

2025-26 QUARTER 2 LOCAL OUTCOME IMPROVEMENT PLAN

ACTION AND PERFORMANCE INDICATOR REPORTING



DF4 - PEOPLE ARE HEALTHIER AND EXPERIENCE LESS HARM AS A RESULT OF POOR HEALTH AND WELLBEING PEOPLE ARE HEALTHIER AND EXPERIENCE FEWER HARMS AS A RESULT OF MAKING WELL INFORMED DECISIONS ABOUT THEIR HEALTH AND WELLBEING						
Action Code	Action Title	Desired Outcome	Due Date	Latest Status Update		Progress
				Progress made	Slippage - 'Go to Green' Plan	
LOIP DF4 4.1	Proactively deliver harm reduction advice and support, including assertive outreach in response to non-fatal overdose	LOIP OUTCOME: People who take harmful drugs are offered evidence-based harm reduction and advice	31-Mar-2026	In Q1 2025/26, 45 naloxone supplies were recorded. This is higher than the very low figure of 5 in Q4 2024/25 but remains lower than the 53 reported in Q3 2024/25, showing some continued fluctuation in uptake. Harm reduction outreach has remained consistent, with daily huddles, assertive follow-up to non-fatal overdoses, and third sector involvement ensuring supplies, training and advice remain accessible. Q2 data is not yet available therefore % complete remains unchanged.	A review of the Q4 2024/25 decrease has been completed, with the Arrows building move identified as a contributing factor. Steps are being taken to ensure future supply remains stable and consistently available across Moray.	70%
LOIP DF4 4.2	Provide direct access to drug and alcohol services through Moray's integrated support and treatment pathway	LOIP OUTCOME: People can access the services they need to support their recovery	31-Mar-2026	In Q1 2025/26, 97.4% of people started treatment within three weeks of referral. In Q2, this remained high at 96.8%. Both figures are above the national target of 90% and continue the positive trajectory seen since Q3 2024/25 (90.2%) and Q4 2024/25 (96.2%). This demonstrates strong referral and triage processes, timely initiation of treatment, and effective inter-agency collaboration. Moray's integrated pathway, with single-point access, same-day prescribing where appropriate, and improved service co-location, continues to ensure accessible and timely support.		80%
LOIP DF4 4.3	Establish and promote a local approach for referring people to residential rehabilitation, which recognises the geographical and financial barriers for people living in Moray	LOIP OUTCOME: People can access the services they need to support their recovery	31-Mar-2026	In Q2 2025/26, 5 people completed residential rehabilitation, an increase from 4 in Q1 2025/26 and consistent with the 5 recorded in Q4 2024/25. The local pathway remains fully established and continues to improve access across Moray. A Residential Rehabilitation Link Worker has now been onboarded to provide tailored support before, during, and after placements. Good working relationships with providers		80%

				have been maintained, and Moray continues to use the Scotland Excel framework to support placement access. The ADP actively attends all Residential Rehabilitation Hubs and participates in national thematic groups on residential rehabilitation, ensuring local practice aligns with national priorities and learning. These actions are strengthening consistency of referral processes, provider engagement, and aftercare arrangements.		
LOIP DF4 4.4	Work in partnership to monitor un-planned discharges and promote re-engagement	LOIP OUTCOME: People remain in treatment for as long as they need to	31-Mar-2026	In Q1 2025/26, 120 unplanned discharges were recorded, a small reduction compared with 126 in Q4 2024/25. Q2 data is not yet available. While this represents a modest improvement, the overall level of unplanned discharges remains high and continues to highlight challenges in sustaining engagement. A joint review has been carried out with MIDAS and Arrows, which identified issues with how discharges were being recorded. Training on the DAISy system has now been implemented for teams to ensure data is entered consistently and accurately. It is anticipated that these changes will lead to more reliable reporting and improved figures in future quarters. Real-time monitoring systems remain in place, with assertive follow-up, welfare checks, and lived/living experience outreach supporting people to re-engage after leaving treatment. Multi-agency partners continue to review discharge trends, and escalation processes have been agreed to ensure risks are identified and addressed promptly.	Progress is dependent on reducing unplanned discharges further. Actions include strengthening early engagement strategies, increasing flexibility in service delivery, and continuing assertive outreach and trauma-informed re-engagement approaches. The recent review with partners and DAISy training is expected to improve data accuracy and support a more positive trend going forward.	60%

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Code	Short Name	Current Target	2023/24	2024/25	2025/26	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Latest Note	Short Term Trend Arrow	Status
			Value	Value	Value	Value	Value	Value	Value	Value			
LOIP_DF4_4.1	Number of Naloxone Supplies and Re-Supplies (increase)	Data only	166	169		64	53	5	45	N/A	Q2 data is not yet available and will be available in the coming weeks. In Q1 2025/26, 45 naloxone supplies were recorded. This shows recovery from the sharp drop to 5 in Q4 2024/25, though still below Q3 2024/25 where 53 supplies were reported. The overall annual figures show some fluctuation, with earlier quarters generally ranging between 47 and 64 supplies per quarter. This indicates challenges in maintaining a consistent upward trend.		

											Ongoing harm reduction outreach, daily huddles, and third sector engagement continue to support distribution and raise community awareness of safer use practices. Further analysis will be possible once Q2 figures are confirmed.		
LOIP_DF4_4.2	Percentage of people waiting no more than three weeks between referral to a specialist drug and alcohol service and commencement of treatment (90% National Target) (increase)	Data only	96.1%	92.6%		86.8%	96.21%	90.2%	97.4%	96.8%	Q2 data is not yet finalised so these figures may change. In Q1 2025/26, 97.4% of people started treatment within three weeks of referral, compared with 96.2% in Q4 2024/25 and 90.2% in Q3 2024/25. Across all three years, Moray has consistently exceeded the 90% national target, apart from Q2 2024/25 where performance dipped to 86.8% due to temporary pressures. Performance demonstrates strong referral and triage processes, timely initiation of treatment, and effective inter-agency collaboration. Work continues to embed the Medication Assisted Treatment (MAT) Standards to ensure consistency across all providers.		
LOIP_DF4_4.3	Number of people completing residential rehab placements (increase)	Data only	3	9		0	4	5	N/A	5	A clear local residential rehabilitation pathway is now fully established. The pathway has been co-produced with people with lived and living experience and promoted widely across Moray. In the past year, we have: Increased the number of individuals completing residential rehabilitation placements from 2 in 2022/23 to 9 in 2024/25, demonstrating improved access and engagement. Employed a dedicated Residential Rehabilitation Link Worker to provide individualised support before, during, and after placements. Joined the North of Scotland Regional Improvement Hub to share learning and drive continuous improvement. Published and implemented the Moray Residential Rehabilitation Pathway, supported by awareness-raising with all referrers and partners. Work will continue to strengthen pathways, reduce waiting times, and		

											improve aftercare to support sustained recovery outcomes.		
LOIP_DF4_4.4	Number of people disengaging from specialist drug and alcohol services (unplanned discharge) (decrease)	Data only	397	475		114	100	126	120	N/A	Q2 data is not yet available. In Q1 2025/26, 120 unplanned discharges were recorded, a reduction from 126 in Q4 2024/25. Despite this improvement, numbers remain high. Data from the PHS DAISy system shows that reasons for unplanned discharge include individuals disengaging, being unable to engage, not completing assessments, or, in some cases, death. These outcomes highlight ongoing challenges in sustaining engagement. Assertive outreach, welfare checks, and lived/living experience involvement continue to be central in re-engagement efforts. Monitoring these discharge categories helps identify trends, inform service improvements, and supports people to remain connected to care.		