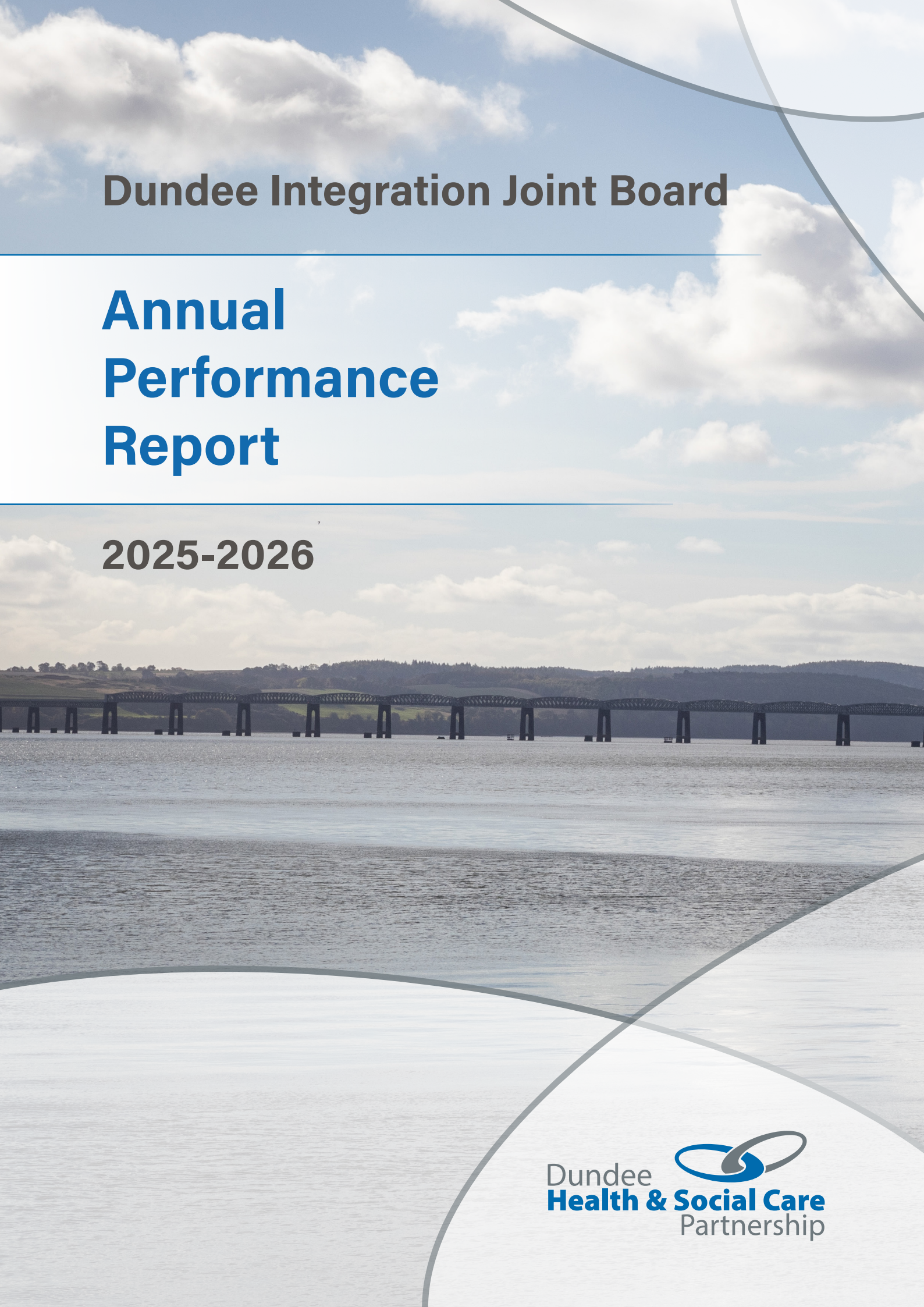


Dundee Integration Joint Board

Annual Performance Report

2025-2026

Dundee Health & Social Care Partnership

Contents

Foreword

I am pleased to present Dundee Integration Joint Board's Annual Performance Report for 2025/26.

This has been another demanding year for health and social care services in Dundee. Demand for support has continued to grow, many people are living with increasingly complex health and care needs, and services have faced sustained pressure from workforce shortages, rising costs and a challenging financial position. At the same time, national policy and legislative developments have reinforced the importance of prevention, early intervention, reducing inequality and providing more support in local communities.

Despite these pressures, the report highlights important progress over the year. This includes continued improvement in supporting people to remain at home wherever possible, to return home sooner from hospital, and to access more joined-up support in their communities. There have also been positive developments in mental health and wellbeing, support for unpaid carers, and partnership working across services. These achievements reflect the commitment and resilience of the workforce, partners, unpaid carers, third and independent sector organisations, and local communities.

At the same time, important challenges remain. Demand across many parts of the system continues to rise, financial pressures are significant, and workforce challenges continue to affect the delivery and sustainability of services. Too many people still experience delays or barriers in accessing the help they need, and health inequalities continue to have a profound impact on individuals and communities across Dundee. In the year ahead, our focus will remain on strengthening the services that matter most to people, particularly those that provide early help, prevent crisis and support independence, while ensuring that our plans are realistic, sustainable and shaped by local need.

I would like to thank all of our workforce, partners, unpaid carers, volunteers and community organisations for their continued commitment over the past year. In a period of significant pressure and change, their dedication has remained central to the support provided to people across Dundee. While challenges remain, I am confident that by continuing to work together, listening to local people and focusing on what matters most, we can continue to make progress towards better outcomes for the people and communities we serve.

Councillor Ken Lynn
Chair, Dundee IJB

Dave Berry
Chief Officer, Dundee IJB

2025/26 Performance Overview

What Went Well This Year

98%
of hospital discharges happening without delay.

Delayed discharge bed days per 1,000 population.

244 Dundee

873 Scotland

101,478 Dundee

108,988 Scotland

Emergency bed day use compared to Scotland average, per 100,000 adults.

Community rehabilitation and therapy services improved access, with some waiting times reduced to around two weeks.

606
people receiving suicide prevention training locally in the last 12 months.

Mental health and wellbeing support expanded, with
1,736 people
supported by Hope Point through
5,953 contacts
during 2025/26.

65.9%
of people with intensive care needs supported at home in 2024/25, compared with 64.7% across Scotland.

Survey feedback showed that of the adults supported at home:

79% felt supported to live independently.

71% felt care helped maintain or improve their quality of life.

82.6%
of people started psychological therapies treatment within 18 weeks, above the national average.

Mental health services rated good or very good in all five quality indicators from an external joint inspection.

Strengthened support for unpaid carers through the review and refresh of the carers strategy.

For carers supported by the Carer Centre 2024/25:

99% reported improved health and wellbeing.

99% felt more confident to care.

91% felt less isolated.

People's experiences are being used to shape improvement:

- 266 Complaints
- 55 Care Opinion Stories,
- Inspection Findings
- Health and Care Experience Survey Results

92%–99% of people started drug treatment within 21 days, across the year (meeting the waiting time standard).

2,266 referrals for alcohol treatment in 2025/26 an increase from 2024/25 (2,015).

2.6% Increase in the number of individuals starting alcohol treatment during the year.

During 252/26 4 Health and Social Care Partnership adult and care homes services were inspected and all received grades of very good.

Community-based and preventative supports have grown:

200 contacts made during Coldside/Maryfield Health Week.

1,100 people supported by Primary Care Sources of Support.

300 people supported by Primary Care Listening Service.

144 people in Community Health Capacity Building Programmes.

Where Performance Remains Under Pressure

Demand for urgent, mental health, primary and social care remains high. Emergency admission rates per 100,000 adults:

15,727 Dundee

11,470 Scotland

Some people still wait too long for support, including:

- Parts of the social care assessment
- Specialist services
- Primary care

Falls rate among people aged 65+ remain higher than the Scotland average, per 1,000 people.

34.5 Dundee

22.2 Scotland

Hospital readmission rates at 149 per 1,000 population compared with 104 across Scotland.

73% Dundee

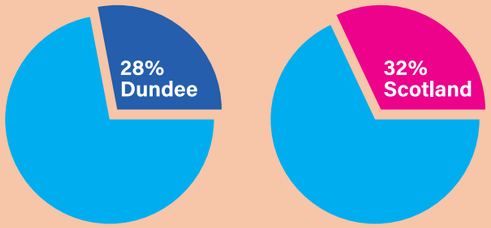
78% Scotland

People reported that GP services are easy to contact/access.

266 Complaints
an increase of almost 50% than the previous year.

Response times for more complex complaints remain below target.

Number of unpaid carers who said they felt supported to continue caring, compared with across Scotland.



Capacity affected by:

- Workforce shortages
- Sickness absence
- Financial pressures

Temporary staffing costs of £6.9 million and a £5.7 million operational overspend in 2025/26.

*Data shown is from 2025 calendar year unless otherwise stated.

Performance Against National Indicators - Comparison Summary

		Dundee	Scotland	Comparison with Scotland
1.	Percentage of adults able to look after their health very well or quite well.			
	2023-24	88%	91%	
	2025-26	90%	91%	
2.	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.			
	2023-24	77%	72%	
	2025-26	79%	74%	
3.	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.			
	2023-24	65%	60%	
	2025-26	67%	64%	
4.	Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated.			
	2023-24	64%	61%	
	2025-26	69%	65%	
5.	Percentage of adults receiving any care or support who rate it as excellent or good.			
	2023-24	68%	70%	
	2025-26	72%	72%	
6.	Percentage of people with positive experience of care at their GP practice.			
	2023-24	71%	69%	
	2025-26	72%	71%	
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.			
	2023-24	71%	70%	
	2025-26	71%	72%	
8.	Percentage of carers who feel supported to continue in their caring role.			
	2023-24	34%	31%	
	2025-26	28%	32%	
9.	Percentage of adults supported at home who agreed they felt safe.			
	2023-24	77%	73%	
	2025-26	79%	75%	

		Dundee	Scotland	Comparison with Scotland
12.	Emergency admission rate (per 100,000 people aged 18+)			
	2024-25	15,366	11,333	
	2025-26	15,727*	11,470*	
13.	Emergency bed day rate (per 100,000 people aged 18+) ****Bar graph = 120,000			
	2024-25	109,652	116,715	
	2025-26	101,478*	108,988*	
14.	Readmission to acute hospital within 28 days of discharge rate (per 1,000 population).			
	2024-25	143	103	
	2025-26	149*	104*	
15.	Proportion of last 6 months of life spent at home or in a community setting.			
	2024-25	90.4%	89.0%	
	2025-26	90.3%*	89.3%*	
16.	Falls rate per 1,000 population aged 65+			
	2024-25	34.6	21.9	
	2025-26	34.5*	22.2*	
17.	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections.			
	2024-25	82.6%	81.9%	
	2025-26	76.7%	83.1%	
18.	Percentage of adults with intensive care needs receiving care at home.			
	2024-25	65.9***	64.7%***	

2025-26 data not available.

		Dundee	Scotland	Comparison with Scotland
19.	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.			
	2024-25	239	899	
	2025-26	244	873	

Dundee Scotland

Worse than Scotland Same as Scotland Better than Scotland

*Calendar year data. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2025; this ensures that these indicators are based on the most complete and robust data available.

*** Figures relate to annual census week which is usually that last week in March.

National data for indicators 10, 11, 21-23 are not available.

Main Risks and Challenges

Rising demand and increasingly complex needs across many services.

Ongoing workforce pressures, including recruitment, retention, sickness absence and reliance on temporary staffing.

Significant financial pressures, including a £5.7 million operational overspend and the need for continued financial recovery.

Pressure on community services, care at home capacity and social care assessment pathways.

The need to improve support for unpaid carers, access to primary care and how services work together around people.

Dependence on wider system partners, national policy, legislation, external funding and provider sustainability.

The need to continue redesigning services while maintaining safe day-to-day delivery.

Key Priorities for 2026/27

Improve access to timely help and reduce delays across key services, including primary care, social care assessment and specialist pathways.

Strengthen prevention, early intervention, support at home and community-based services that help people stay independent for longer.

Continue redesign and transformation in services such as mental health, primary care, urgent and unscheduled care and care at home.

Improve support for unpaid carers, including information, involvement in decisions, short breaks, emergency planning and support at transition points.

Support recruitment, retention, wellbeing and development of the workforce across health, social care, third sector and independent sector services.

Improve financial sustainability while protecting services that make the biggest difference and using consultation feedback to inform decisions.

Continue to reduce inequalities and improve how people experience joined-up, person-centred care.

Introduction

Who We Are

Established in April 2016, Dundee Integration Joint Board (IJB) is responsible for planning, agreeing and monitoring adult health and social care services in Dundee. This includes adult social work and social care, primary and community health services, and some hospital-based care 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 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 set a vision for health and social care in Dundee:

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 plan also identifies 6 strategic priorities that will be the focus for work over the next 8 years. This Annual Performance Report provides evidence of progress against these priorities through key achievements, case studies, and feedback from people who use our services, their representatives and the workforce.

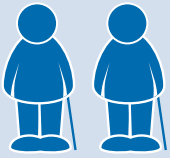
Health and Social Care in Dundee

The graphic below sets out the wider context in which the Integration Joint Board is working and the main challenges it faces in achieving its ambition for the people of Dundee.

Increased Demand

More people need health and social care support.

An Ageing Population



More people are living longer and many need support for longer.

More Complex Needs

More people are living with more than one condition.

Workforce Pressures

Recruiting and keeping enough skilled staff remains a major challenge.

People in Dundee will have the best possible health and wellbeing

Impact on Unpaid Carers

Many unpaid carers are doing more for longer, affecting their own wellbeing.

Financial Pressures

Public sector budgets are under pressure while costs continue to rise.

Rising Cost of Care

The cost of care, medicines, energy and essential services continue to increase.

Pressure on Local Services

GP practices, community services, mental health services and hospital discharge pathways are all under pressure.

These pressures shape how we plan, improve and deliver services across Dundee.

You can find out more about the health and social care needs of people in Dundee in **The Plan for Excellence in Health and Social Care in Dundee**.

Reviewing Our Long-Term Plan for Health and Social Care in Dundee

During 2025/26, Dundee Integration Joint Board reviewed **The Plan for Excellence in Health and Social Care in Dundee**. This review was required by law and looked at whether the plan is still the right one for Dundee.

The review was informed by updated information about local need, work with partners, and engagement with local people, colleagues and stakeholders. This included 129 survey responses, feedback from more than 260 people through community group discussions, and responses from health and social care services.

The review found that the overall direction of the plan is still right. Our ambition, values and main priorities continue to reflect the needs of people in Dundee and are still in line with national policy and local plans. However, the review also found that some of the detailed actions in the plan now need to be updated. Since the plan was agreed, the financial position has become more difficult, and services are working under greater pressure. This means some parts of the plan need to be revised so that they are realistic, affordable and focused on the areas where they can make the greatest difference.

The feedback from the review process showed that people value the support already in place, including community-based services and early help, but also feel there is more to do. In particular, people wanted services to be easier to access and understand, more joined up, and planned more closely with the people who use them. Many people also said that financial pressures should be handled openly and honestly, with clear communication about the impact on services.

Following the review, the IJB agreed to keep the current Strategic Commissioning Framework but revise it. This means the overall plan will stay in place, while the more detailed actions underneath it will be updated. A revised version of the Strategic Commissioning Framework will be developed during 2026 and brought back to the IJB for approval. Until then, the current plan remains in place and continues to guide the work of Dundee Health and Social Care Partnership.

The main challenge will be turning the revised plan into realistic and affordable actions while services continue to face high demand, workforce pressures and financial constraints. There is a risk that short-term operational pressures could limit the capacity available for longer-term prevention and transformation. The review process, strengthened engagement arrangements and clearer prioritisation will help the IJB focus resources on the areas where they can have the greatest impact.

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

Inequalities

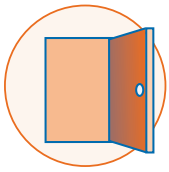
Support where and when it is needed most.

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.

The first three strategic priorities focus on making it easier for people in Dundee to get the right support at the right time, improving access to clear information and early help, and helping people and communities stay well for longer. In the short term, we want to shift more support towards prevention, strengthen local and community-based help, improve how people find and move between services, and make sure support feels more joined up around the person rather than around organisations.

Throughout 2025/26, many developments have helped deliver these priorities. Each example below is shown alongside the strategic priority graphic for the priority area it directly supports.

Racial Literacy Training

The Community Health Team has worked in partnership with Education Scotland to develop and deliver an Introduction to Racial Literacies session for the Community Learning and Development workforce, with 41 colleagues attending. The session aimed to:

- explore why anti-racism matters both in Scotland and in Dundee.
- introduce the concept of racial literacy and highlight key resources and opportunities for further professional learning.
- provide a reflective space for colleagues to consider their own understanding and knowledge; and
- support participants to reflect on how they can build their own racial literacy, embed anti-racist approaches within their practice, and identify meaningful next steps.

Learning Disability Health Checks

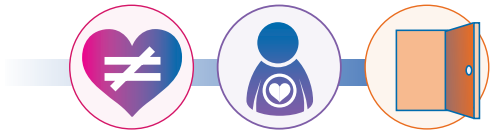
During 2025/26, Dundee Health and Social Care Partnership continued to make progress in rolling out annual health checks for adults with a learning disability. A new delivery model has been introduced, combining nurse-led clinics with support from GP practices. This has created a more flexible way of offering checks and has helped build a central register of around 1,400 eligible people, making it easier to identify who should be invited and supported to take part.

During the year, 197 annual health checks were offered and 144 were completed. This means 73% of the people offered a check took it up. As a result, 61 people were referred on for extra support or treatment, helping improve access to the wider healthcare they needed.

Work has also continued to improve access to national screening programmes. By working with Public Health to review who attends and who does not, the service is building a better understanding of the barriers people face and using this to improve support and access.

A continuing challenge is making sure that all eligible people are identified, invited and supported to attend in a way that meets their communication, accessibility and support needs. Further work will focus on using the register, local data and partnership working with primary care, public health and community services to improve uptake and reduce health inequalities.

Reducing Harm from Drugs and Alcohol Use



During 2025/26, Dundee Alcohol and Drug Partnership continued to improve support for people affected by alcohol and drug use.

One of the main areas of progress was the continued rollout of the national Medication Assisted Treatment (MAT) Standards. Dundee has improved significantly since 2022 and now performs strongly across the standards. People were able to get treatment quickly, with almost no waiting times recorded, and support for people after a non-fatal overdose continued to improve. Harm reduction support, including access to naloxone, also remained an important part of the local response. Across Tayside, most services have now completed psychologically informed and trauma-informed training, supporting a more compassionate and effective response.

Dundee has been developing services for people affected by non-opioid drugs such as cocaine and benzodiazepines. This includes work on new treatment and brief intervention pathways, as well as workforce training to help services respond to these changes. There has also been further work to review and improve the local alcohol pathway, including detox and rehabilitation support.

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

The Partnership has also continued to place strong emphasis on the voices of people with lived and living experience. The Dundee Recovery Network has grown during the year, with more people involved in community work, local planning and recovery-focused activity. Recovery Month was also supported, helping to celebrate people's achievements and promote recovery in local communities. Work has also taken place to strengthen prevention and improve how services are organised. This includes local prevention activity funded through the decentralised fund and continued support for Planet Youth.

Despite this progress important challenges remain. Services continue to work in a difficult financial and workforce context, demand remains high, and the nature of substance use is changing. Some areas of work, including independent advocacy, residential rehabilitation pathways and longer-term prevention activity, will need secure and sustainable funding for the future. Work is also still needed to improve how longer-term outcomes are measured for people as they move through treatment and recovery.

Mental Health and Wellbeing – Strategy Impact

Dundee's Mental Health and Wellbeing Strategic Plan 2019–2024 has helped to strengthen local support over the last five years, with progress made across prevention, early help, crisis support, suicide prevention, community services and workforce development.

One of the main areas of progress has been the development of more joined-up support in community and primary care settings. This has included the introduction of a multi-disciplinary framework in primary care to improve support for mental health and wellbeing, as well as wider health and wellbeing networks in communities, local fairness initiatives, a third sector mental health forum and a health inequalities action plan. Survey findings from Engage Dundee have also helped influence local activity, showing a stronger focus on listening to people and using feedback to shape services.

There has also been progress in improving support for people with more specific or complex needs. This includes expansion of the Tayside Adult Autism Team, additional supported accommodation, and work to create an integrated pathway for people experiencing both mental health and substance use issues. These developments are important because they help build a broader range of support and improve how people move between different parts of the system.

A significant part of the strategy has been the growth of alternatives to traditional clinical services, especially in relation to distress and crisis. Hope Point has been developed as an "always open" service for people in emotional distress, as well as Distress Brief Intervention, providing up to 14 days of non-clinical support from peer practitioners. Emergency Department Mental Health Navigators have also been introduced to improve support at the point of crisis and help people access the right follow-on help.

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

The strategy has also delivered clear progress in suicide prevention. Dundee now has a Suicide Prevention Delivery Plan for 2024–2026. A local suicide prevention training forum has been established, alongside an alliance of facilitators and a more coordinated approach to training delivery. This has led to a significant increase in training capacity and reach. In the last 12 months alone, 606 people received suicide prevention training locally, which demonstrates practical progress in building awareness, confidence and prevention skills across the city.

Co-production and partnership working has been central to these developments. The Strategic Planning and Commissioning Group, which includes people with lived and living experience, has helped guide delivery of the plan. Overall, the strategy has led to a broader range of support being available in Dundee, with more emphasis on early help, community-based support, peer support, crisis response and partnership working. At the same time, it is clear that some areas still need more work, including smoother pathways, better information for the public, stronger transitions for young people moving into adult services, and better links between different parts of the mental health system.

In February 2026, a new one-year project was launched to better understand men's mental health and wellbeing in Dundee. The first stage was a public survey, which closed at the end of March 2026. The In Yir Heid survey received 338 responses, including 225 from men living in Dundee. The findings are now being reviewed and will be used to shape the next stage of the project, which will involve speaking directly with groups of men across the city to build a fuller picture of their experiences and needs.

Primary Care - Impact on People Using Mental Health and Wellbeing Services

During 2025/26, Dundee's Primary Care Mental Health and Wellbeing services continued to expand and strengthen support for people experiencing mental health and wellbeing challenges. The multi-disciplinary team approach means people can access a wide range of help through their GP practice or local community, improving access to the right support at the right time.

Across services, large numbers of people have been supported with practical, emotional and social needs. For example, the Distress Brief Intervention Service supported over 900 people and helped reduce levels of distress by more than half following short-term support. The Sources of Support Service helped over 1,100 people to improve their wellbeing, including support with issues such as housing, finances, loneliness and mental health, while the Community Listening Service provided a safe space for nearly 300 people to talk through difficult experiences.

For many individuals, accessing support through Primary Care has led to practical improvements in their day to day lives. This includes helping people identify wider issues affecting their wellbeing, such as money worries, debt, housing or social isolation, and connecting them with the right specialist support. Services have also helped people to better understand and manage their mental health. Feedback highlights that people feel listened to, supported and more able to cope, with examples showing improved confidence, reduced anxiety, and increased ability to deal with challenges. Short-term interventions, such as digital therapies and coaching-style support, have enabled people to access help more quickly and in ways that suit them.

Importantly, services are reaching people in the most deprived communities, where need is greatest. A significant proportion of those supported live in areas with higher levels of deprivation, and the focus on local, community-based support helps reduce barriers such as travel and cost. However, not everyone has been able to access support as quickly as needed. High demand, workforce pressures and reduced capacity in some services have led to waiting times and, in some cases, limited availability. Digital access barriers and ongoing inequalities also continue to affect how easily some people can use services.

Connections Services

In 2024–25, a service was introduced as a "Test of Change". The aim was to support people before and after an autism diagnosis, people who do not want a formal diagnosis, and/or who do not meet the criteria for support from other services. Direct support is provided and the service works in partnership with other stakeholders in the city, signposting individuals to other services where appropriate. In 2025/26, the Test of Change was extended in duration (until the end of September 2026) and in scope, to include two part-time Peer Worker posts. The service continues to strengthen links with statutory and other third sector provision across Dundee, and support individuals on the Tayside Adult Autism Consultancy Team (TAACT) waiting list.

Since launching in May 2024, the service has supported 689 people across Tayside (567 from Dundee.

Connections Services

Since launching, 689 people have accessed the service*

391 People with Autism

141 Family Members

156 Professionals

*Please note, any anonymous contacts are recorded as one person.

Just over 40% of people who used the service referred themself and the most common types of advice, support and signposting provided were:

- Emotional support
- Autism understanding
- Peer support group
- Being social
- Employment / volunteering
- Mental wellbeing

"Since I started attending Connections, my confidence has grown a lot, both socially and personally. I used to struggle to leave the house, but now I regularly come to peer support group, 1:1s and activities. It's also helped me feel more confident doing things outside of Connections too. I'm really grateful to have a space where I can be myself, feel welcome, and be around people who understand me."

The future sustainability of this support remains an important risk. If ongoing funding or capacity is not secured, there is a risk that people waiting for diagnosis, or who do not meet criteria for other services, may have fewer options for early and preventative support. Evaluation of the test of change, including feedback from people using the service and partners, will be important in shaping future commissioning decisions.

Recovery and Wellbeing – Community Projects

Douglas Community Centre Local Management Group has worked in partnership with the Community Empowerment Team and Hillcrest Futures to deliver weekly drop-in recovery café sessions and provide crisis intervention, guidance, and signposting for individuals to appropriate services. The project supported 22 individuals through 44 one-to-one sessions, resulting in significant positive changes such as increased confidence and reduced drug and alcohol use. The project distributed 32 naloxone kits (containing medication and supplies to temporarily reverse opioid overdoses), conducted substance awareness sessions, and provided wound care advice.

The Wild Dundee Nature Recovery Project delivered eight nature-based activities, developed Nature Recovery Packs for Carseview inpatients, and created a 'wee forest' at Carseview Hospital. Additional initiatives included garden design and wildflower planting at The Friary, co-design workshops, and community events. The project engaged medical students and directly benefited 94 people, with participants reporting increased confidence, purpose, and empowerment.

In the North-East funding was used to deliver drug and alcohol-free events in the community. Resolve and Evolve community group volunteers provided a safe and welcoming environment, providing the opportunity for families and individuals to take part in drug and alcohol-free events in the community.

General Practice – Continuity of Care

During the year, work progressed to develop a proposal to improve continuity of care in general practice across Dundee. Continuity of care means supporting patients to see the same GP, or the same small practice team, more consistently over time. The proposal was developed in response to ongoing pressures in general practice, including increasing workload, recruitment and retention challenges, and wider sustainability concerns. Evidence from research and practice suggests that stronger continuity of care can help reduce demand on services, improve outcomes for patients, and support workforce wellbeing.

A small number of practices will test and develop practical ways of improving continuity of care for specific groups of patients, such as those with complex or long-term needs. The aim is to build local learning and identify approaches that could be shared more widely across Dundee in future. This work is aligned with wider national and local priorities for sustainable, person-centred primary care. It reflects the importance of relationship-based care, particularly for people with more complex health and care needs, and supports longer-term improvement in access, quality and experience of care.

GP Out of Hours Service

During 2025/26, work has progressed to develop a new Strategic Framework for the GP Out of Hours (OOH) service (2026–2036) across Tayside, setting out a long term plan to improve urgent primary care when GP practices are closed. The need for change reflects increasing demand, more complex patient needs and workforce pressures. The new framework sets out a clear vision for a safe, sustainable and person centred service, with a focus on helping people access the right care at the right time and as close to home as possible.

Key developments include a stronger focus on integrated working across the urgent care system, with closer links between out of hours services, NHS 24, ambulance services, GP practices and community teams. This is intended to create more seamless care pathways, reduce delays, and improve the overall experience for people using services. There is also a strong emphasis on workforce development, including improved training, support and team-based working, to ensure the workforce have the skills and confidence to respond to increasingly complex needs. Alongside this, digital tools and data are being developed to improve coordination, decision making and service planning.

Evidence from engagement has highlighted the importance of timely access, clear communication and local provision for service users. While people value the care they receive, concerns remain about waiting times, telephone access, travel and coordination between services. These issues have directly informed the priorities for future service redesign. The planned changes aim to deliver a more responsive, integrated and person-centred service, improving access, experience and outcomes for people.

Tayside Health Arts Trust

Tayside Healthcare Arts Trust (THAT) has delivered arts and health programmes for more than 20 years. In partnership with NHS Tayside, cultural and community organisations, they provide creative opportunities that improve health, wellbeing, and quality of life for people living with long-term conditions. They take referrals from a wide range of services across Tayside, including health and social care teams and mental health services.

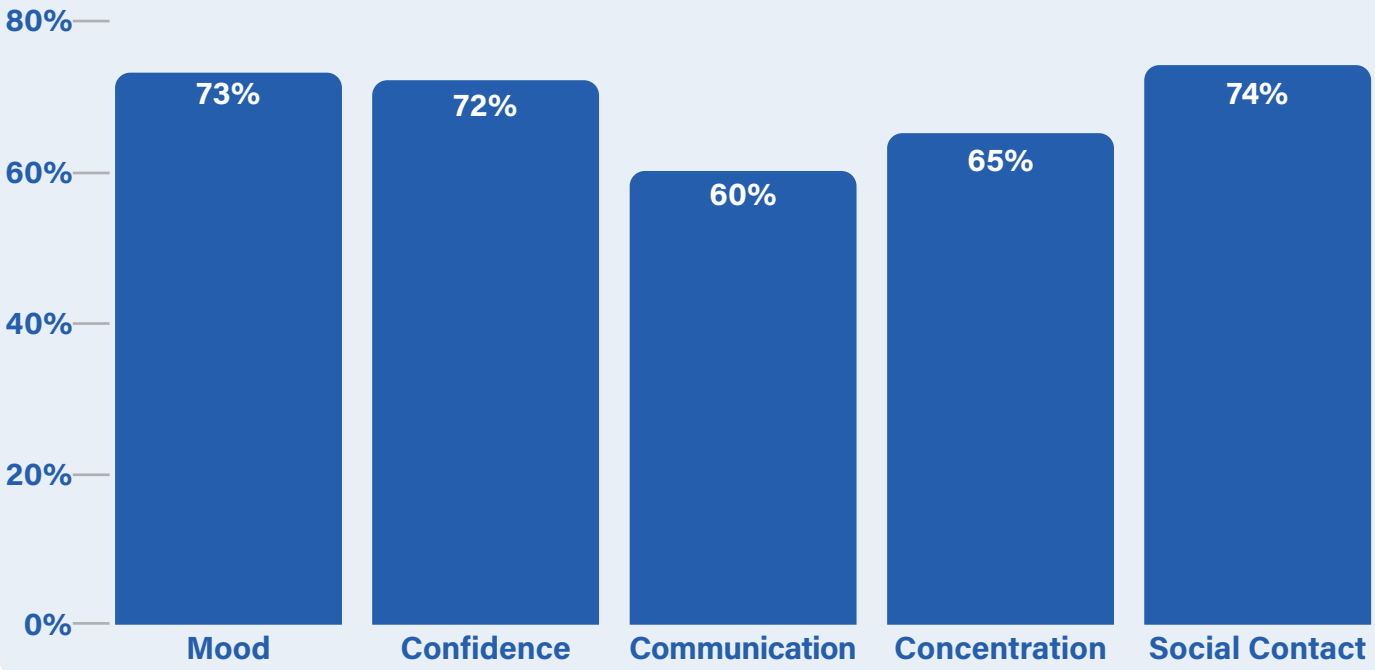
In Dundee, key activity includes:

- RSNO Music Programme – music composition workshops encouraging peer support, with experienced participants encouraging newcomers.
- McManus Galleries – Inspired by A Weather Eye exhibition participants created collages, drawings and paintings. Many gained confidence and continued art practice independently.
- Dundee Radio Club – Listening Festival – including collaboration between RSNO musicians, an audio walk at Hospitalfield, and creative writing recorded at V&A Dundee.
- Inpatient Stroke Units – 12-week creative programme at Royal Victoria Hospital, embedding art rehabilitation and strengthening NHS relationships.
- Kingsway Care Centre – Dementia-Friendly Design – Artist Louise Kirby transformed Ward 1 with nature-inspired designs that created a calmer, more supportive environment for patients, colleagues and visitors.

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

THAT demonstrates that engaging in the arts can significantly enhance physical, mental, and emotional health. Participants described moving from depression and anxiety to feelings of joy, relief, and hope—highlighting the therapeutic power of creative engagement. These findings are supported by participant questionnaires, case studies and programme evaluations, alongside partner and artist observations and reports.

Has Participation Improved Your:



"Before this winter's workshop, I was extremely depressed... it made me want to be with people and be part of life again."

"After my stroke... the art class gave me confidence again."

Community Health Team

The Community Health Team (CHT) uses a community development approach, helping local people to address health challenges, lead healthier lives, tackle the root causes of poor health where this is possible, and influence decisions affecting health and wellbeing at a local and national level. As well as adopting a community-wide approach in specified localities, the team also targets population groups with specific needs. In 2025/26 this included older people, families, men, BME communities/ refugees, people with mental health challenges and women experiencing menopause. Some examples of work that has taken place over the last year are:

- In partnership with Abertay University members of the Charleston Health Issues in the Community Group presented to Mental Health Nursing Students on how taking part in community activities helped them to overcome challenges related to disability, recovery from substance use and caring responsibilities.
- Increased partnership working with the ESOL team has led to a Ukrainian refugee becoming a member of the new Community Health Team Health Issues in the Community Course. Information about Refugees and Asylum Seekers has also been added to the Poverty Sensitive Practice training, helping to address misinformation and tackle racial tensions.
- The Community Health Worker in Strathmartine delivered a Speakeasy course in partnership with a local Primary School with the aim of supporting identified parents to build confidence and skills to talk to their children about relationships, boundaries, privacy, and staying safe in an age appropriate way.
- A new partnership in the East End with the Brooksbank Centre arts and crafts groups, has supported members to access Community Regeneration and Make it Happen Funds. The groups used the funding for a study visit to the Glasgow Craft Fair with walking aids supplied, thus enabling people with disabilities to attend the event.

Dundee Menopause Community Cafés

The Menopause Community Cafés grew from a grassroots support group in Maryfield. It provided a safe, supportive space for women experiencing perimenopause and menopause to share symptoms, concerns, and coping strategies with peers. From the outset, participants highlighted difficulties accessing GP services and a perceived lack of understanding of menopause within primary care, prompting wider engagement with health partners.

A partnership was formed with local GPs, and the group secured a small amount of funding to develop menopause cafés across Dundee. Several local volunteers were trained to become "Menopause Mentors", increasing skills, confidence and capacity to provide support at a local level. The cafés have been delivered at four different venues with an average attendance of 10 women. Evening sessions reduce barriers to access and offer a welcoming environment with refreshments, facilitated discussion, and access to health checks from the Health Inclusion Nursing Team. A key focus is on women feeling "seen, heard and valued" as participants often report feeling invisible during this life stage. Cafés are treated as "tests of change", trialing different facilitation approaches, including structured questions and creative activities to encourage discussion and connection.

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

Evaluation and feedback showed that all participants recommend attending a Menopause Café. Many reported the positive impact of seeking non- medical remedies, feeling valued, having someone who listened, understood, and could offer practical advice. The women highlighted the need for improved GP knowledge, accessible information, and earlier education on menopause for all genders.

Mindful Meals – A Therapeutic Cooking Group

An approach was made to the Community Health Team by Occupational Therapists from the Carseview Centre and the Early Intervention in Psychosis Team looking for cooking groups suitable for patients with significant mental illness, particularly those approaching discharge from inpatient care. These patients often wanted to cook for themselves but felt unable to access community groups due to low confidence, limited skills, and complex mental health needs. To address this, a cooking group was co designed to provide a safe and supportive space where participants could build skills at their own pace.

Six patients took part in this test of change, and impact was evident early on. Sessions were deliberately small and informal, creating an atmosphere that felt social rather than clinical. Easy read, pictorial recipes made tasks accessible, and sessions remained flexible and responsive to how people were feeling on the day helping reduce anxiety and encourage participation. Participants described the group as welcoming and enabling, and the practical design helped people feel capable and included.

One said, "The recipes are easy to follow, and the pictures really help."

For some, the impact was tangible and immediate:

"I only cooked breaded chicken in the air fryer — now I can branch out."

By the end of the programme, participants were cooking more independently, eating a wider range of foods, and relying less on takeaways. Confidence extended beyond the kitchen, supporting greater engagement with OT services and use of community facilities and groups that had previously felt out of reach.

Health Week: Coldside/Maryfield

Engagement in the Coldside/Maryfield area highlighted that many residents would like to try out new activities but lacked confidence or knowledge about what was available. The Community Health Worker planned a series of meetings to explore and plan a "Health Week" involving a wide range of organisations. This resulted in a 7-day programme of 46 activities involving 15 partners. Activities included short walks, cycling, chair yoga, health checks, creative arts, litter picks, healthy eating sessions and many more.

Over 200 contacts were made during Health Week. Feedback indicated that local people found the activities enjoyable and health-promoting and were more aware of what was going on in their community. There was also a subsequent up-tick in attendance at a range of community groups. Plans are underway to offer Health Weeks twice a year and to roll out to other areas.
Although these community-based approaches are making a positive difference, they rely on sustained partnership working, local volunteer capacity and continued access to community spaces and small-scale funding. There is a risk that the people who would benefit most from preventative activity may still face barriers such as poverty, transport, digital exclusion, disability, language or low confidence. Continued engagement with local communities will be needed to make sure activities remain inclusive, accessible and targeted where need is greatest.

Comments from participants:

"The seated exercise session was really good. I have very limited mobility and use an electric wheelchair. I was able to do most of the activities and felt really positive after the class. I attend the sessions on Wednesday afternoons in the Community Centre. I always wanted to join a group but was too shy. I now go every week, makes my day"

"The community café has been a lifeline for me, I go every morning to the breakfast club. I get tea and toast and a good chat with others at the café. I live alone and don't have any family in Dundee. Thank goodness for places like this"

Community Capacity Building

Capacity-building support provided by the Community Health Team supports the development of inclusive, cohesive, resilient, and strong communities. Local people work together and with partners to identify shared issues, priorities, and solutions to tackle health issues in their communities.

- In 2025/26 144 people engaged with community health capacity building programmes, - which is almost 50% more than the target for the year.
- 344 Recovery and Resilience Sessions have been held (annual target of 200).

Health Issues in the Community

Charleston HIIC (Health Issues in the Community) Group members all passed their Part 1 assignments, supported by the Community Health Team. The group has been working towards this for well over a year and 3 out of 4 members have chosen to complete Part 2 to receive accreditation. This is awarded at SCQF level 6 and is a partnership between CHEX/ Scottish Community Development Centre, Public Health Scotland, Scottish Qualifications Authority & Scottish Credit and Qualifications Framework.

HIIC Part 1 courses are currently running in the East End, Coldside and Lochee Council wards, with excellent engagement from community members. The Hilltown group have successfully completed their final assignments, which have now been submitted to an external marker, and several participants have already progressed to HIIC Part 2. The Health Issues in the Community (HIIC) course continues to offer substantial benefits, enabling participants to develop a deeper understanding of the social determinants of health, build confidence, strengthen their community voice, and gain practical skills in community engagement, research, and collective action—all of which support long-term community resilience and empowerment.

Community Health Advisory Forum

The Community Health Advisory Forum (CHAF) and Health and Wellbeing Networks are agreed mechanisms to engage with local people and service providers on health-related developments with information flowing both ways. This year, both were involved in the review of the Integration Joint Board and other HSCP strategic plans and service developments. The Community Health Advisory Forum brings together 12 participants to take city-wide action on health inequalities and ensure that local voices influence plans and practice. Over the past year, the Community Health Advisory Forum has been actively engaged in a range of impactful initiatives including:

- Attending the Community Health Exchange national conference and delivered a workshop to share their experiences and key pieces of work.
- Building a strong relationship with Change to Change from Drumchapel, sharing knowledge, skills and experience.
- Shaping a suicide prevention session to support parents and carers.
- Members have joined the Mental Health and Wellbeing stakeholder group to ensure community voices are represented in the development of the new strategic plan.
- Members also attended an event exploring the idea of public diners in the city.

Community Health Advisory Forum

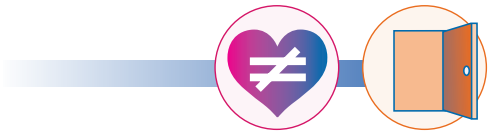
Open Doors

Community Centres across the city continue to run Open Doors programmes, which were heavily promoted over the winter months and advertised on the council website and the In Your Neighbourhood Facebook pages. Additionally, local hubs such as the Brooksbank Drop-in in Mid Craigie, the Douglas Community Centre Wednesday Hub, the Lochee Hub, the Albert Street Food Larder Hub, and Stobswell Connect have a range of co-located services.

New wellbeing web pages were launched on the NHS Tayside website to raise awareness of health services and local organisations through a service directory and were promoted through leaflets and online sessions. Another leaflet to promote mental wellbeing and self-help and was co-produced with local people and circulated in early 2025. GP Practices, community centres, third sector organisations, and schools received copies of the leaflets, as did local food larders and food banks.

Throughout 2025, a co-production exercise has been underway to engage local people and service providers in the development of a Wellbeing Website for Dundee. This is a partnership between primary care, public health, the Community Health Team, and DVVA, with input from a wide range of partners.

Health Inclusion Services



During 2025/26, health inclusion services in Dundee continued to strengthen how people are connected to the right support at the right time. The Health Inclusion Team (HINT) remained active in local communities and multi-agency planning, including through the Multi Agency Contingency Hub, helping to build trust with people who may find services hardest to access. Sources of Support continued to expand its links with GP practices, with direct booking now in place in most practices and community link workers embedded across almost the whole city. At the same time, Improving the Cancer Journey continued to develop as part of the wider Health Inclusion Service, offering support to anyone affected by cancer and strengthening links with a wider range of clinical teams so that people can be identified earlier and supported more consistently. Together, these developments have helped create a more joined-up and accessible approach to support, particularly for people facing health inequalities or multiple challenges.

Sources of Support Patient Feedback

"I was really struggling before I got support. My housing situation was unstable, I didn't understand what benefits I was entitled to, and I felt extremely isolated. The support I received made a huge difference. Everything was explained clearly, and I felt listened to rather than judged. Thank you for having patience I honestly don't know where I'd be without this help."

"I wanted to let you know that the relaxation medication is working very well for me. I'm finally able to sleep and get some rest, which has been one of my biggest challenges. I have lost some weight to help regulate my health. I'm feeling physically better and staying active by running and going to the gym when I can."

Relationship Matters Event

In February 2026 a large social and learning event was held for adults with a Learning Disability and Adults with a Learning Disability and Autism. This was arranged following extensive engagement and discussions with people with disabilities, their carers and their support workers. One of the personal outcomes people identified was regarding relationships and the need for opportunities to have personal relationships and friendships.

A Disco Event was held on a Friday afternoon at Fairfield Social Club; it was attended by over 150 people. The event included information stalls, workshops, a quiet craft area, and a disco with a buffet. Dates and Mates hosted a workshop for a large number of people about relationships and human rights.

A healthcare led workshop for carers, supporters and practitioners took place in the quiet space, led by Public Health and Learning Disability Nursing. Participants shared concerns and perspectives. Colleagues valued hearing from family members and supported more joint sessions in future.

Planning and Working Together

Planning Together

Planning services to meet local need.

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

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.

Our priorities of Working Together and Planning Together focus on improving how partners share information, plan services, make decisions and use resources so that support is easier to navigate and works more effectively across organisational boundaries. In the short term, we want to strengthen collaboration across health, social care and community partners, improve how local needs and lived experience inform planning, and make sure changes are designed and delivered in a more coordinated way.

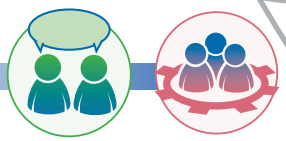
Throughout 2025/26, many developments have helped deliver these priorities. Each example below is shown alongside the strategic priority graphic for the priority area it directly supports.

Inpatient Learning Disability Services

During 2025/26, the first phase of the Tayside Learning Disabilities Inpatient Transition Programme was completed with the opening of the new Learning Disability Assessment Unit at Murray Royal Hospital. In March, patients and staff moved from the previous unit at Carseview Centre to the newly refurbished Rannoch Ward. The move was carefully planned to make sure people continued to receive safe, consistent care throughout the transition.

The new unit offers a much improved environment for the people who use it, with sensory spaces, gym equipment, outdoor areas and better accommodation. Having psychology, occupational therapy and other specialist teams based alongside the unit also means care can be planned and delivered in a more joined-up way, helping improve people's experience of support and their outcomes.

Supporting Unpaid Carers



During 2025/26, Dundee Integration Joint Board completed a review of "A Caring Dundee 2", the local strategy for supporting unpaid carers. There is a legal requirement to complete this review every 3 years. The review found that the current strategy has helped to improve support for carers, but it now needs to be updated to reflect changes in carers' lives, the wider policy environment and the feedback we have heard from carers and partner organisations.

The review showed that good progress has been made under the current strategy. This has included strengthening how carers are involved in planning services, increasing awareness of carers' rights, improving support for carers in the workplace, and continuing a range of services that help carers with their health and wellbeing. Young carers have also been supported through dedicated involvement work, including young carer ambassadors and activities that help ensure their voices are heard.

Evidence gathered through the review also showed the positive impact of local support. Of the carers who accessed support through the Carer Centre, 99% said their health and wellbeing improved, 99% said they felt more confident and able to care, and 91% said they felt less isolated (2024/25 last data available). Nationally, the proportion of carers who said they could access a range of information and advice also increased from 68% in 2022 to 78% in 2023.

At the same time, the review highlighted several challenges. Carers told us about the impact of financial pressure and poverty, difficulties getting the right information and advice at the right time, and the strain that caring can place on their mental health and wellbeing. Many also raised concerns about replacement care, respite and short breaks, especially where this affects their ability to attend their own appointments, stay in work, or take a break from caring. Carers also told us that transition points, such as hospital discharge or a young person moving into adult services, can be especially difficult.

As a result, the IJB agreed that the carers strategy should be revised, along with the local Short Breaks Service Statement. The new strategy and Short Breaks Statements was approved by the IJB in February 2026. It has been developed with carers and will continue to be shaped by carers over time, helping to ensure that future improvements reflect lived experience as well as local need.

The new strategy sets out practical priorities for the coming years, including better identification and support for young carers, increased uptake of Adult Carer Support Plans, stronger emergency planning, and improved support at key transition points. It also aims to strengthen carer involvement in hospital discharge planning, so carers are recognised and included in decisions about ongoing care and support. Other priorities include using data more effectively, improving how carer involvement is recorded, and working more closely with money advice and employability services. The Partnership will also continue to work with carers to identify the most appropriate support, including self-directed support where this is suitable.

Review of Housing with Care

During 2025, we reviewed our Housing with Care services to make sure they continue to meet people's needs and make the best use of public money. Housing with Care provides support for people who live in sheltered or supported housing and need help with daily living. In Dundee, this support is provided at nine sites, with three sites run directly by the Partnership.

The review found that the current in-house model is no longer the best way to provide this support. At two sites, Brington and Baluniefield, services were not always suitable for people's changing needs. Social care supports for the remaining tenants at these sites have now been moved into the mainstream Care at Home service. This means people continue to receive support, but through a different team.

At Rockwell Gardens, the review found that people greatly value the service, especially the relationships they have with their workers and the flexible support available on site. The wider support available at Rockwell, including meals, alarms, wellbeing checks and housing support, will remain important parts of the service. However, the review found that the current in-house care model costs more than externally commissioned services and is not making the best use of available resources and time. The Integration Joint Board therefore agreed to commission the care from an external provider through a formal procurement process. This is intended to provide a more sustainable model while maintaining quality and support for tenants. The review identified that these changes could release around £540,000 each year, helping to use resources more effectively across health and social care services.

We recognised that any change to care arrangements can be worrying for people who use services and their families. Consultation with Rockwell tenants and families showed that, while many understood why change was being considered, they were concerned about losing trusted relationships and the quality of their current support. For this reason, the change at Rockwell will be carefully managed with further consultation, clear communication, support for employees, and a planned handover to reduce disruption.

Mental Health and Wellbeing Strategy

Over the last year work has been carried out to develop a new Dundee Mental Health and Wellbeing Strategic Plan for 2026–2031. The new strategy is being created through a co-production approach, which means it is being shaped with partners, communities and people with lived and living experience, rather than being written only by services.

An important step in developing the new strategy was a city-wide Mental Health and Wellbeing Strategic Planning Event held at The Steeple in April 2025. The event brought together 90 people from across Dundee, including people with lived and living experience, unpaid carers, GPs, community workers, third sector organisations and others. The event gave people the opportunity to talk openly about what is working well, where the gaps are, and what should be prioritised in the future. Feedback from participants showed that the event created a warm and respectful space where people felt genuinely heard. This was seen as an important first step in building a more inclusive and meaningful approach to planning.

Several clear messages emerged from the event. People said they had learned about new services, but also that there needs to be better awareness of the support that is available and fewer barriers to accessing help. They highlighted the importance of stronger signposting to community resources, support to help people access these services, and peer support roles being built into future developments. Hope Point was identified as a particularly welcome addition to the city.

A Stakeholder Group was established following the April event. Facilitated by DVVA, the group met every six weeks and enabled people to take part in person, online or indirectly through outreach work in community settings. This was intended to make sure that the voices of stakeholders, including those with lived experience, continue to influence the development of the strategy over time. The final co-produced strategy is expected to be completed by early 2026.

Improving Service User and Carer Representation on the IJB

During the year, Dundee IJB reviewed how people who use services and unpaid carers are involved in Board decision-making. The IJB recognised that these voices are essential to good governance, but also considered ongoing challenges in recruiting, supporting and retaining representatives. In response, the IJB agreed a more sustainable long-term approach that builds on existing community and lived experience groups, helping people become involved through the Strategic Planning Advisory Group before progressing to IJB membership. Updated role descriptions were also developed for both service user and carer representatives, setting out the support, training and practical help available.

Winter Planning and System Resilience

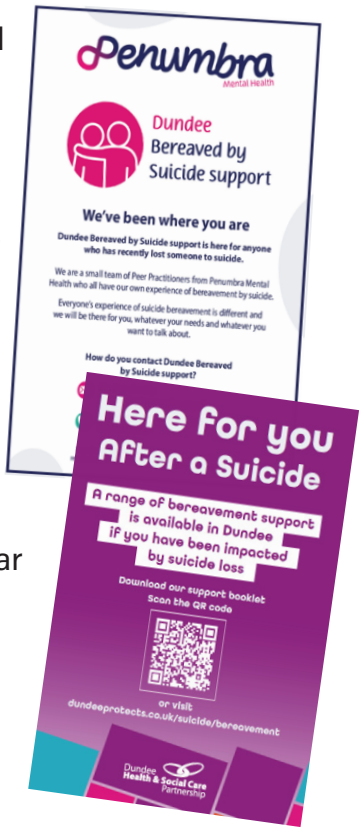
During 2025/26, Dundee Health and Social Care Partnership worked with NHS Tayside and partners across Angus and Perth & Kinross to prepare for the increased pressures typically experienced over the winter period. A whole-system approach was taken to ensure services could continue to deliver safe, effective and person-centred care. Planning focused on helping people stay well at home, improving access to the right care at the right time, and supporting colleagues to manage increased demand. This included strengthening community services, expanding "Hospital at Home" and "Home First" approaches, and improving how people move through hospital and care services.

Across Dundee, additional capacity was put in place over winter, including increased social care support, expanded frailty services, and enhanced rehabilitation provision. These measures helped support people to have an earlier discharge from hospital and reduce avoidable admissions, particularly for older people and those with long-term conditions.

Strong partnership working remained central to delivery. While risks remained —particularly around high demand, workforce pressures and seasonal illness—robust plans helped to manage them and ensure that people received timely, appropriate care throughout the winter months.

Bereaved by Suicide

During 2025/26, Dundee's Bereaved by Suicide Improvement Steering Group introduced several new ways to support people and families affected by suicide. This work was developed with people who have personal experience of this kind of bereavement, helping to make sure support is shaped by what people need most.



In September, a new bereavement support service was launched for people who had recently lost someone to suicide. The service is run by Penumbra Mental Health and delivered by peer practitioners based at Hope Point, all of whom have their own experience of suicide bereavement. This adds to the support already offered by the Survivors of Bereavement by Suicide (SOBS) group, which started in February 2025. SOBS meets every month and has supported more than 78 people so far.

A booklet called Here for You, After a Suicide was also produced to give clear and practical information to people and families after a suicide. It explains what support is available locally and nationally, including the services listed above. The booklet has been shared with local services, community organisations and third sector partners, and Police Scotland also gives it to the next of kin after a death.

Care Home Team

General Adult Nurses

The RGNs (Registered General Nurses) play a vital role in supporting Care Homes by visiting their nominated link homes and interacting with Nursing Home Colleagues and Residents and their visitors. This allows them to offer advice, supervision, guidance, and support without the need for Care Home colleagues to reach out to the service. Both Care Home Practitioners and the RGNs themselves have provided very positive feedback on this arrangement, as it helps build therapeutic relationships, fosters a deeper understanding of the pressures and demands faced by colleagues, and enables the nurses to become more familiar with residents.

To ensure equity and timeliness in care, a structured referral pathway and caseload system has been established for the RGNs. This approach has proven successful, allowing the team to monitor trends and identify areas requiring additional focus, such as end-of-life care. While the RGNs are not positioned as an emergency service, they remain highly responsive. On receiving a referral, they make direct contact with Care Home colleagues to provide reassurance and begin planning appropriate care. This proactive communication ensures that colleagues feel supported and residents receive timely attention.

Mental Health Nurses

The Mental Health Nurse referral process has recently been strengthened with the introduction of a clear priority system, ensuring that residents are seen according to the urgency of their needs. Referral forms have been simplified, making them easier for Care Home colleagues to complete while still meeting essential criteria. Alongside this formal pathway, the Registered Mental Health Nurses (RMNs) continue to provide informal support and guidance, maintaining close communication with colleagues to address concerns quickly and effectively. For routine referrals, the agreed timescale is within 10 working days. In practice, however, the team consistently exceeds this standard, with residents typically being seen within an average of just 3 working days.

Social Work Review Officers

Some of the team's Review Officers (ROs) have begun a trial of drop-in style clinics within specific Care Homes during the early evenings. These sessions provide relatives and colleagues with the chance to raise concerns, seek advice, and receive guidance in a more informal setting, while also giving the ROs valuable opportunities to get to know residents better. The initiative has been very well received and has already expanded to include attendance at family meetings organised by the Care Homes, further strengthening relationships and communication. In addition, the team has introduced clear guidance on the reporting of significant incidents. This framework helps Care Homes capture all the necessary information when incidents occur, ensuring that residents are safeguarded effectively.

Awareness Sessions/Education

The Registered Mental Health Nurses (RMNs) and Registered General Nurses (RGNs) have collaborated to design tailored sessions that provide Care Home colleagues with practical guidance, support, and education. These sessions are deliberately informal and interactive, creating a safe space for colleagues at all levels to engage, ask questions, and share experiences. Feedback from Care Home colleagues has been exceptionally positive, with participants valuing both the approachable style and the relevance of the content. The sessions cover a wide range of topics, each chosen in response to the most common challenges identified by Care Home colleagues in their work with older adults. By focusing on real issues faced in practice, the training ensures that colleagues feel better equipped, more confident, and supported in delivering high-quality care.

Enhanced Support

An enhanced support process has now been developed with the clear aim of reducing the likelihood of a Care Home having issues that would cause them to be subject of a 'Large-Scale Investigation' (LSI). This proactive approach ensures that when concerns about a particular Care Home begin to emerge, key members of the Health and Social Care Partnership responsible for monitoring performance will meet directly with the senior management of the organisation operating the home. These meetings provide a structured opportunity to discuss the concerns in detail and to consider whether an enhanced support action plan is required. The intention is to intervene early, offering targeted support to the Care Home and preventing issues from escalating to the point where an LSI would be necessary.

My Health, My Care, My Home Framework

My Health, My Care, My Home is a Scottish Government Framework for healthcare support in Care Homes. Its purpose is to improve the health and wellbeing of adults living in Care Homes by making sure they receive consistent, person-centred, high-quality healthcare, that is not adversely affected by living in a Care Home. The Framework is being actively embedded across Dundee HSCP to enhance health care across all Care Homes. A strong emphasis is placed on collaboration and involvement. Colleagues, managers, and residents are encouraged to take part in workstreams and working groups, ensuring that improvements are shaped by those delivering and receiving care.

Hospital to Care Home Discharge

The **Hospital to Care Home Discharge video** was created with the aim of highlighting the importance of well-managed, positive hospital discharges to residential Care Homes. By discussing staffing and resources, and exploring both successful and challenging discharge experiences, the aim is to raise awareness within clinical teams about how discharge processes impact patients, colleagues, and the overall Care Home environment.

The intended outcome of this **video** is to encourage and promote mutual understanding and best practices leading to improved outcomes for everyone involved.

This is a first video in a suite intended to be created with Care Home Managers and hospital colleagues. Care Home Managers are being consulted about what they would find helpful to highlight in future educational videos.

Supporting early discharge Royal Victoria Hospital 'Test of Change'

A 'test of change' process is being undertaken to ensure safe, person-centred transfer of Care Home residents from hospital wards back to their Care Home. By promoting discharge arrangements in at an earlier time within day-time hours, the initiative enables better access to key services such as GPs, the Care Home Team, DECaHT(Dundee Enhanced Care at Home), Pharmacy, and the Equipment Store, as well as continued support from the discharging ward. This approach enhances problem-solving opportunities and ensures a broader range of professionals are available to advise and assist if needed.

Independent Sector Lead

The Independent Sector Lead helps make sure Dundee's independent care sector is well supported and involved in planning local services. This includes working closely with care providers, representing their views, and helping them take part in strategic discussions about how health and social care services are delivered and improved. In Dundee, this includes working with 35 commissioned care at home providers delivering more than 23,000 hours of care each week, as well as providers supporting people in 912 independent sector Care Home Placements. Although the role covers a broad range of services, much of the work in Dundee focuses on Care Homes because of their size, complexity and importance within the local care system.

A key part of the role is acting as a clear point of contact for providers, helping to build strong relationships and ensure that important information, guidance and updates are shared consistently. This supports better communication between providers and strategic partners, helping the independent sector to play a full part in delivering high-quality care and support across Dundee.

Regular Provider Forums have helped strengthen communication and collaboration across Dundee's independent care sector. There are 3 Provider Forums (Care Home, Care at Home and Learning Disability) that provide an important space for providers to learn from each other, raise issues and share good practice. They have helped improve relationships between providers and partners, increased engagement, and supported better understanding of the pressures facing services across the city. Information from these discussions is used to help inform wider planning and improvement work within the Partnership. Meeting notes are shared widely to support openness and consistency, and the forums also help identify training and development needs, offering further support to managers and providers where needed.

Dundee Activity Network

The Dundee Activity Network has continued to help older people and other adults who use services stay active, connected and involved in their communities. The network brings together Care Homes and Day Care Services across Dundee to support meaningful activities based on people's interests, hobbies and life experiences. By working closely with partners and sharing ideas across services, the network helps improve physical, mental and emotional wellbeing. Regular meetings bring colleagues together to learn from each other, develop new activities and create more opportunities for people to socialise and take part in community life.

The network has also organised events and activities since 2023 with the aim of reducing isolation and bringing people together. A key highlight is the annual 'Going for Gold' event, which celebrates International Older People's Day and gives Care Homes and Day Care services the chance to come together for a day of teamwork, fun and shared achievement.

This year 18 Care Home and Day Care services participated – with 53 service users and 43 support workers and practitioners joining the event. The event was supported by Wellbeing Activity Co-ordinators, Active Dundee, DVVA, Menzieshill Hub and many volunteers. The range of activities was rated as very good by 94% of Care Homes and participant enjoyment as very good by 100%.

"Myself, my daughter and my mum came along and participated with my dad's Care Home. Everybody absolutely loved it!"

Improving Urgent and Unscheduled Care in Dundee

During 2025/26, Dundee HSCP working closely with NHS Tayside, continued to strengthen how Urgent & Unscheduled Care is delivered across Dundee. Despite sustained pressure on services, real improvements have been made. As a result:

- More people are returning home sooner from hospital.
- Fewer people experience unnecessary hospital stays.
- Rehabilitation and support are reaching people earlier, often in their own homes.
- Discharges from hospital are safer, smoother and better planned.

This progress reflects strong partnership working across the system, particularly through Physiotherapy & Occupational Therapy Services, the Integrated Hospital Discharge Team, and the Dundee Frailty at Home Team. These improvements directly support the IJB's strategic aim of shifting the balance of care - ensuring that people receive support in the least restrictive setting, close to home, wherever it is safe and appropriate to do so.

Physiotherapy & Occupational Therapy Services - Supporting Recovery Sooner

Physiotherapy and Occupational Therapy services have redesigned how rehabilitation is delivered across hospital and community settings. This has included:

- Faster access to therapy assessment after hospital admission.
- Stronger links between hospital wards and community teams.
- Expanded seven-day working in key pathways, including frailty and orthopaedics.

This redesign means people are assessed and supported earlier, helping teams make quicker and safer discharge decisions. Community waiting times for physiotherapy and occupational therapy have reduced to around two weeks, and more people are being supported to regain independence at home. This reduces the risk of extended hospital stays or admission to longer-term care. This has also supported urgent and unscheduled care by maintaining high and sustained rates of same-day and early discharge, reducing the length of hospital stay for people who need rehabilitation, and improving weekend discharge rates so that people can move home more smoothly across the week. For people using services, this means getting the right support at the right time — and spending less unnecessary time in hospital.

As more people are leaving hospital earlier and returning home safely, the Dundee & Angus Joint Equipment Store has continued to play an important role in supporting independence. During 2025/26, demand for equipment increased by 5%. Even with equipment being needed for longer, the service continued to make good use of items by reissuing 70% and recycling 84%, helping reduce waste and make best use of resources.

Integrated Hospital Discharge Team: Making Discharge Smoother and Safer

The Integrated Hospital Discharge Team in Dundee brings together health colleagues, social work and care providers to ensure people experience a safe, timely and well coordinated move from hospital back to their own home or a homely setting.

Working as one team across organisational boundaries, the service:

- Starts planning for discharge early.
- Coordinates assessments and support.
- Removes unnecessary delays.

This joined up approach prioritises ‘Home First’, helping people leave hospital as soon as they are clinically safe to do so.

Discharge planning is now more coordinated and consistent, with pathway teams aligned around Dundee City clusters and working closely with care teams in the community. More people have a clear planned date for discharge, supported by tailored input from teams embedded within hospital wards.

There has also been measurable improvement. Over 98% of hospital discharges now happen without delay. Where delays do occur, they are increasingly linked to complex individual circumstances rather than internal system processes. This means acute hospital capacity is being used more effectively, supporting better flow across urgent and unscheduled care. For patients and families, this means clearer communication, fewer last minute changes, and a safer transition home.

Dundee Frailty at Home Team: Preventing Hospital Admission and Supporting Early Discharge

The Dundee Frailty at Home Team supports older people living with frailty by offering:

- Rapid multidisciplinary assessment in the person's own home.
- Short term, intensive support following illness or deterioration.
- Close working with hospital frailty services to enable earlier discharge.
- A locality based, cluster approach, aligned with other health and social care services to better meet community needs.

This approach makes a practical difference for people living with frailty. Many people can avoid hospital admission altogether or return home sooner, with active rehabilitation and support provided in familiar surroundings. This helps people rebuild confidence, maintain independence and stay more in control of their lives wherever it is safe to do so.

The team also has a wider impact across the health and care system. Strong links with hospital frailty units support safe step-down care, reduce pressure on acute beds during periods of high demand, and support the national Home First approach. By improving how primary and secondary care work together, the service helps people move more smoothly between hospital and community support.

Frailty At Home Team

Working Together as One System

The biggest improvement this year has come not from a single service, but from how services work together across Dundee HSCP, NHS Tayside and partner organisations. Front Door Frailty, hospital wards, therapy services and community teams are now operating as one more connected pathway, with shared performance information supporting continuous improvement.

By addressing challenges together rather than in isolation, this whole-system approach has strengthened early intervention, improved flow through hospital, and supported safer and more timely transitions between care settings.

Despite this progress, urgent and unscheduled care remains one of the most pressured parts of the system. Sustaining improvement will depend on continued investment in prevention, rehabilitation, care at home, frailty pathways and strong coordination between hospital, primary care, social care and community services.

Listening, Learning, Leading: A collaborative model to strengthen future care planning and care around death in Care Homes

NHS Tayside Care Home Collaborative Board identified future care planning and care around death in Care Homes as an area for further development in 2025/2026. Two Nurse Consultants in Dundee HSCP worked collaboratively with two Care Homes in Dundee as part of this Tayside wide improvement work. The mixed methodology study included a review of the information held within future care plans and asking Care Home colleagues to share their experiences of care around dying.

From the information gained from colleagues, education sessions, were delivered in each of the homes. Although colleagues initially indicated that they felt confident in delivering end of life care prior to the education sessions, feedback from Care Home managers reported colleagues increased confidence in holding future care plan conversations. Care plans were reviewed prior to and six months after the education sessions. There was measurable improvement. Of the care plans audited there was:

- An increase from 76% to 100% residents had a documented future care plan.
- An increase from 80% to 100% care plans included details of resident/family wishes.
- An increase from 82% to 85% care plans included a treatment escalation plan.
- An increase from 91% to 94% documented resuscitation status.

For residents and their loved ones this means, when changes in care are required, there are no inappropriate treatments initiated. Feedback from families was positive, indicating satisfaction with the conversations held around future care planning and care around dying.

"The person who I spoke with explained everything to me, it was a positive and sensible discussion".

"It was a relief to have this discussion with mum".

This work has highlighted specific areas where improvements can still be made in person centred care planning for residents with advanced frailty and dementia. The two Care Homes have agreed to continue collaborative working, focussing on the provision of fluid and nutrition for comfort in 2026/2027.

Stroke and Neuro Rehabilitation Services

During 2025/26, Stroke and Neuro Rehabilitation Services made important progress in improving how people progress through rehabilitation processes and return to the community. Stronger multidisciplinary working with health and social care partners, including hospital discharge, social work, housing, carers' services and community rehabilitation teams, helped reduce delays in complex hospital discharge pathways through earlier identification of barriers, better shared planning and more coordinated support around each person. The Stroke Liaison Service also continued to strengthen support for people and their families at key transition points, offering early information, emotional support and better coordination between hospital, community and third sector services. Alongside this, investment in workforce development helped strengthen the service during a period of sustained pressure, with clearer leadership roles, improved clinical supervision, stronger support for decision-making and greater clarity about responsibilities across the team. For families, these improvements meant clearer communication, better support during discharge and greater confidence at what is often a difficult and uncertain time. Together, these developments have supported a more joined-up, person-centred service for people recovering from stroke, traumatic brain injury and major trauma across Tayside.

Patient, carer and workforce feedback highlights:

- Positive experiences of compassionate, specialist care.
- Feeling supported during recovery and discharge planning.
- Strong appreciation for clear communication and practitioner responsiveness.

This feedback informs ongoing service improvement and workforce development.

"The staff were absolutely amazing. All staff members – including nurses, health care assistants, senior charge nurse and doctors – were so friendly, approachable and helpful. Even when extremely busy, they never made anything feel rushed. They are all so compassionate, empathetic and very caring." Relative of a patient, Stroke & Neuro Rehabilitation Unit, Ward 5

"Thank you to all for being part of his journey. He couldn't have done it without the care and dedication you all bring to your jobs." Relatives feedback, Stroke & Neuro Rehabilitation Service

The Stroke Neuro Unit (SNRU) team and Stroke Liaison Service completed the Kiltwalk in Summer 25 walking over 20 miles and raising over £5000 for the unit.

Tayside Primary Care Foundational Strategy 2026-2028

NHS Tayside is developing a new Primary Care Strategy for 2026 to 2028 to help strengthen local health services and make sure they remain safe, accessible and sustainable. Rather than trying to set out a very long-term plan straight away, this strategy focuses on improving stability now, while laying the groundwork for bigger changes in the future. Over the next two years, the focus will be on supporting colleagues, improving joined-up working, and helping services work better together so that people can get the right care, in the right place, as close to home as possible.

A key aim is to support prevention and early help, so that people can stay well for longer and avoid needing more intensive care later on. The strategy also highlights the importance of tackling health inequalities and making sure services meet the needs of different communities across Tayside. It also sets out how Primary Care connects with the wider health and social care system, including urgent care, hospital services, Out of Hours services, NHS 24, the Scottish Ambulance Service and specialist dental services. By improving these connections and strengthening multidisciplinary teams, NHS Tayside hopes to create a more joined-up system that is better able to respond to people's needs now and in the future.

Planning and Working Together

People's views have directly shaped the development of the Tayside Primary Care Foundational Strategy. It strengthened the focus on collaboration across all four contractor groups, prevention and proactive care, workforce sustainability, clearer links between primary and secondary care, and better articulation of how improvement will be measured. In this way, engagement did not just inform the strategy process — it helped shape the priorities, scope and overall direction of the strategy.

The key risk for primary care is that demand continues to grow faster than available capacity, affecting timely access, continuity of care and the ability of services to focus on prevention. Workforce pressures, premises constraints and the need to coordinate change across several contractor groups also make delivery complex. The strategy provides an important foundation, but progress will need to be phased, realistic and supported by clear measures so that improvement can be demonstrated for patients and communities.

Tayside Together – Palliative Care Matters for All Strategy

This year, partners across Tayside developed a new shared strategy for palliative care, care around dying and bereavement support. The strategy sets out how services will work together so that people of all ages with life-shortening conditions, and the people who care for them, can get the right support at the right time and in the right place.

As more people are living longer and often with more complex health needs, the demand for palliative care and bereavement support is increasing across Tayside and across Scotland. The strategy responds to this growing need and aligns with the Scottish Government's Palliative Care Matters for All strategy. The Tayside strategy has been developed with input from health and social care services, partner organisations, independent and third sector representatives, and strategic planning groups. It will provide a framework for improving how care is planned and delivered across the whole system, helping people, families and carers better understand what support is available. Following approval, accessible public versions of the strategy will be published so that communities can see the shared ambitions for palliative care in Tayside.

A key challenge will be ensuring that the strategy leads to consistent support across different communities and care settings. The implementation phase will therefore need to focus on earlier identification, workforce confidence, clear pathways and better public information.

Palliative Care Matters

Our Vision

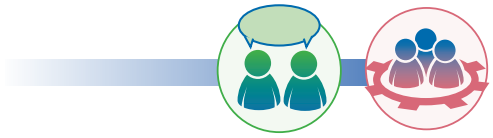
Tayside is a place where people of all ages with life shortening conditions live as well as possible, where everyone affected by dying, death and bereavement receive compassionate and effective support, and where communities and services are supported to work together to provide timely care based on what matters to people.

Our Aims

Enable People and Communities: Support people, families, carers and communities to live well, talk openly and support one another through illness, dying and bereavement.

Strengthening Palliative Care: Ensure timely, person-centred palliative care, care around dying and bereavement support for people of all ages.

Services Led by Angus – Key Developments and Impact



Angus HSCP leads several Tayside wide services that play a vital role in providing urgent care, specialist assessment and community-based treatment across the region. Services hosted in Angus have focused on improving access and outcomes for people with specific health needs. For example, the Continence Advisory and Treatment Service has reduced waiting times significantly—from over 20 weeks to around 10 weeks—meaning people are receiving earlier assessment, treatment and advice, which can improve quality of life and help maintain independence.

The Speech and Language Therapy service continues to support people with communication and swallowing difficulties across hospital and community settings, helping individuals to maintain safety, independence and participation in daily life. However, workforce challenges mean there can be variation in access and waiting times across different areas.

Specialist services such as Forensic Medical and Custody Healthcare have also seen important developments, including improved follow-up care and increased focus on patient feedback, supporting more person centred care for vulnerable individuals, including those affected by trauma or involved in the justice system.

Services Led by Perth & Kinross – Key Developments and Impact

Perth & Kinross HSCP leads a range of services that support some of the most vulnerable people across Tayside. Prison healthcare services have continued to respond to increasing demand and complexity, with people in custody presenting with higher levels of mental health need, substance use issues and long-term conditions. Services provide comprehensive healthcare, including mental health, drug and alcohol support and emergency care, helping to reduce health inequalities and ensure people in custody receive care comparable to that available in the community. Developments such as enhanced inspection processes, workforce support initiatives and improved collaboration with wider health and social care services are helping to strengthen care quality and continuity. However, staffing pressures and the growing complexity of need remain key challenges affecting service delivery.

In podiatry services, there has been a strong focus on early intervention, prevention and improving access. New service models, including direct access approaches and vascular assessment initiatives, are helping people receive diagnosis and treatment more quickly, reducing complications such as infections, amputations and hospital admissions. These developments support people to remain mobile, independent and active for longer.

The Public Dental Service continues to provide essential care for vulnerable groups, including people with additional needs and those unable to access general dental services. Quality improvements have reduced waiting times for some treatments, and health promotion programmes are supporting better oral health outcomes across communities. For example, school based and community programmes help prevent dental disease and support long-term health. At the same time, increasing demand—particularly due to people being unable to access NHS dental registrations—has placed pressure on services and contributed to longer waiting times in some areas.

Performance Against National and Local Indicators

Performance Against National Indicators

National indicators are a set of measures used across Scotland to show how well health and social care services are working. They help us understand whether people are getting the right support, whether outcomes are improving over time, and how Dundee is performing compared with previous years, the Scottish average and similar partnerships. Looking at these indicators alongside our own local measures gives a fuller picture of what is working well, where there are pressures, and where improvement is needed.

In 2025/26, performance across the national health and wellbeing indicators showed a mixed picture for Dundee. Positive areas included emergency bed day use, which was lower than the Scotland average, and delayed discharge bed days, which remained significantly lower than Scotland. People in Dundee also spent a slightly higher proportion of their last six months of life at home or in a community setting than the Scotland average. These measures suggest continued progress in supporting people to remain at home, return home from hospital when they are ready, and receive care in more homely settings. At the same time, Dundee continued to experience higher emergency admission rates, higher readmission rates and a higher falls rate for older people than the Scotland average, showing that urgent care demand, recovery after discharge and prevention remain important areas for improvement.

The national **Health and Care Experience Survey** asks people across Scotland about their experience of GP services, out of hours care, support with everyday living and carers' support. It helps us understand how services feel from the public's point of view, not just how busy they are. We use the results alongside other performance information to identify strengths, gaps and inequalities, and to help target improvement where it is most needed. **Results** from the 2025/26 survey were published in May 2026.[1]

Overall, the 2025/26 Health and Care Experience Survey shows a broadly positive picture for Dundee, with several measures in line with or above the Scotland average. People supported at home reported positive experiences, particularly in relation to being supported to live independently, having a say in how their support was provided, and experiencing well-coordinated care. The survey also highlights areas where further improvement is needed, particularly in supporting unpaid carers to continue in their caring role and ensuring that care consistently helps people maintain or improve their quality of life.

In addition to annual reporting, local performance is also monitored quarterly and compared across Local Community Planning Partnership areas in Dundee 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 on the **Dundee Health and Social Care website**.

[1] The methodology was changed by Scottish Government for the 2019/20 survey and it is therefore not accurate to compare results (except for indicator 8) from before this survey with the more recent survey results.

Performance Against National and Local Indicators

	2017-18 Dundee (Scotland)	2019-20 Dundee (Scotland)	2021-22 Dundee (Scotland)	2023-24 Dundee (Scotland)	2025-26 Dundee (Scotland)	Comparison with Scotland
1. Percentage of adults able to look after their health very well or quite well.	93% (93%)	92% (93%)	89% (91%)	88% (91%)	90% (91%)	↓
2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	84% (81%)	79% (81%)	84% (79%)	77% (72%)	79% (74%)	↑
3. Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.	78% (76%)	73% (75%)	75% (71%)	65% (60%)	67% (64%)	↑
4. Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated.	81% (74%)	72% (74%)	78% (66%)	64% (61%)	69% (65%)	↑
5. Percentage of adults receiving any care or support who rate it as excellent or good.	82% (80%)	75% (80%)	84% (75%)	68% (70%)	72% (72%)	↔
6. Percentage of people with positive experience of care at their GP practice.	84% (83%)	79% (79%)	67% (67%)	71% (69%)	72% (71%)	↑
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.	85% (80%)	77% (80%)	72% (78%)	71% (70%)	71% (72%)	↓
8. Percentage of carers who feel supported to continue in their caring role.	38% (37%)	35% (34%)	27% (30%)	34% (31%)	28% (32%)	↓
9. Percentage of adults supported at home who agreed they felt safe.	87% (83%)	82% (83%)	77% (80%)	77% (73%)	79% (75%)	↑

Better than Scotland

Worse than Scotland

Same as Scotland

[2] *Calendar year data. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2025; this ensures that these indicators are based on the most complete and robust data available.

** Calendar year data i.e. 2020/21 is for 2020, 2021/22 is for 2021 etc. Only data from 2020-2024 is available for this indicator.

*** Figures relate to annual census week which is usually that last week in March.

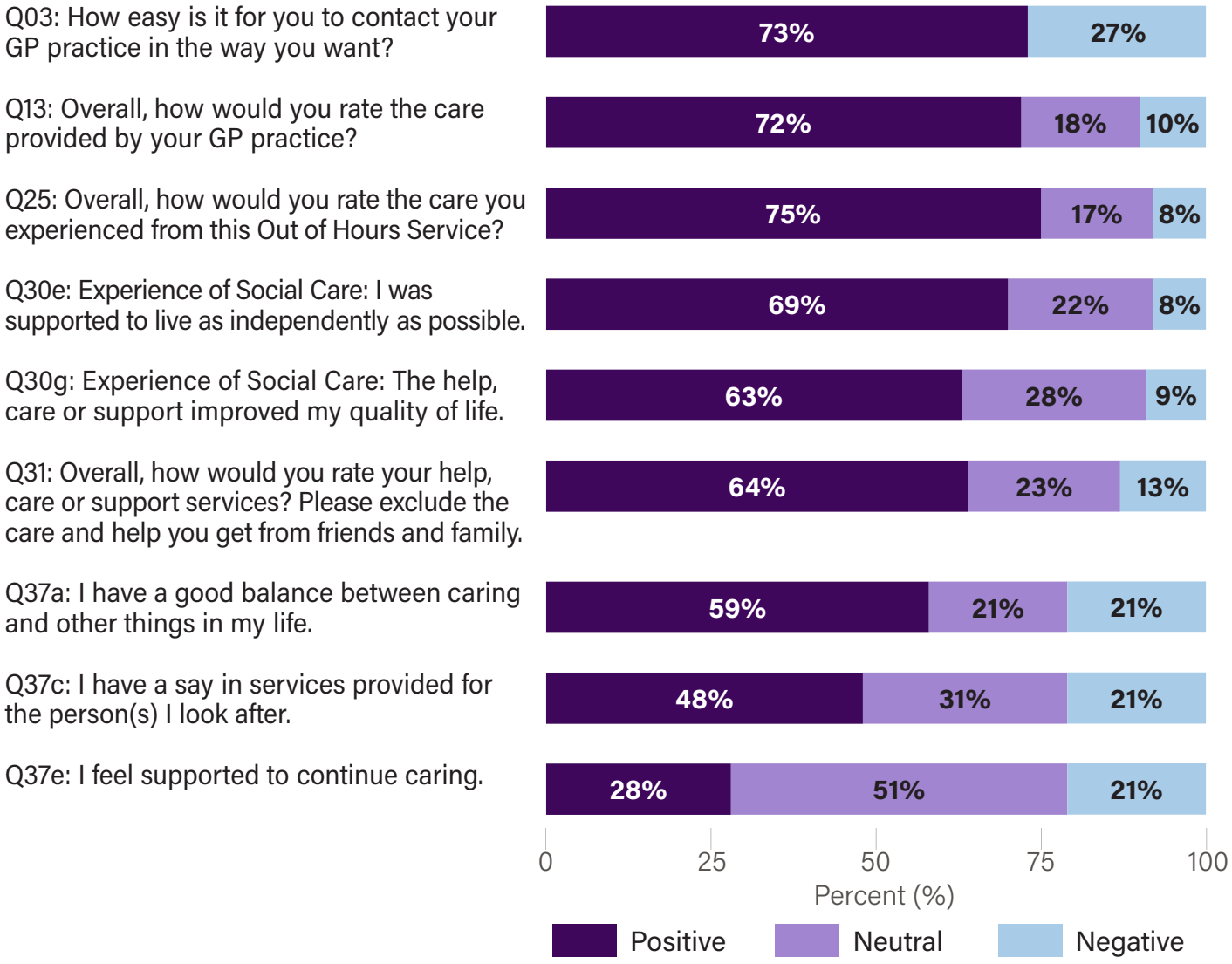
National data for indicators 10, 21-23 are not available.

Performance Against National and Local Indicators

	2020-21 Dundee (Scotland)	2021-22 Dundee (Scotland)	2022-23 Dundee (Scotland)	2023-24 Dundee (Scotland)	2024-25 Dundee (Scotland)	2025-26 Dundee (Scotland)	Comparison with Scotland
11. Premature mortality rate (per 100,000 people aged under 75)**	604 (457)	599 (466)	548 (440)	521 (426)	N/A	N/A	↓
12. Emergency admission rate (per 100,000 people aged 18+)	11,645 (10,965)	12,714 (11,645)	12,999 (11,318)	14,550 (11,857)	15,366 (11,333)	15,727* (11,470*)	↓
13. Emergency bed day rate (per 100,000 people aged 18+)	95,419 (103,433)	111,188 (116,314)	115,106 (122,909)	113,606 (119,922)	109,652 (116,715)	101,478* (108,988*)	↑
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	152 (120)	139 (107)	139 (102)	149 (104)	143 (103)	149* (104*)	↓
15. Proportion of last 6 months of life spent at home or in a community setting.	91.5% (90.2%)	91.7% (89.7%)	90.0% (88.9%)	90.7% (88.8%)	90.4% 89.0%	90.3%* 89.3%*	↑
16. Falls rate per 1,000 population aged 65+	31.5 (21.7)	31.0 (22.6)	32.7 (22.1)	33.6 (22.7)	34.6 (21.9)	34.5* (22.2*)	↓
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections.	80.0% (82.5%)	74.0% (75.8%)	75.2% (75.2%)	77.5% (77.0%)	82.6% (81.9%)	76.7% (83.1%)	↓
18. Percentage of adults with intensive care needs receiving care at home.	59.5%*** (63.0%***)	63.1%*** (64.6%***)	60.6%*** (63.5%***)	61.8%*** (64.8%***)	65.9*** (64.7%***)	N/A	↑
19. Number of days people spend in hospital when they are ready to be discharged, per 1,000 population.	327 (484)	795 (748)	770 (883)	411 (867)	239 (899)	244 (873)	↑

Experiences of Health and Social Care Services

As well as providing data for National Indicators 1 to 9 (see above), the Health and Care Experience Survey also provides data in response to a range of other questions regarding GP services, social care services and carers support. The 2025/26 survey shows that most people in Dundee continue to report positive experiences of health and social care services, with performance broadly in line with, or in some areas slightly above, the Scotland average.



Access to GP services remains relatively strong, with 73% of respondents saying it was easy to contact their GP practice in the way they wanted. While this is slightly below the Scotland average of 78%, it represents a steady improvement locally from 69% in 2022 and 71% in 2024. Similarly, 72% of people rated the care provided by their GP practice positively, broadly in line with the national figure of 71% and showing improvement from a lower point of 67% in 2022.

Performance Against National and Local Indicators

Experiences of out of hours services are more positive, with 75% of respondents reporting good care, compared with 72% nationally. Respondents also reported improvements since 2022 in relation to: being able to involve the people that matter to them, feeling listened to, being treated with compassion and understanding, experiencing well co-ordinated care (included since 2024 survey), feeling in control of their care, being involved about decisions around care and treatment and being treated with dignity and respect (included since 2024 survey). All of these responses were also the same as or better than the Scotland position.

Awareness of help, care and support options increased from 50% in 2024 to 56% in 2026, against a Scotland position of 53%. Improvements were also reported in relation to people being treated with dignity and respect, having a say in how care or support is provided and taking account of the things that matter most to them (both better than the Scottish position). Feedback on social care outcomes is also encouraging. Around 69% of people said they were supported to live as independently as possible, higher than the Scotland average of 65%. In addition, 63% said their care improved or maintained their quality of life, slightly above the national figure of 62%. Overall, 64% of respondents rated their help, care or support services positively, in line with Scotland at 64%.

The survey highlights a more mixed picture for unpaid carers. While 59% of carers reported having a good balance between caring and other aspects of their lives—similar to the national position—only 48% felt they had a say in how services are provided, though this is slightly higher than the Scotland average of 44%. More significantly, just 28% of carers felt supported to continue caring, compared with 32% nationally, indicating a continuing area of challenge.

Quality of Health and Social Care Services

The Care Inspectorate is responsible for the inspection and regulation of all registered care services in Scotland. The Care Inspectorate use a six-point grading system against which specific key themes are graded. The grades awarded are published in inspection reports and on the Care Inspectorate's website at **www.careinspectorate.com**.

The current Health and Social Care Standards for Scotland came into effect in April 2018. The Standards provide a framework that is used by the Care Inspectorate to provide independent assurance about the quality of care and support. Although the inspection process varies across different types of service, some core areas of focus are:

- How well people's wellbeing is supported.
- How good the leadership of the service is.
- How good the staff team is.
- How good the setting (physical environment) within the service is.
- How well care is planned.

In 2025/26, 37 Services for Adults and Care Homes registered with the Care Inspectorate in Dundee were inspected and 45 inspections were completed. Of the services that were inspected, 25 of the 37 received no requirements for improvement. There was no enforcement action taken against any service regulated by the Care Inspectorate.

Performance Against National and Local Indicators

4 services provided directly by Dundee HSCP were inspected during 2025/26:

- Janet Brougham House and the Mckinnon Centre both received 'very good' (grade 5) evaluations for their support of people's wellbeing and quality of the care setting, with no requirements.
- Turriff House received 'very good' (grade 5) evaluations for their support of people's wellbeing, quality of their staff team and quality of the care setting, with no requirements.
- Weavers Burn received 'very good' (grade 5) evaluations for their support of people's wellbeing, leadership and the quality of their staff team, with no requirements.

24 of the 45 inspections in Dundee which were subject to a Care Inspectorate inspection last year received grades of 'good', 'very good' or 'excellent' in all aspects of the service evaluated. Only 2 inspections resulted in the service being evaluated as 'adequate', 'weak' or 'unsatisfactory' in all aspects of the service evaluated.

The grading data shows an improvement in grades between 2024-25 to 2025-26 for Care Homes particularly of note is the reduction of Care Home providers receiving a grade 3 or below. It is a similar picture in other adult services whereby there has been an improvement in the number of services who previously were graded 3 or below however two services received a grade 6 'excellent.'

Seven high performing services achieved grades of 'excellent' and 'very good' across multiple aspects of the key questions utilised for inspection. Common areas of strength identified included: strong person-centred and compassionate care; motivated and well-supported staff teams; effective leadership and oversight; effective quality assurance approaches that support continuous improvement; meaningful engagement and communication with people experiencing care and their families; and positive partnership working with external health and social care professionals and the wider community.

Healthcare Improvement Scotland did not carry out any inspections of Partnership services during 2025/26.

Strategic Inspections – Mental Health Services

A joint inspection of adult mental health services in Dundee was carried out by the Care Inspectorate and Healthcare Improvement Scotland during 2025/26. The inspection looked at how well services work together to support adults aged 18 to 65 living with mental illness, and their unpaid carers. The **report**, published in March 2026, was very positive overall and found that Dundee was performing strongly across all areas inspected.

The inspection included a review of evidence from across Dundee HSCP, including case file reading, workforce feedback, engagement with people using services and carers, and discussions with the workforce and leaders. The report found that all quality indicators were rated good or very good, with particular strength in strategic planning, quality and improvement.

Performance Against National and Local Indicators

Key Area	Evaluation
Key performance outcomes	Good[1]
Experiences of people who use our services	Good
Delivery of key processes	Good
Strategic planning, policy, quality and improvement	Very Good[2]
Leadership and direction	Good

The inspection highlighted strong leadership, effective partnership working, positive experiences for most people using services, and good support for unpaid carers. It also recognised Dundee's investment in early intervention, peer support and direct access community-based mental health support, including Hope Point and the Peer Support Network.

The inspection report included a number of positive comments about Dundee's approach, including:

"Leaders demonstrated a clear vision and commitment to improvement."

"Relationships with staff were impactfully positive for people, and some people expressed that their lives had been thoroughly transformed for the better."

"Carers were acknowledged and supported in their caring role."

"Hope Point provided an immediate, compassionate response for people experiencing emotional distress and crisis."

The **report** also identified areas for further improvement. These include making sure people and carers better understand their rights, improving support for people with multiple health conditions, strengthening how personal outcomes are recorded and analysed, and improving how the impact of strategic change is evaluated. These actions are now being taken forward through existing improvement plans and will continue to be monitored during 2026.

Individual Service Quality

Announced visits by the Mental Welfare Commission during 2025 and 2026 found that people in Kingsway Care Centre generally experienced kind, respectful and person-centred care. Across all wards, individuals spoke positively about staff, describing them as supportive, approachable and responsive to their needs, and observations confirmed caring relationships and a positive ward atmosphere.

There was strong evidence of person-centred care planning and holistic support, with care records showing detailed information about individuals' needs, preferences and physical health. Multidisciplinary teams worked together to support recovery, and a wide range of meaningful activities and therapeutic opportunities were available, contributing to a supportive and engaging environment. The Commission also highlighted examples of good practice in workforce culture and leadership, particularly in Ward 4, where colleagues described a positive team environment, opportunities for learning, and encouragement to develop and lead improvements in care.

However, a number of areas for improvement were identified across the wards. These included the need to:

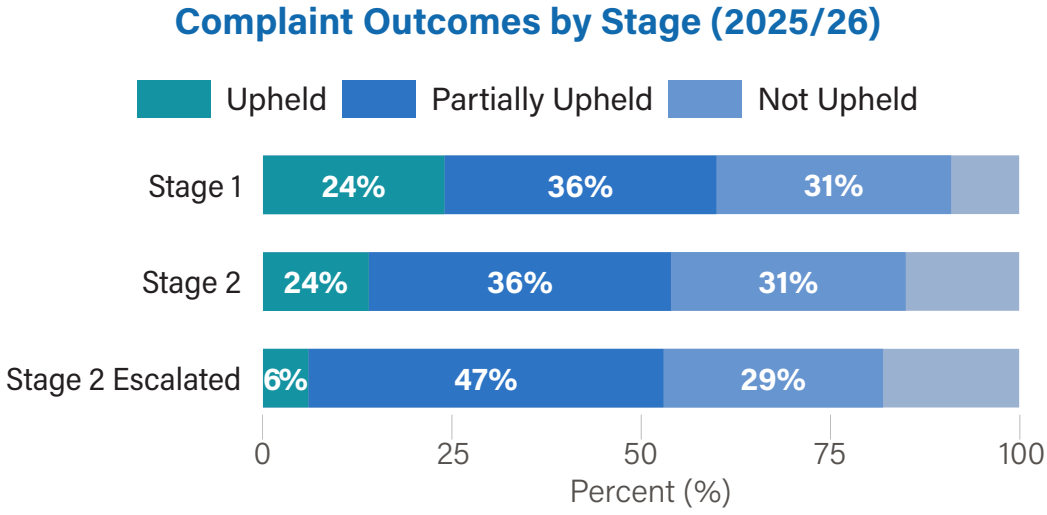
- Strengthen involvement of individuals and families in care planning and decision-making, including participation in multidisciplinary review meetings.
- Improve the quality and consistency of documentation, particularly in recording multidisciplinary decisions, care plan reviews, and risk management planning.
- Ensure full compliance with legal requirements relating to consent to treatment and mental health legislation in all cases.
- Enhance awareness and use of advance statements to support individuals' rights and preferences in care.
- Address some environmental issues, including improving garden privacy and progressing repairs in parts of the estate.

Complaints and Feedback

In 2025/26, Dundee Health and Social Care Partnership received 266 complaints. This was almost 50% higher than the previous year and shows increased concern being raised by people using services, families and carers.

Complaints covered a wide range of services. In health services, the largest share related to mental health services, accounting for almost 34% of complaints. In social work services, the most common issues were failure to provide a service (26%) and concerns about the treatment by, or attitude of, a staff member (23%).

Complaint Outcomes



Percentages do not add to 100% because some complaints were resolved early, withdrawn, transferred, closed without consent, or were still incomplete at the time of reporting.

Six complaints were referred to the Scottish Public Service Ombudsman during 2025/26, split evenly between health and social work. Most were not taken forward for further investigation, although two were still awaiting a final response at the time this report was prepared.

Response times remain an area for improvement. In 2025/26, 64% of stage 1 complaints were answered within the 5 working day target. Performance was lower for more complex complaints, with 39% of stage 2 complaints and 41% of escalated stage 2 complaints answered within the 20-working day target.

You can view our quarterly complaints reports on the **Performance Information section on the Dundee Health and Social Care website**.

Feedback

As well as complaints, we also hear from people through compliments, comments and online feedback. This helps us understand what is working well, where people have concerns, and where services can improve.

Dundee Health and Social Care Partnership now use Care Opinion, an independent not-for-profit website supported by the Scottish Government, where people can share their experiences of care and support. Work is continuing to roll this out more widely across Partnership services, including better use of features such as QR codes and links with other feedback routes.

During 2025/26, 55 stories about Dundee HSCP services were shared on Care Opinion. Most were positive, with 84% fully positive and 16% including some criticism. Care Opinion makes it easier for people to share their experiences and for colleagues to learn from them. It supports a culture of openness, listening and improvement, and over time it will be available across all Dundee HSCP services.

Performance Against National and Local Indicators

Here are examples of stories submitted to Care Opinion about Dundee Health and Social Care Partnership teams.

"I was referred by the GP to the Dundee Adult Psychology Unit in 2024, as I could not manage my OCD. I was suffering frequent panic attacks and felt I could not function properly as I was in a constant state of anxiety. My main anxiety was around food preparation and germs. My psychologist was Glen and he changed my life. He took time to get to the root of my obsessions and worked on a strategy to help me manage the anxiety when it left me"

"Have tried for the past two days (at least 8 times) to make arrangements by phone for blood and urine tests with Dundee Community Care and Treatment Services, only to find each time I am between numbers 12 and 16 in the phone queue. This happened every time I called. I am very disappointed to report such a poor service and would appreciate advice on how to better access this facility."

"We all know MacMillan nurses are very special people, what I did not know was how much of themselves they put into the job. I have watched our amazing MacMillan nurse .... look after my husband and myself in the last weeks of his life. From diagnosis to him passing was less than two months, that was just a week ago. "

Whistle Blowing

During 2025/26 no NHS Tayside whistleblowing cases were raised within Dundee Health and Social Care Partnership. **One complaint decision** was published by the Independent National Whistleblowing Officer for a case which had been referred for external review.

The full **NHS Tayside Whistle Blowing Annual Report** can be found on their **website**.

An overview of whistleblowing cases raised within Dundee City Council that relate to Dundee Health and Social Care Partnerships will be available in October 2026.

Performance and Quality Highlights – Key Measures

Over the past year, the Integration Joint Board has continued to oversee services that are safe, effective and focused on people's needs, supported by regular performance, governance and assurance reporting. Looking at both data and lived experience helps the IJB understand not only how services are performing, but also how they feel for people receiving care and support. A summary of the key messages from all of this information is provided below.

Demand for Urgent and Hospital Care is Increasing

Demand for urgent care services remains high. The number of people needing emergency hospital care has increased compared to pre-pandemic levels, and this rise has continued across 2025. Accident and Emergency attendances have also increased significantly.

Readmissions remain higher than the Scotland average and have increased compared with 2024/25, showing ongoing pressure on services and the need for continued focus on recovery and support after discharge.

Progress in Reducing Time Spent in Hospital

During 2025, there has been good progress in reducing how long people stay in hospital unnecessarily.

- Delayed discharge bed days (standard delays) have reduced significantly compared to earlier years, showing improvements in helping people leave hospital when they are ready.
- More complex delays (code 9) have also reduced overall, although there are still differences between Local Community Planning Partnership areas.
- Early discharge rates remain consistently high, reflecting strong clinical decision-making
- Hospital length of stay for older people has reduced, with further improvement planned.
- Community hospital length of stay improved significantly, supporting better acute flow.

In addition, overall delayed discharge bed days (for all reasons) have reduced compared to both recent years and pre-pandemic levels, showing continued progress in improving patient flow.

Fewer Hospital Bed Days Used Overall Compared to Before the Pandemic

While demand remains high, the total number of days people spend in hospital has improved in 2025 compared with 2024/25 and remains lower than the Scotland average, indicating more efficient use of hospital care and continued progress in supporting people through community-based services.

There has also been a substantial reduction in mental health bed days, showing continued progress in supporting people in the community where appropriate.

Falls and Prevention

Falls among older people remain higher than the Scotland average, although the rate has reduced slightly compared with 2024/25. This suggests some recent improvement, but highlights the importance of continued investment in prevention and community support.

More People Supported at Home and in the Community

There is strong evidence of progress in supporting people to live independently:

- The latest available data shows that 65.9% of adults with intensive care needs were supported at home in 2024/25, above the Scotland average of 64.7%.
- In 2025/26, 90.3% of people spent their last six months of life at home or in a community setting, above the Scotland average of 89.3%.

This positive direction is also reflected in people's feedback. In the 2025/26 Health and Care Experience Survey, 79% of adults supported at home said they were supported to live as independently as possible, above the Scotland average of 74%. In addition, 71% said their care helped maintain or improve their quality of life, slightly below the Scotland average of 72%, and 72% of adults receiving care or support rated it as excellent or good, in line with Scotland. These findings suggest that, while services remain under pressure, many people continue to experience support that helps them stay independent, safe and involved in decisions about their care.

Challenges Remain in Community Services

Demand for social care continues to grow:

- The number of people waiting for a social care assessment is increasing, although very few people are waiting in hospital for care packages.
- There are still some gaps in delivering the full number of care hours required, reflecting ongoing workforce and capacity pressures.

Experience data also shows that access to GP services remains an important area for improvement. In the 2025/26 survey, 73% of people in Dundee said it was easy to contact their GP practice in the way they wanted. This has improved from 69% in 2022 and 71% in 2024, but remains below the Scotland average of 78%. This shows that progress is being made locally, while recognising that people still experience difficulties accessing primary care.

There is clear evidence of progress and improvement across a number of services, particularly where focused action has been taken.

- Mental health services have shown strong overall performance in external inspection. A national joint inspection found that services were rated good or better across all areas, with particularly positive feedback on leadership, outcomes and people's experiences of care. This reflects sustained investment in community-based support and improved access to services.
- Psychological Therapies has made steady progress in reducing waiting times. The proportion of people starting treatment within 18 weeks increased significantly over the year.

Psychological Therapies – Improving Access and Outcomes

Access to psychological therapies has improved over the past year, with more people starting treatment on time. By the end of 2025, over 8 in 10 people (82.6%) began treatment within 18 weeks of being referred. This is a clear improvement on previous performance and is now above the national average.

This improvement is the result of a range of changes to how services are delivered. This includes offering more group-based and online therapy, increasing staffing capacity, and improving how people are assessed and directed to the right level of support. These changes are helping services support more people more quickly.

However, there are still challenges. Demand for services remains high, with referrals increasing significantly compared to before the pandemic. Some people are still waiting longer than they should, particularly in a small number of more specialised services. Recruiting and retaining practitioners in some specialist roles also remains difficult.

- Drug and alcohol services continue to perform strongly. Most people are now starting treatment within three weeks of referral, and performance has remained consistently high over the year. The share of people starting treatment within 21 days was reported as consistently high at 92%–99% across the year (meeting the waiting time standard). The number of referrals for alcohol treatment increased (2,015 in 2024/25 to 2,266 in 2025/26), and there was also a small increase (2.6%) in the number of individuals starting alcohol treatment during the year. Some aspects of the service have also been recognised nationally for innovation and quality improvements.
- Person-centred and early support services are delivering very positive experiences. For example:
  - Feedback from 1,264 young people (2025) who used The Corner showed 100% agreed that their visit helped them, they felt better after attending, and they felt listened to and involved in decisions.
  - Hope Point continues to provide rapid access to support for people in distress, with very positive feedback and strong partnership working. These services demonstrate the value of early intervention and accessible, compassionate care. During 2025/26, Hope Point supported 1,736 individuals with 5,953 support contacts (drop-in, phone and text), and reported 100% of people felt valued and respected, with 100% saying they would seek support again.

Performance Against National and Local Indicators

At the same time, there are a number of significant and ongoing challenges, many of which are shared across the whole system.

- Workforce pressures remain the most significant issue. Absence rates for NHS employed staff within the HSCP have averaged at 7.35% in 2025/26. The cumulative working days lost for DCC employed staff for the year was 11.20%. Many services report difficulties recruiting and retaining practitioners, including in nursing, social care, medical and specialist roles. These pressures affect day-to-day service delivery, slow down improvement work, and make it harder to respond to growing demand.
- Demand for services continues to increase, particularly in:
  - Mental health services, where referrals have risen sharply compared to pre-pandemic levels.
  - Suspected near fatal overdoses reported by Scottish Ambulance Service and Police Scotland increased from 206 (2024/25) to 350 (2025/26), with a multi-agency response underway to strengthen prevention and response.
  - Primary care, where increasing demand is leading to longer waits and limited capacity for service development.
  - Nutrition and dietetics, where referrals for weight management have increased significantly, resulting in longer waiting times.
- There are also ongoing challenges in managing and learning from adverse events. Although there are strong processes in place, many reviews are taking longer than expected to complete. This can delay learning and improvement and reflects wider capacity pressures across the system.
- Complaints performance has been variable, particularly for more complex (stage 2) complaints, where responses are not always provided within the expected timescales. Work is underway to improve this.
- Complaints increased to 266 during 2025/26, almost 50% higher than the previous year. This highlights the need to improve how concerns are responded to and how learning from complaints is used.
- Support for unpaid carers remains a significant challenge. The Health and Care Experience Survey 2025/26 found that 28% of carers in Dundee felt supported to continue caring, below the Scotland average of 32%. This reinforces the importance of the refreshed carers strategy, including work to improve information, involvement in decisions, short breaks, emergency planning and support at key transition points.
- Some services also face practical challenges with buildings and infrastructure, including poor condition of facilities and limited available space for clinics. These issues can affect both the workforce and the quality of the environment for people using services.
- In a small number of areas, there are specific service risks, such as gaps in leadership capacity in mental health and uncertainty about long-term funding for some specialist services.

Overall, the evidence shows a system that is continuing to deliver positive outcomes for people, with clear examples of improvement in access, quality and experience. Services are working hard to innovate and respond to changing needs, and this is reflected in both performance data and feedback from people who use services. However, this progress is taking place in a challenging environment, with increasing demand and ongoing workforce pressures.

Finance and Governance

The IJB is responsible for making sure that health and social care services are planned and funded in a lawful, fair and responsible way. This includes making sure that public money is used carefully and has the greatest possible impact for people in Dundee. To support this, the IJB has clear governance arrangements in place. These include systems for monitoring performance, managing risk, checking financial information and making decisions openly and transparently. These arrangements help the IJB understand pressures, respond to risks and make sure services continue to be delivered safely and effectively.

In 2025/26, the IJB spent £380.0 million on community adult health and social care services. This funding supported a wide range of services for adults across Dundee, including care at home, mental health services, learning disability services, community nursing, primary care and support for older people. The table below shows how this spending was allocated across the main service areas and compares this to previous years.

	2021-22 £m	2022-23 £m	2023-24 £m	2024-25 £m	2025-26 £m
Total Spend	282.5	321.1	340.6	363.5	380.0
Older People	62.3	70.1	75.2	82.0	87.3
Mental Health	9.9	11.2	16.0	14.1	16.3
Learning Disability	31.2	34.1	35.3	38.5	40.7
Physical Disability	6.9	8.1	7.6	8.2	8.4
Substance Misuse	4.8	5.8	4.5	6.5	6.9
Community Nurse Services / AHP / Other Adult Services	16.1	12.8	18.5	19.7	21.0
Community Services (Lead Partner)	18.2	33.0	36.5	38.7	41.0
Other Services / Support / Management	51.4	60.8	58.0	61.4	5.2
General Medical Services (FHS) & Prescribing	81.7	85.2	89.2	94.3	99.2
Funding Received	290.4	328.6	336.8	356.3	374.4
Year-End Operational Surplus / (shortfall)	7.8	7.5	(3.7)	(7.2)	(5.7)

Finance and Governance

At the end of 2025/26, the IJB spent £5.7 million more than the funding available for the year. This is referred to as an underlying operational overspend. Because the overspend was higher than expected, the IJB moved into a period of financial recovery. This means stronger controls and actions were put in place to reduce spending where possible, manage financial risk and continue delivering services safely.

The biggest pressures were in services for older people, learning disability services and mental health services. Demand for care at home and community support remained high, particularly for people with complex needs who require more intensive or tailored support. This additional spending helped people stay at home where possible, return home sooner after a hospital stay, and reduced the number of people waiting in hospital for care packages. However, it also placed significant pressure on the IJB's budget.

Workforce pressures also affected costs during the year. Recruitment and retention challenges meant that services sometimes needed to use agency, overtime and sessional staff to maintain safe staffing levels and keep services running. This cost £6.9 million during 2025/26.

The IJB planned to make savings of £17.5 million for 2025/26 to make sure that their budget was in balance. By the end of the year, £14.8 million had been delivered, which is 84% of the target. Work is continuing to deliver the remaining savings while also protecting safe and effective services. Looking ahead, Dundee IJB, like many IJBs across Scotland, continues to face a very difficult financial position. Further savings, efficiencies and service transformation will be needed in 2026/27 and beyond. Feedback from the budget consultation helped the IJB understand local views and consider the likely impact of savings options before making decisions.

The main risk is that repeated financial pressure could reduce the flexibility to invest in prevention, early intervention and service redesign, even though these are the areas most likely to reduce future demand. There is also a risk that savings decisions could have a greater impact on people who already experience inequality, including unpaid carers, disabled people, people living in poverty and those who rely on community-based support. Ongoing consultation, equality impact assessment, performance monitoring and risk reporting will be important safeguards as difficult decisions are taken.

Budget Consultation 2026/27 – Key Findings

Dundee Integration Joint Board (IJB) carried out a public consultation in early 2026 to help inform difficult decisions about how health and social care services are funded. This was in response to significant financial pressures and the need to balance the budget for 2026/27.

Over a four-week period, 565 responses were received from members of the public, people who use services, unpaid carers, colleagues, and partner organisations. People shared their views through surveys, events and written submissions, providing valuable insight into priorities, concerns and potential impacts.

Across the consultation, there was strong and consistent support for a preventative approach to care. People emphasised the importance of helping individuals stay independent at home, preventing problems before they escalate, and ensuring timely support for those with the greatest need. Services that are local, easy to access, and offer face-to-face contact when required were seen as particularly important.

Several key themes emerged. There were significant concerns about the potential impact on vulnerable groups, including older people, disabled people, unpaid carers, and those living in poverty. The contribution of third and independent sector organisations was widely recognised as essential to supporting people who may not meet statutory thresholds. Feedback on the specific savings options highlighted widespread concern about proposals that could reduce access to preventative and early intervention services. Many respondents described these services as low-cost but high-impact, helping to maintain dignity, prevent deterioration and reduce demand on more intensive services.

In addition to feedback on proposed savings, respondents suggested alternative approaches, including reducing non-frontline costs, improving efficiency, and focusing on long-term planning. There was strong support for protecting services that prevent crisis and reduce future demand.

DVVA Funding Development Programme

The IJB has funded DVVA for one year to run a programme that helps third sector organisations in Dundee, including services funded by the IJB. The programme supports organisations to find funding, improve income planning and build their skills and capacity.

Since the programme began in October 2025, it has provided:

- A Funding Forum held online and in person, where organisations can share learning and good practice about funding and planning. The forum also shares updates about funding, training, events and development opportunities. More than 85 members are involved.
- A joint newsletter produced with Dundee City Council, sharing funding opportunities with more than 120 organisations.
- The Tayside Emerging Leaders programme, delivered with Cranfield Trust and partners across Tayside, to support leadership and organisational development in the third sector. Four workshops are planned on topics such as leadership, governance and organisational development.
- A Meet the Funders event, with workshops and 15 exhibitors, to help organisations connect with funding bodies and build their knowledge of funding opportunities.

Billing and Income Maximization Review

Over the past year, partners have worked together to improve how social care bills are managed. The aim is to make the process clearer, easier to understand and more helpful for people who use health and social care services, as well as their carers and families. Several improvements have now been identified and put in place.

These improvements include:

- Making letters, leaflets and website information clearer, easier to read and available at the right time.
- Improving financial assessments so people are supported to claim any benefits or other financial help they may be entitled to.
- Sending bills more quickly and managing unpaid bills earlier, so the process is fair, clear and helps protect services for the future.

Improving How Clinical Supplies are Managed

During the year, the IJB approved funding to test a new way of managing clinical supplies used in Community Treatment and Care services and at Royal Victoria Hospital. This followed concerns that supplies were being ordered separately by different teams, which could lead to duplication, waste and higher costs.

The new approach introduces dedicated support to coordinate ordering and stock control. This is expected to reduce unnecessary spending, lower the risk of items going out of date, and make sure supplies are available when needed. It should also free up colleagues time so that more time can be spent on direct care rather than ordering and checking stock. The IJB invested £80,000 over 18 months from its Transformation Fund to support this work. Early analysis suggests the new approach could deliver recurring savings as well as improving efficiency and oversight.

Improving How We Manage Risk

During 2025/26, Dundee IJB reviewed and updated how it manages strategic risks. This work was carried out to make sure our arrangements remain effective, reflect current priorities, and respond to audit recommendations and governance actions.

As part of this, we updated our Strategic Risk Management Framework, refreshed the Strategic Risk Register, and improved the way risk is reported to the Performance and Audit Committee. We also introduced a new format for Board reports so that the risks linked to decisions and proposals are more clearly explained. Together, these changes have strengthened the IJB's governance arrangements and improved how risks are identified, monitored and reported. Further work will continue in 2026/27, including work with partner organisations on shared strategic risks.

Workforce

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.

Strategic Priority: **Workforce**

Valuing the workforce

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

Our workforce priority is about making sure we have the right people, skills and support in place to deliver high-quality care now and in the future. In the short term, this means improving recruitment and retention, supporting employee wellbeing, developing skills and leadership, and making better use of workforce planning so that services are more resilient, sustainable and able to respond to changing demand. Throughout 2025/26, many developments have helped deliver this priority, including the examples below.

Workforce pressures remain one of the most significant risks to service delivery and transformation. Recruitment and retention challenges, sickness absence, workload pressures and reliance on temporary staffing can affect continuity of care, staff wellbeing and the pace of improvement. These pressures are also experienced by third and independent sector providers, meaning workforce sustainability needs to be addressed across the whole system rather than by individual services alone.

Integrated Workforce Plan

The Dundee Health and Social Care Partnership updated its Workforce Plan for 2025 to 2028 to make sure it has the right people, skills and support in place to meet the needs of people in Dundee. The new plan replaces the previous version and was developed using national guidance, audit findings, workforce data, research and feedback from colleagues. It is intended to support the Partnership's wider strategic priorities and recognises that the workforce across health and social care are its most important asset.

The report also recognises that there are still important challenges to address, including improving access to data, strengthening workforce forecasting and balancing workforce needs with financial pressures. Progress will continue to be monitored and reported to the Integration Joint Board each year.

In 2025/26, Dundee Integration Joint Board produced its second statutory **annual report** under the Health and Care (Staffing) (Scotland) Act 2019. The report explains how Dundee IJB and Dundee City Council have worked together to meet their duties when planning and securing relevant care services from external providers. It highlights that many of the Act's requirements are already reflected in existing commissioning, procurement and quality assurance arrangements, while also noting some ongoing risks linked to provider sustainability and the potential for increased reporting bureaucracy.

Multi-Agency Anti-Discrimination Working Group

The group has been established to address and eliminate racism within the workforce, beginning with Care at Home services, through coordinated, evidence-based action. Its focus is on ensuring that all colleagues experience a safe, equitable, and antiracist working environment across the Dundee Health and Social Care Partnership (DHSCP) and commissioned provider services.

The group will gather and analyse information relating to experiences of racism within the workforce, using this evidence to inform meaningful anti-racism actions. A multidisciplinary referral panel will be established to consider incidents, concerns, and systemic barriers related to racism. The panel will provide recommendations for action, support, and organisational learning. This work will support continuous learning and improvement and contribute to the development of a more inclusive and supportive working culture.

Kingsway Care Centre Mental Health Week

During Mental Health Week, Kingsway Care Centre hosted visits from a range of community groups, including HOPE, DVVA, Andy's Mans Club, the Maxwell Centre and the Quality Improvement and Practice Team (QIPT). These groups provided information about the support they provide, as well as volunteering opportunities. The QIPT shared wellbeing resources available to colleagues including restorative supervision and health apps. The bring and buy sale was a huge success, raising £540 for the Staff Wellbeing fund and the Mental Health Foundation. A staff newsletter reflecting on events over the week was also an opportunity to share a wide range of further mental health and financial help resources and raise awareness of the four Wellbeing Champions for the service.

Kingsway Care Centre Mental Health Week

Workforce Wellbeing Culture

During 2025, Dundee Health and Social Care Partnership worked closely with Dundee City Council HR and Dundee City Council Learning and Organisational Development (LOD) to better understand why absence levels were higher in some services and what support would help.

Together, they carried out workforce surveys, focus groups and discussions with managers and employees. This helped identify a range of issues affecting attendance, including long-term health conditions, bereavement, workload pressures and differences in how absence procedures were applied. HR and LOD then worked with services to put practical support in place. This included guidance and coaching for managers, stronger early wellbeing conversations, and a more supportive and consistent approach to return-to-work discussions. They also worked together with occupational health colleagues to improve how support is coordinated. This helped reduce conflicting advice, improve communication and create a more joined-up, person-centred approach to attendance support. Alongside this, HR and LOD supported wider wellbeing activity across services, including the development of Wellbeing Ambassadors and better promotion of the support available to colleagues.

Dedicated Physical Activity Time

A three-month pilot gave Allied Health Professional (AHP) staff at Ninewells Hospital 30 minutes of protected time each week to take part in physical activity during working hours. The aim was to support staff health and wellbeing, reduce stress and improve team culture.

The pilot showed clear positive benefits. More than half of survey respondents took part, with many attending regularly. Across the three months, there were 209 attendances at sessions including yoga, circuits and walking. Staff reported improvements in several areas. Many said they were more physically active, felt less stressed, and had better mental wellbeing. They also described feeling more energised and motivated at work. The pilot also had a positive effect on workplace culture. Staff said they felt more connected to colleagues, more supported by managers, and more comfortable taking time for wellbeing during the working day. Feedback suggested the pilot helped build a stronger sense of teamwork and a more positive working environment.

Leadership and System Improvement

During 2025, Dundee City Council Learning and Organisational Development (LOD) supported work to strengthen leadership across Dundee Health and Social Care Partnership. This included helping managers and team leaders develop the skills and confidence they need to lead services in a changing and demanding environment. It also supported the development of new and evolving roles, helping teams respond more effectively to people's needs. LOD helped put a more structured approach in place for leadership development. This focused on supporting managers to lead through pressure and change, support workforce wellbeing, and maintain service quality. Together, this work is helping to build stronger teams, improve supervision and support better decision-making across services.

Independent Sector Workforce

Independent and social care services continued to face significant pressure during the year. Providers experienced ongoing difficulties recruiting and keeping staff, alongside rising costs and increasing demand for care. Financial pressures also remained a major challenge. Funding for health and social care has not always kept pace with the true cost of delivering services, particularly in home care. These combined pressures have affected the resilience and sustainability of services across the sector.

Despite these challenges, there have also been opportunities to strengthen partnership working. Continued dialogue between independent providers, the Health and Social Care Partnership and national partners has helped improve understanding of shared pressures and priorities. This collaborative approach is important to support sustainable services, improve commissioning arrangements and ensure the independent sector is recognised as a key partner in delivering high-quality, person-centred care.

Awards, Accreditations and Recognition

The Pelvic & Obstetric Physiotherapy Team PRI were formally recognised at the NHS Tayside STAR Awards named Gold Winners in the Innovation and Improvement Award category.

Workforce

Laura Binmore, Physiotherapy Student Educator of the Year.

The award was presented to Laura having been nominated by students on placement. Laura is the lead for physiotherapy in oncology and haematology and has supported a number of student placements over the last year.

Emma Mills has been shortlisted as finalists for the Clinical Professional of the Year and **Rachel Stewart** for the award for Commitment to Patient Care at the Clinical Nutrition Awards that will take place in September 2026. These nominations recognise their outstanding contribution to cancer nutrition and patient care.

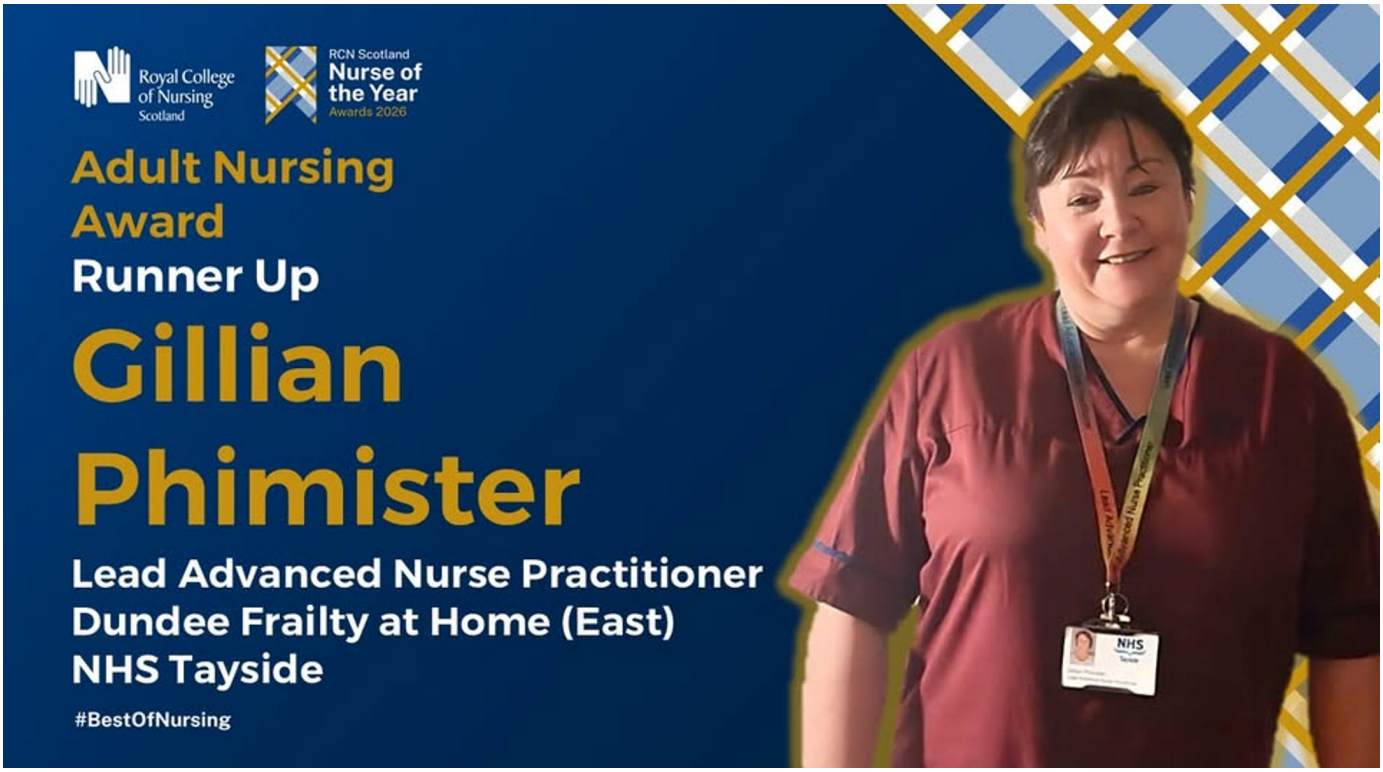
The **Integrated Hospital Discharge Team** has a workforce with a mixed skill base to ensure the best support is provided for people when they are discharged from hospital. This work has been formally recognised at the NHS Tayside STAR Awards, where the Integrated Hospital Discharge Team were named Silver Winners in the Support Team Award category.

This reflects the team's commitment, collaboration and outstanding contribution to improving patient experience and flow across Dundee.

Integrated Hospital Discharge Team

Gillian Phimister, Dundee-based advanced nurse practitioner and Adult Nursing Award runner-up at the RCN Scotland Nurse of the Year 2026 awards, transformed care by establishing an ANP-led community frailty model. Delivering urgent, specialist home treatment, her work improved triage, reduced admissions, and has contributed towards shaping wider NHS Tayside practice.

Adult Nursing Award



Congratulations to **Liam McGinlay**, who 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 in all GP practices in Dundee. As a primary care link worker, he supports patients whose physical and mental health and wellbeing is impacted by social and economic issues.

Sources of Support team leader Theresa Henry said, "We were 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 all very proud of him."

Liam McGinlay, Primary Care Link Worker Finalist

Workforce

Theresa Henry and Laura Campbell from the Sources of Support Team were invited to attend the King's Garden Party at Holyrood Palace. Their attendance recognises the outstanding work of the Sources of Support Service within Dundee GP practices.

Theresa Henry and Laura Campbell, Sources of Support Team

Positive Steps was awarded the Welcoming Women Certificate in 2025. In recognition of our commitment to delivering safe, effective, and responsive support for women, we have been awarded gender-specific certification. This recognises our ability to provide trauma-informed, gender responsive services that reflect the specific experiences of women, particularly those affected by trauma, exploitation, and gender-based violence. This strengthens our approach in Dundee by ensuring women receive support that is safe, appropriate, and empowering.

Positive Steps - Welcoming Women Certificate

The Corner also received the Welcoming Women Certificate in 2025/26.

The Community Health Team supports the **Charleston Health Issues in the Community Group**, which won a National Adult Learning Award Charleston Health Issues in the Community Group presented at an event in the Scottish Parliament in January 2026. With help from their Community Health Worker, group members overcame challenges such as living with disabilities, recovering from addiction, and responsibilities as a kinship caring to complete the course and gain accreditation at SVQ level 6.

Charleston Health Issues in the Community Group

Workforce

Dundee General Practice Substance Use Team were celebrated at the Scottish Healthcare Awards. The team won the Management of Substance Dependency Award for an initiative which has resulted in reduced stigma, increased patient engagement, a reduction in opioid substitution therapy, and the securing of employment. The service is centred around a model of GP, specialist nurse and third-sector key workers to deliver person-centred, holistic substance dependency care within primary care. The team offers at least four annual GP appointments, health checks, on-call key worker support, same-day prescribing, community pharmacy injections, and at-home visits.

Dundee General Practice Substance Use Team

Kingsway Care Centre has been celebrating its Sunflower Award winners. This is an initiative that gives colleagues the chance to recognise colleagues for everyday acts of kindness that make a real difference. Colleagues can nominate others for things like checking in after a tough visit or taking a moment to make someone a cup of tea during a busy shift. Award recipients receive a Sunflower badge to wear with pride, along with a certificate that can be used for revalidation and appraisals. This year saw a record number of nominations, highlighting just how much these small actions are valued across the team.

Sunshine Award Kingsway Care Pictured are Amy Paul, Scott Parker, Selom Seshi Doe and Claire Rice with their certificates

Challenges, Risks and Priority Areas for Next Year

The year ahead will be shaped by a challenging operating environment. Demand for health and social care support continues to rise, and many people need more complex, coordinated support across services. At the same time, the Partnership is working within significant financial constraints, ongoing workforce pressures and increasing pressure on primary care, community services, urgent care and social care assessment pathways. Performance during 2025/26 also shows areas where further improvement is needed, including emergency admissions, hospital readmissions and falls among older people, all of which remain higher than the Scotland average. Support for unpaid carers, timely access to help, and more joined-up pathways also remain important areas of risk and improvement.

These challenges are closely linked. Financial pressures can limit investment in prevention and early help, while workforce shortages can affect day-to-day delivery and the pace of improvement. Wider risks also remain around national policy and funding, provider sustainability, the condition and suitability of some buildings, and the need to continued redesigning services while maintaining safe care. The priorities below set out where Dundee IJB will focus effort during 2026/27, how these risks will be managed, and what success should look like for people and communities.

1. Improve Access to Timely Help and Support

A key priority for 2026/27 will be improving how quickly and easily people can get the help they need. This will include continuing work to reduce delays in hospital discharge, improve access to primary care, mental health and community support, and make services easier to understand and navigate. Particular attention will be needed in areas where demand remains high, including urgent care, social care assessment and specialist mental health support. This priority also responds to areas where performance remains under pressure, including emergency admissions, hospital readmissions and falls among older people, as well as people still waiting too long for help or finding support difficult to access. Success will mean more people getting the right support earlier and a clearer, more joined-up experience of care.

2. Strengthen Prevention, Early Intervention and Care at Home

The Partnership will continue to shift the balance of care towards prevention, early help and support in local communities. This includes strengthening frailty pathways, hospital at home and home first approaches, improving support for unpaid carers, and protecting services that help prevent crisis or worsening health. It will also include further work to improve information, signposting and community-based support, especially for people affected by inequality. Support for unpaid carers will be a particular focus, including better information, involvement in decisions, short breaks, emergency planning and support at key transition points. The main risk is that financial pressures could reduce investment in the very services that help avoid more costly intervention later. Success will mean more people being supported to stay well, safe and independent at home for longer.

3. Deliver Redesign and Transformation in Key Services

During 2026/27, several important pieces of redesign and transformation work will continue. This includes revising the Strategic Commissioning Framework, progressing new mental health and wellbeing priorities, developing primary care and out of hours improvement plans, taking forward agreed changes in areas such as palliative care, and improving how services work together across organisational boundaries. This work will also need to address pathways that remain fragmented, difficult to access or insufficiently joined up, and make better use of data, feedback, complaints, Care Opinion stories and survey results to understand outcomes and unmet need. This work will need to balance long-term improvement with the need to maintain safe day-to-day services. Success will mean that future plans are realistic, affordable and shaped by evidence, engagement and local need, with clearer pathways and more sustainable models of care.

4. Support, Develop and Sustain the Workforce

Having the right people, skills and support in place will remain essential to improvement. The Partnership will continue to focus on recruitment, retention, workforce wellbeing, leadership development and better workforce planning across health, social care and commissioned services. Particular pressures are expected in services already affected by vacancies, sickness absence and high demand, including care at home, primary care, nursing, specialist services and parts of the independent sector. Workforce pressures also affect day-to-day delivery, the pace of improvement, and the capacity available for longer-term change. Success will mean a more stable workforce, better support for colleagues, improved resilience in key services and greater capacity to deliver change.

5. Improve Financial Sustainability and Use Resources Well

The financial outlook will remain extremely challenging, and the IJB will need to continue its financial recovery work while protecting people as far as possible from the impact of change. Priorities will include delivering agreed savings, identifying efficiencies, improving how resources are targeted, and making sure that investment supports strategic priorities and prevention where possible. Rising demand, increasing costs, pressure on care at home, older people's services and learning disability services, and uncertainty around wider funding and provider sustainability all add to this risk. This will require difficult decisions and continued engagement with the public, partners and providers. Success will mean a more sustainable financial position, better alignment between spending and priorities, and greater confidence that limited resources are being used where they can make the biggest difference.

The scale of challenge means that improvement will require sustained partnership working, difficult choices about priorities, and a continued focus on reducing inequalities while maintaining safe, person-centred care. Progress will also depend on strong collaboration with NHS Tayside, Dundee City Council, neighbouring HSCPs, the third and independent sectors, and national partners.

Dundee
Health & Social Care
Partnership