Glasgow City IJB Integration Joint Board

Item No: 11

Meeting Date: **Wednesday 25th September 2024**

Glasgow City Integration Joint Board

Report By:	**Jackie Kerr, Interim Chief Officer, Glasgow City HSCP**
Contact:	**Kelda Gaffney, Interim Assistant Chief Officer**
Phone:	**0141 314 6219**

Implementation of the Alcohol and Drug Recovery Service (ADRS) Review

Purpose of Report:	The purpose of this report is to update the IJB on the progress of the implementation of the commissioned independent Review of Glasgow Alcohol and Drug Recovery (ADRS) community services. To provide an update on the review of Shared Care and seek approval to implement phase 1 of the staffing and skillmix model.

Background/Engagement:	This update follows an IJB paper in June 2023, *Progress towards Implementation of the Medication Assisted Treatment (MAT) Standards and Alcohol and Drug Recovery Service (ADRS) Review*. In January 2021, Glasgow Alcohol and Drug Recovery Services commissioned an external review of service to consider the effectiveness of the service model. The review was published in November 2021, with 10 key recommendations relating to resource and capacity, workforce development, and governance. An implementation board was established to progress work in response to the recommendations and this paper outlines the progress to date. All workstreams and developments have been discussed with the lived experience reference groups and feedback incorporated into plans. Staff have populated both the implementation board and the workstreams. VSDAA are represented on the Implementation Board.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☐

	Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☒ Alcohol and Drug Partnership Adult Core Leadership

Recommendations:	The Integration Joint Board is asked to: a) Note the contents of this report in concluding the work to implement the ADRS Review recommendations; b) Note that outstanding work in relation to Shared Care will progress under the implementation of the MAT Standards; c) Approve implementation of Phase 1 of the staffing and skill mix model; and d) Support the full staffing and skill mix proposals detailed in the report, subject to funding being identified.

Relevance to Integration Joint Board Strategic Plan:

Implementation of the ADRS Review will support the delivery of the Medication Assisted Treatment (MAT) Standards, which is the responsibility of Glasgow City IJB and plays a significant role in relation to the health and wellbeing of the Glasgow population. Implementation of the MAT standards is a rights-based approach and follows the principles of the Scottish Government Health & Social Care Standards: my support, my life, dignity and respect, compassion, inclusion and support to wellbeing.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	Outcomes 1, 3, 4, 5, 7, 8, 9

Personnel:	Implementation of the ADRS Review Recommendations will require workforce investment and development, and investment in third sector providers. Staffside and Council trade unions are involved in all discussions and are key members of the ADRS Review and MAT Standards Implementation Steering Group.

Carers:	Families, carers and people with living and lived experience are fully engaged in the planning for implementation of the ADRS Review.

Provider Organisations:	Third sector partners are represented on the ADRS Review and MAT Standards Implementation Steering Group and the Alcohol and Drug Partnership. Provider organisations are involved in Test of Change models to inform future procurement activity.

Equalities:	Implementing the ADRS Review, and consequently the MAT Standards, will reinforce a rights-based approach by ensuring people have choice and are empowered to access the right support for where they are in their recovery journey. EQIA may be required in respect of the Shared Care implementation and will be published as per guidance.

Fairer Scotland Compliance:	None

Financial:	Full implementation of the ADRS Review recommendations can only be achieved with investment and additional staffing. This paper seeks approval for phase one implementation of the staffing and skillmix model at a cost of £386,166, which will be met within existing Alcohol and Drug Recovery service budget, supplemented by the recurring element of National Mission funding allocation.

Legal:	The ADRS Review was a service led commissioned review to support improvements in service provision. The review informs the implementation of the MAT Standards, the requirements of this comes via a Ministerial letter of direction using authority from section 52 of the Public Bodies (Joint Working) (Scotland) Act 2014. Failure to comply with the request would risk being non-compliant with the Act. GCC Legal and Audit provide the support required to ensure that procurement activity is compliant with procurement legislation and the Council Standing Orders.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	Detailed risk implications are included in the Implementation Plan developed by the Planning and Implementation Group of the MAT Standards and ADRS Review Implementation Steering Group.

Implications for Glasgow City Council:	GCC will wish to be assured that the implementation of the MAT standards is progressing at a pace to meet the requirements of the Scottish Government.

Implications for NHS Greater Glasgow & Clyde:	NHSGG&C will wish to be assured that the implementation of the MAT standards is progressing at a pace to meet the requirements of the Scottish Government.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☐
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☒

1. Purpose

1.1 The purpose of this paper is to update the IJB on progress of implementation of the commissioned independent Review of Glasgow Alcohol and Drug Recovery (ADRS) community services, seek approval to progress to Phase 1 recruitment, and seek support for the proposed staffing and skill mix changes in community Alcohol and Drug Recovery Services.

2. Background

2.1 Glasgow Alcohol and Drug Recovery Service (GADRS) provides a Recovery Orientated System of Care to adults in Glasgow City experiencing difficulties in relation to problem alcohol and/or drug use.

2.2 Glasgow Alcohol & Drug Recovery Services represent the overarching term to describe a suite of treatment, care & recovery focused services and opportunities within Glasgow City. The community care and treatment service was previously reviewed in 2013/14, with a new model of service delivery implemented in 2016. A new model of delivery was introduced, with an emphasis on recovery-oriented systems of care and positive exit strategies from treatment and care. The staffing model was predicated on high numbers of patients moving out of care and treatment teams into shared care and/or detoxing from prescribed medication.

2.3 However, implementation was challenging as a consequence of the changing landscape. Glasgow City began to see a significant increase in drug-related deaths, poly drug use, and harms associated with injecting drug use. ADRS experienced increasing rates of adverse incidents, including deaths in treatment. There was a substantial rise in alcohol referrals to the service, and an increase in presentations to acute hospitals and community settings as a consequence of alcohol harms. The anticipated exit strategies from services were challenging, despite the range of commissioned and peer-led services. It was further recognised that quality of service delivery had been compromised by a range of factors including workforce capacity, impacted by vacancies and a high turnover of staff. Performance data and Adverse Event findings also highlighted significant variations in the implementation of the service specification across the city. The policy agenda had also developed by 2018 with the new national strategy, Rights Respect and Recovery, and thereafter the establishment of the Scottish Drug Deaths Taskforce, and the introduction of the National Mission outcome framework.

2.4 Glasgow Alcohol and Drug Recovery Services (GADRS) therefore commissioned an external review in January 2021, to consider the efficacy of the community care and treatment teams and the model of service delivery,

and to consider next steps to take forward the ethos and aspirations of the national strategy over the following 5 -10 years. The Review undertook an analysis of service data and consultation with key stakeholders. The report highlighted areas of good practice and challenges to the delivery of effective and responsive care and treatment in line with the service specification and the Medicated Assisted Treatment Standards. The review was published in November 2021, with 10 key recommendations relating to resource and capacity, workforce development, and governance, summarised below in *Table 1* below.

2.5 A number of the recommendations can be aligned to the Medication Assisted Treatment (MAT) Standards, published by the Scottish Government in 2021. These are evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland, initially focussing on opioid substitution treatment. The standards ensure that individuals and family members should expect to receive good quality, person centred care with supports into other services and opportunities for challenge and growth.

2.6 A MAT Standards and ADRS Review Implementation Board was established in 2022 to consider implementation of the key recommendations from the ADRS review and the MAT Standards. The steering group established a number of workstreams to develop plans in respect of each of the relevant recommendations – Resource & Capacity, Workforce Development, Shared Care and Performance & Governance, aligned in *Table 1* below. Membership across the implementation board and workstreams has included a range of stakeholders including GADRS/HSCP management, clinical, care management and recovery staff, third sector, people with lived experience, primary care, Alcohol and Drug Partnership (ADP), staffside and local authority trade union, MAT project managers, prison and police custody.

Table 1 – ADRS Review Recommendations

Recommendation Summary	Workstream
Recommendation 1 - The current level of activity is unsustainable. There needs to be a significant investment in the recruitment and retention of staff to safely and effectively manage current and future demand.	Resource & Capacity
Recommendation 2 - The service specification should be reviewed to address specific issues including continuity of contact and the development of a step up- step down system.	Resource & Capacity
Recommendation 3 - The role of primary care practitioners, and the contractual arrangements by which they deliver services should be reviewed. Training and resources should be aimed at supporting GPs to be autonomous in their clinical practice for people who use drugs.	Resource & Capacity - Shared Care
Recommendation 4 - Management need to put robust, auditable systems in place to manage, support and develop the workforce.	Performance & Governance

Recommendation 5 - The SMT should consider conducting a Training Needs Analysis to identify requirements across the service.	Workforce Development
Recommendation 6 - A 'Time in Motion' study should be conducted to identify the skill mix required within the ADRS staff team to meet these challenges.	Resource & Capacity
Recommendation 7 - Ensure that there are effective measures in place to communicate the vision and strategy for future service provision throughout the service.	Performance & Governance
Recommendation 8 - An information dashboard should be further developed to inform performance management and promote quality improvement across the service.	Performance & Governance
Recommendation 9 - The key action points identified here should be incorporated into the GADRS risk register and may warrant escalation of remedial measures to mitigate these risks.	GADRS Management Team
Recommendation 10 - There is potential learning from the measures that were brought in to minimise the spread of COVID-19 and there is merit in further exploration of their impact.	Implementation Board

3. Resource and Capacity (Recommendations 1,2,3,6)

3.1 The Resource and Capacity workstream have focused on recommendations 1, 2 and 6, benchmarking across current and future demand. Staffside did not support a 'Time in Motion' study as per Recommendation 6, however work took place within the workstream to consider roles and responsibilities, staffing skill mix, tasks and interventions, interface arrangements and governance (Appendix 1).

3.2 GADRS community assessment, care and treatment is delivered through locality teams in North East, North West and South Glasgow. A sub-team structure was implemented following the Community Addiction Team Review, introducing multi-disciplinary teams focused on particular needs – Access (first point of contact and early intervention), Core (the majority of people who use the service, in treatment and requiring a range of psychosocial interventions and wider support), Parents, Justice, Young People and Recovery. Shared Care has continued as a partnership approach with primary care prescribing for patients, who are also supported by social care staff.

3.3 As at August 2024, the service has a caseload of approximately 7,500 people within the community care and treatment teams, including around 6,000 people receiving Opiate Replacement Therapy.

3.4 **Access**

As detailed in the paper presented to IJB on 28th September 2022, the Access model, which is the team that manage new referrals from first point of contact, has been implemented with additional capacity across staffing groups funded by Scottish Government allocation alongside realignment of existing resource.

The aim of the Access outreach team is to provide a person-centred, trauma-informed and barrier-free approach to referrals, using the principles of Time, Space, Compassion and a “no wrong door” policy. The teams identify immediate needs in relation to treatment and care, whilst supporting individuals to develop a recovery plan to achieve their recovery goals. An assertive approach to engagement is employed which endeavours to reduce barriers to care and treatment. The multidisciplinary Access team members are skilled in assessment and delivering a wide range of treatment options to minimise harm, using a psychologically informed approach. The model was implemented across the ADRS teams in April 2023.

3.5 **Core**

The Core team offer assessment and care planning, harm reduction interventions, care and treatment, psychosocial supports, and recovery interventions. The remit of the Core team is to deliver care and treatment to people who were established with a treatment plan via the Access team, or transferred into service with an established treatment plan, and who require continued GADRS intervention to achieve their recovery or maintenance goals.

The multi-disciplinary team includes care managers (social care staff and registered nursing staff), medical officers and pharmacist non-medical prescribers, psychiatry, psychology, occupational health and other allied health professionals. Commissioned recovery communities, recovery hubs and community third sector services also play an integral part in supporting service users open to the Core Team.

Consultation with staff and people with lived and living experience highlighted the importance of staff having time to build therapeutic relationships with service users and their families, and capacity to undertake meaningful interventions to support service users onto the next stage of their recovery journey. The workstream analysed the full range of harm reduction, care, treatment and recovery interventions and proposed a skillmix and caseload/ workload that will provide capacity to deliver trauma-informed care, undertake quality assessments, reviews and interventions, meet the demands of MAT standards implementation, alcohol and care and the Substance Use Treatment Target, and afford time for supervision, training, and development. The recommended skillmix for the model is outlined at Section 7.

3.6 **Parents**

The Parents sub-team provide a focus on working with parents/carers around their alcohol and drug issues whilst taking account of the impact on children, working in partnership with other stakeholders to focus on achieving improved outcomes for parents/carers and their children.

In addition to the roles and responsibilities outlined under Core, parents teams will undertake parental assessments, ensuring that the needs of the adult is balanced with risks to children, move families into recovery to support more nurturing family lives, respond to immediate or changed needs of parent and/or child(ren), and support statutory and universal assessments with Children's Services and Education, support Learning Hubs.

3.7 **Justice**

The remit of the ADRS Justice Team is to support service users whose alcohol and/drug use impacts on offending behaviours, to reduce harms associated with drug or alcohol use, support care planning to address offending behaviours and recidivism, and progress recovery goals.

Justice Teams work with service users with harmful, as well as dependent, alcohol and/drug use. Additional responsibilities include supporting prison release and individuals involved with Justice community and throughcare services and subject to MAPPA arrangements, attend and provide assessments to the Alcohol Court, and joint care planning with specialist services such as Tomorrow' Women, Glasgow Drug Court and Positive Outcomes Project.

3.8 The **Young Person**'s service is currently delivered in locality teams by social care staff, providing outreach support. There is no standard treatment option for young people under 16 years however a centralised treatment and care model is currently being developed and will be reported to the IJB early 2025.

3.9 **Supported Treatment and Recovery Service (STARS)**

A test of change model was introduced in August 2023, following approval at the IJB on 28th June 2023, as a means of introducing a step-down model of care for people, providing wellbeing support and recovery opportunities to people who are engaged with treatment. The model involves commissioning third sector partner With You to deliver on key worker support to individuals, whilst prescribing and treatment plans are provided by ADRS.

As per the aims of the model, ADRS care management caseloads have been reduced to release capacity, and service users receive care appropriate to their needs within a community setting, in line with the Maximising Independence agenda and the National Mission Outcomes Framework.

3.10 **Shared Care**

The IJB were informed of the outcomes of a Review of the Shared Care model on 28th June 2023, as part of the update on progress towards implementation of MAT Standards and ADRS Review, particularly Review recommendation 3.

The current Shared Care model involves GPs prescribing and reviewing treatment with service users, with ADRS providing care management by social care workers, within a clinic setting. 60% of GP practices are currently involved with the enhanced service, and therefore 40% of practices do not offer any MAT option to their patients. The previous paper noted issues in relation to sustainability of the model and resource implications for ADRS in terms of managing Tier 2 patients, rather than those with more complex needs who require specialist alcohol and/or drug support.

The review considered a range of options, including the Lothian model, highlighted by Scottish Government as an effective means of engaging people in primary care, whereby the treatment service supports GPs through a facilitation team but no additional care management or key working support. The review group however considered this unpalatable in terms of withdrawing all support to patients. The recommendation was to implement a blended model to include a Primary Care Facilitation Team who would offer guidance and advice to GPs in terms of prescribing practices, assume responsibility for a training and development agenda, progress the roll out of long-acting buprenorphine, proactively identify patients suitable for Shared Care, and support implementation of MAT Standards within Primary Care. Primary Care would be supported by a commissioned third sector recovery and wellbeing support for people receiving treatment via Shared Care.

Scottish Government funding was anticipated to support implementation of MAT Standard 7 Primary Care, and the work was paused whilst discussions took place nationally. Additional funding was not forthcoming and therefore a short life working group has recently been re-convened to consider implementation of a third sector model within existing budgets. It has been recognised that the level of support required will be more intense than the STARS model referenced above, as some patients who have more complex needs and higher risk of harms choose to remain within primary care. A full proposal will be presented to the IJB in 2025.

The overall workforce plans incorporate the move of social care workers who currently support Shared Care patients, taking up posts within ADRS community teams, to increase capacity and reducing overall caseloads/ workload.

3.11 **Long-Acting Injectable Buprenorphine (Buvidal)**

Buvidal is a long-acting injectable formulation of buprenorphine available in weekly and monthly depot-type preparations, which requires administration by a suitably qualified health professional. Evidence on the use of Buvidal as a treatment option note reports from patients of reductions in cravings, lower levels of anxiety, reductions in offending and abstinence from illicit opioids.

Whilst Buvidal is clearly a positive option for service users, the increase in use has had a considerable impact on resource within the community teams due to the need to deliver Buvidal administration clinics. In line with MAT Standard 2, *all service users are supported to make an informed choice on what medication use for MAT and the appropriate dose*. There are currently over 1000 patients currently prescribed Buvidal via Glasgow ADRS teams. Nursing staff are required to be available each day to administer treatment and assertively follow up people who do not attend planned appointments.

It is proposed that the additional staffing required to deliver on Buvidal is 4 Band 6 Nurses and 3 Band 5 Nurses, incorporated into Phase One of the staffing model outlined at Section 7.

4. Workforce Development (Recommendation 5)

4.1 The Workforce Development workstream undertook a training needs analysis for the ADRS community teams in 2022. The group have developed a full training and development workplan, with a focus on upskilling all staff to improve the quality of assessment and interventions delivered to people accessing care and treatment.

4.2 A core list of training, alongside tools and guidance, have been introduced and includes Alcohol and Drug awareness, Cocaine harm reduction and toolkit, Suicide prevention, Harm reduction, Understanding Stigma, Risk management, Wound Care, Children affected by parental substance use, Malnutrition, a Nursing core competency framework and a Matrix of learning for Social Care.

4.3 The group have proposed the introduction of an integrated Grade 7 Training Coordinator on a 2 year fixed term basis, to support the implementation of the mandatory and additional training across health and social care ADRS staff. The postholder would also implement, monitor and review the web-based induction toolkit, develop further to include all available training and development and make proposals for longer term use. The post would be hosted within the GCC Learning and Development Team for a period of two years. It is proposed that this post is funded through the Alcohol and Drug Partnership, and fits with the city's ADP strategy in terms of developing a skilled and resilient workforce who are psychologically informed to deliver on high quality treatment and care.

4.4 The workstream have also led on the implementation of Trauma Informed Care (MAT Standard 10) and a psychologically informed workforce with capacity to offer evidence based low intensity psychosocial interventions (MAT Standard 6). This includes Trauma Skilled Practice modules, Safety and Stabilisation, Motivational Interviewing, Reflective Practice, Coaching and a Psychological Approach to Understanding and Preventing Suicide. The increase in demand for the delivery of psychological therapies, particularly in relation to lower intensity therapies, requires an increased commitment to the matched stepped care model.

4.5 In order to meet these demands, a model of psychological therapies workforce across the three community teams has been recommended. Implementation will require additional recurring funding and has therefore been included in Phase Two of the implementation plan.

4.6 The recommended model also involves the introduction of an enhanced Low Intensity Psychological Therapies service to support a sustainable model of matched stepped care. Two nursing/social care staff per locality would take referrals specifically for Tier 2/Low Intensity therapies using an identified referral criteria and pathway, with input would be provided separate to service users' normal appointment setting. Staff would receive monthly supervision and coaching provided by a member of the psychology team. This would require a reduction in caseload/workload for the identified staff and therefore is a longer-term aim in line with the full implementation of staffing and skill mix recommendations.

5. Governance and Performance (Recommendations 4,7,8)

5.1 The ADRS Review highlighted gaps in staff understanding of the vision of the service. This is clearly critical in relation to staff awareness of national and local strategies, as well as roles and responsibilities and performance.

5.2 The ADP now facilitate a staff reference group, to engage with staff from across the partnership and is populated by ADRS and third sector representatives. The group fulfills two functions – to provide a vehicle for staff consultation in respect of strategic priorities, service developments and MAT Standards implementation, and to listen to and respond to staff suggestions, challenges and feedback.

5.3 The Implementation Board also includes 6 members of frontline staff and managers, and each of the workstreams include staff delegates, to ensure full representation and contribution to the proposals outlined in the paper.

5.4 A staff newsletter is distributed on a quarterly basis across the service, providing updates on all ADRS and ADP programmes, updates on local and national strategies, and performance information.

5.5 The Performance and Governance workstream collates and reports on data from across various recording systems including EMIS, Carefirst, Clinical Portal, and Neo, to support staff and inform service improvement. As an integrated service, performance reporting has been challenging however the group are now able to interrogate a wide range of data. The priority areas for development are outlined below:

- Analysis of routine reports now available from Carefirst including Caseloads, Referrals, Assessments, Impact of Parental Substance Use, Discharges, to inform practice and respond to emerging trends as quickly as possible;
- Dry Blood Spot Testing and Twinrix reporting to support a more assertive harm reduction in relation to Blood Borne Virus across ADRS;
- Reporting from Tier 4 and City Centre services to ensure that service provision meets the needs of the city;
- Implementation of a recording mechanism for Alcohol interventions, specifically Pabrinex, Detoxification and Protective Medications, to ensure that appropriate care and treatment is being delivered within the community;
- MAT Standards numerical reporting currently requires manual collation on several areas, and work is progressing on reporting frameworks. Implementation of trauma informed practice;
- Requests to the Intelligence Hub to provide an overview of trends across the city in relation to demographic, public health, justice, mental health, and acute data.

5.6 A new role for a Band 7 Performance and Data Advanced Analyst has been recommended to support performance monitoring, service improvements and the primary care facilitation team. This role would also assume responsibility for MAT Standards reporting when the fixed term project manager post comes to an end therefore has been included in Phase Two of the implementation plan.

6. Investment 2021-2024

6.1 Whilst the paper presents the final recommendations and concludes the ADRS Review proposals, it should be noted that significant additional investment has been progressed throughout the life of the Implementation Board in response to emerging issues and specifically to address workload pressures within the community teams. Total investment to date, funded by National Mission allocation and core ADRS budget, is in excess of £2.2million. All posts noted below are included in the staffing and skillmix proposals in Section 7.

6.2 As detailed in the IJB paper in September 2022, a specific allocation in relation to implementation of Mat Standards 1-5 was invested in the Access Model, to ensure that people have access to same day treatment, choice of treatment, and a full range of harm reduction, care and treatment and recovery options from first point of contact. The funding led to the recruitment of 25.5 WTE staff across the three locality teams (6 Social Workers, 5 Social Care Workers, 6 Nurses, 4 Senior Nurses, 3 Team Leaders and 1.5 WTE Pharmacy Independent Prescribers).

6.3 As a consequence of the withdrawal of clinics, prescriptions are now delivered to pharmacies. There has also been an increase in the delivery of medication to service users who are unable to travel to their pharmacy either on a temporary basis due to illness or a longer-term basis due to mobility issues. The service invested in 6 WTE delivery drivers to remove these duties from staff.

6.4 Investment into the STARS model described above includes a direct contract with WithYou, as well as recruitment in late 2023 to 6 Social Care Workers and 1.5 Senior Addiction Practioners. This has redirected over 800 service users from care management staff to recovery workers in WithYou, with a duty response being delivered from the ADRS STARS team. This however did not address the pressures to the medical officers and other prescribing staff as treatment remains attached to ADRS and therefore recruitment to 3 Pharmacy Independent Prescribers is currently being progressed.

6.5 In recognition of the continued pressures on staffing and complexity of presenting needs, recruitment of 3 Social Workers and 1.5 Senior Addiction Practioners took place in late 2023. A further recruitment of 3 Social Workers is currently underway.

6.6 Recruitment to an additional 6 Administration Officers was progressed in early 2024 to realign duties that had been identified as work undertaken by care managers that could be managed by admin staff.

6.7 The success of a Community Pharmacy Long-Acting Buprenorphine pilot, approved by the IJB in June 2023, led to an upscaling of the model, with approximately 285 patients planned to receive their treatment via community pharmacies by December 2024, to support the nursing staff workloads within ADRS teams.

7. Staffing and Skillmix proposals

7.1 A full staffing and skillmix model has been developed to deliver trauma informed care and treatment and the range of interventions and tasks required for full implementation of the MAT Standards and Alcohol Framework. See Table 1 below.

7.2 Recommended caseloads for each of the sub-teams have been proposed in order to create capacity to manage the level of complexity, risk and clinical activity across the service in relation to assessment, care management and psycho social interventions (Appendix 2). The model incorporates wider requirements outlined in the report in relation to Buvidal clinics, training, performance and psychological therapies.

7.3 It is proposed that the workforce changes are implemented in two phases, to reflect both the available funding and the changes to Shared Care. The model assumes that Shared Care will be implemented in financial year 25/26 and that social care staff will be realigned to other sub-teams in the community ADRS teams.

Table 1: ADRS Staffing and Skill Mix Model

GLASGOW ADRS	GRADE/ BAND	CURRENT STAFFING (WTE)	TOTAL REQUIRED (WTE)	DIFF +/-	Phase 1 Costs	Phase 2 Costs From April 25
Nurse Team Leader	B7	9	9	0	£0	£0
Senior Nurse	B6	41.8	51	9	£157,800	£315,600
Nurse	B5	50.9	56	5	£171,200	£42,800
Health Care Support Worker	B3	28.6	22	-7	£0	-£253,400
Social Work Team Leader	G8	16	16.5	0.5	£0	£35,112
Social Worker	G7	12	26	14	£0	£811,622
Senior Addiction Practioner	G7	38.7	34	-5	£0	-£289,865
Social Care Worker	G6	109.3	99	-10	£0	-£480,770
Consultant Psychologist	B8c	1	1.5	0.5	£0	£53,600
Principal Psychologist	B8a	3	3	0	£0	£0
CBT/CAAP	B7	2.5	3	0.5	£0	£32,100
Assistant Psychologist	B4	1	3	2	£0	£79,400
Integrated Training & Development Officer	G7	0	1	1	£57,116	£0
Performance and Data Advanced Analyst	B7	0	1	1	£0	£64,200
QSW Training						£65,000
Total Cost					**£386,116**	**£475,399**

7.4 Phase 1 will be funded by the recurring aspects of National Mission allocation and core ADRS budget. Phase 2 will require a realignment of staff and managed over a period of time through changes to the Shared Care model, vacancy management and training opportunities. In particular, plans to develop a training pathway for social care staff to access Social Work training will be explored.

7.5 Scottish Government have indicated that the full National Mission funding will be baselined from 25/26, which would provide an opportunity to review current investments and invest in the delivery of the psychological therapies workforce. However, the level of funding and any specific criteria is as yet unknown.

7.6 It should be noted that the Resource and Capacity workstream has focused attention on community care management and delivery of psychological therapies. ADRS is a multi-disciplinary service and the pressures and changes to service delivery outlined in the paper impacts on the wider professional groups, particularly the medical and non-medical prescribing staff within the community teams. A separate piece of work is being undertaken with this group of staff in relation to workload, prescribing activity and overall roles and responsibilities.

8. Recommendation 10 - Service Model

8.1 ADRS Review Recommendation 10 highlighted the potential to learn from contingency measures implemented in response to Covid restrictions. This related mainly to the withdrawal of the clinic model and the move to an outreach model for most service users. Feedback from service users and people with lived experience noted significant criticism of the clinic model, describing it as transactional in nature and not conducive to developing therapeutic relationships. This was due to large clinics being delivered with short appointment times, and limited opportunity to engage in any meaningful care planning. Some people experienced the clinic model as punitive, with varying practice across the city in response to non-attendance or late attendance at appointments, and on occasions prescriptions were withheld, taking people out of treatment. Concerns were highlighted around the culture in some teams with a lack of cognisance of the impact of trauma and challenges that people face. The previous clinic model is also not in line with the ethos of the National Mission, Glasgow ADP’s strategy, or the MAT Standards.

8.2 An outreach model has continued since Covid restrictions were in place, alongside a risk management RAG model. Prescriptions are sent directly to community pharmacies, with the focus of home visits and appointments by nursing and social care staff on assessment, care planning and psycho-social supports. Clinics have been introduced for the administration of Buvidal however service users’ contact with care managers is outwith these clinic appointments. Clinics remain in place for people starting in OST treatment and alcohol treatment initiation and review, due to the associated risks. Physical health clinics are also delivered by nursing and medical staff to undertake baseline physical health observations. These clinics are however not an alternative to care management responsibilities.

8.3 Whilst the outreach model has introduced a more person-centred and trauma informed approach to engaging with service users, staff and trade unions have raised concerns in respect of capacity, risk management and harm reduction. Monitoring and review of treatment and care is not possible if service users do not engage with appointments. This is particularly challenging when there are concerns in relation to a person's alcohol and/or drug use, mental health, physical health or wider social circumstances, both from a perspective of reducing harms and governance in terms of treatment. The move to an outreach model also had an impact on workload for staff in relation to the expectation of home visits, with a caseload of 50-60 people. The work outlined in this paper aims to reduce caseloads.

8.4 Further work has begun on a blended model of service user contact and engagement, to include clinic-based tripartite reviews with medical officers and non-medical prescribers. Progress on this piece of work will be reported to the MAT Standards Implementation Board and developed in conjunction with staff and trade unions.

9. Recommendations

9.1 The Integration Joint Board is asked to:

a) Note the contents of this report in concluding the work to implement the ADRS Review recommendations;
b) Note that outstanding work in relation to Shared Care will progress under the implementation of the MAT Standards;
c) Approve implementation of Phase 1 of the staffing and skill mix model; and
d) Support the full staffing and skillmix proposals detailed in the report, subject to funding being identified.

Direction from the Glasgow City Integration Joint Board

1	**Reference number**	250924-11
2	**Report Title**	Implementation of the Alcohol and Drug Service (ADRS) Review
3	**Date direction issued by Integration Joint Board**	25 September 2024
4	**Date from which direction takes effect**	25 September 2024
5	**Direction to:**	Glasgow City Council and NHS Greater Glasgow and Clyde jointly
6	**Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)**	No
7	**Functions covered by direction**	Alcohol and Drug Recovery Services
8	**Full text of direction**	Glasgow City Council and Greater Glasgow and Clyde Health Board are directed to approve the implementation of Phase 1 of the staffing and skill mix model, and to support the overall proposed staffing and skill mix model to deliver on all aspects of alcohol and drug care and treatment.
9	**Budget allocated by Integration Joint Board to carry out direction**	The total amount required to implement Phase 1 of the proposed service model is £386,116. This will be met by existing Alcohol and Drugs Recovery Service core budget funding and recurring National Mission uplift allocation.
10	**Performance monitoring arrangements**	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
11	**Date direction will be reviewed**	September 2025

Appendix 1 – Roles and Responsibilities

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Weekly Allocations								
Update the waiting times tracker								X
Allocation of work, recording allocation decision	X	X	X					
Allocate case to staff member on Emis and Carefirst - including appropriate episodes								X
Update spreadsheet	X							
Email to staff member advising of allocation								X
Core Care Manager - Initial Task's								
Arrange transition meeting with previous CM and service user		X	X	X	X	X		
Telephone contact / consultation with client to introduce		X	X	X	X	X		
Create / amend Emis schedule	X	X	X	X	X	X		
Review clients records and care plan goals / RAG category		X	X	X	X	X		
Update client's RAG status ensuring it’s assigned to a CORE episode of care		X	X	X	X	X		
Ensure client is linked into correct clinic		X	X	X	X	X		
Meet with client to review care plan and NOK/ emergency contact		X	X	X	X	X		
Communication with GP and other key members of the care team regarding treatment		X	X	X	X	X		
Support to link in with Recovery communities		X	X	X	X	X	X	
Complete EMIS Addiction Template	X	X	X	X				
Review RAG status and up-date if required	X	X	X	X	X	X	X	
Review CRAFT transition of care	X	X	X	X	X	X	X	
Ongoing Care Management								
Ongoing assessment and care planning		X	X	X	X	X		
Referral to partner agencies if required & record in EMIS/Carefirst and upload referral form (electronic upload)	X	X	X	X	X	X		X

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Record Keeping - EMIS is primary recording system need to be aware information requires to be recorded on both EMIS and Carefirst - i.e., ASP / hospital discharge CP	X	X	X	X	X	X	X	X
Core staff case management								
Face to face appointments - Home visit/Office		X	X	X	X	X	X	
Telephone contact as per RAG		X	X	X	X	X	X	
Review RAG monthly to determine contact level		X	X	X	X	X		
Harm reduction interventions		X	X	X	X	X	X	
Alcohol brief interventions		X	X	X	X	X	X	
Motivational interviewing		X	X	X	X	X		
Core Skills		X	X	X	X	X	X	
Cocaine toolkit		X	X	X	X	X	X	
Working with people using street benzo guidance		X	X	X	X	X	X	
Sexual health - harm reductions / sign posting / Condom provision		X	X	X	X	X	X	
Gender based violence discussions & support		X	X	X	X	X	X	
Mental health overview		X	X	X	X	X	X	
Physical health overview		X	X	X	X	X	X	
Referrals to Tier 4 ADRS services - OT, ARBD, Dietetics, psychology, psychiatry	X	X	X	X	X	X	X	
Referral to carers team, family support, advocacy	X	X	X	X	X	X		
Record all contact and interventions on Emis & CF6 where appropriate	X	X	X	X	X	X		
Attend MDT's	X	X	X	X	X	X		
Support acute hospital discharge - contact with ward, hospital visits, arrange COS, arrange house cleans	X	X	X	X	X	X		
Contact with family members or nominated support		X	X	X	X	X		
IEP provision & Naloxone Provision Framework		X	X	X	X	X		
FAST / SADQ toolkit		X	X	X	X	X		
Support clients re housing/ benefits / fire safety in house - social issues etc.		X	X	X	X	X		
Clinic Prep	X	X	X	X	X	X		

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Admin clinic support and prep								X
Review / assessment								
Update RAG as per guidance	X	X	X	X	X	X		
Update CRAFT as per change in need (annually as a minimum)	X	X	X	X	X	X		
Week 12 Daisy Review, thereafter 6 monthly		X	X	X	X	X		
Addiction assessment and care plan every 3 months		X	X	X	X	X		
Update parental substance use tool as agreed in care plan or annually		X	X	X	X	X		
Complete paperwork for rehab/ residential care		X	X	X	X	X		
Complete SNA				X				
Reviews for those in residential placement	X	X	X	X	X	X		
Complete/ Contribute to Briefing notes and SAERs	X	X	X	X	X	X		
Send family condolence letter following client death as per SOP	X							
Complete Datix - Incident recording	X	X	X	X	X	X		
Prep for MDT - SBAR, Craft, Updated RAG, Residential paperwork	X	X	X	X	X	X		
Risk Management / support								
Make referrals - Fire safety checks		X	X	X	X	X	X	
Support with calls to benefits agency		X	X	X	X	X	X	
Support with calls to energy providers		X	X	X	X	X	X	
Referral to advocacy services if required		X	X	X	X	X	X	
Tripartite reviews		X	X	X	X	X	X	
Duty								
Duty home visits		X	X	X	X	X	X	
Check Duty SWINBOX	X	X	X	X				
Allocation of duty tasks	X	X	X	X				
Travel to clients	X	X	X	X	X	X	X	
Assessment of clients (face to face contact)	X	X	X	X	X	X		

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Data processing on return Emis	X	X	X	X	X	X		
Referrals to other services	X	X	X	X	X	X	X	
Environmental risk Assessment	X	X	X	X	X	X		
Respond to unplanned presentations	X	X	X	X	X	X		X
Support Prescription management for alcohol and OST	X	X	X	X	X	X		
Ad hocs for cases where care manager is not available		X	X	X	X	X		
Email care manager re duty tasks undertaken for ad hoc cases.		X	X	X	X	X		
Management of ORT Delivery	X	X	X					
Accessing OST								
Consult / liaise with medical and prescribing staff, and book appointment when restart required	X	X	X	X	X	X		
Meet client screen for drugs / breathalyser as required or minimum of 3 monthly	X	X	X	X	X	X	X	
Generate prescriptions	X	X	X	X	X	X		
Contact pharmacy as required - re changes / missed doses etc.	X	X	X	X	X	X	X	
Clinical assessment including assessment of drug and alcohol use								
Explore treatment options								
Consent to treatment as required - change of treatment etc.								
Agree a treatment plan, including a plan for titration to optimal dose OST		X	X	X	X	X		
Consider treatment interventions for other drug use		X	X	X	X	X		
Consideration of alcohol interventions, including consideration of alcohol protective medications		X	X	X	X	X		
Communication with GP and other key members of the care team regarding treatment plan		X	X	X	X	X		
Check patient clinic prescription		X	X	X	X	X		
Sign patient clinic prescription								

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
WAND								
Wound management - identification of issues and signposting for treatment	X	X	X	X	X	X		
AIR - assessment of injecting risk	X	X	X	X	X	X		
Naloxone provision	X	X	X	X	X	X	X	
DBST	X		X			X	X	
BBV risk reduction	X	X	X	X	X	X	X	
Integration & Maintenance to Recovery								
Support Recovery hubs/Recovery communities								
Access and support people to Recovery opportunities		X	X	X	X	X	X	
Attend community recovery review/ care planning meetings		X	X	X	X	X	X	
Attend residential reviews		X	X	X	X	X		
Move on/ exit planning								
Identify appropriate move on plan	X	X	X	X	X	X	X	
Manage transition from Core Team via positive discharge	X	X	X	X	X	X		
Handover between care managers / prescribers / service users where appropriate	X	X	X	X	X	X	X	
Liaison and joint working with all statutory and non-statutory agencies required to ensure no “unmet need”	X	X	X	X	X	X	X	
Preparation for protective medications alcohol		X	X	X	X	X		
ECG			X			X	X	
Physical health assessment	NTL		X			X	X	
Bloods	NTL		X			X	X	
Generate schedule on Emis / forward plan		X	X	X	X	X		
Discussion regard suitability with medical and prescribing staff			X			X		
Psychological support for protective meds / disulfiram		X	X	X	X	X		
Urgent mental health review (referral to CMHT)	X		X			X		
Week 1 to 4 Audit, Readiness to change, SADQ tools			X			X		

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Nurse specific duties								
Mental health assessments planned	NTL		X			X		
Recording assessment MHA tool (Emis)	NTL		X			X		
Mental health meeting (every 2 weeks)			X			X		
Depo Injection Clinics – Buvidal	NTL		X			X		
Physical Health Assessment	NTL		X			X	X	
Administration of Buvidal			X			X		
Home detox and preparation			X			X		
Arrange contact			X			X		
Assessment of suitability (include environment RA)			X			X		
Home detox			X			X		
Arrange medications/ prescription & collection			X			X	X	
Contact with client twice daily (3 days twice daily then once daily for 2 days)			X			X		
Breathalyser			X			X	X	
Assessment for withdrawals - short alcohol withdrawal scale			X			X		
Pabrinex			X			X		
Bloods			X			X	X	
Home visit	X	X	X	X	X	X	X	
ECG			X			X	X	
Fibroscan	X *		X			X		
Blood Borne Virus								
Discussion re risks		X	X	X	X	X	X	
Twinrix			X			X	X	
BBV screening			X			X	X	
Post diagnosis signposting/ support			X			X	X	
Developing C+T interface with BBV specialists			X			X	X	
Standalone Pabrinex			X			X		
Bloods			X			X	X	
Physical health assessment			X			X	X	
Kardex			X			X	X	

Task	Team Leader (TL)	Senior Addiction Practioner (SAP)	Senior Addiction Nurse (SAN)	Social Worker (QSW)	Social Care Worker (SCW)	Addiction Nurse (AN)	Health Care Support Worker (HSCW)	Admin
Provision and wait time			X			X	X	
Adult Support and Protection								
Duty to enquire	SW TL	X		X	X			
Investigation	SW TL			X				
Case discussion / conference	SW TL	X	X	X	X	X	X	
ASP Care Management	SW TL			X				
Review of ASP Care Management	SW TL	X	X	X	X	X		
Professional development								
PDP	X	X	X	X	X	X	X	
Staff Supervision	X	X	X	X	X	X	X	
Staff support and mentoring	X	X	X					
Monitoring performance	X	X	X					
Managing performance	X	X	X					

Additional Sub-team specific tasks:

Parents Team	TL	SAP	SAN	QSW	SCW	AN	HCSW
Attend and Contribute to CP meetings	X	X		X	X	X	X
Availability to support Rehabilitation and permanency plans	X	X		X	X		X
Providing reports on parents' progress for statutory meetings		X		X	X		
Working with whole family and all parties involved		X		X	X		
Providing support to learning hubs		X		X	X		X
Input and attendance to Pregnancy Liaison Group (PLG)	X	X				X	
Supporting clients through GIFT assessments		X		X	X	X	X
Support to parents whose children have been removed from their care		X		X	X	X	
Attend children's hearings.	X	X		X	X	X	
Attend and contribute to pre & post birth meetings	X	X		X	X	X	X
Responsive assertive outreach		X		X	X	X	X
Screen and attend MARAC meetings	X	X		X			

Young Person's Team	TL	SAP	SAN	QSW	SCW	AN	HCSW
Screen into service	X	X		X			
Intensive assertive outreach approach to service delivery		X		X	X		
Attend and Contribute to VYP meetings	X	X		X	X		
Prepare reports & attend children's hearings		X		X	X		
Working with whole family and all parties involved in YP support network		X		X	X		
Supporting YP to attend ADRS clinical appointments		X		X	X		
Attending Secure Screening meetings	X	X		X			
Work with Children’s Houses staff – education, support care planning		X		X	X		

ADRS Justice	TL	SAP	SAN	QSW	SCW	AN	HCSW
Attend and contribute to the Alcohol Court		X		X			
Screen all Alcohol Court Referrals	X	X		X			
Alcohol assessments for Alcohol Court		X		X	X	X	
Point of contact for locality Criminal Justice team	X	X		X	X		
Face -to face meeting with service user & CJ worker within 1 week of allocation	X	X		X	X		
Summary of assessments/ review to be sent to CJ worker		X		X	X		
Joint 4 weekly reviews with CJ worker	X	X		X	X	X	
Work with/refer to third sector partners to reduce recidivism							
Attend citywide ADRS Justice interface meeting	X						
Attend locality interface meeting	X	X		X			
Attend MAPPA meetings	X	X		X		X	
Dual recording on Carefirst/Emis	X	X		X	X	X	

Appendix 2 – Caseloads

NORTH EAST ADRS	ACCESS	JUSTICE	PARENTS	YOUNG PEOPLE	CORE (inc BUVIDAL)	STARS/ SHARED CARE	TOTAL REQUIRED	CURRENT STAFFING	REALIGNMENT REQUIRED (WTE)
SERVICE USER NUMBER	**380**	**180**	**240**	**60**	**1480**	**700**			
NURSE TEAM LEADER	1.0				2.0		3.0	3.0	**0.0**
SENIOR NURSE	5.0				13.0		18.0	15.0	**3.0**
NURSE	5.0	0.5	0.5		14.0		20.0	18.8	**1.2**
HEALTH CARE SUPPORT WORKER	2.0		1.0		5.0		8.0	11.0	**-3.0**
TEAM LEADER	1.5	0.9	1.0		2.5	0.4	6.3	6.0	**0.3**
SOCIAL WORKER	2.0	1.0	2.0		4.0		9.0	4.0	**5.0**
SENIOR ADDICTION PRACTIONER	2.0	2.0	1.0	1.0	5.0	1.0	12.0	16.6	**-4.6**
SOCIAL CARE WORKER	6.0	3.0	5.0	2.0	19.0	5.0	40.0	40.4	**-0.4**

NORTH WEST ADRS	ACCESS	JUSTICE	PARENTS	YOUNG PEOPLE	CORE (inc BUVIDAL)	STARS/ SHARED CARE	TOTAL REQUIRED	CURRENT STAFFING	REALIGNMENT REQUIRED (WTE)
SERVICE USER NUMBER	**420**	**180**	**270**	**60**	**1270**	**500**			
NURSE TEAM LEADER	1.0				2.0		3.0	3.0	**0.0**
SENIOR NURSE	5.0				13.0		18.0	13.9	**4.1**
NURSE	5.0	0.5	0.5		14.0		20.0	16.3	**3.7**
HEALTH CARE SUPPORT WORKER	2.0		1.0		4.0		7.0	7.6	**-0.6**
TEAM LEADER	1.5	0.6	1.0		2.0	0.4	5.5	5.0	**0.5**
SOCIAL WORKER	2.0	1.0	2.0		4.0		9.0	4.0	**5.0**
SENIOR ADDICTION PRACTIONER	2.0	2.0	1.0	1.0	5.0	1.0	12.0	12.0	**0.0**
SOCIAL CARE WORKER	7.0	3.0	6.0	2.0	12.0	4.0	34.0	33.3	**0.7**

SOUTH ADRS	ACCESS	JUSTICE	PARENTS	YOUNG PEOPLE	CORE (inc BUVIDAL)	STARS/ SHARED CARE	TOTAL REQUIRED	CURRENT STAFFING	REALIGNMENT REQUIRED (WTE)
SERVICE USER NUMBER	**320**	**130**	**180**	**60**	**1000**	**550**			
NURSE TEAM LEADER	1.0				2.0		3.0	3.0	**0.0**
SENIOR NURSE	5.0				10.0		15.0	12.9	**2.1**
NURSE	5.0	0.5	0.5		10.0		16.0	15.8	**0.2**
HEALTH CARE SUPPORT WORKER	2.0		1.0		4.0		7.0	10.0	**-3.0**
TEAM LEADER	1.5	0.8	0.8	0.3	1.0	0.3	4.7	5.0	**-0.4**
SOCIAL WORKER	2.0	1.0	2.0		3.0		8.0	4.0	**4.0**
SENIOR ADDICTION PRACTIONER	2.0	1.0	1.0	1.0	4.0	1.0	10.0	10.1	**-0.1**
SOCIAL CARE WORKER	5.0	3.0	3.0	2.0	8.0	4.0	25.0	35.6	**-10.6**