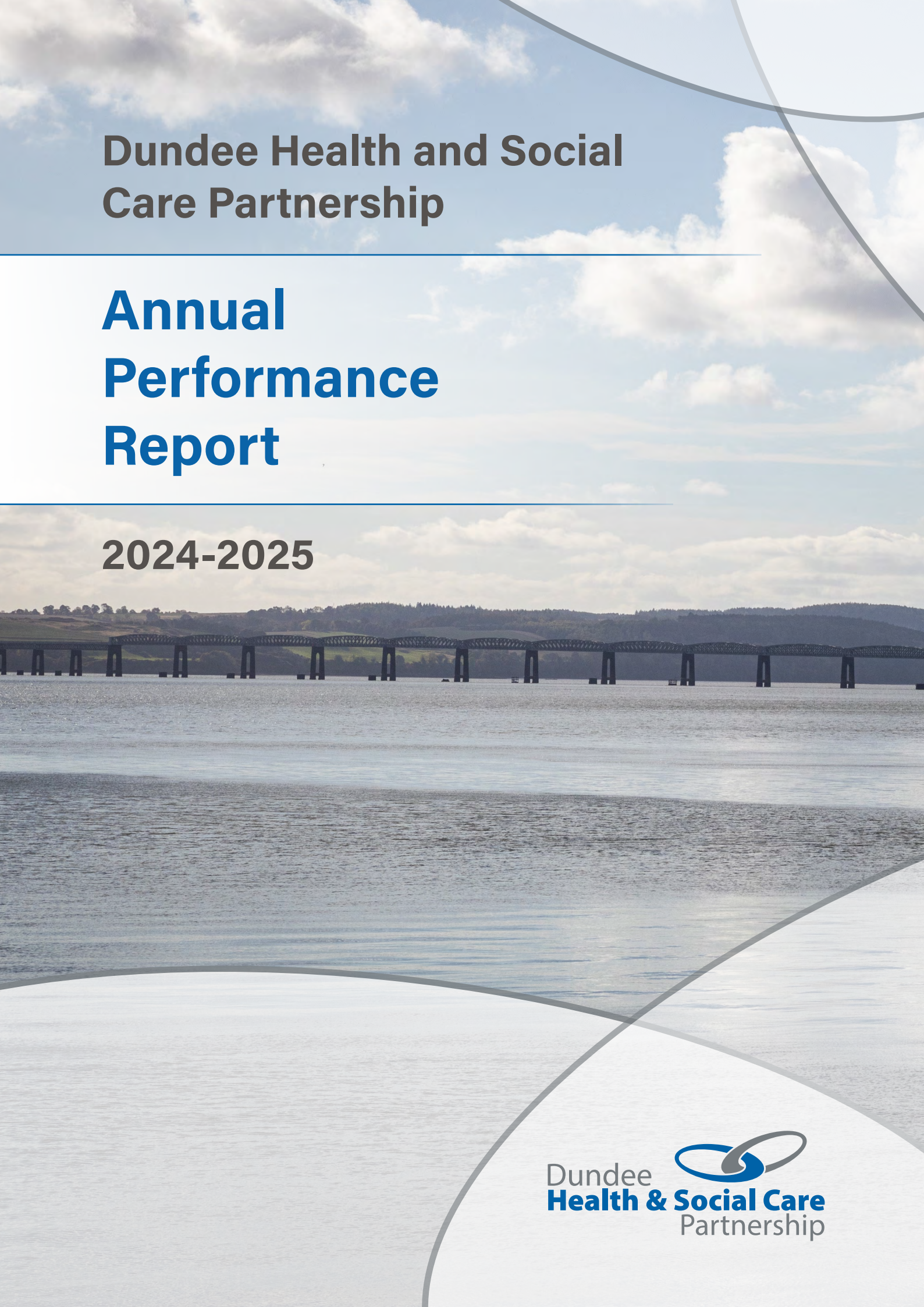

Dundee Health and Social Care Partnership

Annual Performance Report

2024-2025

Dundee Health & Social Care Partnership

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Foreword

2024/25 has been another challenging year however we are once again proud to present our achievements in our annual report.

The current fiscal challenges have led to many difficult challenges and concerns about current and future resource, but this has also led to transformational change projects to identify how we can enhance efficiency and productivity in response to those challenges.

We cannot make these service changes without engaging and listening to our fantastic staff, who are pivotal to delivering successful change, and also the people who use our services, their representatives and carers and our communities.

Many Dundee citizens continue to experience the effects of multiple deprivation and the associations this has with mental illness, drug and alcohol use, obesity and frailty associated with early diagnosis of long-term conditions such as diabetes and chronic obstructive pulmonary disease.

We will continue to work hard to ensure that services are accessible and are of high quality, are focussed on prevention and are designed around people rather than systems or services.

Improving access to services and treatments in communities will also mean using resources differently and this will mean; further integration with key stakeholders, considering different models of care and considering how we use digital technologies to make use of the right information and enhance the care of service users.

Our external commissioned care providers are an essential and highly valued part of our workforce, and we will continue to support the care market by ensuring that fair work principles are embedded in our approach to procuring services for our population.

This annual report is a snapshot of the achievements undertaken by our teams this year which will be built upon and expanded as we continually change and improve.

Councillor Ken Lynn
Chair, Dundee IJB

Dave Berry
Chief Officer, Dundee IJB

Who We Are

Established in April 2016 the IJB is the group of people responsible for planning, agreeing and monitoring community-based health, social work and social care services for adults. The Dundee Health and Social Care Partnership ('Partnership') is responsible for delivering person centred adult health and social care services to the people of Dundee in-line with the ambition and strategic priorities of Dundee Integration Joint Board. The IJB's ambition for health and social care in Dundee is:

People in Dundee will have the best possible health and wellbeing. They will be supported by services that:

- Help to reduce inequalities in health and wellbeing that exist between different groups of people.
- Are easy to find out about and get when they need them.
- Focus on helping people in the way that they need or want.
- Support people and communities to be healthy and stay healthy throughout their life through prevention and early intervention.

The Partnership consists of Dundee City Council, NHS Tayside and providers of health and care services from across the third and independent sectors. This includes all adult social care, adult primary health care and unscheduled adult hospital care.

The Plan for Excellence in Health and Social Care in Dundee, Strategic Commissioning Framework 2023-2033

As part of The Plan for Excellence in Health and Social Care in Dundee the IJB identified six strategic priorities that will be the focus for work over the next eight years, supporting them to deliver their ambition for health and social care.

Strategic Priorities

Inequalities

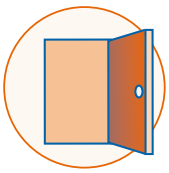
Support where and when it is needed most.

Targeting resources to people and communities who need it most, increase life expectancy and reduce differences in health and wellbeing.

Self Care

Supporting people to look after their wellbeing.

Helping everyone in Dundee look after their health and wellbeing, including through early intervention and prevention.



Open Door

Improving ways to access services and supports.

Making it easier for people to get the health and social care supports that they need.

Planning Together

Planning services to meet local need.

Working with communities to design the health and social care supports that they need.

Workforce

Valuing the workforce.

Supporting the health and social care workforce to keep well, learn and develop.

Working together

Working together to support families.

Working with other organisations in Dundee to prevent poor health and wellbeing, create healthy environments, and support families, including unpaid carers.

This Annual Performance Report, the ninth published by the IJB provides evidence against each of these Priorities by summarising key achievements, case studies and information about what people who use our services, their representatives and our workforce have told us about the quality and impact of health and social care services and supports.

Dundee is Scotland's fourth largest city, with a population of 153,000 people (Source: NRS, 2024).

The city has an ageing population, with a 9% increase in the 75+ age group expected by 2028, lower than Scotland's 25% average. (Source: NRS, 2024).

21.6% of the population reported that they live with a long-term illness, disease or condition (Source: Scotland's Census, 2022).

Dundee has approximately 18,300 adult carers, and 830 young carers among its 20,936 children aged 4-17.

Life expectancy of males in Dundee is 74.6 and for females in Dundee it is 79.2 (Source: NRS, 2024).

Dundee is the 5th most deprived local authority in Scotland, with 36.6% of its population living in the 20% most deprived areas, leading to significant health and social inequalities (Source: SIMD 2020).

23% of working people in Dundee are employed by accredited Living Wage Employers.

2,690 people work directly for the Partnership, employed by Dundee City Council or NHS Tayside, and many more people work in the Third and Independent Sector, in services commissioned on behalf of the IJB.

Over 4,000 people receive a service from the HSCP across older people and adult services.

On a snapshot day in March, 0 people waited in hospital and 138 people waited in the community for a social care assessment. One person was assessed and waiting for a care at home package in hospital (12 hours to be provided). Two people were assessed and waiting for a care at home package in the community (four hours to be provided).

The Partnership is one of the top performing in Scotland in Delayed Discharge. This means that the length of time people remain in hospital when they are well enough to return home is less than other Partnerships across Scotland.

30 people died of probable suicide in Dundee in 2023, with 22 of these being male and eight being female. (NRS, 2024)

Dundee has the highest rate of Drug Related Deaths in Scotland with 46 Drug Related Deaths in 2024, which is an increase of eight deaths from 2023. (NRS, 2024)

Dundee is one of the highest three Partnerships in Scotland for alcohol specific mortality rate with 36 Alcohol Specific Deaths in 2024 which is an increase of one death from 2023. (NRS, 2024)

Achievements

A change in the Pulmonary Rehabilitation model to ensure all patients taking part in Pulmonary Rehabilitation over all sites have access to COPD Clinical Nurse Specialist. This raises awareness and also identification of self-management issues which can also be supported.

Individuals presenting with acute mental health distress are now able to access physical health screening to ensure any reversible cause of distress (i.e. infection) is addressed promptly, in a trauma and mental health informed manner. This has addressed a significant health inequality for older adults with mental health conditions.

The 'home first' approach, prioritising care delivery as close to individuals' own home as possible has contributed to ensuring they remain in hospital only for essential treatment periods and are promptly transitioned back to their homes or community settings. This success was due to all partners working together to ensure joined up working and personalised approaches to individual health and care needs.

When people need support, especially when leaving the hospital, clearer steps and plans were developed to ensure that care continues smoothly. This involves different teams knowing exactly what to do and when, so people have a safe and supported transition.

Over the last year access to learning on equality and fairness matters increased. An Equality & Human Rights Workforce Learning Network was established and communication methods were reviewed and made more accessible. This included reviewing the way the IJB completes and assesses detailed Integrated Impact Assessments on all proposed changes that might affect protected groups.

99% of unpaid carers supported by the Dundee Carers Centre reported that they felt their health and wellbeing increased as a result of receiving support.

Challenges

Health and Care needs associated with high levels of multiple deprivation in the city, including high levels of drug and alcohol use, mental illness and multiple long term conditions and frailty at a younger age, create high demands on services.

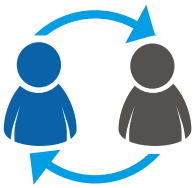
Significant challenges resulting from demand exceeding budgets for social care is unsustainable. Unless this is addressed, delayed discharges, for instance, are likely to increase and would impact disproportionately on older people as the predominant users of services. This will also impact the wider population due to the impact this will have on acute beds. In the context of current resources, it emphasises the importance of transformational change in the way we prevent escalation of concerns and jointly design and deliver care and support.

Challenges continue to arise in ensuring that teams are situated locally and within communities. This has involved changing the roles of staff and requesting that they work in different ways. These changes require significant consultation with teams to ensure that they are supported through change whilst ensuring that models of service delivery are efficient and outcomes focussed.

The scale and complexity of improvement and transformation required to keep pace with demand is significant and must be delivered within a reducing level of financial resources. This activity also requires co-ordination both within the Partnership and at the interface with Dundee City Council, NHS Tayside and other partner organisations, in order to ensure that high quality services are delivered at the right time and in the right places.

Although absence levels have started to reduce, they remain high and have a significant impact on workforce availability and the health and wellbeing of wider staff groups. There is a need to continue to focus on reducing absence levels whilst managing current absences.

Challenges



There are specific workforce availability challenges relating to Occupational Therapists, Social Care Workers and General Practitioners. Challenges are also experienced, to a lesser extent in relation to, Advanced Nurse Practitioners and Physiotherapists. This can impact the ability to provide an optimal service, particularly regarding the availability of appointments and workforce wellbeing. Services have used a range of approaches to support recruitment and manage vacancies, however the local position reflects national workforce supply challenges.

Challenges continue to present within Primary Care services, due to recruitment issues, inadequate infrastructure including IT and locations, and inadequate funding to fully implement the Primary Care improvement plan. 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 there may be challenges to meet the health needs of the population.

Cost of living and inflation 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

Priority Areas for Next Year

- Publish a revision of A Caring Dundee Two Strategy for Carers.
- Ensure the delegated budget is targeted towards areas of spend which contribute to delivering the IJB's strategic priorities and delivers best value.
- Continue to shift the balance of care from bed-based models of care to community-based health and social care services.
    - Develop frailty focused Multi Disciplinary Team team, ensuring seamless care delivery across hospital and community pathways.
    - Create a Single Point of Contact for Urgent Care: Collaborate with partners to develop a unified access point for urgent care services, coordinating appropriate community-based support and enabling enhanced care closer to home.
    - Strengthen "Home First" Principles: Continue to build upon and promote the "Discharge Without Delay" (DWD) and "Home First" ethos, alongside the setting of realistic Expected Dates of Discharge (PDD).
    - Optimise Discharge to Assess (D2A) for Care Home Avoidance: Utilise data proactively to support a reduction in, or complete avoidance of, care home admissions from a hospital setting by maximising the effectiveness of the D2A service.
    - Transition to seven-Day Urgent Community and Allied Health Professional (AHP) Services: Move towards providing a seven-day service for urgent community care and AHP support to enhance responsiveness.
- Prioritise investment in early intervention and prevention for longer term impact on demand for health and social care services.
- Support the development of a whole system approach to improve food environments; ensure a healthy balanced diet is accessible and affordable to all; and improve population levels of healthy weight.
- Continue to work with statutory partners to develop the use of technology to enhance direct service user/patient contact and to support staff in the community to work in a more mobile way.

- Set out clearly the eligibility criteria under which the local population can access the range of health and social care services available, including signposting to the most appropriate services where applicable.

- Increase the pace of major transformation programmes, and work with statutory partners, including neighbouring IJB's to identify wider transformation programmes within which health and social care services can benefit.

- Continue to focus on the longer-term sustainability of the ten Medication Assisted Treatment (MAT) standards, including immediate responses to non-fatal overdoses, to ensure fast and effective access to treatment, safeguarding people from drug-deaths.

- Continue to ensure the implementation of fair work practices in social care provider contracts.

- Strengthen mechanisms for member of the workforce to share their experiences and views regarding discrimination and make improvements to how incidences are recorded and reviewed.

- Continue to take an active leadership role in wider multiagency developments as part of the Protecting People Committees and Chief Officers Group.

- Continue to implement the Dundee Adult Support and Protection Inspection Improvement Plan six key recommendations for improvement.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

Tayside Primary Care Strategy 2024-25

The Tayside Primary Care Strategy 2024-25 was published.

The Vision:

"To deliver excellent, high quality preventative Primary care in a sustainable way, improving the health and wellbeing of the population of Tayside"

What do we mean by Primary Care?

General Practice Services

Primary Care Out of Hours Services

Pharmacy

Dentistry

Optometry

Aims

Proactive and Community-Based Health & Wellbeing

- People will be supported to take more of an active role in improving and managing their own health and be better informed about which professional is best able to help them.
- Effective and efficient interventions, where needed, will be delivered in the right place, by the right person at the right time.

Independence, Care and Quality

- Care organised around populations, individuals and their carers, as opposed to organisations.
- Delivering the right type of care, in the right setting, based on people's needs.
- Primary care supports and enables people to achieve and engenders pride among those who work in it and respect by those who use it.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

Effective Resource Utilisation

- Fully integrated, highly skilled multidisciplinary and multiagency teams, are the first point of contact, delivering integrated, person-centred models of care, designed around the needs of our population, focused on prevention, self-care and shared health outcomes, delivered closer to home, utilising new technologies which minimise the need for hospitalisation or residential care, whilst improving workforce sustainability and resilience.

- A sustainable model of Primary Care, supported by appropriate estates, facilities.

The strategy has been developed with the following principles at its heart:

- **Person-centred.** The views of the population of Tayside will be routinely sought and will guide the development of the Primary Care system, putting people at the centre of service provision.

- **Empowerment.** Providing individuals with the opportunity to take greater responsibility for their own health and wellbeing.

- **Partnership.** Working collaboratively with the population of Tayside and the primary care workforce to ensure an integrated team-based approach.

- **Excellence.** Promoting excellence in service delivery and building on evidence-based practice.

- **Safety.** Ensuring that practice and services are of the highest possible quality.

- **Deliver best practice.** Ensuring that all services are affordable and delivered efficiently and cost effectively.

- **Equity.** Consistency in service delivery ensuring equity of access and treatment for those in need of services.

- **Outcome focused.** Aimed to achieve the priorities that patients/service users identify as important.

Further information about the Tayside Primary Care Strategy can be accessed here.

Dundee IJB General Practice Strategy

Dundee IJB has responsibility for the provision of the full range of general practice services across the city, working with NHS Tayside Board and Primary Care Contractors.

The scope of the Dundee General Practice Strategy is general medical services and services covered by the GP 2018 Contract and Memorandum of Understanding.

There is a national challenge to the sustainability of general practice which is reflected in Dundee. The contributing factors include:

- Increasing practice list sizes as practices close and patients are allocated to other practices. For example, Park Avenue Medical Practice closing as the practice was unable to recruit GPs to vacancies.

- There are challenges to workforce recruitment and retention across general practitioners, practice nurses and those with the skills needed to provide the services. Around half of Dundee practices have at least one GP vacancy. This is compounded by the numbers of clinical colleagues due to retire within the next five years.

The following activities have been undertaken to improve access:

Information and Education

- Care Navigation Training during May and June 2024. The purpose of this training was to build knowledge, confidence, and resilience in this front-line staff group to enable them to be better able to direct patients to the most appropriate services in primary care.

- Service specific training to increase knowledge about the services. Reception colleagues had opportunities to spend time with their colleagues to learn from each another, to discuss issues, achieve a better understanding of each other's perspective and develop relationships. For example, in June at the General Practice Learning Time event, the Sources of Support team shared with practice staff how their service supports patients.

- Televisions with media players have been installed into practice waiting rooms in order to share information about services and supports to improve health. Only one practice was unable to take part due to space and one is awaiting some remedial work to enable the install.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

Access to Appointments

The public consultation, undertaken as part of the GP Strategy, found that 66% of responses asked for improvements in accessing appointments. This is ongoing work but to date:

- Funding has been provided to enable six GP Practices to test asynchronous consulting. This is where a health assessment is done remotely, with the patient completing an online assessment form which is then reviewed by a clinician who responds within 72 hrs. By offering this alternative route it is anticipated it will reduce telephone traffic making it more straight forward for those that prefer to telephone and to support practices to manage incoming requests. Asynchronous consulting complements care navigation by signposting patients to the most appropriate clinical provider. For example, directing eye related concerns to a community optician as the first point of contact.

- All Practices in Dundee have an opportunity to test a digital solution called Medlink. It has a variety of functions, including the ability to do bulk text messaging, online medication reviews (for example, contraception checks), to share information with patients (for example, videos on asthma inhaler techniques) and the ability for patients to submit information (for example, blood pressure or blood sugar readings). Patients receive a message by text or email and respond by clicking on the link. Patients do not need to download any software. Evidence suggests using Medlink enables routine work to be done more efficiently including reducing unnecessary appointments.

- Self check-in has been tested in a few practices to enable patients to confirm they have arrived for their appointment at the practice. The clinician can then call the patient through to the consulting room. This frees up reception colleague time to answer and respond to other patient enquiries.

Mental Health and Wellbeing in Primary Care

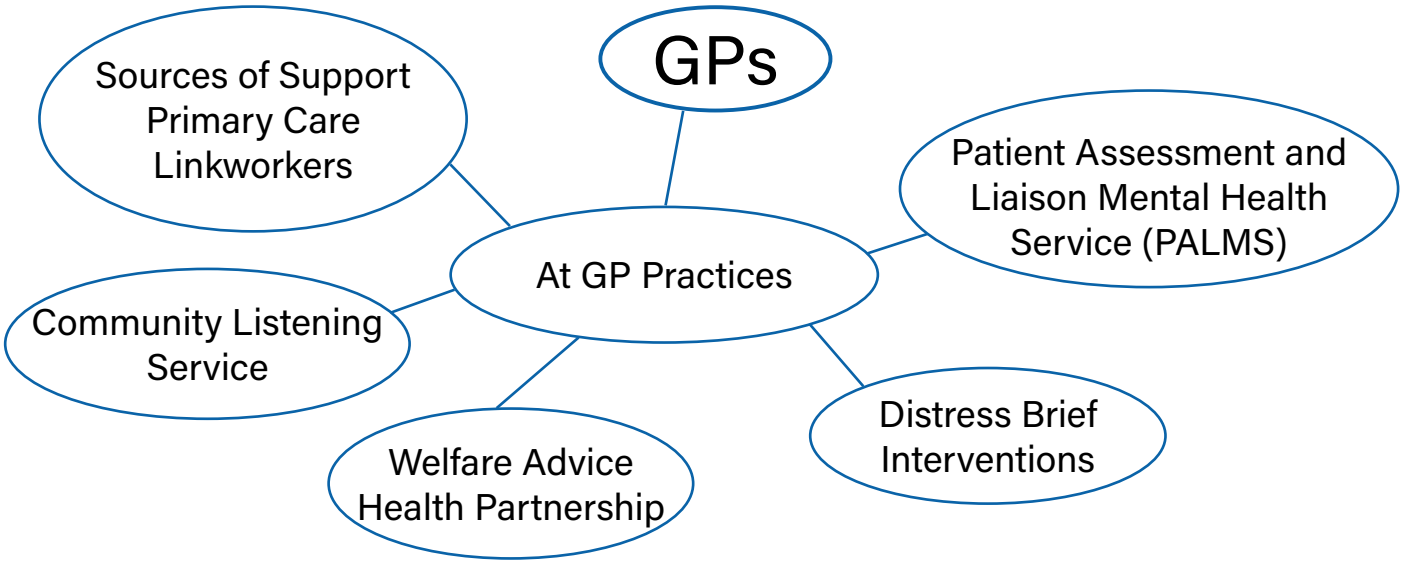
The Primary Care Mental Health and Wellbeing Programme aims to provide mental health and wellbeing services in Primary Care that enable people to access the;

- right support
- at the right time
- in the right place
- by staff who have the knowledge and skills to deliver this.

This is achieved through the Primary Care Mental Health and Wellbeing (MHWB) Framework utilising a multi-disciplinary team and collaboration with communities, third sector, and specialist services.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

General Practices currently offer:



Feedback from service users:

"Thank you very much for your support throughout the most difficult time in my life"

"Great service"

"Was lovely and supportive, made me feel very at ease and I felt this was a safe and good place to discuss some difficulties I had"

"This made me feel things will get better"

"She helped you to become less fearful and guilt free"

"It's nice to know that I no longer have to worry about money or barely making ends meet"

"I now have all the current support in place and a better relationship with my GP"

"I felt listened to and understood"

Website Development

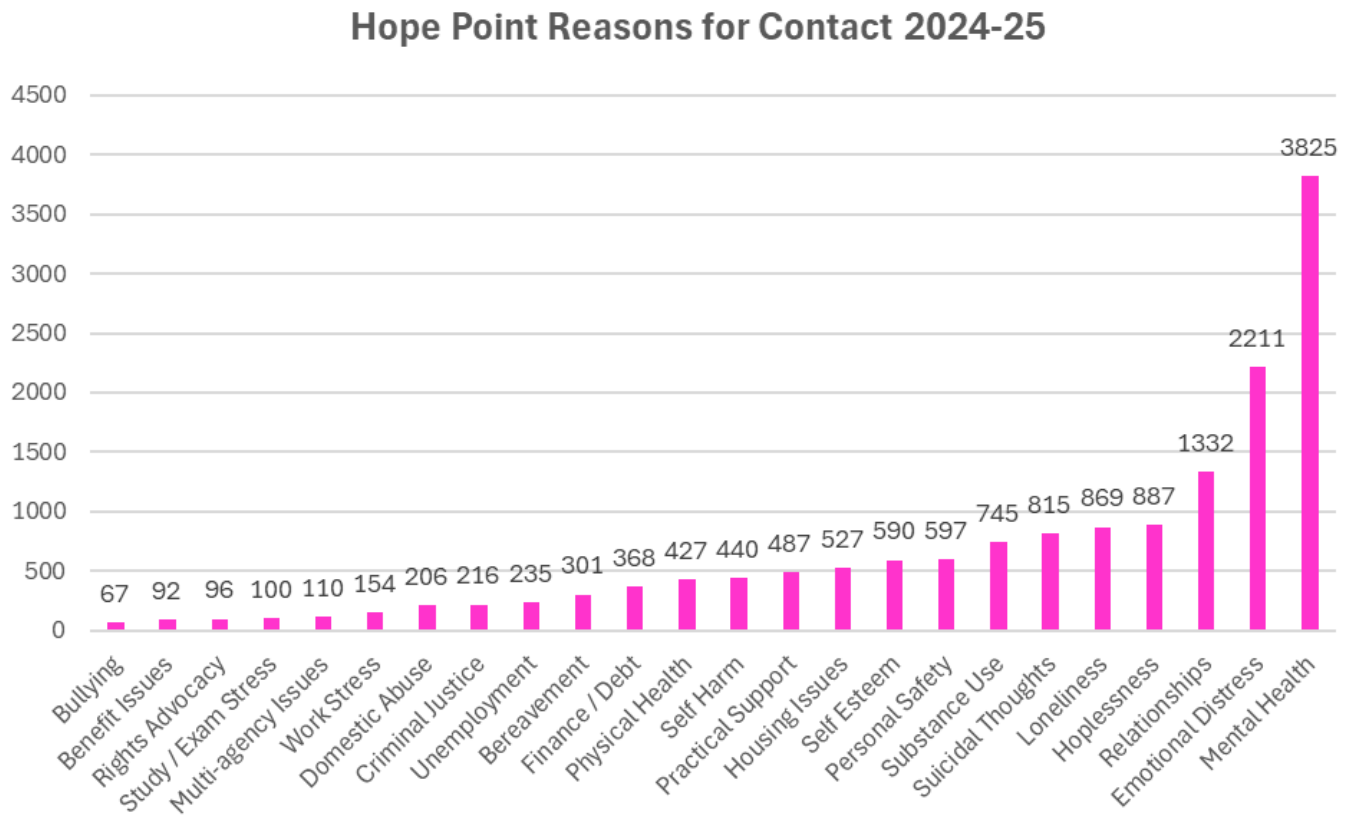
In November 2024 new pages were launched on the NHS Tayside website providing information about mental health and wellbeing support available at GP practices. The website also holds information for people who may be seeking support urgently while in distress. It also has an A-Z Directory of services available in Dundee to support mental health and wellbeing. A poster and leaflet campaign is underway to raise awareness of the new web pages and information sessions have taken place in person and across teams for local groups and services to attend. The website can be accessed by typing 'Dundee Mental Health and Wellbeing' into your search engine. Services can be accessed by phoning your GP practice.

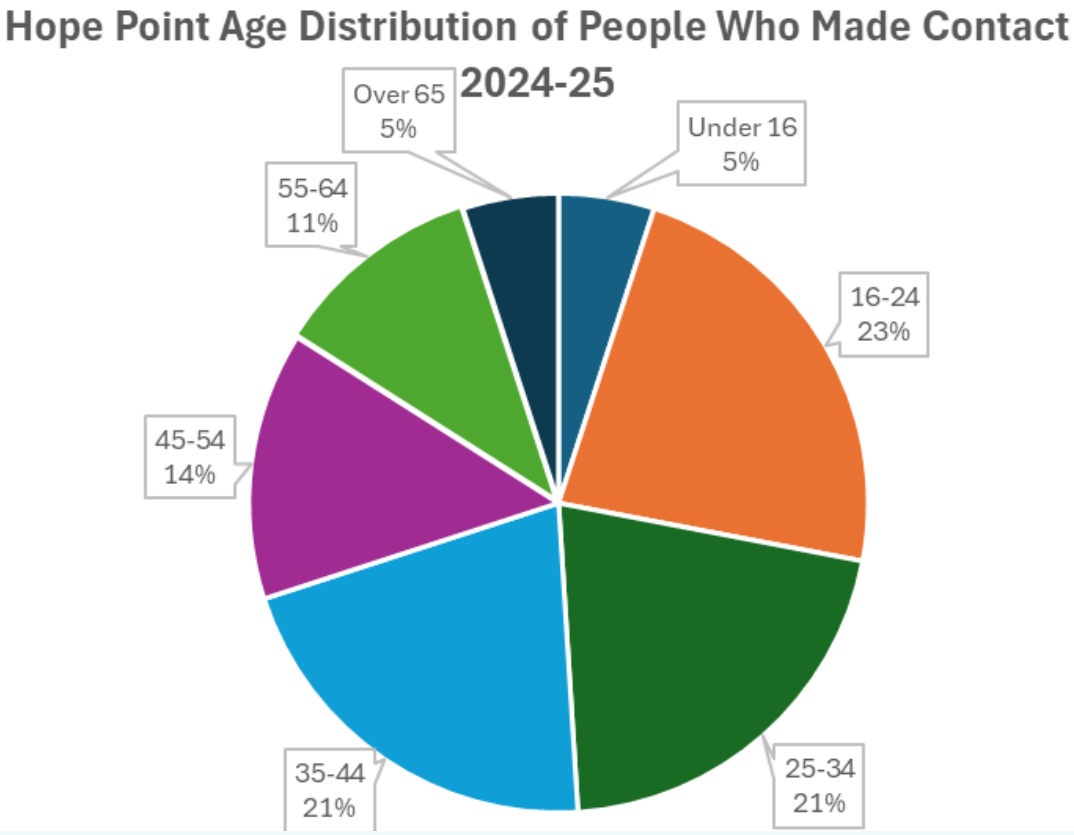
Hope Point

HOPE Point is a partnership between Penumbra that provides peer support to people experiencing emotional distress.

Hope Point has continued to provide 24/7 support for people experiencing emotional distress. An average of 75 new people each month accessed Hope Point during 2024-25. People cite feeling welcome, heard and understood and thus able to return for support when required. A significant milestone was the agreed pathway with Police Scotland becoming operational in October 2024. This allows for improved transitions for people requiring support due to distress, who do not meet the threshold for clinical input. In March 2025, Hope Point and Distress Brief Intervention partners were awarded 'Policing Partner of the year' at the Tayside Division, Divisional Commander's Annual Awards & Recognition ceremony for "delivering an outstanding level of performance in support of individuals in distress and experiencing mental health concerns".
Hope Point has been influential in a range of forums across the city. In particular, links with drug and alcohol services have been established and improved, ensuring that people experiencing both mental health challenges and substance use can receive timely, compassionate, and non-judgemental support. The service has continued to promote the support on offer via local networks and online platforms. Significant work has been undertaken with primary care colleagues, resulting in a continued increase of people being sign-posted for support by their GP practice.

During 2024-25 1,078 new individuals were supported, with 6,015 supports carried out.


Hope Point Reasons for Contact 2024-25
4500
4000
3500
3000
2500
2000
1500
1000
500
0
67
92
96
100
110
154
206
216
235
301
368
427
440
487
527
590
597
745
815
869
887
1332
2211
3825
Bullying
Benefit Issues
Rights Advocacy
Study / Exam Stress
Multi-agency Issues
Work Stress
Domestic Abuse
Criminal Justice
Unemployment
Bereavement
Finance / Debt
Physical Health
Self Harm
Practical Support
Housing Issues
Self Esteem
Personal Safety
Substance Use
Suicidal Thoughts
Loneliness
Hoplessness
Relationships
Emotional Distress
Mental Health


Hope Point Age Distribution of People Who Made Contact 2024-25
Over 65 5%
Under 16 5%
55-64 11%
16-24 23%
45-54 14%
35-44 21%
25-34 21%

"I am leaving much more uplifted than when I arrived. I am extremely grateful for your help. Hope Point is an amazing service, all the staff here do such a great job and you should be proud of yourselves in what you do."

"It was good to speak to someone who has been through the same experiences, more personal instead of medical."

"Reaching out to Hope Point tonight was my final attempt to get help as I just didn't feel I could carry on with life. I feel so much better, our conversation has given me hope"

"Most amazing support in Dundee, thank you from the bottom of my heart :)"

"I have never experienced something that has helped me as much as Hope Point has"
"talking to you all made me realise that I was not alone, and my feelings were not that unusual or weird"

"I am extremely impressed by the quality of care at Hope Point Dundee, their kindness is outstanding"

"You have saved my life twice now, If Hope Point wasn't here, I don't know if I would be here"

"Exactly what I needed at the time, not someone trying to fix me, just being there, understanding and caring"

Community Health Advisory Forum

The Community Health Advisory Forum (CHAF) is a Dundee group who commit to learning about health and wellbeing and undertake health-related groups and activities in their local community. The Community Health Team support the group to meet monthly to share experiences and ideas, hear about local and national developments, and discuss how to take forward action that can help reduce health inequalities. Group members are actively listening to people living in the most disadvantaged local communities to find out what matters to them. Group members support Dundee Health and Social Care Partnership and other organisations to ensure that residents at higher risk of poor health and wellbeing are meaningfully involved in decisions. CHAF members undertake an accredited Health Issues in the Community Course, which explores topics such as social justice, democracy, and participation. They are committed to the inequalities agenda and use their own experience in addition to hearing from others. In November 2024, the group organised a city-wide drop-in information event to respond to the findings of the Engage Dundee Survey, which was attended by over 80 people.

The CHAF has contributed to several important developments in the city including the Suicide Prevention Delivery Plan, the GP Premises Strategy, the IJB Plan for Excellence, the Community Learning and Development (CLD) Plan, and mental health promotion materials. CHAF members also reviewed the information about services available in general practices.

Drug and Alcohol Use

Working Better Together Project (funded by CORRA)

The Alcohol and Drug Partnership continues to prioritise progress with the local implementation of the National Mission to reduce drug deaths. Focusing on the implementation of Medication Assisted Treatment (MAT) standards, access to residential and community rehabilitation, and a quick response to the high risk reflected in non-fatal overdoses. During the past year, individuals in Dundee had immediate access to treatment, they had more choice about treatment options and could remain in treatment for as long as they require. More people then ever successfully accessed residential and community rehabilitation, and those experiencing a non-fatal overdose received immediate support on an outreach basis.

The Working Better Together, Substance Use & Mental Health (WBT) project commenced in 2022 with the aim of improving collaboration between substance use and mental health services. The key focus was to help individuals affected by substance use to access mental health services. Some parts of the project focused on the specific needs of women and worked closely with Women's Services to develop support.

Throughout the project, services listened and learned from the experiences of individuals and families. The Multi-Agency Collaboration Hub (MACH) was developed to provide quick joint assessments and access to services for individuals. Information sharing systems were also developed, including considering data protection requirements, to ensure that up-to-date information was available to all relevant professionals. Since the implementation of MACH, by December 2024, 85% of referred individuals received support from or are engaging with at least one other service for their identified co-occurring condition. Individuals report they are able to access a wider range of services, reducing risks of suicide and psychological harms.

During this project an extensive programme of staff development and training was delivered. This was done in collaboration with Health Improvement Scotland.

The funding from CORRA has now finished but new, improved multi-agency approaches are in place, which will continue to be developed.

What people said

"I am now getting specific support for my substance abuse with Thrive thanks to [Thrive staff member] and this meeting and I'm on the waiting list for community mental health for more support."

"I just feel that people are understanding my difficulties better."

"I am more aware of what is going on to help me. Before, I felt like I was being kept in the dark at times."

During 2024-25 the ADP reviewed its Delivery Plan (originally published in 2023), updated some of the actions and monitored progress.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

The implementation of the delivery plan reflects the high priority given by all local partner agencies to tackling harm caused by drugs and alcohol and recognises the need to continue to work at pace to improve responses to people currently affected, alongside preventing future harm. Significant progress was made during the second year of the strategic framework (2024/25) towards achieving the five key priorities.

ADP members have continued to build on progress with all aspects of the Medication Assisted Treatment Standards achieving a green status in all ten standards in the latest benchmarking report produced by Public Health Scotland. Green status is given when there is evidence of full implementation and meaningful change in services.

Key developments under this work have been the expansion of the shared care pathways bringing further GP practices on board to deliver shared care and the development of the Multi Agency Consultation Hub (MACH).

The ADP continued to allocate funding to local organisations to develop trauma-informed spaces and the Trauma Steering Group are continuing to lead multi-agency work to develop both trauma informed leadership and practice. There has also been significant improvement, via the establishment of Dundee Women's Hub, in providing safe and supportive services to women. Looking beyond the implementation of the MAT Standards, other notable developments in drug and alcohol services during 2024/25 included:

- Services have created and implemented a training programme of Cocaine Brief Interventions to ensure a first line response to increasing cocaine use.

- Dundee's Recovery Network continues to thrive , the Lived Experience Framework developed, and a robust system for gathering evidence from those receiving MAT is in place.

- Independent Advocacy (IA) is available to all individuals accessing specialist substance use services. Individuals with living experience report that this support has been key to help them remain in services and have access to all the support they need.

- Dundee has continued to develop the Whole Family Approach through a joint project with Scottish Families.

- The 'decentralised fund' was allocated for the third year and continues to support all the Local Community Planning Partnership to work with local services to tackle stigma and ensure individuals feel welcomed by communities. The 'Year of Kindness' project, started in April 2024.

- Hillcrest Futures continues to work in partnership with Scottish Government and University of Dundee to progress the set up of the Drug Checking Service in Dundee, as one of the three pilot sites in Scotland. The service will be offered as part of Hillcrest's existing harm reduction services, with people submitting a sample of a substance to get an analysis of the types of drugs contained in it.

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

We have continued to support individuals from Dundee in accessing residential rehabilitation. During 2024-25 11 people from Dundee accessed residential rehabilitation establishments. All these individuals are supported through the dedicated pathway to enter the residential treatment, during their stay and on their return to the community.

The Primary Care Drug Redesign Project continues to test ways of working to provide care for substance use patients. Currently three practices provide care for stable patients on Opioid Substitution Therapy (OST) and a fourth practice provides care for both OST and patients taking other illicit substances. The Practice Key Worker (from Hillcrest Futures or With You) is the patient's key contact. A further six practices provide holistic health checks to those on OST. Results include patient attendance almost doubling and non-attendances almost halving, one patient is no longer on OST and a number of patients are reducing their OST dose. Health checks include a patient diagnosed and treated for deep vein thrombosis, another for narrowing of arteries and another for menopause symptoms. this project involves many partners including general practices, psychological therapies, DIAS and the Public Dental Service.

Long-term funding has been allocated by the ADP to Positive Steps to support and develop the assertive outreach project. Staff from Positive Steps worked jointly with Dundee Drug and Alcohol Recovery Service (DDARS) to support 159 individuals in crisis to access treatment services. Near Fatal Overdose Rapid Response and Assertive Outreach services ensured that 75% of those people experiencing a high-risk event during 2024-25 were contacted within 24 hours.

Screenshot of STV News Interview "East coast 'lacking' in drug addiction services for women" 26/03 - Video linked below

Please click the **link** to watch the interview from STV News 26/03 which covers the current work being conducted through the Drug Deaths Deep Dive, highlights the importance of a gendered approach and the Welcoming Women Accreditation.

The video can be found at: https://www.youtube.com/watch?v=NisxBnP_UtQ

Community Sexual and Reproductive Health Team

The Community Sexual & Reproductive Health Team (CSRH) was created in 2024 to reduce sexual health inequalities. TSRHS is committed to improving access to care in all three localities in line with the Sexual Health and Blood Borne Virus Action Plan (2023-2026), Women's Health Plan (2021) and Dundee Health and Social Care Partnership Strategic Priorities 2023-2033. There is a focus on enhancing service delivery within a community setting in Dundee currently and expanding service provision in Angus. Meetings are planned to consider models of care.

The CSRH team strives to deliver training, development and support to enhance the capacity of key agencies and services to deliver a tier of sexual health care and assessment for vulnerable individuals. This will help ensure harm is reduced through improved access and early intervention. Sexual health services are being delivered by the nurse led CSRH team in community settings including emergency contraception, LARC, smears, STI and BBV screening and treatment.

Cognitive Decline/Dementia

Within the Older People Community Mental Health Teams, a Cognitive Behavioural Therapist (CBT) post has been introduced as part of the strategy to reduce reliance on the nursing and medical team within the service and to offer further psychological support to people over 65. The new post commenced in August 2024 and there has been 6 clinics every week held between Kingsway Care Centre (KCC) and home visits. A total of 162 appointments have been offered since the post commenced and the therapist has seen 29 new patients from the psychology waiting list, 10 of which have already been seen and discharged.

In addition to this, regular weekly Nurse Led Memory Clinics were held at Kingsway Care Centre. This resulted in waiting times being reduced from months to weeks allowing the nurses an opportunity to provide information and reassurance to patients and their families before being seen by the Psychiatrist for a potential dementia diagnosis. The newly qualified Advanced Nurse Practitioners were also able to assist the Psychiatrist and impart diagnosis if appropriate. This means that patients could be seen in a timely manner and a management plan be put in place to help them live well with the diagnosis.

The Partnership has successfully reduced the waiting list for accessing specialist assessment and diagnosis.

"A thank you note for being so kind to the both of us. You were very smart, professional, dedicated and heartfelt. Words seem inadequate to express the depth of gratitude. We hope to meet you again."

(Feedback from a family member regarding the Memory Clinic)

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

Advance Nurse Practitioners (ANP) have been working closely with the Hospital at Home team to raise awareness of delirium in older adults. This has led to individuals with an acute delirium being successfully identified and supported in their home environment which prevented escalation to hospital services.

The teams have also been supporting Foundation Apprenticeships throughout the year meaning 5th/6th year school students who have expressed an interest in mental health have come to shadow the teams twice a week during a school term.

The Post Diagnostic Support (PDS) team have successfully completed the Care Co-ordination programme with Health Improvement Scotland (HIS). The programme consisted of quality improvement methodology, supporting robust development of theory of change, required to ensure that people living in Dundee diagnosed with dementia receive high quality post diagnostic support.

The PDS Team also facilitates Cognitive Stimulation Therapy groups which continue to be well attended and received, along with ongoing exercise groups. Groups are held in Community Centres and the Hub at Royal Victoria Hospital as part of community engagement and vision under Reshaping Non-Acute Care. A monthly drop-in session has also been created for anyone with a dementia diagnosis to ensure ongoing support is available once discharged.

Dementia post-diagnostic support - NHS Scotland performance against LDP standards - gov.scot

Psychology

'Hello In There Wee One' is a unique project and beautiful book, designed to support expectant parents to communicate and bond with their baby. The book is given to all expecting families across Dundee at their 16-week midwifery appointment, free of charge and has already reached 600 families. It has been translated into multiple languages, including Dundonian Scots. It was designed in partnership with local families, who worked with artist Louise Kirby at a series of workshops to develop the book.

Lesley Sharkey (Nurse Director Acute Services, NHS Tayside) said:

"Research shows and clinical practice tells us that babies' emotional health and wellbeing begins before they are born. Hello In There Wee One helps parents in Dundee find ways to bond with their babies before they arrive. This can help build strong bonds between babies and the important people in their lives right from the start, and supports infant development and mental health."

Beth Bate, Director of DCA said:

"We're delighted to have been nominated for Hello In There Wee One - this project is an incredible demonstration of the ways art and culture can support health, wellbeing and social care outcomes, through working in partnership with some of our most important services and institutions"

Reducing Inequalities, Supporting Self-Care and Ensuring Services are Open Door

The English language version of book can be viewed here:
https://indd.adobe.com/view/906e7871-0c70-4bfe-a6d8-5d7b61739394

Please click here to access the book in alternative versions
NHS Tayside

Please click here to watch Hello in there wee one video:
https://youtu.be/e_OZotEsDTQ

This project was funded by the Scottish Government's Children's Rights Unit through CORRA. It brought together a collaboration of partners from NHS Tayside, Dundee City Council, Dundee Contemporary Arts and University of Dundee.

The experience and advice of professionals across Midwifery, Health Visiting, Family Nurse Practitioners, Infant Mental Health, Speech and Language Therapists, and Social Work teams was also used to develop the book.

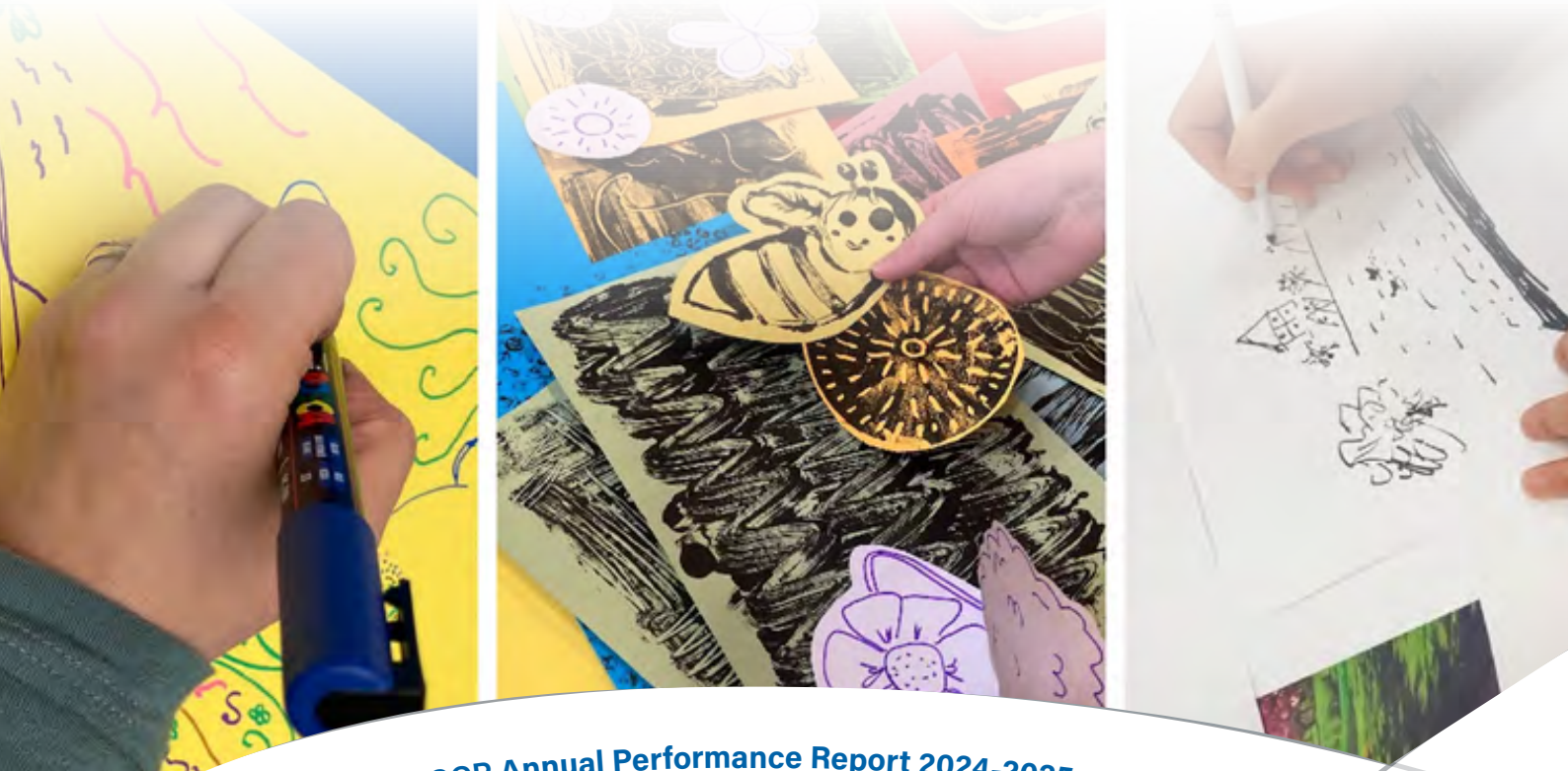
DCA Dundee Contemporary Arts

NHS Tayside

Dundee Health & Social Care Partnership

Dundee City Council www.dundeecity.gov.uk CHANGING FOR THE FUTURE

University of Dundee



Best Foot Forward

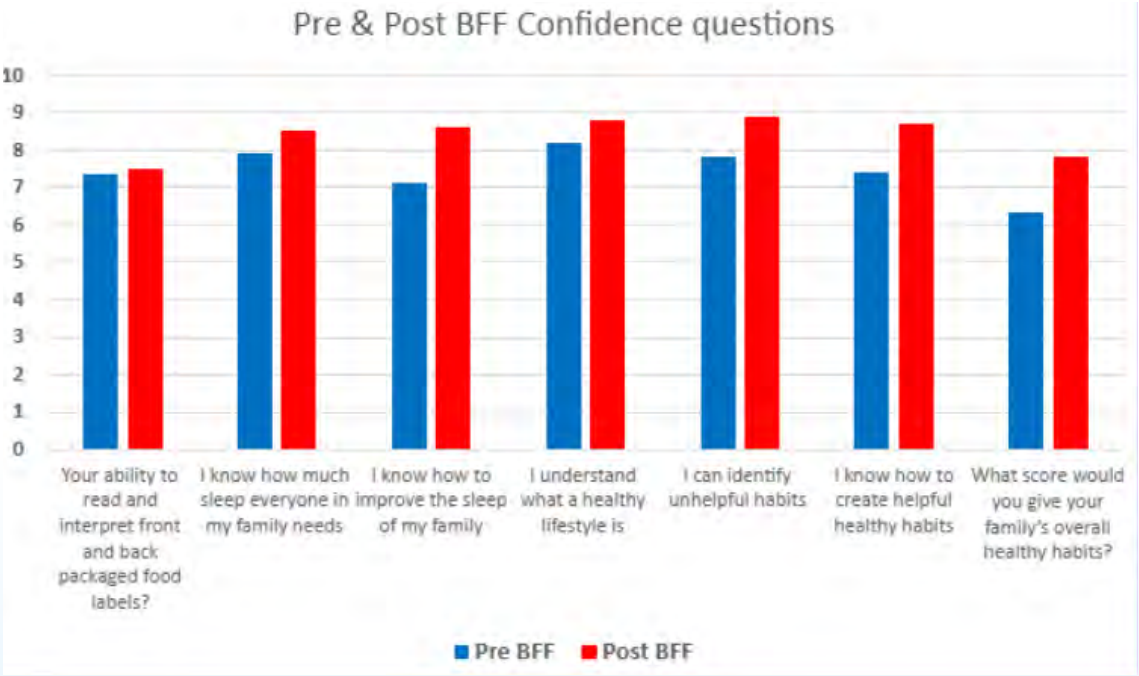
Best Foot Forward is a partnership between the NHS Healthy Weight team, Active Schools and 20 Primary schools in Dundee. It aims to encourage peer support and relationships between parents/carers, and to foster open and honest conversations around the challenges of achieving healthy eating and physical exercise day to day.

The sessions are 1.5 hours long with both adults and children attending together. Each week there are healthy snacks available for the families to try - rotating these so that participants will try new foods (various fruit and veg, oat cakes, dips etc.). Parents/carers were asked to sign up to the group if they felt this was an area of family life that they were interested in talking about/seeking support for.

- 104 families have started Best Foot Forward.
- 88 families attended the group regularly.
- 44% of families live in the 10% most deprived data zones in Scotland and 82% of families live in the 30% most deprived data zones in Scotland.
- By the end of the programme families increased their number of physical activity days by one day compared to week one.
- Compared to the start of the programme 20% of families felt a lot more active.
- There was a reduction in screen time use by families.

Working in partnership with:

- Active Schools Tayside
- NHS Oral Health Improvement (Childsmile)
- Dundee FC Community Trust
- Arbroath FC Community Trust
- Saints in the Community
- Signpost International
- Heart Space Yoga
- Tayside Contracts
- Sustrans
- Fairfield Community Football
- Perthshire Rugby Club
- Kobudo Martial Arts
- West End Tennis Club
- Dundee West FC
- Camoy Growers
- Kanzen Karate
- Ancrum Outdoor Centre (bikeability)
- Baldragon Academy Swimming Pool



Care Homes for Older People

Dundee Activity Network

The Activity Network aims to improve the quality of life and physical and mental health and wellbeing of care home residents through offering person-centred meaningful activity which is focussed on the needs, interests, and hobbies of residents.

Benefits of being involved in an activity network:

- Sharing of good practice, activity ideas and how to adapt, materials and resources.
- Networking and support.
- Training opportunities for care home staff.
- Bring information from the network back to the care home.
- Facilitates collaborative working and inter-care home activities such as Go4Gold.
- Opportunities to be involved in national initiatives.

Since September 2023, the DAN have held get togethers, events and some friendly competitions along the way. However, a wish of the network was to be able to relaunch the Going for Gold Event in Dundee, which last happened in 2019. Working in conjunction with staff from Leisure and Culture, Dundee and DVVA, the 2024 Going for Gold was relaunched on 6 September 2024.

The theme was the 'Dundee Olympics' and all care homes/daycare services that took part were tasked in the lead up to the games to get everyone involved to choose a team name, make a team badge and a flag that was decorated and represented the area of Dundee where the care home/daycare was situated. In the weeks leading up to Going for Gold, everyone practiced for taking part in the team events, which included boccia, football, golf, javelin throw, tennis, cup pong, basketball/netball, ten pin bowling and sport reminiscence. There was also a station set up for people to rest up and have a well-earned cup of tea between events.

Everyone was welcomed to the Menzieshill community hub by a piper before the care homes took part in the opening ceremony where everyone showed off the flags they had made before all competing against each other in the team events. There was lots of fun and laughter throughout the day, and STV News came along to capture what was happening on the day, which was televised that evening.

The day was brought to a close with the prize giving with each of the participants all receiving an Olympic medal and a certificate of achievement for every care home or change to daycare service that took part.

Trophies/certificates were given for the best scores from the team events on the day with Balcarres also taking home a celebration basket to be shared amongst all their residents.

The trophies will take pride of place in the winning homes throughout the year until the next Going for Gold in 2025.

6th September 2024
Dundee Olympics

20 Care Homes & Day Cares	59 Participants	48 Support Staff

1	2	3
Balcarres	Lochleven	St. Ronan's

Best Flag Design

1st Lochleven
2nd St. Ronan's
3rd Menzieshill

Best Team Name

1st Carmichael
2nd Clement Park
3rd Ballumbie

Best Badge

1st Riverside View
2nd Turriff House
3rd Mackinnon

Participant Feedback

"The whole event has been fantastic. Sign me up for next time!"

"More of the same please."

"Thoroughly enjoyed myself - very nice."

How would you rate the following?

Information provided before the event:
Not Good - 0 Ok - 1 Good - 3 Very Good - 16

The range of activities offered on the day:
Not Good - 0 Ok - 0 Good - 1 Very Good - 19

How the activities/stations were set up:
Not Good - 0 Ok - 0 Good - 3 Very Good - 17

Suitability of the venue:
Not Good - 0 Ok - 0 Good - 1 Very Good - 19

Participants enjoyment of the day:
Not Good - 0 Ok - 0 Good - 1 Very Good - 19

Working and Planning Together

The Mental Health and Learning Disability Whole System Change Programme in Tayside has made positive progress since its approval in June 2023.

The vision for the mental health and learning disability whole system change programme is in three parts reflecting different parts of the system and includes:

- Providing excellent care and treatment for people for whom inpatient treatment is the best option through a redesigned service model with strong evidence base;
- A co-produced model of care ensuring equitable, effective, treatment, care and support for people living in the community with complex and severe mental illness; and
- In partnership with commissioned providers, deliver Coming Home ambitions so that people with a learning disability receive the right support at home/community to maintain their health and wellbeing and minimise the likelihood of hospital admission.

There has been considerable progress in creating the conditions for whole system collaborative leadership and decision-making, improvements in the reporting of progress across partners, and better involvement and participation of people with lived experience across the programme. This is resulting in an integrated whole system change programme.

1. The model of care development aims to deliver a community mental health framework that integrates secondary, primary, and community mental health services. A comprehensive and co-produced engagement plan has been developed which aims to achieve whole-system, multi-sector and significant stakeholder involvement in shaping and ownership of the final model.

2. The V&A Dundee design accelerator workshops generated four ideas for whole system redesign, including crisis support, individualised care, alliance commissioning approaches and improved voice for people with learning disabilities.

3. The “Care and Share Together” approach is ensuring ongoing sustainable and meaningful engagement and is gaining traction with a dedicated co-production development officer. A co-production working group is preparing a framework based on the ladder of co-production, defining roles and expectations for service providers and users.

4. NHS Tayside is a national pathfinder site for Early Intervention in Psychosis (EIP) services. The EIP team has achieved positive outcomes, reducing inpatient re-admissions and improving engagement with the service and consideration for resourcing and roll-out is now required. In summary, the program is advancing toward a whole system model of care, emphasising community/place-based services, stakeholder involvement, and financial sustainability. The focus remains on improving and achieving excellence in mental health and learning disability services for people in Tayside.

Enhanced Community Care Model for Palliative and End of Life Care (PEOLC)

An enhanced model of community based palliative care was developed and tested in Dundee between March 2023 and March 2024. The model was designed to support palliative and end of life care at home, or in a hospice setting, if people wished to avoid hospital admission. A rapid response, multidisciplinary service was offered to people living in Dundee which provided urgent help with symptom control, holistic support and coordination of care with other community services. This team of specialists included a palliative care doctor, Macmillan nurses, health care support workers, physiotherapists and occupational therapists. An evaluation of the project showed that the majority of people supported by this service died either at home or in Roxburghe House, and only a very small number of people died in hospital. The feedback from people and families who used the service was also very positive. As a legacy of this project, Dundee Community Palliative Care Service now employs a permanent specialist palliative care doctor, who works closely with the Macmillan nurses and GP practices to support end of life care at home.

"The speed of delivery of equipment and medication was beneficial. The team were able to quickly build rapport and understand my Mum's wants as an individual...an outstanding service" (relative)

"Having someone checking in on us and able to action things quickly if required. Both medical and pastoral support has been beneficial and has provided practical advice and a calming effect on the situation" (relative)

"We appreciated the timely communication between all teams in, and having access to nurses in and out of hours" (relative)

"A wrap around service that was there when required" (relative)

"It is good to have the expertise from the team and they are more visible. Communication has improved and it is good to get prompt input when needed" (Community Nurse)

"The community palliative care doctor has provided excellent advice and support for the practice" (GP)

Suicide Prevention

Following the publication of the new national strategy in 2022, local arrangements to support suicide prevention were also revised. Suicide prevention has now been fully integrated as part of the remit for the new Children at Risk and Adults at Risk Committees within the multi-agency protecting people structure. Through agreement between Dundee Health and Social Care Partnership a dedicated Suicide Prevention Co-ordinator post has been established within the multi-agency Protecting People Strategic Support Team (hosted by the Health and Social Care Partnership) to lead this area of work, supported by colleagues across the wider team structure. Alongside other duties, the Suicide Prevention Co-ordinator has a lead role in supporting the development, delivery and evaluation of local suicide prevention delivery plans, aligned to both the national strategy and relevant local strategic plans and policies.

Dundee Suicide Prevention Delivery Plan 2024-2026 can be viewed **here**.

Suicide Prevention Training in Dundee Snapshot Report 1st April 2024 – 31st March 2025

The number of facilitators to deliver and test a recommended training programme developed by NHS Education for Scotland and Public Health Scotland as part of their Mental Health Improvement and Suicide Prevention Knowledge and Skills Framework has increased. In the last year a new training alliance called Every Life Matters was also established in Dundee to build training capacity across a range of Third Sector organisations and wider partners including Dundee City Council, and the University of Dundee. This was funded for 18 months by the NHS Tayside Charitable Foundation to co-produce and pilot the initiative. The training figures above include participants from these programmes and the others as named below:

During 2024/25 the following levels of training was delivered:

- Suicide Awareness for Volunteers and Volunteer Co-ordinators (Informed)
- Let's Talk About Suicide (Informed)
- Save a Life Dundee (Skilled)
- Let's Stop Suicide (Skilled)
- Applied Suicide Intervention Skills Training (ASIST) (Skilled)
- Suicide Intervention and Prevention Programme (SIPP) (Skilled)
- Formulation Based Approach to Suicide Risk Assessment (Enhanced)

Save a Life – Supporting People at Risk of Suicide

Save a Life is a one-day workshop that offers 'skilled level' learning using the NHS Education for Scotland/Public Health Scotland resources. It is aimed at non-specialist front line staff and volunteers working in health, social care, wider public and other services who are likely to have direct and/or substantial contact with people who may be at risk of suicide. Participants complete a post-training evaluation which found that:

94%
of participants reported increased knowledge of suicide risk and protective factors.

99%
of participants reported feeling more confident in having sensitive and compassionate conversations about suicide.

94%
of participants reported feeling more confident to support someone at risk of suicide to develop a safety plan.

Participants found safety planning the most useful element of the training.

Quotes from participants:

"Overall, all learning has been useful. I've come into this with no knowledge and feel I'm leaving with lots."

"What I found most useful was understanding how to start a conversation with someone I am worried about, and knowing the tools/resources available to help further."

"The session was delivered really well with it being both sensitive and informative."

Future Plans

In the coming year partners aim to:

- **Expand** the pool of suicide prevention trainers and increase the number of workshops available at informed and skilled level.
- **Streamline** and raise awareness of suicide prevention training to offer clarity and consistency for communities and organisations in Dundee.
- **Target** specific priority workplace settings such as schools and universities.
- **Extend** delivery for wider communities, including volunteers.
- **Improve** the evaluation approach to better measure the impact of training.

Carers

There are in the region on 20,000 unpaid carers living in Dundee.

99% of Carers supported by the Dundee Carers Centre reported.

'I feel my health and wellbeing has increased as a result of receiving support'
(Dundee Carers Centre)

The Carers Partnership finalised their Involvement Framework in August 2024. This is a framework designed to actively promote engagement and participation of Carers in Dundee. The framework supports involvement of carers of all ages, from varied backgrounds, caring for a diverse range of people. The framework recognises that engagement and participation methods need to take account of individual circumstances and the issues being considered.

Carers of Dundee

Further information about carer involvement, including a draft of the Carers Partnership Involvement Framework can be found at: https://carersofdundee.org/carer-involvement/.

Within the context of the overall Involvement Framework, the Carers Partnership has identified the following opportunities as being key to successful involvement of stakeholders in the statutory review process:

- Use of the Involvement Page on Carers of Dundee website to inform people of the statutory review and opportunities for involvement, including directed links to digital opportunities.
- Targeted engagement with young carers and parent carers, supported by Children and Families Services.
- Ensure that surveys of the workforce and partner agencies recognise that some employees will themselves be unpaid carers.
- Carers focus groups and support services continue to be provided on a locality basis with improved links to existing locality planning and involvement groups, such as Local Community Planning Partnerships, Health and Wellbeing Networks and the Community Health Advisory Forum.
- A public facing survey.
- Targeted engagement with age, health, and disability groups and with individuals and organisations representing people with protected characteristics.

Working and Planning Together

In addition the Carers Partnership has also achieved the following:

- Supported Health and Social Care professionals and associated workforce to proactively involve and seek the views of Carers when planning supports for the person they care for.
- Reviewed emergency planning procedures which includes information completed by and jointly held by carers, of which a copy is scanned to electronic records.
- Worked with Council Advice Services to identify carers who may benefit from a benefits check to ensure that their income is maximised.
- Improved and streamlined processes for Young Carers to be able to access a short break.
- Worked in partnership with Dundee City Council and schools to enable Young Carers to access peer support in school, college and their community to maintain attendance/ attainment and life balance.

Community Care and Treatment (CTACS)

Following on from the 2018 General Medical Council (GMC) contract, GPs identified aspects of their services that could be redesigned to allow practice staff to focus more time on managing patients with long term conditions more effectively. CTACS was introduced to be able to provide patients with person-centred treatment room care services.

The primary aim is to increase multidisciplinary team working and improve access to care and treatment at the right time, with the right person and closer to home:

- 34 wound clinics and 63 healthcare clinics are provided per week.
- The team comprises of 50 clinical staff and eight admin staff members.
- Admin staff respond to up to 10,000 incoming calls a month.
- Approx 7,500 appointments booked every month.

Feedback

"Fantastic service, all staff kind, caring and helpful. Felt listened to when describing my symptoms and previous wound healing experience. Can't thank you all enough"

"Excellent care and attention given to me by a variety of nurses for which I am very grateful."

Patients or staff can phone CTACS to be booked in directly for any wound care required including removal of sutures / clips. Patients can also phone and be booked in directly to have ear irrigation providing patients have been instilling ear drops for seven days.

Patients will be directed to the service from GP for chronic disease monitoring and non-urgent blood sampling, for example leg ulcer clinics and warfarin service require referrals into service from either GP or hospital staff.

Achievements

Two nurses qualified as Non Medical Prescriber (NMP), one nurse completed Leg Ulcer Management course, six nurses completed Tissue Viability Module, one nurse commenced NMP module, one nurse undertaking Ear Care Diploma. This is enhancing the anticipatory and preventative healthcare provided in the community and reducing the requirement for acute hospital care.

Winter Planning

The Winter Resilience Plan (NHS Tayside and Partner Organisations) 2024/25 was published and can be accessed here.

The aim of the 2024/25 Winter Resilience Plan is to formalise plans and processes between Acute Services and Health and Social Care Partnerships to improve capacity and resilience during winder periods, when pressures on systems are at their greatest. This continues to build upon the design and delivery of a whole system framework for predicting, responding to and managing peak periods of unscheduled activity. This also focusses on whole system communication and responses to support both unscheduled demand and urgent and planned elective care.

A whole system Health and Social Care approach to develop an integrated plan is essential. The Tayside and Fife Health and Social Care Partnerships, the Scottish Ambulance Service (SAS), 3rd Sector, as well as staff side/partnership representation have been involved in the development of the plan to ensure timely access to the right care, in the right place, first time. Third sector involvement is provided through the Health and Social Care Partnerships.

Section five of the Winter Plan details the specific actions for the Health and Social Care Partnerships. The primary focus continues to be ensuring that individuals receive appropriate care, in a timely manner, in the most suitable setting, with the goal of preventing unnecessary hospital admissions and promoting swift discharge when readiness permits. This approach contributes to improved health outcomes and maximises resource utilisation.

Key actions for Dundee Health and Social Care Partnership include:

- GAP community discharge hub in place.
- An intensive programme of improvement has achieved a significant reduction in unmet care need hours through working with care providers to enhance efficiency. The focus is now on sustaining performance.
- A promotion campaign is being undertaken to encourage social care support workers to access vaccination services.
- A Self-Directed Support event was held for frontline staff on 4th September to raise awareness and identify opportunities for using different SDS options to deliver care at home.
- The Spasticity Service is now fully operational as a means of supporting further rehabilitative approaches for stroke and neurology patients in a community setting.
- There is ongoing development of the Community Rehabilitation Service as a means of shifting rehabilitation closer to community settings.

Working and Planning Together

- An improvement programme is being progressed across Dundee Enhanced Care at Home Team (DECAHT) focusing on:
    - Streamlining the process for transfer of care between in-patient services and DECAHT to support care closer to home.
    - Participating in optimising access workstream to ensure appropriate use of services to optimise early access to preventative approaches.
    - Reviewing practice-based Multi Disciplinary Teams (MDTs) to support early appropriate referral.
    - Promoting joint working between cluster consultants and GPs/ Community services to support care at home.
    - Implementing remote prescribing to reduce unnecessary travel time and optimise capacity.
    - Working collaboratively across the Medicine for the Elderly (MFE) pathway to implement medication reviews for those most at risk of negative impact of polypharmacy.
    - Ongoing review of patient pathways within the service to reduce risk, reduce duplication and improve the quality of service provided.
    - Supporting the completion of RESPECT documentation to ensure that ceilings of care are agreed with the patient and shared across the MFE pathway.
    - Continuing to embed the Cluster model to ensure MDT working across the MFE pathway.
- Implementation of locality working model in community nursing to reduce unnecessary travel time and optimise capacity.
- Discharge to Assess social care service has been re-focused on front door frailty wards within Ninewells. The service Team Leader works collaboratively with the ward multi-disciplinary team to prioritise how the service is most appropriately allocated to support early discharge and assessment in a home environment.
- Redesign of rehabilitation model on the Royal Victoria Hospital site aligned to excellence in care standards
- The Stroke Neuro Rehabilitation Pathway Redesign is in progress, aiming to deliver an interdisciplinary approach to deliver an outcomes focused personalised rehabilitation pathway.

Dundee Community Living

The Dundee Community Living Service continued to achieve high standards of care and support to vulnerable adults with a wide range of needs and helped individuals to achieve their outcomes. The outcomes varied from securing a voluntary job for some individuals to feeling comfortable and safe while receiving palliative care.

This is both a responsive and flexible service which has moved resources between different parts of the provision at very short notice to meet changing needs.

The service has focussed on employee wellbeing which has positively contributed to sickness absence levels by actively promoting wellbeing conversations, peer support and the sense of being valued by the service for each member of the team.

The service continues to collaborate closely with health colleagues, for example psychology, psychiatry, learning disability nurses, GP's, mental health crisis team, also with learning and organisational development team, social workers, police and other agencies. Effective collaboration with these partners provides learning opportunities for all involved and enables development of robust systems of support for individuals to minimise the incidents of reaching a crisis point and to enable people to live a fulfilled life.

The following are results from the recent annual stakeholder analysis:

- 100% of staff, supported people, families and involved professionals said that the service was either very good or excellent in treating people with respect.

  In all interactions with supported people and families staff speak and listen in a person centred, courteous and respectful manner. Relationships of trust have been built up though regular discussions and communications.

- 100% of staff and involved professionals said that the service was either excellent or very good in following professional advice and treatment plans.

  Staff team within Dundee Community Living have built and maintain effective multidisciplinary collaboration with professionals from different services and organisations to ensure we are meeting the health and wellbeing needs of our supported people. This includes multidisciplinary communication, risk management and collaborative learning events.

"I enjoy my job and it has changed a lot for the better"
(feedback from staff member)

"Staff listen to me, have a laugh and joke and I know they are there for me"
(feedback from supported person)

"I find the staff work to the highest of standards and I cannot fault the dedication of them all" (feedback from family member)

"We would like to thank the staff for their kind and caring attention. They are brilliant"
(feedback from family member)

"Excellent support provided to service users. Staff have really good understanding of needs and knowledge of care plans. Senior staff are excellent"
(feedback from professions working with the service)

"Staff are excellent at communicating concerns surrounding service users. Families and professional agencies are kept informed very well"
(feedback from professions working with the service)

"Very good service and very apparent that the interests of service users are at the forefront of their practice. Welcoming service. Staff are knowledgeable, approachable and always keep me up to date as appropriate"
(feedback from professions working with the service)

"The staff team are very committed to providing a high standard of person-centred care"
(feedback from professions working with the service)"

There are plans to further develop in the following areas:

- To support staff to further develop their IT skills and become more confident with Microsoft 365.
- To continue developing multidisciplinary collaboration and using a range of learning opportunities to enhance staff skills and knowledge.
- To continue improving opportunities for wellbeing conversations, staff mutual support and support from management.
- To further develop staff understanding of outcome focused approaches and to embed it in our engagement with supported people.

Working and Planning Together

"My relative is being followed up by the CONNECT Early Intervention Psychology Service following a nine-week inpatient admission due to a first presentation psychosis. His world had crashed, and the future was uncertain. We were in unchartered waters.

Almost five months on due to the intense, regular input he has had from his nurse and OT, I can't believe the difference in him. He is back at work, and his nurse has supported him to break a ten year cannibas habit, which he used to self regulate his ADHD. He now accepts that cannibas is a trigger. He is taking his medication and now accepts he needs it, but there is a plan over a two year period to reduce his antipsychotic and restart non stimulant based ADHD medication.

Breaking away from his cannibas friends, the OT and Nurse have supported him to get back to work and introduced him to the SAMH Chrysalis Project. He is enjoying this and meeting other people which in time will support him to develop friendship groups. He also has had support worker and peer input at social group which again is supporting more positive social networks.

I am aware his nurse is now considering clinical psychology which I feel will address some of his issues around poor self esteem because of traumatic experiences earlier in life.

The staff from EIP have very much worked with us as a family, providing reassurance and support all the way.

His nurse is now facilitating with his Consultant Psychiatrist a return to driving.

Probably one of the most important things is that he has been scaffolded by both the Team and ourselves.

We cannot thank CONNECT EIP enough. In my opinion, their early timeous intervention is an investment and preventative measure to prevent a long term interventions and journeys within Psychiatry Services."

Discharge Without Delay : No Place Like Home

Discharge Without Delay is a whole-system initiative designed for frail older people currently accessing hospitals in Scotland. It integrates best practices, individual services, and care pathways into a cohesive model that prioritises delivering Comprehensive Geriatric Assessment (CGA) promptly. This approach ensures that patients experience no negative consequences from hospital- induced harm or dependency, while facilitating a smoother transition from hospital to home.

Overall acute, health, and social care spending will be more effectively controlled if frail older patients spend less time in hospital and maintain greater independence. This can be achieved by discharging patients without delay, minimising hospital-induced dependency, and preventing the over-prescription of social care services.

The Discharge without Delay programme has been in place in Scotland since 2023 and has four co-dependent workstreams.

Home First / Discharge to Assess

Aims to facilitate discharge from the hospital, without delay, for frail people, enabling them to undergo a more accurate and comprehensive assessment of their care needs in a more suitable, homely environment.

Please click here for campaign assets:
Home First Video links Campaign Assets | Scottish Government Marketing News – Campaign Assets | Scottish Government Marketing News

There has been collaboration with the broader health and social care system across Dundee and Tayside to champion a 'home first' approach, prioritising care delivery as close to individuals' residences as possible. This commitment is evidenced by the Partnership's consistently strong performance in minimising acute hospital delayed discharges, a proxy measure of whole-system efficiency. The Partnership is proud to be recognised as one of the top-performing Health and Social Care Partnerships (HSCPs) in Scotland in this regard, demonstrating a sustained reduction in bed days lost due to unnecessary hospital stays.

This is made possible with truly partnership working with all partners to ensure joined up working across health and social care across individuals' care journeys.

This achievement translates to tangible benefits for individuals, ensuring they remain in hospital only for essential treatment periods and are promptly transitioned back to their homes or community settings. This success underscores our dedication to a truly integrated, whole-system approach to care.

Discharge to Assess (D2A)

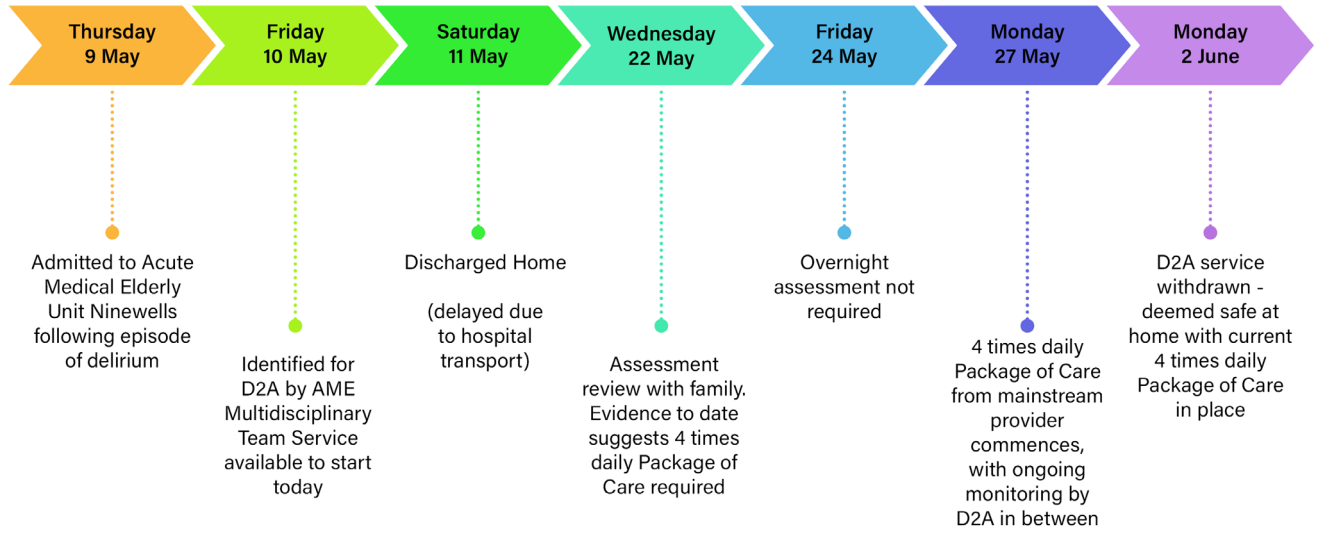
A significant development in the last year is the integration of the D2A Red Cross Test of Change into a mainstream service, which has become a main feature in national collaborative work. Discharge to Assess (D2A) service underwent a significant strategic shift from May 2024, to concentrate its resources entirely on supporting timely patient discharge from the Acute Medical Elderly (AME) unit at Ninewells Hospital.

The service has successfully refocused on resolving package delays within and, bridging care gaps for patients awaiting long-term packages, demonstrating adaptability in managing delayed discharges and optimising patient flow.

Discharge to Assess (D2A) Patient Pathway Example 1.

Dundee Health & Social Care Partnership — BritishRedCross

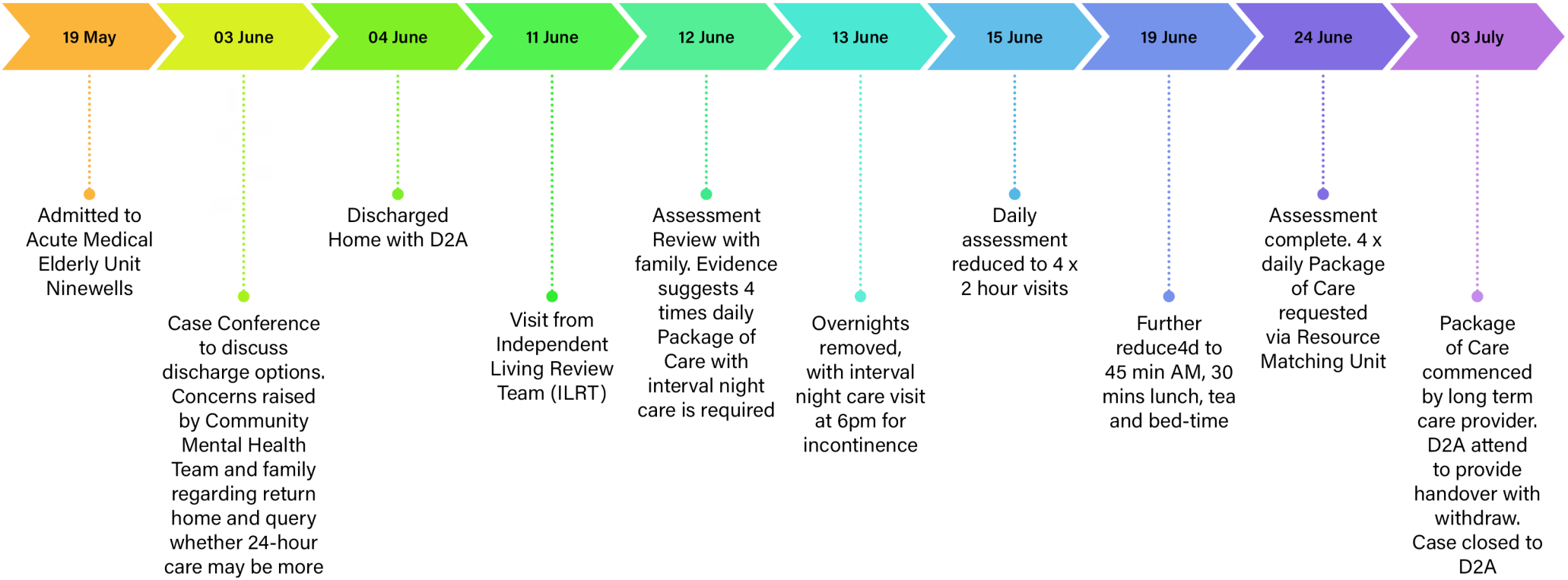
Presentation	▪ Delirious/confused in the last few days and wandering. ▪ Son was struggling to manage at home. ▪ Diagnosed with a lower respiratory tract infection and commenced on oral antibiotics for this. ▪ Mobilising independent. ▪ Ongoing issues with confusion likely to be caused by infection and environmental changes. ▪ Awaiting Psychiatry of Old Age (POA) review in the community.
Length of time on Service	24 days
Outcome of Assessment	Remain home with Package of Care.



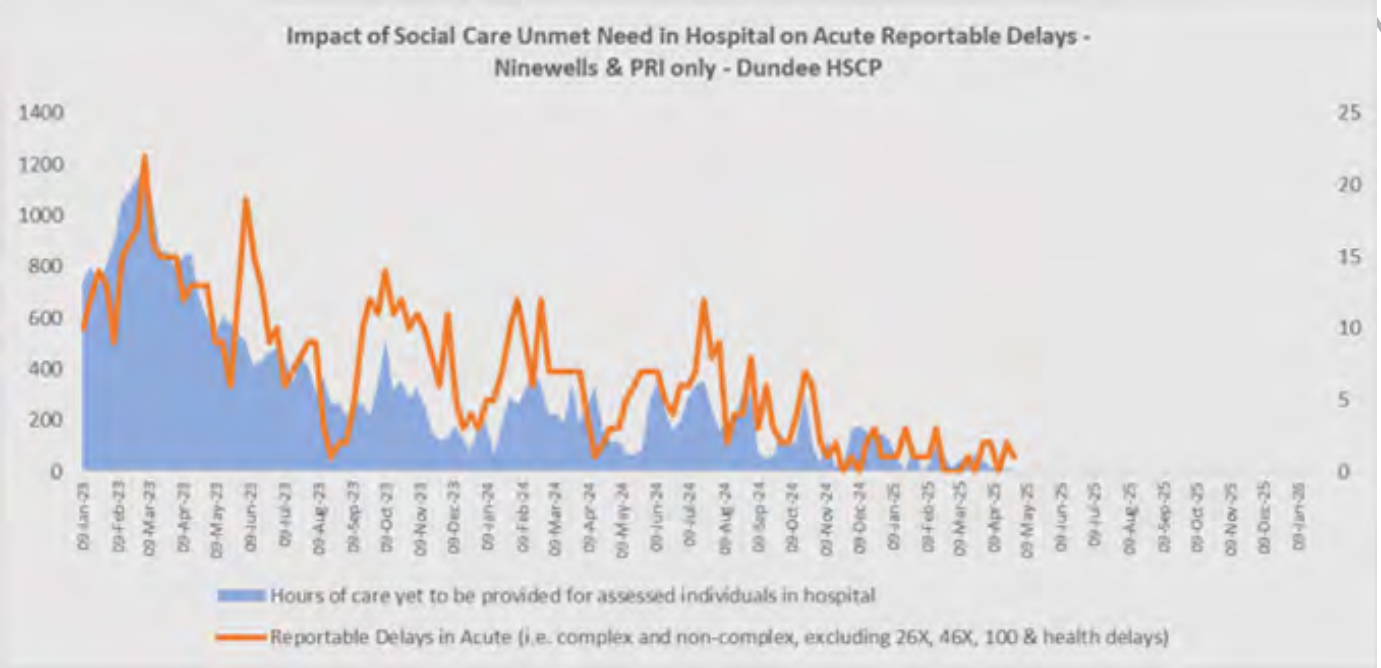
By implementing improvement measures aligned to the Discharge Without Delay workstream within the local Urgent & Unscheduled Care Board programme of work, Dundee has successfully and consistently achieved excellent performance in relation to the locally set targets, and is consistently performing in the top five HSCPS across Scotland. This involves key performance metrics with regular data reports on progress.

Discharge to Assess (D2A) Patient Pathway Example 2.

Presentation	▪ Admitted following fall at home 3 days prior which resulted in increasing pain and reduced mobility. ▪ Has input with the community mental health team including a support worker, social worker and Community Psychiatric Nurse. ▪ Befriending service in place who visit on a Tuesday, Thursday and Sunday for an hour. ▪ Significant overnight needs due to incontinence. ▪ District nurses to continue medication administration AM and PM - has a venalink and locked box.
Length of time on Service	30 days
Outcome of Assessment	Remain home with 4x daily Package of Care and interval night care.



Working and Planning Together



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 12 at April 2025.

Acute Frailty Units

Focuses on providing early frailty Multi Disciplinary Team (MDT) assessments in an environment centred around the person, seamlessly integrating with pathways such as Home First. By leveraging the Planned Date of Discharge (PDD) process, it ensures timely and efficient discharge without delay.

Planned Date of Discharge (PDD) process and Integrated Discharge Teams

The goal is to ensure frail people are discharged from hospital promptly, without delay, by ensuring that discharge conversations and planning include multi disciplinary teams involving family members and the patient as necessary. By proactively considering all of the needs of the patient being discharged, the enhanced team directly contributes to reducing the risk of poor patient outcomes and improving overall patient experience associated with hospital stays.

Community hospital and step-down inpatient rehabilitation workstream

Aims to empower the role of non-acute hospitals in delivering timely in-patient assessment and rehabilitation for frail people within their localities. By embedding the principles of Planned Date of Discharge (PDD), ensuring appropriately staffed units with focus on rehabilitation, and facilitating early transfers from acute and frailty units, the goal is for patients in each locality to access these facilities without delay.

Dundee Enhanced Care at Home Team

Reshaping our workforce to Dundee Communities

There have been changes to how our teams work in Dundee, to better serve the community. Staff have been organised into smaller, local teams, dividing the city into East and West areas. Each area is then further divided into four smaller groups.

These smaller groups work closely with other local services, like GP practices , community nurses, social care, and other care providers. This closer collaboration means teams can work more efficiently, understand the specific needs of each community better, and provide more joined-up care for people in their own neighbourhoods.

Scottish Ambulance Service Test of Change

A collaborative partnership has been established with the Scottish Ambulance Service (SAS) to expand access to community-based urgent care services for individuals who are assessed as clinically safe to stay at home but require higher levels of support to do so. This initiative facilitates a professional-to-professional link for SAS personnel to directly refer patients to the DECaHT team for appropriate community-based interventions. This process facilitates patient discharge from ambulance care with the assurance of timely, local follow-up, thereby reducing unnecessary hospital admissions and promoting care delivery within the patient's community.

Working and Planning Together

Physiotherapy and Occupational Therapy - Dundee HSCP

The Partnership continues to support primary care through the first contact physiotherapy service which can offer physiotherapy assessment and triage in a timely manner with most patients seen within five days. Having reviewed staffing and capacity the outpatient musculoskeletal waiting list continues to reduce towards the four week target and it is expected that the community therapy waiting list will follow a similar trend following a more recent review.

A physiotherapist within the pelvic and obstetric physiotherapy team has recently had two papers published and the team is working closely with partners in acute services to look at innovative ways of addressing the long waits for gynaecology assessment.

This builds on developments within Orthopaedics and Plastic Surgery where advanced physiotherapists can deliver appropriate assessment and intervention in what traditionally was a medical role.

Enablement Support Workers

Key Priority Areas:

Safety	Medication	Cognitive Supports	Skin Integrity Promotion	Continence Care
Meal Preparation	Equipment	Mobility and Falls Prevention	Moving and Handling	Technology
Personal Care Needs	Health	Daily Living	Physical Movements/ CAPA	Observations and Goal Setting

Case Study

Background

Over the weekend an elderly woman experience a suspected mini stroke, leading to significantly reduced mobility. Previously, she was independent in daily activities such as making tea and heating meals for herself and her husband. Her son and daughter had been providing assistance with toileting, meal preparation and other daily tasks. The son who has been off work for two days is scheduled to go on holiday for three weeks and the daughter will also be away for one week.

Request

The family requested temporary support, particularly for morning and evening routines to ensure their mother's safety and well-being during their absence.

Assessment

An Enablement Support Worker conducted a comprehensive assessment focusing on the following areas:

- Sit to stand
- Pivot turns
- Mobilising
- Kitchen assessment
- Bathroom assessment
- Getting in and out of bed

Findings and Recommendations

The ESW determined that the mother would benefit from an Occupational Therapy assessment to identify aids that could support her independence. The recommended equipment includes:

- Mowbray toilet frame
- Bed rail
- Personal walking aid

Additional advice was provided to the daughter who was present during the assessment

-Use alternative footwear as the current backless slippers are unsafe
-Consider a lighter kettle such as a travel kettle
The ESW noted that the mother is currently able to manage her venalink for medicines independently.

Outcome

No immediate social care input was deemed necessary. The focus was on promoting independent living with discussions and advice provided to both the mother and daughter. An OT referral was made to support the mother's independence through appropriate aids and adaptations.

Dundee and Angus Equipment Service

Dundee and Angus Health and Social Care Partnerships jointly provide community living and nursing equipment to support people at home with physical disability and illness.

Equipment can include:

- adjustable beds and mattresses
- toileting equipment
- seating accessories
- bathing equipment

Equipment can be provided following an assessment by a community nurse or occupational therapy worker.

- 44,066 people are supported by the Dundee & Angus Equipment Service.
- 87% people received their equipment within 1.7 days of the order being placed.
- 92% of collections were collected within 0.8 days.
- The service currently has 174,670 individual pieces of equipment out on loan which equates to £6,951,591 in value.
- 17,360 individual pieces of equipment were recycled and returned to shelf for reissue which equates to £2,836,474 in value, and a reissue rate of 68%. This evidences effective reissuing of stock with minimal new spend.
- 14,000 people responded to a satisfaction survey and of these responses, 99.8% rated the service as good.




Adult Support and Protection Multi Agency Audit

A multi agency audit of Adult Support and Protection took place between 29 October 2024 and 1 November 2024. This multi-agency audit was co-ordinated by the Self Evaluation and Continuous Improvement Subgroup of the Adult Support and Protection Committee (now the Adult at Risk Committee). The aim of the subgroup is to oversee regular partnership quality assurance activity and self-assessment, including against the Care Inspectorate quality improvement framework. This includes the organisation of a range of methods across the committee to gather evidence in relation to agreed frameworks. This activity should encourage partners to scrutinise and reflect upon practice and identify strengths and areas for improvement.

This audit focused on cases where the adult had been the subject of an investigation or case conference (initial or review) in the year between September 2023 to October 2024. The tool required case file readers to consider all stages from duty to inquire onwards and asked whether all partners were involved, all relevant files were shared, and what the quality of decision making, chronologies, risk assessments and outcomes were.

The audit process identified some areas of strength:

1. How partners work together to assess whether adults are at risk of harm. This includes how Adult Support and Protection legislation is applied and how inquiries are made to support the initial assessment of risk.

2. How case conferences are used to identify, assess and manage risk and to plan supports for adults at risk of harm.

3. How adult support and protection processes and supports make a positive impact of outcomes and quality of life for adults at risk of harm.

The audit also identified areas for improvement, including improving chronologies, risk assessments, information sharing and involvement of adults at risk and all relevant professional partners are each stage of the adult protection process.

Significant work has occurred in the partnership focusing on improving chronologies and risk assessments, however, this has been hampered by the impact of Covid and changes to the operational management structure. Nonetheless chronologies and risk assessments quality and quantity have been improving, e.g., chronologies - 60% were Good or better in 2020, improving to 82% Good or better in this audit; risk assessments - 67%, Good or better improving to 74% Good or better.

Working and Planning Together

To continue to address the areas for improvement, the Partnership is focusing on two areas of work:

1. Participating in a national pilot project alongside the Children and Families Social Work Service and IRISS focused on improving chronologies. A reflective practice tool has been developed nationally which is now been implemented across social work teams. Team managers are leading discussions within their own teams and testing different ways of using the tool, meeting every six weeks to learn from each others successes and agree what needs to change to support further improvement.

2. Working with multi-agency partners to implement a new pathway of support for adults at risk. This includes a multi-agency risk management approach (Team Around the Adult) and a collaborative approach to initial assessment of adult concern reports (Adults Multi-agency Safeguarding Hub). It will also include co-location of Partnership staff with colleagues from Police and NHS Tayside to help promote joint working and communication.

Performance, Finance, Workforce and Governance

Finance

The IJB is responsible for making sure that it works in a way that follows the law and best practice standards. It must also make sure that public money is properly managed and used in a way that maximises its impact on delivering services to the public. To help them to do this the IJB has a range of different governance systems, procedures and controls in place. These arrangements help to reduce the risk that the IJB will not be able to deliver its ambitions and planned improvements. Similar systems, procedures and controls are also in place in Dundee City Council, NHS Tayside, Angus IJB and Perth & Kinross IJB and these are also used to support the IJB's work.

The Governance Framework and Internal Control System

- Safe guarded
- Properly accounted for
- Used economically, efficiently and effectively

Performance, Finance, Workforce and Governance

The IJB spent £363.5 Million on community adult health and social care services during 2024/25 to support the needs of the people of Dundee. A breakdown of this is described in the table below.

	2020-21 £m	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m
Total Spend	299.7	282.5	321.1	340.6	363.5
Older People	63.1	62.3	70.1	75.2	82.0
Mental Health	9.4	9.9	11.2	16.0	14.1
Learning Disability	28.7	31.2	34.1	35.3	38.5
Physical Disability	5.6	6.9	8.1	7.6	8.2
Drug and Alcohol Services	5.2	4.8	5.8	4.5	6.5
Community Nurse Services/AHP/Other Adult Services	16.8	16.1	12.8	18.5	19.7
Community Services (Lead Partner)	28.8	18.2	33.0	36.5	38.7
Other Services/Support/ Management	60.8	51.4	60.8	58.0	61.4
General Medical Services (FHS) & Prescribing	81.4	81.7	85.2	89.2	94.3
Funding Received	301.8	290.4	328.6	336.8	356.3
Year-End Operational Surplus/(shortfall)	2.1	7.8	7.5	(3.7)	(7.2)

Performance, Finance, Workforce and Governance

The IJB reported a year end underlying operational overspend of £7.2m for 2024/25, arising from an underlying overspend of £5.8m in social care budgets and an underlying underspend of £2.6m in health budgets, alongside an anticipated shortfall within the integrated budget setting process for 2024/25 of £4.0m.

Increasing demand for Older People's community care has resulted in increased hours for services such as care at home which has seen an overspend of £3.4m. However, the increased care at home activity has continued to have a beneficial impact for in-patient services in Tayside through sustained reductions in Delayed Discharge, as well as reducing unmet need for service users in the community awaiting packages of care. Further demand pressures have also been experienced in Learning Disability services where individuals with particularly complex needs require enhanced and bespoke packages of care. The operational teams within the Partnership continued to experience workforce recruitment and retention challenges, which has resulted in use of agency, overtime and sessional staff where necessary with a total of £7.2m spent over 2024/25.

As a result of the higher than anticipated overspend during 2024/25, the IJB entered a period of Financial Recovery to address and minimise the unplanned overspend through enhanced actions and controls, while also maintaining performance and service delivery.

Dundee IJB, similar to other IJB's across the country, continues to face a challenging financial environment looking ahead to 2025/26 and beyond, with significant savings, efficiencies and transformation required to enable delivery of a balanced budget position. The Budget Consultation process assisted the IJB to make informed decisions regarding the proposed savings options.

Budget Consultation

The IJB launched its first budget consultation in February 2025. Regular promotion of the consultation was undertaken during the consultation to encourage feedback from a variety of stakeholders, including people who use health and social care services and supports, unpaid carers, members of the health and social care workforce and providers of health and social care services in the third and independent sector. There were a total of 560 responses.

Key findings from the budget consultation exercise are summarised below:

- Respondents were asked about factors they felt should be given greatest priority by the IJB when it is making decisions about how available budgets should be allocated. Factors that respondents felt should be given greatest priority were:

    - meeting the needs of people who need services right now/are in crisis,
    - helping people with the highest levels of need and,
    - helping people to live independently in their own community.
    - In relation to how services are delivered in the future, respondents felt greatest priority should be given to timely access, services being free to access and use and, services being provided in-person.

- Respondents expressed most support for saving options to work with NHS Tayside to improve the use of digital technology across health and social care services and to work with Dundee City Council to maximise income from chargeable services. Least support was expressed for reducing flexibility in service budgets to respond to unexpected changes in demand and for reducing the amount of funding the IJB provides to the Third Sector. Respondents were most concerned that saving options would result in services not being available in crisis situations and on the number and length of delayed discharges.

- Many respondents took the opportunity to also provide further feedback on the potential impact of savings options (between 89 and 200 responses were received for each option). Overall, these responses focused on protecting those services which serve vulnerable people; many respondents mentioned the impact of the savings options on older people, disabled people and people who long-term health issues, including mental health issues and drug and alcohol use, and unpaid carers. Feedback also emphasised the impact in particular on those living in poverty in the city.

The full report of the budget consultation can be read **here**.

Quality of DHSCP Services

The Care Inspectorate regulates and inspects care services to make sure they meet the right standards. It also works with providers to help them improve their service and make sure everyone gets safe, high-quality care that meets their needs. The Care Inspectorate has a critical part to play to make sure that care services in Scotland provide good experiences and outcomes for the people who use them and their carers.

The current Health and Social Care Standards for Scotland came into effect in April 2018 and apply across social care, early learning and childcare, children's services, social work, health provision and community justice. They seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld.

The Care Standards provide a framework that is used by the Care Inspectorate to provide independent assurance about the quality of care and support. By setting out what Inspection Officers expect to see in high-quality care and support provision, it can help support improvement too. Using a framework in this way also supports openness and transparency of the inspection process.

The Care Inspectorate continues to inspect using a six-point grading scale (see below) against which the following key themes are graded:

People's Wellbeing	Leadership	Staff Team	Setting	Care and Support Planning

Each theme is assessed from one to six with one being 'unsatisfactory' and six 'excellent.'

In 2024/25, 46 services for adults and care homes registered with the Care Inspectorate in Dundee were inspected and 58 inspections were completed. Of the services that were inspected, 31 of the 46 received no requirements for improvement. I service received a statutory notice of improvement.

Seven of the services provided directly by the Partnership were inspected during 2024/25:

- MacKinnon Centre Care Home received grade 5's (wellbeing and staff) and no requirements.
- Janet Brougham House Care Home received grades 5 (wellbeing, setting and care and support planning) and no requirements.
- Menzieshill House Care Home received grades 5 (wellbeing, staff, setting and care and support planning) and grade 4 (leadership) and no requirements.
- White Top Centre received grades 6 (wellbeing and leadership) and no requirements.

Performance, Finance, Workforce and Governance

- Dundee Community Living Housing Support Service received grades 5 (staff), 4 (wellbeing) and 3 (leadership) and no requirements.

- Dundee Care at Home Citywide Housing Support Service received grade 5 (staff) and 4 (wellbeing) and no requirements.

- Dundee Homecare Social Care Response Housing Support Service received grades 5 (staff and wellbeing) and no requirements.

42 of the 58 inspections in Dundee which were subject to a Care Inspectorate inspection last year received grades of '4 - good', '5 - very good' or '6 - excellent.'

A full list of Care Inspectorate inspections with gradings can be viewed **here**.

Seven services received one or more complaint.

One care home service regulated by the Care Inspectorate was issued an improvement notice. A large scale investigation commenced in Benvie Care Home during July 2024 with voluntary cessation of new admissions. These measures ended during August 2024 and a follow up inspection during August 2024 identified that all improvement notice requirements had been met.

Mental Welfare Commission for Scotland

The Mental Welfare Commission for Scotland conducted an announced visit to Kingsway Care Centre on 1 October 2024.

Ward 4 is a 14-bedded, mixed-sex unit that provides care for older adults, typically aged 65 and older, who requirement assessment for a functional mental illness.

Summary of recommendations

Recommendation one: Managers should ensure that individuals and their relatives (where appropriate) are involved in developing care plans, where possible. Their participation should be recorded in the care records, and they should be offered a copy of their care plans. If individuals choose not to or cannot be involved, this should be recorded.

Recommendation two: Managers should ensure that all MDT document sections are completed comprehensively.

Recommendation three: Managers should ensure that all older format MDT document templates should be taken out of circulation and newer templates used consistently.

Recommendation four: Managers should ensure a robust system is in place to notify ward staff that an individual is subject to a guardianship order or has a power of attorney.

Recommendation five: Managers must ensure welfare proxies who have powers to decide on medical treatment are consulted and their consent to proceed with treatment is obtained.

Recommendation six: Managers should ensure all individuals receiving care and treatment in Ward 4 are made aware of their rights with regards to locked door policy and these conversations should be documented in the care records.

Recommendation seven: Managers should ensure the existing fencing in the garden area is altered to one which fits with this natural environment and provides privacy for individuals using the garden.

The full report can be viewed here.

Complaints

Since the 1st April 2017 both NHS and social work complaints follow the Scottish Public Service Ombudsman Model Complaint Handling Procedure. Both NHS Tayside Complaint Procedure and the Dundee Health and Social Care Partnerships Social Work Complaint Handling Procedures have been assessed as complying with the model complaint handling procedure by the SPSO.

Complaints are categorised by two stages: Stage one: Frontline Resolution and Stage two: Investigation. If a complainant remains dissatisfied with the outcome of a Stage one: Frontline Resolution complaint, it can be escalated to a Stage two. Complex complaints are handled as a Stage two: Investigation complaint. If a complainant remains dissatisfied with the outcome of Stage two: Investigation complaint they can contact the Scottish Public Services Ombudsman who will investigate the complaint, including professional decisions made. Complaints about the delivery of services are regularly presented to the Clinical, Care and Professional Governance Group to inform service improvement.

179 number of complaints were received in 2024/25 of which 142 were received through the NHS Tayside Complaints Process and 29 were received through the Dundee City Council Complaints Process.

50% of complaints received by Dundee City Council and 52% of complaints received by NHS Tayside were upheld or partially upheld.

You can view our quarterly complaints reports here.

Upheld Complaint Example:

A complaint which was received regarding incorrect medication. A message was sent out to all Home Care and Housing with care staff across the city reminding them of the importance of checking the name at every prompt and when putting new venalinks (venalinks are methods of organising medicines using blister packs to assist patients and their carers) in place when they come in from the pharmacy to a service user. This was discussed at Team meeting with Home Care and Housing with Care Organisers for immediate action.

Feedback

As well as complaints the Partnership also receive feedback from people who use services, family members, representatives and staff.

"Go to physiotherapy at Kings Cross and I feel more confident after it. Really makes a difference and the staff I've seen have been great".

"I was diagnosed with rheumatoid arthritis several years ago and the care I was given was superb. I recently had a flare up in my hand and contacted the occupational department in Ninewells. I was seen within two weeks and have now had two sessions, the end result being that my hand is improving. The professional I saw was just that, professional, but kind and caring. I'm still not right but I am working hard on the exercises and am grateful for the support."

"Following diagnosis of fracture I underwent an operation at Ninewells Hospital, Dundee. I was then referred to MSK Physiotherapy at Kings Cross Hospital. I am in my 80's and with a diagnosis of leukaemia I was feeling very sorry for myself. The physiotherapist was very positive and reassuring at our first meeting. A planned programme was outlined, and I was urged to throw away my sling! This was a major step for me as the sling had become a physical and psychological crutch. I followed the detailed exercise programme at home and was provided with an illustrated printout. I religiously followed the programme of exercises 3xdaily and although I had some discomfort at the outset it soon became apparent that I was making progress. This was confirmed at my next appointment when I was prescribed additional exercises. I have been discharged but encouraged to continue with the exercise programme. Having been apprehensive at the outset my consultations gave me the encouragement and assurance that I needed. Most importantly the programme I followed strengthened my arm and shoulder and gave me back my quality of life."

"I have had excellent care and support from Ninewells Oncology Dietitians during Chemo-Radiation treatment last year. During the treatment and for a year after, I have had contact with the dietitians and been given good helpful advice. I followed this and felt the benefit, such that in terms of nutrition diet and weight I am now back to normal. I was very impressed indeed with the care and interest shown by the Oncology Dietitians, and I am very grateful to them. Thank You."

Equalities

Public Sector Equality Duty

Over the last year access to learning on equality and fairness matters increased. An Equality & Human Rights Workforce Learning Network was established and communication methods were reviewed and made more accessible. Detailed Integrated Impact Assessments are completed on all proposed changes that might affect protected groups.

Dundee IJB Equality Mainstreaming and Equality Outcomes Progress Report 2023-2025 can be viewed here.

Core Equality Training provided through NHS and Council E- Learning

All Social Service Employers and Workers must comply with Scottish Social Services Council Codes of Practice. Employers are expected to provide good quality accessible induction and learning and development opportunities to support workers to carry out their role safely and effectively. This means the workforce will have Equality and Human Rights learning that supports them to respect and promote the rights and, where appropriate, the views, wishes and choices of individuals and carers; respect and maintain the dignity and privacy of individuals; and promote diversity and respect for all identities, values and culture.

From April 2023 until November 2024, 290 council colleagues working in HSCP completed equality e-learning as part of their induction to a variety of roles including social care workers, social workers, peer support workers, administration colleagues and domestic assistants. In November 2024 92% of HSCP colleagues working in NHS Tayside had completed e-learning at Foundation Level - Equality, Diversity and Human Rights (1,523 colleagues in total). Eight care and support workers in contracted third sector and independent sector agencies will be supported to fulfil their equality learning requirements and providers can arrange to access the e-learning available from the Council and NHS if desired.

Transgender People

As part of discussions around the Plan for Excellence in Health and Social Care in Dundee 2023-2033, it was noted that it had not been possible to hear from local people who identified as Transgender. It was acknowledged that not enough was known about what is needed to achieve the ambition of 'excellence' in Health and Social Care in Dundee with regards to Transgender people.

Engagement with Transgender people continued into 2024, enabling ongoing discussion and feedback and this included follow-on engagement with a number of organisations including;

- the Scottish National Gender Identity Clinical Network;
- NHS Tayside Public Health;
- Dundee Health and Social Care Partnership Psychology Services;
- the local Managed Care Network for Sexual Health & BBV;
- some local Third Sector Agencies; and,
- 'Scottish Trans' (a national third sector organisation funded by Scottish Government).

Through engagement with Transgender people and supporting organisations and services key themes emerged in terms of health and social care needs, preferences and experiences. In response to these themes Partnership services, supported by the Strategic Planning Advisory Group, have identified a number of areas for improvement in relation to delivering the strategic shifts within the Plan for Excellence for Transgender people in Dundee:

- Strengthening the focus on the needs and experiences of Transgender people within the Trauma Informed Practice and Leadership programme of work that is in place within Dundee.

- Identifying and implementing approaches to sharing good practice approaches and positive feedback / impacts with the health and social care workforce and with Transgender people.

- Developing local information web resources around services and supports for Transgender people and enhancing the use of social media to communicate key information.

- Working with local Transgender people to develop learning and development resources for the health and social care workforce, with an initial focus on Primary Care, Community Pharmacy, A&E and Mental Health crisis support services.

- Providing learning and development opportunities for those in leadership and governance roles, including IJB members.

- Considering further opportunities to clarify and improve pathways of care for Transgender people, including meeting both clinical and wider health and wellbeing needs.

Race Discrimination in the Workplace

The health and social care workforce includes people from ethnic minority communities who, as well as being valuable and valued colleagues, can be a rich source of information relating to workforce matters and who have cultural and language insights to share about their wider community. It is important to acknowledge that racial inequalities and race discrimination do exist in health and social care in Scotland and will have affected colleagues across the Dundee Health and Social Care Partnership workforce. It is known that colleagues can also be subject to, and observe racism in interactions with service users, carers and the public while at work. Although there is little or no, reported racism from colleagues and mangers it is also recognised that members of the workforce may also experience racism from colleagues.

72 NHS employees and 46 Dundee City Council employees stated they were from a minority ethnic background, which is 4% and 5% of employees respectively. This is lower than the 16% of Economically Active and Employed Dundee residents ages 16+ who stated they were from a minority ethnic group in the 2022 Census.

There are very few formal grievance and/or disciplinary cases in either Dundee City Council or NHS Tayside for Partnership staff where race or ethnicity has been a factor. This does not mean that race discrimination has not happened in the workplace and may reflect under reporting and low confidence in reporting.

Significant work has been progressed with a view to better understanding the experiences of the Dundee health and social care workforce, including direct engagement with workforce members and with their employers (particularly in Care at Home Services). This engagement has identified a significant increase in the number of Social Care Workers in Dundee who are of Black African origin, having moved to Scotland as economic migrants. It has also identified that members of the workforce delivering Care at Home Services are experiencing race discrimination and other equality discrimination from services users, unpaid carers and wider family members. Workforce members and their employers have shared that individuals have felt vulnerable whilst carrying out their duties, both in people's homes and within the wider community.

Performance, Finance, Workforce and Governance

Across Health and Social Care in Scotland there is a strong desire to eliminate discrimination and inequality both in service delivery and in the workplace overall. The following progress has been made within Dundee:

- Connections have been made between local officers and relevant national networks and organisations, including attendance at learning and development events.

- Identification of work being undertaken by the Scottish Social Services Council to develop resources to inform and upskill social workers about anti-racist practice and consideration of how these can be promoted and used within Dundee.

- Connections have been strengthened to the NHS Tayside Employee Network (which is available to NHS and Council employed staff, but not third and independent sector), as an important site through which to gather ongoing feedback about local workforce experiences and regarding anti-discriminatory work being progressed by the corporate bodies.

- Identification of work progressing between NHS Education for Scotland and the Coalition for Racial Equalities and Rights (CREAR) to develop learning materials for the NHS and integrated health and social care workforce.

- Promoting the 'Help Tackle Racism' survey from CREAR for the health and social care workforce. Results are not yet available but will be utilised to inform future actions and planning.

- Provision of local learning and development opportunities, including a Hate Incident, Hate Crime session for 30 colleagues across social care, housing support and employability services, and a Mental Health Foundation session on Engaging with Refugees and Asylum Seekers for 20 colleagues across the health and social care workforce.

- Identifying Renfrewshire Health and Social Care Partnership as an example of a best practice approach to tackling race discrimination, including having developed a policy framework within which to address instances of race discrimination that applies across all employers.

Workforce

The Dundee IJB's Plan for Excellence in Health and Social Care in Dundee (2023-2033) sets out six strategic priorities, including a commitment focused on valuing the workforce.

Strategic Priority: **Workforce**
Valuing the workforce

Supporting the health and social care workforce to keep well, learn and develop.

The Health and Social Care Partnership workforce is made up of people employed by Dundee City Council and NHS Tayside, as well as the workforce employed in the third and independent sectors. The combined workforce is the single biggest asset available to the Partnership to enable them to provide the services and supports that the IJB has commissioned from them.

The first Partnership Workforce Plan was approved by the IJB in June 2022 in response to guidance from Scottish Government. The National Workforce Strategy for Health and Social Care (published March 2021), led to a requirement for Partnership's to develop and submit three-year workforce plans. After this the plan has been refreshed on an annual basis.

The most recent version of the Workforce Strategy can be found **here**.

Our workforce plan reflects these strategic commitments and aims to enable the Health and Social Care Partnership to:

- Meet future workforce requirements – identify the number and types of health and social care professionals needed to meet future service demands.
- Promote skill development and training – ensure that the workforce has the necessary skills and competencies through access to continuous professional development and training programmes.
- Support recruitment and retention – support strategies to attract and retain skilled professionals in the health and social care sector.
- Develop integrated workforce planning – promote collaboration between health and social care services to create a more cohesive and efficient workforce.
- Support workforce wellbeing – implement measures to support the physical and mental well-being of health and social care workers.
- Adapt to change – ensure the workforce is supported to adapt to changes in technology, policy and service user needs.

Performance, Finance, Workforce and Governance

There are several challenges

- Ageing workforce, including in key staffing groups delivering frontline care and support.
- Decreasing social care workforce set against ageing population, rise in demand for social care services and complexity of need.
- The demographic profile of the workforce does not reflect the diversity of the community that it serves.
- High absence levels across both employers, with mental health and wellbeing as a specific driver of absence levels.
- There are specific workforce availability challenges relating to Occupational Therapists, Social Care Workers and G.P.s. Challenges are also experienced, to a lesser extent in relation to, Advanced Nurse Practitioners and Physiotherapists.
- There is a risk of reduced workforce availability, particularly for social care services, due to planned changes to immigration rules.

For 2024, the iMatters* process identified four areas to further improve across the Partnership (based on 54% response rate across all Partnership aligned staff):

- Performance management – I am confident performance is managed well within my organisation.
- Confidence and trust in management – I have confidence and trust in Board members who are responsible for my organisation.
- Partnership working – I am sufficiently involved in decisions relating to my organisation.
- Visible and consistent leadership – I feel that board members who are responsible for my organisation are sufficiently visible.

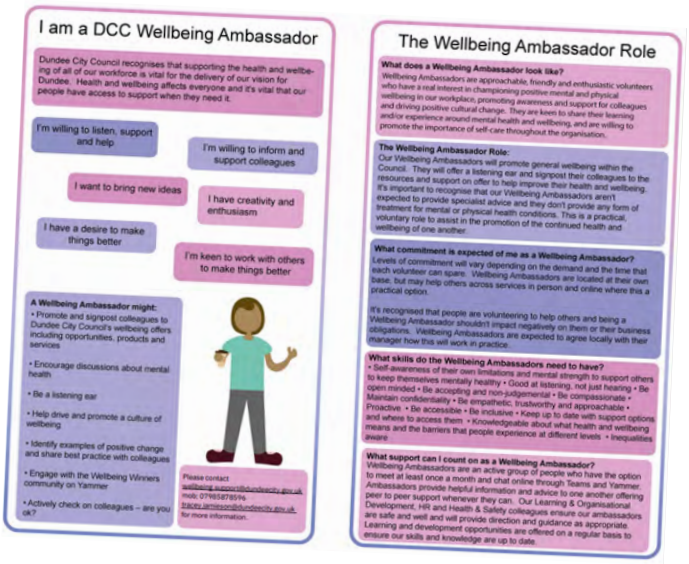
The Dundee City Council Annual Employee Survey (based on 14.3% response rate across all Council employed staff aligned to the Partnership) also identified areas for improvement, including staff being involved in decisions about their work, having enough time to do their job well and feeling that day-to-day decisions demonstrate that quality and improvement are top priorities.

*iMatters is a staff experience continuous improvement tool which is used to understand and improve how staff feel at work.

Supporting Employees

NHS Tayside Employee Networks are available for all Council and NHS Tayside employees in DHSCP. DHSCP can access the following groups which are supported by NHS Tayside Corporate Equalities Team Leads: LGBTQA+, BAME, Disability, Armed Forces and Carers Network.

Dundee City Council hosts a 'Workforce with Lived experience of Trauma' Project which is a support for employees of the council who experienced Trauma for any reason including related to Protected Characteristics. In addition to this, Dundee City Council also have a dedicated Employee Health and Wellbeing Support Service, employ a full-time Employee Wellness Advisor, and have a network of peer Wellbeing Ambassadors who support embedding a culture of wellbeing across all services. In Health and Social Care, we have 12 Wellbeing Ambassadors who are DCC employees. The Employee Wellness Advisor for DCC links in with NHS Wellbeing Champion network to ensure there is a strong ethos of partnership, sharing of best practice and learning, and minimising of duplication.



In 2024, members of the team from Oakland Daycentre presented at both Dundee City Council's Corporate Leadership Conference (a gathering of senior leaders from across the council, HSCP and LACD) and at a conference for all Wellbeing Ambassadors, showcasing their experiences of developing a culture of wellbeing within their team. Their presentation was powerful and impactful and highlighted the differences small actions and activities can make in improving wellbeing.

"It has benefited staff morale"

"The curry lunch got staff mixing together and brought the team together"

"With the 'shout out board' I feel appreciated, and comments make me feel good"

"By helping others we bond with each other and focus on common goals"

"The suggestion box has been great as we now have a toasty machine which enables me to have better lunches"

"The meetings let you vent and see how your colleagues are feeling"

Images of some of the activities the team have undertaken and some feedback within their presentation used at the events.

Additionally, the council's Employee Wellness Advisor works with Homecare, an area within the Partnership with higher-than-average sickness absence rates. Since starting in post in September 2024, the Advisor has delivered 33 Team Wellbeing Introductions, events or 1:1 support sessions focusing on topics such as burnout, vicarious stress and reflective practice.

"All in all, D had given us a lot of information which is ever so helpful. She is very professional, and the session was really interactive, I would give her a solid 10/10 for the work she is doing"

"100% this service. D was amazing, very caring and thoughtful, thank you"

Quotes are from the feedback survey issues after each interaction to teams and individuals.

Employee Absence

Between June and December 2024, work was undertaken to look at the reasons for absence within certain areas of the council where absence rates were significantly higher. A survey, focus groups and some 1:1 discussions with managers and others highlighted some areas for improvement which are being progressed.

Key Actions identified were:

Enhance Support Systems: Increase the frequency and quality of face-to-face interactions between staff and occupational health professionals to provide more personalised support. Implement more flexible working arrangements and workplace adaptations to accommodate employees' health needs and promote quicker returns to work.

Improve Communication: Ensure clear and consistent communication between occupational health, hospital consultants, and managers to avoid conflicting advice and support decisions. Encourage regular and empathetic check-ins by line managers to maintain employee engagement and well-being.

Review Absence Procedures: Reevaluate the absence monitoring system to reduce stress on employees, particularly those with long-term health conditions or those returning from bereavement.

Some quotes from participants who were involved in this work include:

"I have spoken to occupational health in the past and recently and the outcome of my meeting was that certain adaptions were put into place to help me at work. My manager has been extremely helpful ensuring my runs have been manageable and checking in with me regularly ensuring all is well."

"Absence Review Meeting with my manager who was very understanding and provided support and guidance on my return to work, was very helpful"

"I found speaking with my councillor on PAM (Occupational Health) very helpful. I have more confidence and a better positive attitude about everything not just work."

Kingsway Care Centre introduced Wellbeing Champions in 2023 and there are now three champions.

The images are from a recent Kingsway Care Centre Day of Happiness which was held to celebrate the International Day of Happiness on 20th March 2025.

Achievements so far:

- Identified wellbeing spaces on the wards and outside to support staff mental wellbeing.
- Asked all staff for their feedback via a survey on what is important to them.
- Had a successful Support Workers Day to celebrate the hard work that is carried out by Support Workers in Kingsway Care Centre.
- Celebrated Happiness Day to bring about cheer and joy to brighten up staff's day to promote self-care.
- Wellbeing Champions have supported staff on individual basis and signposted to appropriate supports.

Kingsway Care Centre Support Workers

Developing the Young Workforce: Myth Busting Event into working in a care home (March 25)

Recruitment and retention continues to be a challenge for social care and attracting new people to the sector in competition with other sectors. Working in conjunction with the Developing the Young Workforce Team (Dundee), a pilot event was organised in Baldragon Academy to showcase a day in the life of a care home and demonstrate the many different roles that make up a team including qualifications and career pathways into working in social care.

Managers and staff from a number of care homes set up a round robin event with ten tables, providing pupils with a very interactive insight to working in a care home. There was also input from some of our younger workforce who spoke about their journey/experience of working in social care and also three residents spoke about their day to day living in their care home and what, in their opinion makes a good carer.

Some of the tables:

Residents and our younger workforce

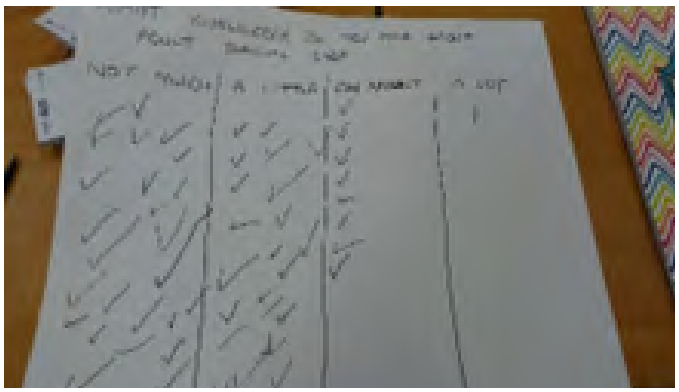
How to support different types of dietary needs

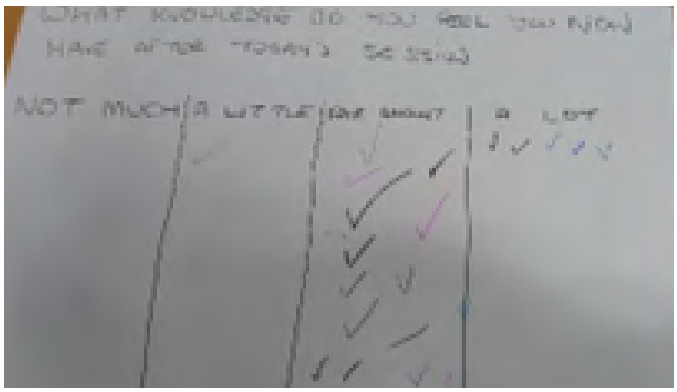
Safe moving and handling practices

Pupils creating a personal support plan for Taylor Swift

Some of the words collated for the event were:

Most pupils at the start of the session indicated that they did not know much or very little about adult social care but at the end of the session many more felt that they knew a fair amount/ more about adult social care. A number of the pupils also asked about work experience, jobs and apprenticeships that may be available to them.





The pilot event in Baldragon Academy was the springboard to holding a larger event in September 2025, which will involve all schools across Dundee to continue to promote social care as a career and in discussion with other services, a number of Care at Home, LD and DHSCP providers have stated that they would also like to get involved in the events going forward.

Primary Care

The following actions took place to maintain a healthy workforce in Primary Care:

- A training framework to improve the experience of the physiotherapists and build resilience into the system to assist with cover.
- New ways of working with a multi-organisation approach being explored including a possibility of some Multi-Disciplinary Team development.
- Providing colleagues with the opportunity to learn about quality improvement and the opportunity to work across different teams. For example, bringing together Physiotherapy colleagues, GP Practice teams and members of the Primary Care team to improve patient access to First Contact Physiotherapy.
- A Staffnet page to host educational material and links which provide a central repository of information for GPs is under development.

Awards and Accreditations

Veterans First Point Tayside (V1P) service has been awarded with accreditation by the Royal College of Psychiatrists. V1P is a service that support veterans and their families and offers a range of services including mental health support, information and signposting and peer support.

Hello in there wee one won the award for Creative and Innovative Practice and was declared Overall Winner at the Advancing Healthcare Awards UK 2025.

The book was created in partnership between NHS Tayside's infant mental health team, Dundee Contemporary Arts (DCA), Dundee City Council and University of Dundee. It is given to all expecting families across Dundee, free of charge, at their 16-week midwifery appointment to support expectant parents to communicate and bond with their baby.

Since launching last year, the book has already reached 600 families and has been translated into multiple languages, including Dundonian Scots.

Liam McGinlay was a finalist in the Outstanding Community Link Worker of the Year Award at the Scottish Community Link Worker Network Conference.

Liam works in the Sources of Support Service, which operates is all General Practices in Dundee. As a Primary Care Link Worker, he supports patients whose physical mental health and wellbeing is impacted by social and mental health issues. Liam works alongside the patient for up to 20 weeks, offering non-medical interventions and co-ordinated care to improve patients personal circumstances.

"We are delighted to see Liam being recognised as a finalist for this award. It was a huge achievement to make it to the final three and we are very proud of him" Theresa Hendry, Sources of Support Team Leader.

Liam McGinlay,
Sources of Support Worker

The Corner, Dundee's Health and Wellbeing Service for young people, has been awarded for their commitment to providing a safe, inclusive, and empowering environment for women across the city.

The team has received the Welcoming Women Award from the Dundee Violence Against Women Partnership (DVAWP). The certification is for organisations who actively think about the needs of women.

The Corner has worked alongside the DVAWP over the past year to identify areas of service delivery that could be improved. The Welcoming Women Award recognises efforts made to understand and address the unique challenges, issues, and needs faced by women in Dundee.

Zara Cargill, Clinical Team Lead said, "We are delighted to be recognised for our commitment to making The Corner a welcoming and supportive environment for women. This award reflects the hard work of our entire team and our ongoing dedication to meeting the needs of the community we serve."

The Corner is a health and wellbeing service based in Dundee City Centre for young people aged 11-19 years or up to age 25 for vulnerable young people. An NHS Tayside multi-disciplinary team provides a range of supports including sexual health, emotional health, crisis intervention, drug and alcohol use, young carer support and counselling.

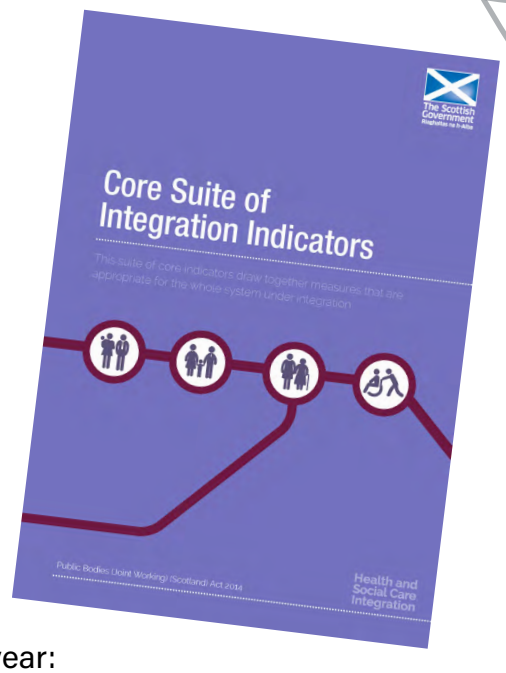
Performance, Finance, Workforce and Governance

DFN (David Forbes-Nixon Family Charitable Foundation) Project SEARCH Ninewells aims to support young people with diverse additional needs into meaningful employment. A partnership between Dundee& Angus College, NHS Tayside and Dundee HSCP has developed a local Project SEARCH initiative which is based at Ninewells Hospital.

The project addresses areas of key skills shortage within NHS Tayside, whilst transforming the lives of the learners and their families. Dundee and Angus College provide a structured, supportive pathway to meaningful employment. Support is highly individualised, with one-on-one training provided for young people who have complex barriers to employment. There is significant support throughout the 36-week programme as well as an extensive aftercare period to ensure sustainability. An additional benefit of the programme has been a wider recognition of the needs of employees with disabilities, not just those within Project SEARCH. Removing Barriers to Employability.

Project SEARCH won the SURF Awards for Best Practice in Community Regeneration in 2024 for Removing Barriers to Employability.

Performance



The Scottish Health and Care Experience Survey is a postal survey that is administered to a random sample of people who were registered with a GP in Scotland. The survey has been run every two years since 2019 and forms part of the Scottish Care Experience Excellence Programme, which is a suite of national surveys aiming to provide local and national information on the quality of health and care services from the perspective of those using them. The results from this survey are used to calculate National Health and Wellbeing Indicators 1-9. The results of the 2023-24 survey for Dundee Health and Social Care Partnership can be accessed **here**.

Where the Partnership improved from the 2019/20 baseline year:

- Hospital emergency bed day rate for people aged 18 and over decreased by 8.6% and for the last five years the Dundee rate has been less than the Scotland rate.
- The proportion of the last six months of life spent at home or in a community setting increased from 89.5% in 2019/20 to 90.8% in 2024 and since 2019/20 Dundee's performance has been better than the performance for Scotland.
- The % of adults with intensive care needs receiving care at home increased from 57.8% in 2019 to 65.4% in 2024.
- The number of days people aged 75+ spent in hospital when they were ready to be discharged, per 1,000 population decreased from 443 in 2019/20 to 245 in 2024/25 and for the last 5+ years, the Dundee rate has been lower than the Scotland rate.

In addition to annual reporting, performance is also monitored quarterly and compared across Local Community Planning Partnership areas and reported to the Performance and Audit Committee of the IJB. Where further analysis in required to understand the data and improve services in-depth analytical reports are also developed. These can be viewed **here**.

The methodology was changed by Scottish Government for the 2019/20 survey and it is therefore not accurate to compare results from before this survey with the more recent survey results. Note: 2024 calendar year or 2024/25 financial year data was not provided by Public Health Scotland for indicators 10,11,17 and 20-23 therefore they have not been included in the table below. Further information about these can be viewed **here**.

Better than Scotland | Worse than Scotland | Same as Scotland

National Indicator	Improvement from 2019-20	Improvement from 2021-22	Comparison with Scotland 2023-24
1. Percentage of adults able to look after their health very well or quite well.			
2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible.			
3. Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.			
4. Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated.			
5. Percentage of adults receiving any care or support who rate it as excellent or good.			
6. Percentage of people with positive experience of care at their GP practice.			
7. Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life.			
8. Percentage of carers who feel supported to continue in their caring role.			
9. Percentage of adults supported at home who agreed they felt safe.			
12. Emergency admission rate (per 100,000 people aged 18+).			
13. Emergency bed day rate (per 100,000 people aged 18+)			
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population).			
15. Proportion of last six months of life spent at home or in a community setting.			
16. Falls rate per 1,000 population aged 65+.			
18. Percentage of adults with intensive care needs receiving care at home.			
19. Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.			

Dundee
Health & Social Care
Partnership