**Public Health Drugs Special Interest Group**

2021\_04\_28

***Draft Meeting Note***

***Chair: Tara Shivaji – Public Health Scotland***

**Attending**

Tara Shivaji – Public Health Scotland (Chair)

Duncan McCormick – Public Health Scotland

Ashleigh Jenkins – ScotPHN, Public Health Scotland

Kirsten Horsburgh – SDF

Elinor Dickie – Public Health Scotland

Laura Docherty

Lee Barnsdale- Public Health Scotland

Elisabeth Smart - NHS Highland

Phil Mackie – ScotPHN, Public Health Scotland

Trevor Lakey – NHS GG&C

Trish Tougher - BBV Networks Manager

Wendy McConnachie - NHS Shetland

Andrew McAuley – Public Health Scotland

Louise Pollock- Specialist Midwife in Pregnancy and Newborn Communicable Disease Screening programmes

Tracey Clusker

Sharon Mooney – Scottish Government

Liz Taylor – Public Health Scotland

Kirsty License – NHS Tayside

Daniel Carter- NHS GG&C

Ann Conacher – ScotPHN, Public Health Scotland

**Apologies**

Denise MCHUGH- ScotPHN, Public Health Scotland

Emma Fletcher (Departed Group – replaced by Kirsty License) – NHS Tayside

Deborah Stewart (NHS Highland)

Jackie, DAVIES- NHS DUMFRIES AND GALLOWAY

Elaine Lawlor (NHS Forth Valley)

Dave Liddell – SDF

Maggie, WATTS - NHS WESTERN ISLES

Lorna Douglas

Claire Glen

1. **Welcome**

Tara Shivaji welcomed all to the meeting noting that she will Chair today’s meeting of the group.

1. **Previous meeting actions**

Actions from previous meeting were agreed to be taken as per agenda items/matters arising

1. **Matters Arising - Local Volunteer Co-Chair local leadership and visibility**

Tara notes interest in continuation of practical support to the group and acknowledges the requirement for consideration to widen group participation – including potential for identifying representation from the specialist pharmacist network (with PH function)

\*TS to approach specialist pharmacy network to scope potential and to explore connect to substance misuse pharmacy contacts

\*group to re-visit co-chairing arrangements and local representation as Quarter 3 business

1. **NRS and DRD reporting update**

TS - Currently Drugs Related Death (DRD) quarterly data is available via NRS (by wider ONS definition), however, these are noted to be impacted by delays, including toxicology reporting. Work is actively being undertaken to improve the toxicology pathway and the timeliness of DRD confirmation however it will take some time for these enhancements track into real time reporting. At present conversation focuses on national level data with deliberation on the feasibility of local level to follow. There is also consideration on the accuracy of final published/public data. And lots of acknowledgement on the challenges/limitations (overall and at present) with planning now moving onto ‘how to improve’ following the problem assessment phase. Plans seek to scale up surveillance efforts, monitor trends including localised issues and to identify early action/intervention.

\*TS engaged in active discussion and will continue to update the group as improvements progress

The SIG considered how be they can/should be involved in the interpretation of data moving forward. Noting that for now, no change to the current data or information sharing process in indicated.

LB is also engaged in discussion with NRS and Police Scotland and advises that the preliminary enhancements are good with some uncertainty on the conclusion post parliamentary recess.

DMcC advises that the enhancements are more akin to a form of ‘modelling hybrid of police and NRS data’ or an ‘estimated projection’.

AMcA- on the basis ‘estimations’ has ownership been considered (NRS led/owned or SG?)

\*TS to raise consideration of ADP/local level breakdown on behalf of the group. Including raising the potential for a broader coalition of partners and Senior NRS engagement as critical.

KH – what’s required in terms of purposing the new resource at SG to enable the significant enhancement in accuracy. In light of the DRD emergency, same action required as was undertaken for the covid19 emergency, we must commit to continuing our advocacy for proposed enhancements and beyond.

LB – acknowledges the frustration and upstream blockers noted and noted that the Covid report on DRD demonstrates the potential for greater alignment on data. There is potential for the quarterly dashboard to link from Police Scotland data, as guide/estimation for where of figures/projections against NRS. The processes for confirmation are fixed.

The National DRD database short life working group is actively considering innovation, closer relationships and the potential for a national co-ordinator. The group are 3 of 4 planned meetings now underway with shared principles agreed to date and recommendations to follow.

LS – Highlights the potential harm arising from media interest which must be noted and mitigated if local level data is to be made available.

TS summarised discussion noting that the group are very supportive of timelier reporting, albeit aware of the need for clarity of messaging relating to the potential for harm, with a proactive approach required for how to mitigate this, balanced by the need for local information that hasn’t previously been published.

1. **COVID-19 Impact – workforce and recovery**

TS- Summarises the situation to be that the pandemic continues to place pressures on the sector and wider community. Some elements of the service were retained and continue, those element within the PH workforce have some scope for recovery. There is increased demand and focus from Scottish Government accompanies with additional investment and commitment to preventing DRD

What impact has there been on workforce and resourcing?

* What are PH workforce needs to support high demand in recovery phase (but really just another phase)?
* What are development priorities that have emerged as a result of the pandemic- if we are to take a PH approach, are there particular lessons emerging to be captured (for renewal)?
* Use of PHDSIG meetings- engaging with SDsPH for workforce incl. ADPs etc?

NHS GG&C maintained capacity and continues with some strands of work coupled with a major new programme on drugs based stigma on which they are eager to link learning/developments with other boards. The Board are engaging with x6 ADPs on the alcohol and drug prevention framework and are launching a new network mid May 2021.

Nevertheless, workforce remains thin on the ground and workforce development needs continue despite linking with SDF. In particular the gap remains in the underlying determinants and upstream action.

\*TS to link with TL to bring L&D to a future meet

NHS Highland- Argyll & Bute and Highland ADP capacity is noted to be reduced. However, also acknowledging that ‘living with COVID’ has reached another phase (noting current low prevalence in Highland regions.)

The SIG Chairs meeting seeks to identify cross cutting opportunities

Contact tracer capacity? Is there scope to be doing things differently / doing different things (e.g. some ‘no case’ days in Highland...) How best can this opportunity be explored and utilised?

AMcA – by example (as follow on) is there potential for contact tracers to assist in HepC follow up? Identifies vaccination as a key point of engagement, not only for service staff but also service users, noting that this too is unequal across the country, across services. All agree that this is a vulnerable population at increased harm of direct/indirect harm.

\*SIG in agreement to consider as a key item in coming months

KL – drugs services are having conversations about vaccination delivery to users. ADP previously in discussion about users within priority groups and acknowledge service engagement limitations.

Reference ‘Everyone In’ campaign as an example of the potential/will to mobilise at scale. What potential learning can be taken into vaccination/test and protect programmes.

NHS Tayside experience is that there has been fall off in IEP Harm Reduction services with overall footfall reduced presenting an area of concern. As we restart, how best can we identify and pick up on the harms arisen in the interim.

KH – in regard to the potential impact of Covid on DRD, are we sufficiently assured that we are being proactive enough given what we know already about compromised respiratory for this population? Noting evidence of overdose/cause for concern calls relating to Covid from the Naloxone Police trial.

Scottish Analysis on the Covid impact is being undertaken using the CMS Covid database and Scottish Drug user database. Anecdotally the read out is that this group are ‘not affected’ however is this as result of data being unavailable.

AMcA- data linkage for the above has been approved (Covid to drugs data sets, pre-christmas led by Sharon Hutchinson.) Linkage is to commence in the coming weeks with analysis planned thereafter.  
Analysis on impact on BBV testing, opiate subscribing, naloxone- analysis is complete and undergoing author review. Services have been significantly impacted and stagnating. Cohort analysis on morbidity and mortality to follow soon (incl. prisoner cohorts- pre-approved) Homelessness is included as a marker although more difficult assessment and requires in-depth work. This includes case control work (drug user identified in past) and case control relating to risk of CV19 outcomes so technically retrospective but as close to prospective as possible.

LT – NHS Forth Valley undertook outreach vaccination project with Scottish Ambulance Service targeting homeless and gypsy traveller communities

\*LT to forward to ScotPHN for sharing

DS- ‘The Wand’ NHS GGC model is another programme incorporating vaccination approach into existing services

\*DS to exchange programme information to ScotPHN/SIG

TS- Biggest themes for impact of covid19 are on access to care (remembering that care has to be holistic addressing multiple and complex needs of pop group), to include vaccination as oppose to immunisation being approach separately. Have any preferences around the needs for this particular group been identified? Or what other actions are appropriate to take?

\*TS & DMcC to consider who best in clinical and protecting health on vaccination strategy to connect with on issue/opportunities identified (incl. Clare Cameron)

LS- NHS Highland have vaccination oversight group for process including consideration of excluded groups to ensure invitation and access for vaccination. This includes acknowledgment that not everyone is registered with GP and therefore approaches based on CHI are not comprehensive enough.

KH- vaccination letters are likely less effective, need more creativity for ways to reach the population and to ensure that vaccination opportunities are enabled via existing services.

ED- Identifies the opportunity to raise with community pharmacist directorate as an engaged/motivated network.

CG- NHS Lothian - sub-strand of Vaccinaton Programme Board has a current focus on homeless population and actively identifying other population groups and the services/clinicians linked to them.

\*TS to explore the feasibility of one pager statement (for SDsPH and then out to local leads) to help mobilise vaccination sub-groups action on excluded groups.

\* All group members to provide options /solutions to assist.

1. **MAT update**

Elinor D –updated the group on MAT standards/consultation status and provided details of progress including the publication of [MAT subgroup interim report publication. Interim Report Published March 2020](https://drugdeathstaskforce.scot/media/1207/mat-subgroup-interim-report-on-programme-to-date_mar21.pdf)

DMcC – updated the group on early discussion on national MAT MIST planning for scale up and agreed for the group to consider for response via email exchange in due course.

\*DMcC to update and consult SIG members on national developments in due course.

1. **Close of Meeting/ DONM**

TS thanked all for attendance and shared Date of Next Meeting as:

Date: 22 June 2021

Time: 10:00 – 11:30

Location: MS Teams (see calendar entries and/or contact [phs.sig@phs.scot](mailto:phs.sig@phs.scot))