.24 The role of a Finance and Performance Group is being considered as part of ongoing discussions within the Senior Leadership Team regarding the structure and focus of leadership and management meetings. This will include consideration of the group / process by which analytical reports can be commissioned. In the meantime the new Quality, Data and Intelligence Team has introduced a formal process for requesting analytical work. The PAC action tracker also provides a mechanism for recording and tracking requests made by the PAC and / or IJB
12		DHSCPGAPIA20211124-1.5 **Development of Strategic Plan Performance Measures – 2023/24**	31 Mar 2024	Head of Service, Strategic Services	10.09.24 Scoping work for the Performance Framework required within the Integration Scheme has been undertaken. Further development of the framework

		The IJB should monitor the work of the ISPG to ensure that it develops the new SCP in such a way it embeds meaningful performance measures which can be reported regularly to allow a conclusion on whether the SCP is being implemented effectively and is delivering the required outcomes (not just inputs or outputs).  **No change in % achieved**			will be a priority within the Partnership Delivery Plan for 2024-2026.
13		DHSCPGAPIA20220622-2 **Consideration will need to be given to how the IJB will receive assurance and monitor progress against these actions.** Having carried out the statutory review of the current strategic and commissioning plan, the Strategic Planning Advisory Group found that the vision and strategic priorities, as well as the overall format of the plan, remained fit for purpose but work was required to update the action lists associated with each priority. An addendum to the original plan was published which is supported by care group strategic planning / commissioning statements and transformation plans and reflects priorities arising from Covid19 remobilisation activity. These actions will be monitored by the Strategic Planning Advisory Group (SPAG).	31 Dec 2022	Chief Finance Officer	23.10.24 IJB has endorsed the HSCP Delivery Plan for October 2024 to March 2026. This will be monitored via the Senior Management Team and the Strategic Planning Advisory Group, with exception reporting to the IJB where required.

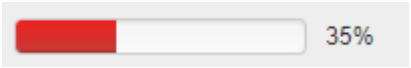
		 **No change in % achieved**			
14		DHSCPGAPIA20220622-4 **The IJB should receive relevant, reliable and sufficient assurances against its strategic risks especially high scoring ones (above the risk appetite to be established)**  **No change in % achieved**	31 Dec 2022	Chief Finance Officer	10.12.24 Development session focused on risk has now been delivered. Risk appetite survey of IJB members has been developed and will be finalised for issuing early in January 2025. Meantime routine reporting against the strategic risk register remains embedded as part of the IJB meeting cycle
15		DHSCPGAPIA20220622-5 **Clinical and care governance arrangements will feed into the formation of IJB directions** A draft Directions Policy & Procedure is being considered as an associated document with the revised Integration Scheme. We would reiterate our position that as part of any further developments in this area, consideration should be given as to how clinical and care governance arrangements will feed into the formation of IJB directions. 	31 Dec 2022	Chief Officer Clinical Director	23.10.24 IJB Directions policy has now been agreed and is being implemented. At the next review of that policy the interface with CCPG will be considered and relevant amendments recommend to the IJB.

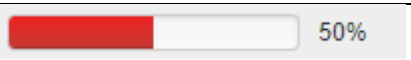
		No change in % achieved			
16		DHSCPGAPIA20220622-7 **Overall assessment of progress in delivering the Risk Management Action Plan is included in the Governance Action plan (40% progress as at February 2022) but the individual actions are not reported to the PAC.** Reporting should clearly set out progress against individual actions to allow for clear monitoring of the maturity assessment.  **No change in % achieved**	30 Nov 2022	Chief Finance Officer	23.10.24 Following the risk management development session (November 2024) consideration will be given to how these individual actions are subsequently reported to the IJB.
17		DHSCPGAPIA20220622-8 **CCPG Annual Report** Dundee HSCP provides regular, high-quality assurance reports to the NHS Tayside Care Governance Committee as well as the PAC. An annual report for the year is planned for the June IJB. The report is comprehensive and well-written, but does not reference relevant strategic risk, or areas for development. There might be benefit in it being used to reflect on key concerns during the year and priorities for the coming year, as well as views on the relevant Strategic Risks.	30 June 2023	Chief Officer Clinical Director	23.10.24 Annual CCPG report is in place and provides a comprehensive retrospective overview of activities and concerns during the previous 12 months. It also reflects on impact in terms of the IJB's strategic risks. The 2025 report will be developed to also include forward looking content / priorities.

		 **No change in % achieved**			
18		DHSCPGAPIA20220720-1 **Cat 1 Responder -Definition of IJB Duties** Category 1 responder resilience arrangements have not been fully and adequately incorporated into the IJBs governance structure. In addition to implementing the recommendation contained within the Internal Audit Annual Report 2020/21 (Action Point 3) relating to the PAC, it should be ensured that the duties of the IJB are fully defined.  **No change in % achieved**	31 Oct 2022	Head of Service, Strategic Services Head of Health and Community Care	23.10.24 This will be added to the next revision of the IJB Standing Orders in 2025.
19		DHSCPGAPIA20230130-1 **Sustainability of Primary Care - assurance from lead partner** Angus IJB, as the lead partner for primary care, should provide assurance to Dundee IJB regarding progress against the audit recommendations and management actions arising from the Internal Audit of the Sustainability of Primary Care.	31 Mar 2023	Head of Health and Community Care	23.10.24 Assurance to be requested from Angus Chief Officer to inform the next Governance Action Plan update to Dundee IJB, due for submission in January 2025.

		 **No change in % achieved**			
20		DHSCPGAPIA20230621-1 **Sustainability - Delivering the IJB's strategic and commissioning priorities within the budget and resources that it has available will be a significant challenge.** Delivering the IJB's strategic and commissioning priorities within the budget and resources that it has available will be a significant challenge. In these circumstances monitoring of the implementation of the SCF and of the development and then implementation of the supporting documents including the Annual Delivery Plan, Resource Framework, Workforce Plan and Performance Framework will be fundamental. Management should clearly set out how the IJB will receive assurance, including assurance over transformation. Reporting on implementation of Strategy and financial monitoring should have a clear focus on the success of transformational projects i.e. what has changed and how services are better delivered, with savings achieved, as a result of transformation. 	31 Dec 2023	Chief Finance Officer	24.12.24 Financial recovery and budget planning for 2025/26 continues through development sessions and IJB reports. The scale of the financial challenge is recognised, and needs to be managed alongside strategic and commissioning priorities.

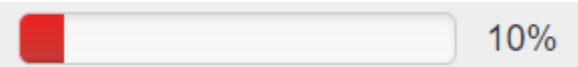
		No change in % achieved			
21		DHSCPGAPIA20230621-2.1 **Consideration is given to how IJB members could be involved in the development and agreement of the organisation's risk profile.** The Risk Management Strategy agreed in April 2021 states that the IJB Board is responsible for 'receipt, review and scrutiny of reports on strategic risks'. The latest risk update was provided to the May 2023 PAC meeting and noted that "target risk scores will be revisited following planned Risk Appetite sessions for the recent development work around risk appetite". We welcome this intention and note that further work will also be required to identify how the new risk appetite will affect Strategy, decision-making prioritisation and budget setting and organisational focus, the 'so what?' question, which will be fundamental to making risk appetite real. 75% **25% increase in % achieved**	31 Dec 2023	Chief Finance Officer	10.12.24 Risk development session delivered to IJB members. Risk appetite survey is being developed and will be finalised for issuing in early January 2025.
22		DHSCPGAPIA20230621-2.2 **Implementation of Risk Appetite** To help implementation of the Risk Appetite to be agreed, we recommend that the IJB sets out clearly how:· risk appetite is to be taken into consideration as part of decision making· risk appetite affects	31 Dec 2023	Chief Finance Officer	10.12.2024 Risk appetite survey of IJB members is being developed and will be finalised for issuing in early January 2025. This will then allow risk appetite to be set and follow-on actions to be progressed.

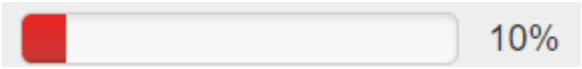
		monitoring and escalation processes for individual risks· Risk appetite is reflected in target risk scores and how the IJB will understand whether target is actually being achieved.  **5% increase in % achieved**			
23		DHSCPGAPIA20230927-1.1 **Viability of External Providers - Financial Monitoring Process** It is recommended that the Monitoring and Review Protocol is enhanced to include a clear escalation process in the event that financial sustainability of a Care Provider is deemed to be at risk. This should include thresholds for each of the ratios considered in the financial monitoring template which would trigger escalation for enhanced monitoring, or other appropriate action, to ensure a consistent approach is taken.To ensure sufficiently regular financial monitoring of annual accounts is conducted for each provider, a review should be performed at least annually, including ensuring that a copy of the Care Provider's recent annual accounts is held. Overall assurance against this risk should then be reported to a pertinent Committee, or the IJB itself, and could include KPI reporting relating to the financial sustainability ratios.	31 Dec 2023	Head of Service, Strategic Services	10.12.2024 Detailed process for escalation / reporting of risk continues to be developed. This includes reporting to the IJB, either via Clinical, Care and Professional Governance reports or as an additional section within the annual Care Inspectorate Grading Report submitted to PAC. It is intended that processes will be finalised by the end of 2024/25.

		 **25% increase in % achieved**			
24		DHSCPGAPIA20230927-2.1 **Viability of External Providers - contract monitoring template** It is recommended that a single standardised template is developed and implemented for quarterly monitoring to ensure an agreed minimum level of quality monitoring is undertaken in respect of performance, quality, staffing levels and financial information. The template should also contain a further section which can be tailored to include any metrics specific to the provider to enable tailored monitoring as needed, above the minimum expected monitoring activities. Any monitoring reports identified which lack sufficient documentation of the quality assessment should be escalated and discussed with the Contracts Officer to ensure appropriate action is taken in conjunction with the provider. When providers are subject to external review (e.g. through the Care Inspectorate), these findings should be triangulated with previous internal quality assessments to review whether pertinent issues were picked up, and therefore if the quality of the internal assurances is sufficiently robust or requires further improvement.	31 Dec2024	Head of Service, Strategic Services	24.10.24 Senior Officer has reviewed all templates in use and confirmed that these are fit for purpose for the service area. All templates in use require updates around quality assurance/care inspections/internal quality checks/evaluations/complaints/compliments and anonymised case study to demonstrate impact. Care at Home version revised to focus on service specific information. Broader exercise now underway to look at quality accreditation aligned to contract clause – online survey results being considered with a view to making clear our expectation around accredited quality assurance systems. Small working group also in place to consider requirements in terms of submission of workforce data as part of monitoring templates.

		 **No change in % achieved**			
25		DHSCPGAPIA20230927-3.1 **Viability of External Providers - signing of contracts** It is recommended that all contracts with care providers are signed by both parties as soon as possible after the contracting period starts if there is a change to the financial elements of the contract, or no later than the date which the contract commences where any other changes are made. To enable internal monitoring of this, the contracts register should be reviewed regularly to ensure contracts approaching renewal are suitably prepared and they can be signed in sufficient time for the new contract commencing  **5% increase in % achieved**	30 April 2024	Head of Service, Strategic Services	10.12.2024 Small working group established in November to support process of issuing contracts for 2025/26. Clear workplan established to ensure tasks associated with issuing new Contracts are carried out well in advance of new financial year. Model contracts have been retyped and password protected to prevent the same IT and formatting issues experienced in previous years. Funding letter will be prepared in advance of the national and local financial position being confirmed, ready to be updated and issued. As it is necessary to wait for the national position and the IJB is unable to set its annual budget until the end of March each year as it is dependent on the local authority and NHS Tayside to set their budgets. It is not feasible for these contractual agreements to be put in place by the 1st April each year, despite best efforts. Once the financial position is confirmed, funding letters and Contracts will be issued as timeously as they can during April and contracts officers will follow up on any outstanding unsigned contracts in their portfolios.
26		DHSCPGAPIA20240131-1.1	30 Sept 2024	Chief Finance Officer	10.12.24

		Operational Planning - Development of operational plans All transformation boards should articulate the pathway towards the development of their underpinning operational plan, and report on its progress to a relevant governance group.  **5% increase in % achieved**		Head of Service, Strategic Services	Through agreement with the Strategic Planning Advisory Group work is being progressed to map and then review the structure of strategic planning groups. Once the structure is confirmed key governance documents for each group will be developed / updated. The SPAG has also agreed, at a high level, an approach to managing reporting against the strategic framework and delivery plan - this is to be worked into a written proposal for further discussion with the group at their first meeting in 2025.
27		DHSCPGAPIA20240131-2.1 **Operational Planning - Review of Terms of Reference** Terms of reference for governance and management groups and committees should specify the review period, generally annually, and Terms of Reference should be updated if necessary. This should, at a minimum, require that the remit of groups is reviewed each time the Strategic Commissioning Plan, or relevant strategic objectives, are updated.  **5% increase in % achieved**	30 June 2024	Chief Finance Officer Head of Service, Strategic Services	10.12.24 The Strategic Planning Advisory Group has agreed an approach to mapping and reviewing current groups. Once the structure has been confirmed terms of reference documents will be developed and updated as appropriate.
28		DHSCPGAPIA20240131-3.1 **Operational Planning - project management arrangements**	30 June 2024	Chief Finance Officer	23.10.24 Both Dundee City Council and NHS Tayside have recently developed a Project Management Office approach to support transformation activity. The

		The HSCP should outline the circumstances in which it is considered appropriate that formal project management is applied, and the minimum set of controls that should be applied. The complexity of the arrangements for delivery of the Strategic Commissioning Plan, and its underpinning delivery plans and programmes of transformation, is such that it may be appropriate to adopt a principles based approach.  **No change in % achieved**		Head of Service, Strategic Services	HSCP will make connections to these emerging structures to progress discussions regarding a collaborative approach to project management and access to available resources.
29		DHSCPGAPIA20240131-4.1 **Operational Planning - alignment to strategic plan** The HSCP has committed to the development of a revised set of Strategic Plan performance measures throughout 2023/24.Groups responsible for the implementation of delivery plans and supporting performance management frameworks should take cognisance of this work, and in developing their own suites of performance measures, should:• Align the objectives of their implementation plans to the performance measures identified for the Strategic Plan, where it makes sense to do so• Consider other workstreams within delivery plans that contribute to the same objectives, and the relative impact. Measurement of indicators and their reporting should account for the situation where indicators at a service	30 June 2024	Chief Finance Officer Head of Service, Strategic Services	23.10.24 The HSCP is working through the complexities of this within some groups but at the pace that available resources allow. Some additional service level datasets have already been developed for the Performance and Audit Committee e.g. around mental health, drugs and alcohol and hospital discharge management which are trying to focus on improvement and where possible impact. There is a national challenge regarding how to measure impact. The HSCP is engaged with and contributing to ongoing work within Scottish Government on a new National Improvement Framework for health and social care. The HSCP will complete the work on the main performance framework and continue to work with strategic planning / transformation

		level are improving, while deteriorating for the HSCP as a whole, or vice versa.  **No change in % achieved**			groups to further develop and align their reporting as resources allow

ITEM No …12……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 JANUARY 2025**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC6-2025**

1.0 PURPOSE OF REPORT

1.1 This paper provides the Performance and Audit Committee (PAC) with an update on the completion of the 2023/24 Internal Audit Plan and progress of the 2024/25 internal audit plan. This report also includes internal audit reports that were commissioned by the partner Audit and Risk Committees, where the outputs are considered relevant for assurance purposes to Dundee IJB.

2.0 RECOMMENDATIONS

It is recommended that the PAC:

2.1 Notes the completion of the 2023/24 internal audit plan and work undertaken on the 2024/25 plan.

2.2 Notes that Internal audit report D06/24 Workforce provided Limited Assurance report and is presented as a separate agenda item.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Public Sector Internal Audit Standards (PSIAS) require that the Chief Internal Auditor reports periodically to the PAC on activity and performance relative to the approved annual plan. We have previously set out that audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

4.2 The PAC approved the 2023/24 Internal Audit Plan at the September 2023 meeting and completion of the plan is set out in Appendix 1.

4.3 The PAC approved the 2024/25 Internal Audit Plan at the September 2024 meeting. Internal audit work undertaken in 2024/25 is also set out in Appendix 1.

4.4 Working with our partners in Dundee City Council, we are committed to ensuring that internal audit assignments are reported to the target PAC. The progress of each audit has been risk assessed and a RAG rating added showing an assessment using the following definitions:

Risk Assessment		Definition
Green		**On track or complete**
Amber		**In progress with minor delay**
Red		**Not on track (reason to be provided)**

4.5 An update on the progress of all the IJB's Internal Audits is shown in Appendix 1. Resources to deliver these audits are provided by NHS Tayside and Dundee City Council Internal Audit Services.

4.6 In order that all parts of the system receive appropriate information on the adequacy and effectiveness of internal controls relevant to them, including controls operated by other bodies which impact on their control environment, an output sharing protocol was developed and approved by all partners' respective Audit and Risk Committees. This protocol covers the need to share internal audit outputs beyond the organisation that commissioned the work, in particular where the outputs are considered relevant for assurance purposes. The following reports are considered relevant and are summarised here for information. It should be noted that the respective Audit and Risk/ Scrutiny Committees of the commissioning bodies are responsible for scrutiny of implementation of actions.

4.7 The NHS Fife internal audit External Quality Assessment (EQA) is ongoing and meetings have been held by the Chartered Institute of Internal Auditors Assessors with a sample of FTF staff and key stakeholders. The EQA report will be presented to the IJB Audit and Assurance Committee in 2025.

NHS Tayside reports:

Report Description	Assurance	Key findings
T25/25 Financial Sustainability – Scottish Government Self-Assessment Review	N/A	The NHS Scotland Financial Delivery Unit (FDU) issued financial considerations information for the NHS Support and Intervention Framework (the Framework) in June 2024, setting out an assessment process for NHS Boards. Boards were required to submit their self-assessment alongside their Quarter 2 financial results, to inform the Scottish Government's escalation status consideration for NHS Boards. The Director of Finance commissioned a review of the adequacy of the Board's financial sustainability arrangements through validation of the self-assessment undertaken by NHS Tayside against the Financial Escalation Assessment template. The results of the internal audit work were communicated in an audit memo issued on 18 October 2024 and we will

		report our findings on areas for further improvements to support financial sustainability as part of internal audit report T26/25 on Savings. We validated the draft Financial Escalation Self-assessment and reviewed available documentary evidence. In our opinion, based on internal audit professional judgement, our knowledge of NHS Tayside, and the outcomes of previous internal and external audits, the draft self-assessment is factually accurate. Of the 34 questions, we fully agreed with the assessment reached for 29 questions. We partially agreed with the assessment for four questions and the Scottish Government submission was updated to reflect audit feedback. Further evidence is to be provided to validate one question.

Dundee City Council reports:

Report Description	**Assurance**	**Key findings**
Absence Management and Staff Wellbeing	Limited Assurance	The audit reviewed the arrangements in place within the Council to mitigate long term and future absence arising from sickness absences, and the governance arrangements in place to promote and support staff wellbeing. The following areas for improvement were identified: • Roles and responsibilities in respect of producing monthly sickness absence statistics and how the data is used and monitored are not clearly defined within policy documentation. • The policy on Promoting Health and Attendance has not been subject to regular review and does not include a definition of long-term sickness absence. • The Employee Health and Wellbeing Framework is out of date and could be more readily accessible to all staff. • The short-term sickness absence documented process has not always been followed. • The long-term sickness absence documented process has also not always been followed. • Arrangements for obtaining and reporting on staff wellbeing feedback require improvement. • The Health and Wellbeing Action Plan does not have assigned action owners. • There is currently a lack of oversight of compliance with sickness absence management processes. • There is scope to improve the Council's arrangements for measuring the effectiveness of wellbeing support/initiatives.
Corporate Governance	Substantial Assurance	The Annual Governance Statement Questionnaire and the underpinning process by which information is compiled to inform the Annual Governance Statement is well designed and delivers the necessary assurance over the requirements of relevant guidance. A number

		of recommendations were identified; however, these primarily relate to opportunities for improvements which would enhance consistency and further enhance the quality of assurance obtained.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

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

7.0 CONSULTATIONS

7.1 The Chief Officer, Regional Audit Manager, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Christine Jones
Acting Chief Finance Officer

Date: 15 January 2025

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
2023/24								
D01-24	Audit Planning	Audit Risk Assessment & Operational Planning.	Complete 	✓	✓	✓	✓	**N/A**
D02-24	Audit Management	Liaison with management, Pre-Audit Committee liaison with Chief Finance Officer, preparation of papers and attendance at PAC.	Ongoing/ May 2024 	✓	✓	✓	✓	**N/A**
D03-24	Annual Internal Audit Report (2022/23)	CIA annual assurance statement to the IJB and fieldwork to support this.	June 2023 (IJB) 	✓	✓	✓	✓	**N/A**
D04-24	Governance & Assurance	All actions have now been added to the Ideagen performance management system following completion of the mapping exercise by Internal Audit. Officers across the Partnership have now updated each of the actions uploaded to Ideagen; a full overview of progress across all actions on the Governance Action Plan is on the agenda at the November 2024 PAC meeting.	~~September 2023~~ ~~May 2024~~ ~~September 2024~~ November 2024	✓	✓	✓	✓	**N/A**

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
								
D05-24	Internal Control Evaluation	Holistic assessment of the internal control environment in preparation for production of 2023/24 Annual Internal Audit Report. Follow-up of previous agreed governance actions including Internal Audit recommendations. Incorporated into the Annual Internal Audit report 2023/24 and reported to the June 2024 IJB meeting	Dundee IJB meeting June 2024 	✓	✓	✓	✓	**N/A**
D06-24	Workforce	Related risk: Staff Resource Scope: coherent, co-ordinated, adequate and effective approach to managing significant workforce risks. Strategic & operational responses across the totality of the workforce, including contracted services and 3rd sector. The initial scope of the audit was adjusted to reflect the updated description and mitigations for the relevant risk, resulting in a delay in starting the audit fieldwork. Audit fieldwork has been completed and a closure meetings was held on 10 October 2024.Draft report to be issued to management week beginning 11 November 2024.	~~February 2024~~ ~~September 2024~~ ~~November 2024~~ January 2025 	✓	✓	✓	✓	**Limited Assurance**
2024/25								
D01-25	Audit Planning	Audit Risk Assessment & Operational Planning.	Complete	✓	✓	✓	✓	**N/A**

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
								
D02-25	Audit Management	Liaison with management, Pre-Audit Committee liaison with Chief Finance Officer, preparation of papers and attendance at PAC.	Ongoing/ May 2025 	✓	✓			
D03-25	Internal Control Evaluation	Holistic assessment of the internal control environment in preparation for production of the 2024/25 Annual Report. Follow up of previously agreed governance actions including Internal Audit recommendations.	May 2025 	✓				
D04-25	Annual Report 2024/25	Chief Internal Auditor's annual assurance statement to the IJB with fieldwork to support this.	September 2025 (IJB meeting June 2025) 	✓				
D05-25	Lead Partner Services	Lead Partner Governance and Assurance arrangements	May 2025 	✓				

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
		Scope to review status of information sharing related to finance / financial outlook / risks / clinical and care governance / activity and strategic planning (Scope still to be finalised)						

ITEM No …13……..

PAC11-2025

PERFORMANCE AND AUDIT COMMITTEE – ATTENDANCES - JANUARY 2024 TO DECEMBER 2024

COMMITTEE MEMBERS - (* - DENOTES VOTING MEMBER – APPOINTED FROM INTEGRATION JOINT BOARD)					
Organisation	**Member**	**Meeting Dates 2024**			
		31/01	22/5	25/9	20/11
Dundee City Council (Elected Member)	Ken Lynn **	A/S	✓	✓	
NHS Tayside (Non Executive Member)	Bob Benson				✓
Dundee City Council (Elected Member)	Dorothy McHugh *	✓	✓	✓	A/S
Dundee City Council (Elected Member)	Siobhan Tolland				✓
NHS Tayside (Non Executive Member)	Beth Hamilton		✓		
NHS Tayside (Non Executive Member)	David Cheape		✓	✓	✓
NHS Tayside (Non Executive Member)	Sam Riddell *	✓			
NHS Tayside (Non Executive Member)	Donald McPherson*	✓			
Chief Officer	Vicky Irons	A	A	A	
Chief Finance Officer/Acting Chief Officer	Dave Berry	✓	✓	✓	✓
Acting Chief Finance Officer	Christine Jones		✓	✓	✓
NHS Tayside (Registered Medical Practitioner – not providing primary medical services)	Sanjay Pillai		✓	A	✓
NHS Tayside (Registered Medical Practitioner – not providing primary medical services)	James Cotton	A			
Dundee City Council (Chief Social Work Officer)	Diane McCulloch	✓			
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	A	A	A	A
Carers' Representative	Martyn Sloan	✓	✓	A	A
Chief Internal Auditor ***	Jocelyn Lyall	✓	✓	A/S	A/S

✓ Attended

A Submitted apologies

A/S Submitted apologies and was substituted

☐ No longer a member and has been replaced / was not a member at the time

* Denotes Voting Members

** Denotes Office Bearer. Periods of appointment are on fixed terms in accordance with legislation.

*** The Chief Internal Auditor is a member of the Committee and is not a member of the Integration Joint Board.

**** Audit Scotland are not formal members of the Committee and are invited to attend at least one meeting of the Committee a year.

(Note: First meeting of the Committee was held on 17th January, 2017).

(Note: Membership are all members of the Integration Joint Board (only exceptions are Chief Internal Auditor and Audit Scotland).