ANNUAL PERFORMANCE REPORT

2016-17

Dundee
Health & Social Care
Partnership

CONTENTS

FOREWORD

The Public Bodies (Joint Working)(Scotland) Act 2014 (the Act) required NHS Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. The main purpose of integration is to use the available resources to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex and who require both health and social care support at the same time.

Following the establishment of the Dundee Integration Joint Board on 1st April 2016, the Board and the wider Health and Social Care Partnership have worked together with services users and their families, carers and communities to support the citizens of Dundee to live a fulfilled life. We know that the provision of health and social care services is a complex task involving enquiries and referrals, visits and assessments, care planning, service delivery and reviews. Over the last 12 months these activities have been delivered against a challenging financial and resource pressure for all of those involved in the Partnership.

In our first year of operation we have made progress in both redesigning the way we deliver health and social care services and in enhancing the positive impact these services have on individuals and communities. Over the last 12 months we have substantially increased investment in home based care services and reduced the time people spend in hospital due to emergency admissions and delayed discharges. We have also maintained excellent performance in relation to the provision of post diagnostic support for people with dementia and in the quality of care home and support services provided directly by the Partnership. In addition to a range of work that has begun to shift the balance of care from hospital to community based service provision, we have also started the process of planning and delivering integrated health and social care services within local communities.

None of these achievements would have been possible without the contribution of service users, their families, carers and wider communities. They have worked alongside us to design, develop and deliver services that work 'with' people in a way that enables them to live an independent life and direct the support they need to achieve this. We also recognise the commitment that the workforce within the Partnership, and within other organisations who we work collaboratively with, has shown over the last year to improve services for individuals and communities.

We want to make a difference to the lives of those who need our support. Our collective ambition is to achieve the best outcomes for families and communities, so people are at the heart of everything we do. Whilst we have much to celebrate in terms of the progress we have made and outcomes that have been achieved during the last year, as described in this report, we know that there is more to do to. In particular, we are committed to working over the next 12 months, and beyond, to ensure that people receive the right support at the right time and place, to increase choice of support which enables individuals to make the best use of personalised supports (including Self Directed Support), to improve outcomes for individuals living in Dundee's most deprived communities and to increase the proportion of carers who feel supported to continue in their caring role. We look forward to reporting our progress in these areas and across the broad range of services planned and delivered by the Partnership, when we publish our second Annual Performance Report in 2018.

Ken Lynn
Chair, Dundee Integration Joint Board

Doug Cross
Vice Chair, Dundee Integration Joint Board

WHO WE ARE

1.0

The Public Bodies (Joint Working) (Scotland) Act 2014 required NHS Boards and Local Authorities to integrate the planning and delivery of certain adult health and social care services. The Dundee Integration Joint Board (IJB) was established on 1st April 2016 to plan, oversee and deliver adult health and social care services through the Dundee Health and Social Care Partnership.

The Dundee Health and Social Care Partnership consists of Dundee City Council, NHS Tayside, partners from the third sector and independent providers of health and social care services. The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly people whose needs are complex and require support from both health and social care services. The Vision of the Health and Social Care Partnership is:

"Each citizen of Dundee will have access to the information and support that they need to live a fulfilled life"

The Scottish Government identified nine National Health and Wellbeing Outcomes that apply across all integrated health and social care services. These outcomes provide a high level strategic framework for the planning and delivery of health and social care services which is focused on improving the experiences and quality of services for people, their carers and families. You can read more about the National Health and Wellbeing Outcomes here and find a full list of the outcomes in appendix 1.

To deliver our Vision and the National Health and Wellbeing Outcomes, Dundee Health and Social Care Partnership has focused on 8 Strategic Priorities:

1. **Health Inequalities**
2. **Early Intervention / Prevention**
3. **Person Centred Care and Support**
4. **Carers**
5. **Localities and Engaging with Communities**
6. **Building Capacity**
7. **Models of Support / Pathways of Care**
8. **Managing our Resources Effectively**

In our first year of operation we continually focussed our efforts on delivering services that improved the lives all of the people living in Dundee and those who accessed health and social care services. Our 8 Strategic Priorities link directly to the 9 National Health and Wellbeing Outcomes and these links are identified in figure 1.

Figure 1

NATIONAL HEALTH AND WELLBEING OUTCOMES	DUNDEE STRATEGIC PRIORITIES							
	1. Health Inequalities	2. Early Intervention/ Prevention	3. Person Centred Care and Support	4. Carers	5. Localities and Engaging with Communities	6. Building Capacity	7. Models of Support/ Pathways of Care	8. Managing our Resources Effectively
1. Healthier Living	X	X	X					
2. Independent Living		X	X	X			X	
3. Positive experiences and outcomes	X	X	X	X	X	X	X	X
4. Quality of life	X	X	X	X	X	X	X	X
5. Reduce health inequality	X				X	X		
6. Carers are supported				X				
7. People are safe	X	X	X	X	X	X	X	X
8. Engaged workforce			X				X	X
9. Resources are used efficiently and effectively						X	X	

You can read more about how we identified our strategic priorities and what we plan to do from now until 2021 to achieve them in our Health and Social Care Strategic and Commissioning Plan 2016-2021.

In our first year of operation we did not review our strategic and commissioning plan, however we plan to do this following our second year (2017-18). Our review will incorporate our learning and build on what is working well. We will also ensure a clear focus on any areas where we are not yet achieving the level of impact on outcomes for individual and communities that we aspire to.

1.1 This Report

The Partnership is required to publish an annual performance report which assesses how well it has planned, overseen and delivered the services it is responsible for. This is the first annual performance report for the Dundee Health and Social Care Partnership and it reflects on what we have achieved and the challenges we have faced during 2016-17, as well as looking forward to our priorities for next year (2017-18).

This annual performance report includes;

- information about how the IJB and Partnership work, our priorities and how we have measured and managed our performance,
- a description of the resources we have received, as well as how we have spent and managed them,
- an assessment of how well we are doing in delivering each of the 9 National Health and Wellbeing Outcomes, including our key achievements and successes and how these have had a positive impact on individuals and communities and
- information from external inspection and scrutiny bodies about the quality of the services we provide and commission.

Additional information and documents referenced in this report can be accessed at https://www.dundeehscp.com/our-publications/

1.2 What we do

Dundee City Council and NHS Tayside were required to delegate some of their functions to the Partnership. By delegating responsibility for health and social care functions the objective was to create a single system for local joint planning and delivery of health and social care services by the Health and Social Care Partnership.

The Partnership is responsible for planning and delivering a wide range of adult social work and social care services and primary and community health services for adults. The Partnership is also responsible for some acute hospital care services such as accident and emergency, inpatient palliative care, substance misuse and mental health services and inpatient hospital services for areas such as geriatric medicine and respiratory medicine.

Additionally Dundee, Angus and Perth and Kinross Health and Social Care Partnerships have hosting responsibilities on behalf of each other. Hosting arrangements were agreed for highly specialist or area wide services. On behalf of the Tayside Health and Social Care Partnerships, Dundee hosts and leads the planning and delivery of a number of services including sexual and reproductive health, specialist palliative care and the centre for brain injury rehabilitation.

A full list of services delegated to or hosted by the Dundee Health and Social Care Partnership can be found in our Strategic and Commissioning Plan.

As well as working with other Health and Social Care Partnerships across Tayside and the rest of Scotland the Partnership also works closely with the Dundee Community Planning Partnership, including the Children and Families Executive Board, Community Safety and Justice Executive Board and Public Protection Committees.

1.3 How we measure our performance

During the last year we have continued to develop our outcomes and performance framework. As a Partnership we recognise the importance of self-evaluation, quality assurance and performance monitoring to enable us to identify areas of strength that we wish to build upon and areas for improvement. Our commitment to continuously improve services, in order to promote good outcomes for individual and families, underpins everything that we do.

During 2016-17 the IJB established its Performance and Audit Committee (PAC) to scrutinise the performance of the Partnership in achieving its vision and strategic priorities, including overseeing financial performance and other aspects of governance activities. Throughout the year the PAC has received quarterly benchmarking performance reports, which describe the performance of the Partnership against other Health and Social Care Partnerships across Scotland, allowing improvement actions to be identified. Benchmarking with other Partnerships assists the interpretation of data and identifies areas for improvement. Partnerships with similar traits, including population density and deprivation have been grouped into 'family groups', which consist of approximately eight comparator Partnerships. You can see the Partnership's quarterly performance reports on our website. The PAC has requested additional analytical reports in areas where performance has been poor, such as falls, to support an improved understanding of underlying challenges and the development of more detailed improvement plans.

Over the last 12 months we have worked with teams across services to identify appropriate outcomes and performance indicators to form the basis of internal team and service delivery area performance reports. As we move forward with locality planning and service delivery arrangements this will support sharing of best practice between service delivery areas and enable a continuous improvement approach to be embedded at all levels within the Partnership. In addition, individual teams and services have continued to undertake a range of self-evaluation activities such as audits, surveys of service users and case reviews.

Clinical care and professional governance is an important aspect of our work to improve the wellbeing of people and communities by ensuring the safety and quality of health and social care services. During the last year we have further developed a range of groups at service, locality and Partnership level to ensure clinical care and professional governance activities form a central part of our day-to-day work, as well as to monitor these activities to identify patterns of events that require a focused response to improve. You can read more about our approach to clinical care and professional governance on our website.

Whilst the Partnership has developed a range of different mechanisms to scrutinise the performance and quality of services over the last 12 months, we recognise that there is further work to be done during 2017-18 to embed self-evaluation, quality assurance, performance monitoring and clinical care and professional governance in our locality planning and service delivery arrangements.

1.4 How we deliver services in communities

Dundee Health and Social Care Partnership is organised into four service delivery areas. The concept of dividing the city into service delivery areas supports community engagement and planning across universal, preventative and specialist services for people with all levels of need.

Dundee has a strong ethos of working in partnership with its communities and the people it supports. There are eight Local Community Planning Partnership (LCPP) areas with established communication and development plans and regular meetings between community representatives and statutory services. The Health and Social Care Partnership is an active partner in Local Community Planning Partnerships. A map of the eight LCPPs is shown in figure 2.

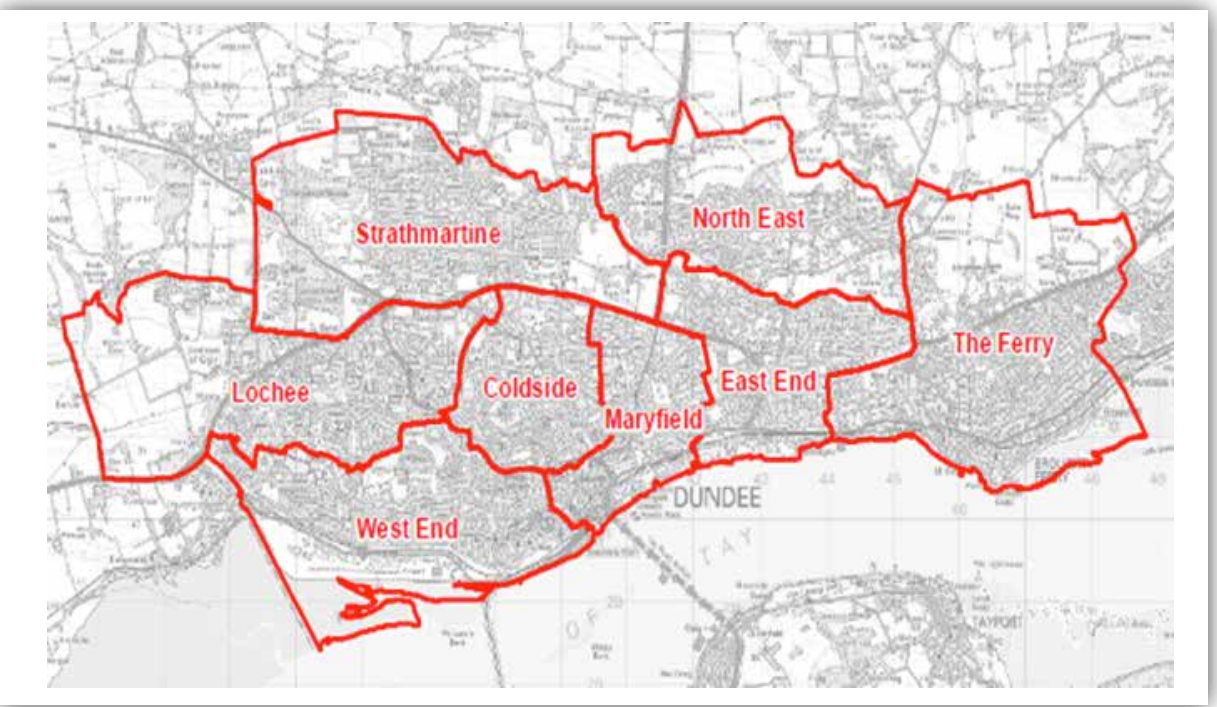


Figure 2 - Map of 8 LCPP areas in Dundee

The four Health and Social Care Partnership service delivery areas map across to the LCPPs, with two LCPP areas forming a single Partnership service delivery area:

- **Strathmartine and Lochee**
- **West End and Coldside**
- **Maryfield and East End**
- **The Ferry and North East**

The eight LCPPs are made up of 54 natural neighbourhoods. Unlike rural areas, where a sense of community can be linked to a whole village or small town, the nature of Dundee's communities can mean that the natural neighbourhoods that sit within the LCPP areas often have differing demographic, health and socio-economic profiles. This has been highlighted throughout this report as part of the 'How well we are performing' sections. We recognise that as well as identifying as a member of a neighbourhood or locality many people will also identify as a member of a non-geographical community based on personal characteristics or experiences, such as people from the

same ethnic background or people who are carers.
We provide some direct services on a geographical locality basis but as General Practices (GP) provide services to people from across the city and beyond, our service model is cluster based. Four GP Clusters have been established to support quality improvement and shared learning and they consist of the following GP practices:

- Family Medical Group (Wallacetown and Douglas), Maryfield, Park Avenue, Whitfield, Erskine, Mill (Arthurstone and Fintry Mill) and Terra Nova.
- Grove, Broughty Ferry, Taybank, Stobswell and Princess Street.
- Ancrum (two practices), Invergowrie, Coldside, Lochee, Downfield and Hillbank.
- Nethergate, Hawkhill, Westgate, Tay Court, Ryehill and Muirhead.

Each practice sends a practice representative (usually a GP) to a cluster meeting approximately every six weeks to meet with all the other practices in the cluster. These are led by a GP who is nominated as the lead cluster GP. The four leads meet with the Clinical Director and other members of the Partnership on a regular basis. Other services (including medicine for the elderly, practice pharmacy, psychiatry teams) are aligned to clusters. From time to time the cluster will invite representatives of these other services to a cluster meeting.

1.5 How we promote equalities and human rights

The Partnership is committed to embedding the principles of equalities and human rights in the planning and delivery of good quality health and social care services. We strive to encourage equal opportunities and respond to the different needs and service requirements of all people, including those with protected characteristics outlined in the Equality Act (2010). In addition, the Partnership has a focus on reducing health inequalities and supporting efforts across the Local Community Planning Partnerships to tackle deprivation and promote fairness.

During the last year we have continued to be active participants in the Dundee City Council Corporate Equality Group and the NHS Tayside Equality and Diversity Steering Group. However, moving forward we recognise the need to establish our own integrated arrangements for promoting equalities and human rights across the Partnership at governance, strategic and service delivery levels.

We have developed and published our Equalities Outcomes and Mainstreaming Equalities Framework 2016-17. The outcomes and framework were developed in consultation with people who have experienced discrimination and prejudice as a result of having one or more protected characteristic.

During 2016-17 a range of activities took place to support the achievement of our equalities outcomes, including

- A programme of consultation activities between the Public Protection Committees and Ethnic Minority (EM) groups, resulting in the identification of a number of service improvements such as the establishment of women only swimming sessions to enable women from EM communities to participate in physical activity.

- Supporting Dundee Women's Aid, as a commissioned third sector partner, to secure additional funding of more than £300,000 from the Tampon Tax Fund and the Big Lottery to develop a clinical psychology service for women experiencing domestic abuse and enhance volunteer recruitment, training and support.
- Providing funding to all care homes in Dundee to take part in the Promoting Excellence Dementia Champion programme.
- Introducing the Making Recovery Real initiative that has improved the ways in which we involve people with mental health issues in developing recovery focused mental health services.
- Participating in the Dundee City Council Harassment Support Officer arrangements to ensure that staff working within the Partnership have access to advice and support from a skilled colleague who has awareness of equality issues and is trained to support early resolution (where appropriate) of potential bullying or harassment issues.
- Providing training opportunities to staff within the Partnership regarding inclusive communication (facilitated by Sense Scotland) and intersectionality and mental health (facilitated by the Equality Network).

An Equality Outcomes and Mainstreaming Report setting out our progress during 2016-17 will be published before the end of 2017.

2.0 OUR RESOURCES

2.1 Where our resources come from

The Partnership's integrated budget for adult health and social care services was agreed by the IJB in March 2016. This budget consists of resources delegated to the Partnership by Dundee City Council and NHS Tayside to support the delivery of adult health and social care services. Before the budget was agreed, as part of the process of due diligence, checks were undertaken to assess that the resources being given to the Partnership were adequate to fulfil its functions and deliver its priorities. A number of challenges and risks were identified as part of this process due to the overall public sector financial position and the impact this has had on NHS Tayside and Dundee City Council. These challenges included substantial efficiency savings which meant that the Partnership had to deliver its services and strategic priorities within a restricted budget.

The new integrated budget also included additional investment from the Scottish Government to support the integration of health and social care through the Integrated Care Fund, Delayed Discharge Funding and Integration Funding. The total value of these funds to Dundee in 2016-17 was around £11.6m. Integration Funding from the Scottish Government included a commitment to ensure that all adult social care workers received the Scottish Living Wage from October 2016, a commitment which has been delivered by the Partnership.

2.2 How we have used our resources

Dundee Integration Joint Board received regular financial monitoring information throughout 2016-17 which identified a range of pressure areas and services which were likely to over or underspend. The overspend areas included the GP Prescribing budget and services hosted by Perth and Kinross and Angus Integration Joint Boards on behalf of Dundee, of which Dundee is responsible for meeting a proportionate share of costs. A risk sharing arrangement is in place between the IJB, Dundee City Council and NHS Tayside in relation to situations where overspends occur, which in 2016-17 resulted in any overspends being met by the Council or NHS Tayside.

The actual financial position for the delegated budget for 2016-17 was as follows:

- Dundee Integration Joint Board had an overall surplus of £4.963m in 2016-17 on the total delegated budget of £257.494m. This overall surplus (1.9% of 2016-17 budget) has been carried forward into 2017-18 through the Integration Joint Board's reserves, mainly to support the further development of new models of care.
- In social care budgets an underspend of £1.032m was reported. A further underspend of £3.931m was reported in Integration Change Funding. These underspends have resulted from timing differences between planned investment in adult care and the development of the required service infrastructure.
- In health budgets an overspend of £3.462m was reported. This consisted of overspends of £2.209m in prescribing and £1.394m in relation to Dundee's proportionate share of overspends in hosted services across Tayside. There was however an underspend of £141k on health services directly operationally managed by the Dundee Partnership.

The actual expenditure profile for integrated health and social care services for 2016-17 is shown in figure 3

Figure 3 – Annual Expenditure Profile 2016-17

Service Type	2016-17 Net Expenditure / (Income) £000
Older People's Services	61,545
Mental Health	21,836
Learning Disability	27,932
Physical Disability	7,301
Substance Misuse	1,316
Community Nurse Services/AHP*/Other Adult	12,009
Community Services (Hosted)	10,184
Other Dundee Services/Support/Management	4,737
Prescribing	35,450
General Medical Services (FHS**)	24,533
FHS - Cash limited & Non Cash Limited	20,048
Total of Costs Reported during 2016/17	**226,891**
IJB Operational Costs	229
Central Support Recharge	4,352
Acute Large Hospital Set Aside	21,059
Total Cost of Services	**252,531**
Delegated Budget 2016/17	(257,494)
Surplus on Provision of Services	**(4,963)**

Notes
** AHP – Allied Health Professionals*
*** FHS – Family Health Services*

The summary of this financial performance is shown in figure 4.

Figure 4 – Financial performance summary

	2016-17 Expenditure £000
Health Services - Hospital In-Patients	44,696
Other Health Care Services	116,068
Care Home and Adult Placement Social Care Services	45,660
Supporting Unpaid Carers	1,158
Other Social Care Services	44,949
Total Expenditure	252,531

You can read more about our financial performance in our Annual Accounts 2016-17.

2.3 What we have spent in communities

The Health and Social Care Partnership's service delivery areas have continued to develop throughout 2016-17 and into 2017-18. Future performance reports will reflect these new structures and service delivery area expenditure profiles once these arrangements are embedded.

OUR PERFORMANCE

This section describes and analyses our performance. We have used the 23 National Health and Wellbeing Indicators and local indicators to demonstrate our performance against the nine National Health and Wellbeing Outcomes and our eight Strategic Priorities.

You can find more details about how well we are performing against the 23 National Health and Wellbeing Indicators in our 2016-17 quarterly performance reports on our website.

National Outcome 1 Healthier Living – People are able to look after and improve their own health and wellbeing and live in good health for longer.

National Outcome 1 links to the following Strategic Priorities:

- Early Intervention / Prevention (Strategic Priority 2)
- Person Centred Care and Support (Strategic Priority 3)

National and local data provides strong evidence of the high levels of deprivation in Dundee. Deprivation is associated with higher prevalence of health conditions and multiple long-term conditions and this association is clearly visible in Dundee. In addition to the frailty and ill health which is prevalent in the ageing population, many younger people are experiencing health conditions earlier in life as a result of deprivation. The combined effects of these are evidenced by the increased demand and usage of health and social care services in Dundee.

How well are we performing

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over:

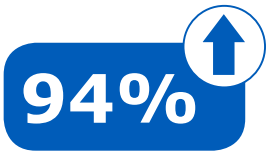
"In general, how well do you feel that you are able to look after your own health?"

93% of respondents agreed that they were able to look after their own health very well or quite well. This is similar to the Scotland response of 94%.

Dundee City Council's Citizen Survey, conducted in December 2016, asked a sample of Dundee citizens aged 16 and over:

"How good is your health overall?"

84% of respondents rated their health as very or fairly good, compared to 9% who said it was fair and 7% who said it was very or fairly poor. The proportion of respondents who said their health was very or fairly good has remained consistent with the 2015 survey results, however the proportion of participants staing their health was very good has increased significantly since 2015 (from 45% to 60%).



Despite Dundee citizens giving a positive response to how good their health is and their ability to look after their own health, emergency admission (to hospital) rates are high. This means that per head of the population a large number of people aged 18 and over are being admitted to an acute hospital in Dundee as an emergency. In 2016-17 for every 1000 people in Dundee who were aged 18 and over, there were 124 emergency admissions. This is higher than the Scottish rate (120 emergency admissions for every 1000 people) and was the 12th poorest performing Partnership in Scotland, out of all 32 Partnerships.

Emergency admission rates vary across the city. The highest emergency admission rates were jointly in East End and Lochee (151 admissions per 1000 people) and the lowest rate was in West End (87 admissions per 1000 people). There is also high variation between the neighbourhoods within each LCPP. An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on the Annual Performance Report page of our website.

Whilst emergency admission performance is poorer in Dundee than across Scotland, when assessment is made alongside the other 'family group' Partnerships performance is more positive. Dundee is the best performing Partnership in the family group it is aligned to.

Encouraging people to have choice and control over the services and supports they receive is a priority, however figure 5 shows that the number of people who received Self Directed Support options 1 and 2 remains low. The amount spent on delivering services and supports under options 1 and 2 has increased considerably from over £96k to over £308k. This is because the people who are receiving options 1 and 2 have complex packages of care.

Figure 5 – Self Directed Support – Options 1 and 2

	2015-16		2016-17	
Option	**No. of people**	**Cost**	**No. of people**	**Cost**
Option 1 - Direct Payments	58	£928,673	60	£1,087,024
Option 2	22	£96,279	30	£308,726

Dundee has a high number of people living with dementia. At March 2017 there were 977 people with a diagnosis of dementia. The health and social care workforce works hard to ensure that people with dementia are identified and supported as early as possible and this is measured using a European methodology for estimating prevalence and rates of diagnosis. NHS Tayside measures this against a standard, called the Local Delivery Plan standard, and expects there to be a minimum of 50% rate of diagnosis. Dundee is performing well against this standard, with a 65% diagnosis rate.

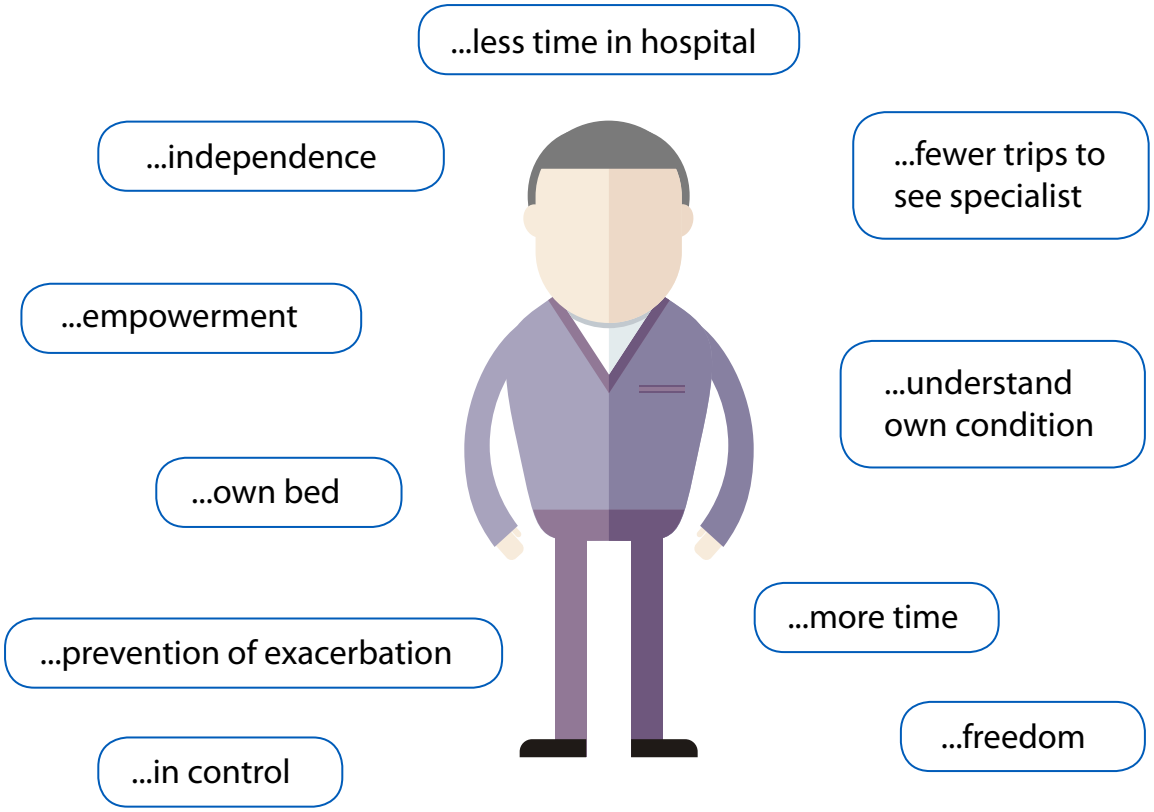
Post diagnostic support, provided over an extended period, is essential in order to equip people with dementia and their families and carers with the tools, connections, resources and plans they need to live as well as possible with dementia and prepare for the future. Everyone diagnosed with dementia is entitled to receive at least 12 months of post diagnostic support. There are five key pillars which are recognised as essential to supporting people after their diagnosis, outlined in figure 6.

Figure 6 – Alzheimer Scotland's Five Pillars

Of the 977 people living with dementia in Dundee, 955 (99%) received support that met national standards in the last 12 months.

What we have achieved to deliver this outcome

- Progress has been made in embedding an outcome focused approach to assessment across the Partnership with the introduction of a new assessment tool. Training has been delivered to support staff to shift their assessment practice from an approach focused on identifying needs, where people are matched to existing services, to focus on what outcomes matter to people living independently in the community. This approach does not just focus on what health and social care services can support a person but also takes into account all aspects of the person's life (social, relationships, being active, health, safety, independent living). An asset based approach is promoted, where the tasks that a person can do for themselves are determined along with who else currently supports the individual and what other community resources could help. So far, 18 training workshops have been held with 472 staff participating.
- The Partnership is committed to offering personalisation by embedding outcomes focussed approaches at all levels of the partnership, focusing on integrated assessments and organisational development in the context of locality working. In particular, we want to increase the uptake of Self Directed Support Options 1 and 2. We are developing additional capacity



to promote the mainstreaming of personalised supports across all of our services. So far, 18 training workshops have been held in order to support the implementation of outcome focussed assessments. 410 people have participated from all services across the Partnership. A further 3 workshops were delivered which were specific to staff involved in engaging with the Lead Professional Model for Homelessness (62 people attended from across the Partnership).

- Every 6 months an eNewsletter is distributed to staff informing them of up to date local and national information around self-directed support developments and provides practical examples of how it has helped people to live fulfilled, independent lives in a more personalised way. The information provides staff with inspiration around some alternative ways that people have used their health and social care budgets to meet their outcomes that might not be traditionally commissioned. It also provides links to training opportunities and provides updates around current systems, processes, procedures and workflows given the amount of transformational change ongoing across the Partnership.
- Personalising supports sits at the heart of the newly implemented Lead Professional Model of the homelessness partnership. The identification of personal outcomes and working towards them with a multi-disciplinary team is the concept which underpins the Lead Professional Model. This approach has been established following findings from many consultation opportunities established over the past two years with people who have been homeless or who have been potentially homeless.
- Although the majority of people rated homeless services singularly as being 'good' or 'very good' in terms of quality, they didn't feel that services were joined up enough or shared information easily about a person. They stated that this meant they had to 'tell their story over and over again', arrange appointments themselves and attend them, all of which they found challenging

at a time in their lives where they just needed support to do this. The Lead Professional Model has gone live and an evaluation will ask employees what they feel is working well and what could be improved.

- A questionnaire was disseminated at relevant team meetings to allow employee to give their views on the uptake of self-directed support. The questionnaire focused on confidence levels of staff, the knowledge and skills that they have in relation to offering and setting up the self-directed options for people that are in line with their choices. Focus groups were subsequently held with the teams following the completion of the questionnaire to allow for further discussion.
- The findings from the questionnaire identified a relationship between the staff who stated they had been trained and the level of confidence they reported in offering and facilitating the delivery of self-directed support. Those who had been trained reported 'good' or 'very good' levels of confidence. More training has been planned and will be rolled out later in 2017 for all staff who missed the original sessions and also for any new starts. Suggestions for improving systems, processes and paperwork were offered from employees and these have been incorporated into the action plan and risk log which is overseen by the local Personalisation Board.

CHOICE AND CONTROL

Mr S was admitted to the Kingsway Care Centre for assessment. Mr S' wife, who was also his Welfare and Financial Power of Attorney, felt that caring for him at home may not be possible. Mainstream social care supports had not worked previously as Mr S was still a relatively young and active man and the type of support and timings required could not be met flexibly by the services available. The recommendation from Mr S' assessment was initially for a care home placement. His Social Worker facilitated a Direct Payment under Self Directed Support and Mr S returned home with a tailored service which suited both his and his wife's needs. This involved employing personal assistants which provided the flexibility required. The Carer's Centre were also involved in supporting Mrs S with information. Mr S remains at home with his wife.

- Scotland's second National Dementia Strategy (2013), introduced a target which guarantees that everyone newly diagnosed with dementia receives at least a year's post-diagnostic support, including a person-centred support plan. The previous systems for delivering post-diagnostic support in Dundee were fragmented but during the last year a dedicated post diagnostic support team (PDS) has been established to provide a holistic, patient-centred approach. Self-evaluation of PDS has taken place, including reviewing care plans to establish if people newly diagnosed with dementia received appropriate care and had established support plans. Patients and carers were also surveyed on their experiences. Analysis of care plans identified excellent compliance with PDS monitoring – there was a 100% rate of referral and 98% of patients had either one or more aspects of their care met. Additionally 84% of people who responded to the survey were either satisfied or very satisfied. Patient and carer feedback included the following comments:

"We would like to thank the service for making mum feel safe and comfortable"

"As a carer it's good to know there is somebody at the end of a phone "

"Information and help was very much appreciated"

"Service provided by my worker was excellent"

"Extremely professional but also down to earth"

CO-ORDINATED CARE AND SUPPORT

Mr T was diagnosed with Alzheimer's disease in 2013 and lived at home with his wife. He was diagnosed through the detection and diagnosis clinic at Kingsway Care Centre and followed up with Post Diagnosis Team support. As his illness progressed he was referred for further input and assessment to the Community Mental Health Team (Older People). Both the Post Diagnostic Team and the Community Mental Health Teams are based together which ensured the transition between workers went smoothly for both Mr T and his wife. Supports and services were agreed between Mr T and his Social Worker in the Community Mental Health Team. When it was appropriate other members of the Community Mental Health Team became involved. The Psychiatrist monitored medication and the Mental Health Nurses gave advice to Mr T's carer about managing any symptoms and changes in behaviour. The Social Worker was identified as the lead worker so the carer knew who the main contact person was throughout.

- Dundee Third Sector Interface Healthcare and Wellbeing Team aims to build the capacity of communities to improve their own wellbeing and live in good health for longer and examples of projects include:
  - Community Companion Project – aimed at adults living in Dundee who are either experiencing or have the potential to experience social isolation. Each service user is matched up to a community companion based on personality, hobbies and interests. Community companions visit people in their own homes, accompany them to social activities and shopping trips.
  - Men's Sheds – provide a place for men to gather and participate in a variety of activities whilst supporting each other in a relaxed environment. The team is supporting the development of Men's Sheds in the East End, Lochee and Maryfield.

COMMUNITY COMPANION

Mr G was identified as someone who could benefit from a Community Companion through a care home consultation carried out by the Reshaping Care Team of Dundee Voluntary Action. Mr G was 92 years old and had lived in a care home for three and a half years. Throughout the duration of his time there he had very few visitors. It was difficult for Mr G to interact with his fellow residents in part due to his limited ability to communicate. After a few visits the Project Co-ordinator began to get to know Mr G and assess the ways in which he could benefit from a Companion. The Care Home Manager was keen to get Mr G involved in the project and gave full support.

A major issue for Mr G was the loss of his hearing. Mr G was reluctant to ask about hearing aids as he thought that they would not make a difference to him, he also did not want to 'bother' the staff for getting help with putting them on. To address this the Project Co-ordinator contacted Action on Hearing Loss and asked a worker to visit Mr G with the Co-ordinator to discuss the options available for his hearing loss. Mr G was given a personal listener to show him how his hearing could be improved and within 30 seconds he said "I'll take it, give me everything you have, I can hear". With this it was advised that Mr G be seen by his GP and a referral made to the Audiology department to be assessed for hearing aids.

Currently Mr G has a volunteer who visits him every week. With the use of his own personal listener he can chat away over a cup of coffee and interact with staff and fellow residents. Staff have noted an improvement in his mood and communication. The Community Companion who visits him has also managed to encourage Mr G to go into the garden and is planning a trip to the farm he previously worked at as well as a visit to the horses.

- The House of Care framework is focussed on care and support planning. This is a different way of working to support people with one or more long term conditions (LTCs). The underlying principles help to shift the emphasis of routine LTC care from the professional viewpoint to more collaborative and meaningful interactions between people with LTCs and professionals, to enable people to be in the driving seat of their care and supporting self-management. Implementation is focused within general practices across Tayside, but also within specific specialist services. This approach has led to positive feedback from people with LTCs regarding the difference this way of working is making to their care and support, plus professional satisfaction in offering a more person-centred approach. Training has been delivered to staff including clinicians (GPs/Practice Nurses) from 20 general practices across Tayside and specific specialist services (100 professionals). There has also been wider awareness raising across Tayside regarding the benefits of taking a person-centred care approach.
- The Listening Service "Do You Need to Talk?" was developed in 2012 in two sites in Dundee. In 2017 it received additional funding and is now available at over 18 sites. The service is provided within local general practices, and uses an asset based approach, building individual resilience and supporting a sense of well-being. A third of people using the listening service talk about bereavement issues, with others talking about relationships, stress, depression, ill health, fear, anxiety and a range of other issues.

"I came away with a feeling of optimism. I have since taken positive steps to make some changes in my life, which have improved my mental and emotional wellbeing."

- Over the last year we have taken a collaborative approach to the use of technology enabled care. Some important developments include:
    - Investment in step-down accommodation, including reconfiguring a demonstration SMART flat into a multi-purpose facility which can be used to demonstrate technology, rehabilitation and intermediate care upon discharge from hospital.
    - Increased investment in telecare provision as a way to support people to live independently.
    - Piloted the Florence system, which provides cost effective home health monitoring using mobile phone texts and we have applied our learning to inform how we will roll out telehealth across the Partnership in the future.
    - Developed a joint approach with Angus Health and Social Care Partnership for the provision of equipment and adaptations across nursing, allied health and housing professions.

National Outcome 2: Independent Living

People, including those with disabilities, long term conditions or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.

National Outcome 2 links to the following strategic priority:

- Models of Support / Pathways of Care (Strategic Priority 7).

We know that people want to live as independently as possible and would prefer to be supported at home or in a homely setting rather than be in a care home or hospital. We know that the hospital environment is not the best place to provide long term care when needs can be better met at home.

How well we are performing

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over to state if they agreed with the following statement:

"I was supported to live as independently as possible"

88% of respondents stated that they were supported to live as independently as possible. This is higher than the 84% of respondents across Scotland who felt the same. There was variation in responses across general practices ranging from 86.5% to 98.3%.

Dundee had a high rate of readmissions to hospital, where the patient had previously been discharged within the last 28 days. In 2016-17, 12.5% of people discharged from hospital following an emergency admission were readmitted within 28 days. This is an increase compared with 2015-16. Dundee had the highest 28 day readmission rate in Scotland.

Despite a high rate of readmissions to hospital, the number of bed days lost to delayed discharges for people aged 75 and over was relatively low. Lost bed days are counted from the day the patient was assessed as medically fit to return home to the date they were discharged. In 2016-17, for every 100 people aged 75 and over, 75.5 bed days were lost due to a delayed discharge. This was an improvement compared with 2015-16, when there were 83.2 bed days lost for every 100 people aged 75 and over. In 2016-17 Dundee performed better than the Scottish average.

There was variation between the number of bed days lost to a delayed discharge across LCPPs. People aged 75 and over who live in the East End contributed to the largest rate of delayed discharge bed days. For every 100 people aged 75 and over living in the East End, there were 138.5 bed days lost in 2016-17, which was four times higher than the rate in The Ferry. The lowest delayed discharge bed day rate was in The Ferry where for every 100 people aged 75 and over there were 30.5 delayed discharge bed days used in 2016-17.

There are a number of preventative and rehabilitative supports available in the community, however the measure most commonly used to measure performance in this area calculates the number of people who received personal care or a Direct Payment for personal care as a % of all people with intensive needs. Using the most recent national data available for 2015-16, 54% of people aged 18 and over with intensive needs received personal care at home or a Direct Payment for personal care. This is lower than the Scottish figure of 62%.

Despite Dundee citizens feeling that they were supported to live as independently as possible and preventative and rehabilitative services and supports being delivered in the community, emergency bed day rates for people age 18 and over remain high. Dundee has a high rate of emergency bed days occupied, although there was a reduction between 2015-16 and 2016-17. This is a positive change, meaning that on average, for every 100 people in Dundee, 136 bed days were occupied during 2016/17, compared with 142 bed days occupied in 2015-16. Despite this improvement, Dundee is still performing more poorly than the Scottish average and was the seventh poorest performing Partnership in Scotland, out of all 32 Partnerships. For every 100 people in Scotland, 120 bed days were occupied during 2016-17.

Emergency bed day rates vary across the city. The highest emergency bed day rate was in Lochee (186 bed days occupied per 100 people) and the lowest rate was in West End (91 bed days occupied per 100 people). There is also high variation between neighbourhoods within each of these LCPPs.

An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on the Annual Performance Report page of our website.

Whilst performance in Dundee is poorer than the Scottish average, when assessment is made alongside the other 'family group' Partnerships performance is more positive. Dundee sits at approximately the median point, which means than 3 Partnerships performed more poorly than Dundee and four Partnerships performed better than Dundee.

What we have achieved to deliver this outcome

- During the last twelve months the Partnership has increased investment in home based care services, including funding the implementation of the living wage for care workers in this sector, through increased investment of over £1.5 million.
- Established an integrated discharge hub based at Ninewells Hospital to support the implementation of our Home and Hospital Transition Plan. The hub has supported a number of integrated approaches to be taken that enable people to be discharged when they are well. This is reflected in our improved performance for delayed discharges over the last year.

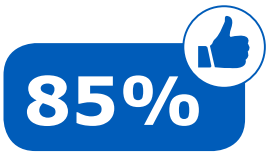
- The Home from Hospital service is a short-term service supporting older people for up to six weeks following their discharge from hospital. Volunteers visit regularly during the 6 weeks to aid the person's recovery and to rebuild their confidence and independence. The service does not provide personal care, any lifting or cooking but will encourage an older person to cook for themself. What the service does provide is all the small things that many of us take for granted; making sure that the heating is on, making sure that there is food in the cupboard, doing shopping, helping with light housework, helping people to attend follow-up hospital or doctor's appointments and many other small tasks depending on the needs of the individual person. It may be purely company and someone to talk to. Volunteers will encourage the person to be more active and will assist them to get back into their old routine or will help them try new things if they are interested and able. The volunteers also try to identify opportunities where other organisations can help the person on a longer term basis such as The Food Train and Dundee Community Transport. The service provided varies from person to person depending on their particular needs and abilities, therefore, no two services will be exactly the same.

HOME FROM HOSPITAL

One of the newer volunteers began working with Mrs A and built up a very good relationship with her. Mrs A had family but they were in Fife and neither she nor her family had transport. The family keep regular contact but it had been a while since they had seen each other. The volunteer asked if she could take Mrs A to visit her family and was supported to do this. The volunteer fed back that she had never felt so good about helping someone in her life. Mrs A was overwhelmed at this offer and her family were very excited at 'gran' coming to visit. The volunteer left Mrs A with her family and returned to pick her up some hours later. The gratitude of the family and the very happy Mrs A on her way home from that visit made the volunteer appreciate how such a simple thing can make such a difference to someone's day. The volunteer said that she has definitely done the right thing signing up for volunteering with the service and is looking forward to helping more people.

- The model of developing step down services to support early, safe discharge from hospital has been successful. Step down support can be provided in a care home, sheltered housing, housing with care, accommodation with supportive technology (SMART flat) or in a person's own home. The main purpose of step down support is to assess outwith an acute hospital and this may include a period of monitoring in order to assess levels of need in a community environment.
- A rehabilitative care pathway has been developed in order to support the transition of people between the Centre for Brain Injury Rehabilitation to a more homely, community based environment. People with a brain injury are supported to leave hospital earlier and rehabilitation is continued in the MacKinnon Centre for a defined period of time, whilst personal planning for their future takes place.
- Over the last year we have developed a Nurse led Community Leg Ulcer Clinic for non-housebound patients with chronic venous leg ulceration. During its first year the clinic has focused on the development of a model of care, including referral criteria, patient and onward referral pathways and operating standards in addition to providing ongoing leg ulcer care to people. The clinic has;

- improved the rate of patients healed within 12 weeks from 29% to 85%,



- reduced the number of dermatology clinic appointments needed from 35 to 7 per 100 patients and

- reduced the number of nurse hours needed from 35.3 hours to 7.3 hours per week for every 100 patients.

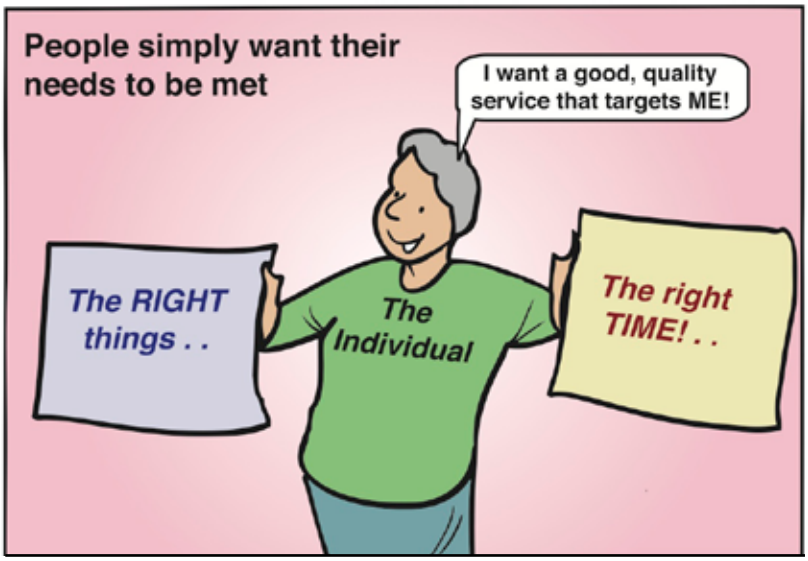
- Dundee and Angus Health and Social Care Partnerships have launched a new shared community equipment loan service for people with disabilities. The new venture is based at the Dundee Independent Living and Community Equipment Centre in Dundee and provides, delivers, installs, repairs, maintains and recycles a range of equipment to help people of all ages to live independently. It also provides a technical advice service and carries out risk assessments with medical and care professionals, both in-store and in people's homes.
- The Youth Housing Options Service is a model of early intervention, conflict resolution and support to assist young adults and their families to repair and rebuild relationships. In 2016-17 there were 380 young adults who presented for housing options advice from a range of sources such as housing, health and social care services. Engagement in conflict resolution and support resulted in 132 young adults remaining in or returning to the family home and 148 young adults were supported to obtain alternative accommodation. 175 young adults were also supported to maintain or secure vocational placements.
- We have implemented a Power of Attorney Campaign in partnership with Angus and Perth and Kinross Health and Social Care Partnerships, which will now take place annually. The campaign was supported by additional local awareness raising events to help to promote Power of Attorney, reduce the need for guardianship and enable people to be discharged from hospital when they are well. Initial data gathering indicates an increase in Power of Attorneys and this will continue to be monitored over coming years.

Outcome 3: Positive Experience and Outcomes

People who use health and social care services have positive experiences of those services and have their dignity respected

Outcome 3 links to all of the Partnership strategic priorities.

Improving health and social care outcomes for people who use services and their carers underpins the entire integration agenda. The Partnership knows that individuals and communities expect services that are of a high quality and are well co-ordinated . Our commitment to equalities and human rights includes taking approaches that mean service users, carers and their families are treated with dignity and respect.



How well we are performing

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over to respond to the following questions or statements:

"I had a say in how my help, care or support was provided"

"Overall, how would you rate your help, care or support services?"

"Overall how would you rate the care provided by your GP practice?"

79% of Dundee respondents who were supported at home agreed that they had a say in how their help, care or support was provided. This is the same level of satisfaction as for Scotland as a whole.

79%

84% of Dundee respondents who received any care or support rated it as good or excellent. This was slightly higher than the 81% of respondents from Scotland as a whole who reported this. There was variation in responses across GP practices in Dundee ranging from 67% to 100%.

84%

90% of Dundee respondents reported that they had a positive experience of care provided by their GP practice. This is slightly higher than the 87% reported by Scotland as a whole.

Experience of care appears to be positive and this is particularly important when people reach the later stages in their life. It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care. Of the people who died during 2016-17, 87% of time in the last 6 months of life was spent at home. This is a positive result (similar to the Scottish average and third best in the 'family group') and could not be achieved without a strong partnership between acute and community teams, the third and independent sectors and patients and their loved ones.

In 2016-17 a total of 45 complaints were received regarding social work and social care services provided by the Partnership. Most complaints (73%) were resolved at the first stage of the complaint process, frontline resolution. For 45% of the total complaints received the Partnership was able to respond within target dates set out in our own procedures or agreed directly with the complainant. Complaints related to a number of different aspects of social work and social care service provision are categorised in figure 7.

Figure 7

Complaint reason	Number of complaints
Delay in responding to enquiries and requests	3
Dissatisfaction with our policy	5
Failure to follow the proper administrative process	2
Failure to meet our service standards	21
Failure to provide a service	2
Treatment by, or attitude of, a member of staff	12

(Please note that some complaints have multiple complaint reasons)

62% of the complaints were upheld or partially upheld and we agreed that the complainant had reason to complain.

In 2016-17 a total of 68 complaints were received about health services provided by the Partnership, with an additional 4 complaints being re-opened. Most complaints (74%) were responded to and resolved within the target timescale of 20 days. Data regarding the underlying reasons for complaints is only available from July 2016 to March 2017, during this period 51 complaints were received and these related to a number of different aspects of health service provision. These are categorised in Figure 8.

Figure 8

Complaint reason	Number of complaint reasons for the 51 complaints
Lack of clear explanation	18
Disagreement with treatment / care plan	17
Staff attitude	14
Lack of support	10
Unacceptable time to wait for an appointment	9
Problems with medication	8
Wrong diagnosis	6
Patient not being verbally told things	6
Other	78

(Please note that some complaints have multiple complaint reasons)

The Partnership also regularly receives compliments from the people who use our services, their families and carers. Some compliments received during the last year include:

"My brother passed away a little over two weeks ago and I wanted to send a note to you as Head of the Dundee social services team to let you know how well I and my family feel we were supported…both Care Managers attended his funeral, and it just demonstrated to me in particular the real and sincere quality they both brought to being part of your team…"

"NHS 24 contacted the Community Response team late last night after my wife had fallen…We are both very grateful to the team that arrived to assist. They were both very professional, friendly and supportive and we can't thank them enough for their help and good humour…"

"I would like to pass on our thanks for referring us to your Telecare Team. The support we received is first class. They were able to offer suggestions as well as solutions…which, in the short term we have had this, has returned a degree of independence to one of our residents."

The Care Inspectorate is the regulator of care services in Scotland and as part of their inspection they award grades. National data for 2016-17 is not currently available, however we reported in 2015-16 that Dundee had the sixth highest proportion of care services rated as good or better in Scotland (88%). Of the 18 services directly provided by the Health and Social Care Partnership that were subject to inspection by the Care Inspectorate over the last year 89% received grades of 'very good' or 'excellent'.

What we have achieved to deliver this outcome

- The Care Home Liaison Team was established to provide a dedicated service to residents living in care homes suffering mental ill health and supports the wider care home team. The team of four nurses is supported by medical colleagues who provide specialist assessment and treatment to individual residents as well as facilitating training specific to older people with mental health issues and dementia. In the first year there have been many positive outcomes for residents and families, including a reduction in hospital admissions. In this period the admission rate from care homes to Kingsway Care Centre dropped from 28 to 7. Colleagues who work in care homes have found many benefits from having a specific link nurse and prearranged times to visit each area. This provides a consistent and dependable service. Following a successful first year, the team are working on planning further developments for the service including; collaborative training with care homes, peripatetic services and older people review officers and enhancing their knowledge regarding the essentials in psychological care.

The Care Home Liaison Team

- Over the last year, we have been working in partnership with Macmillan Cancer Support, Dundee City Council, Leisure and Culture Dundee, NHS Tayside and voluntary sector organisations to develop the Dundee Macmillan Improving the Cancer Journey project. During February 2017 we formed a Cancer Voices Panel, made up of members who have had a cancer diagnosis or cared for someone with cancer, which has helped us to shape the project . The Improving the Cancer Journey project will offer tailored practical, personal and emotional support to local people affected by cancer, based on a holistic needs assessment and what matters to them. The service will be trialled from July 2017 in Coldside and Lochee.
- The Palliative Care Tool Bundle and Response Standards is used across community based health and social care services in Dundee to enable staff to identify, assess, plan and evaluate care for any person with palliative and end of life care needs. The aim of this project is to give the person the best appropriate care through an individualised care and support plan which suits that person's needs and wishes. It also enables clear, consistent communication between secondary and primary care and reduce delays in starting treatments, or highlight where treatments or investigations would not be beneficial.

- Welfare Rights Officers have been co-located in a number of general practices to support individuals around issues related to benefits and finance, with the aim of improving health and wellbeing longer term and reducing inequalities. The service has demonstrated a shift from reactive longer term work (such as tribunals) to more proactive preventative work. Five general practices are now involved in this work with positive feedback and outcomes across stakeholders. Financial gains for those individuals supported through this process in the last year are over £1 million. The advantages of co-location and integration into the general practice teams, has been very positive for all the staff involved. There has also been consensual access to medical records which has been helpful for the welfare rights staff in terms of supporting claims processes and appeals. There has been a national evaluation, looking at work in Dundee and Edinburgh, to assess the social return on investment. This found that

"For every £1 invested in general practice co-located advice service, £39 of social and economic benefits would be generated."

- At the point of integration the Dundee Health and Social Care Partnership inherited three separate complaint handling procedures: NHS Complaints, Statutory Social Work Complaints, and Dundee City Council Complaints. Over the course of the last year we have aligned these separate procedures and now follow the Scottish Public Services Ombudsman's model complaint handling procedure. This means that there are now only two complaint procedures: the NHS Complaint Procedure and the Dundee Health and Social Care Partnership Social Work Complaint Procedure. The aim being to provide a single response if a complaint is received that is about both health and social care services.
- The Partnership values the complaints it receives and we use them to improve our services. Where complaints are upheld or partially upheld we aim to make improvements. Over the last year planned service improvements have been carried out following the resolution of 28 complaints. Examples of some improvement made include; improvements made to recording systems, refreshed staff training being delivered and guidance issued, team development activities being undertaken and improvements to communication and supervision systems.
- People who use services in Dundee have been part of the National Involvement Network (NIN) for a number of years. Local members of the NIN enjoy contributing to national meetings where they have helped develop a Charter for Involvement and tools to assist both people with learning disabilities and service providers to monitor, evaluate and measure their performance against the standards in the Charter. People with a learning disability and/or autism in Dundee and their service providers have learned about the Charter for Involvement through national meetings and a number of local sessions. A significant number of local providers have signed up to the Charter and local people are supported to be more involved in their service. As not everyone is able to attend national meetings, people in Dundee agreed to form a local involvement group which meets regularly to share experiences, support each other to speak up and learn from each other. 77 people attended the most recent meeting.

Service users at a local Charter for Involvement Event

Outcome 4: Quality of Life

Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of services no matter where they live.

Outcome 4 links to all of the Partnership strategic priorities.

This outcome is important to ensure that service users and their carers are supported to consider the most appropriate options available to them to meet their care and support needs and improve their outcomes, including at the end of life. Conversations with people accessing health and social care services need to focus on what matters to them in their own lives, what they can do for themselves, what supports they already have available and how services can complement the personal resources already available to them.

A shift is being made from the more traditional 'medical model' and service led approach, to a more integrated and holistic approach to improving quality of life and outcomes. In relation to the provision of mental health and substance misuse services, there is also a growing focus on the adoption of recovery based approaches to the delivery of treatment and support services.

How well we are performing

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over if they agreed with the following statement:

"The help, care or support improved or maintained my quality of life".

88 % of Dundee respondents supported at home agreed that their services and support had an impact on improving or maintaining their quality of life. This is slightly higher than the 84% reported by Scotland as a whole. There is variation in responses across GP practices ranging from 66.7% to 100%.

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major and growing concern. Measuring the rate of hospital admissions as a result of a fall by the population who are aged 65 and over indicates the quality of life and the mobility of people as they live independently in the community.

Dundee had a high rate of hospital admissions as a result of falls, with a rate of 26 admissions for every 1,000 people aged 65 and over. In 2016-17 Dundee was the second poorest performing partnership in Scotland. The average rate in Scotland was 21 admissions due to a fall for every 1,000 people aged 65 and over.

West End had the highest admission rate due to falls in Dundee with 32 per 1,000 people aged 65 and over. The North East had the lowest rate in 2012-13 but there was a sharp increase in 2014-15 and again in 2016-17. The Ferry has seen a continual decrease in their rate and now has the lowest rate with 19 admissions due to a fall, per 1,000 people aged 65 and over.

An in-depth analysis of rates of hospital admissions due to falls by neighbourhoods within localities has been completed and can be found on the Annual Performance Report page of our website.

What we have achieved to deliver this outcome

- We have expanded our falls service to ensure patients aged 65 and over are routinely screened by Allied Health staff if presenting with a fall and follow up interventions are put in place. This expanded service includes a single point of referral, triage by nurses, self-referral option to Community Rehabilitation Team and improved information sharing practices. In addition, we have introduced falls prevention care home education and this has resulted in a reduction in falls in care homes. Otago falls classes are now well established in community venues and are responsible for improvements in clinical outcomes for people who have experienced a fall.
- Our Medicine for the Elderly (MfE) Consultant, Social Work teams, Community Rehabilitation Team, Community Nursing teams and Psychiatry of Old Age services have been realigned to enable them to work more closely with our GP clusters on community based service delivery. These teams have regular multi-disciplinary meetings with individual GP practices and with GP cluster areas to look at quality improvement. This has led to a number of projects aimed at improving prescribing safety and patient management for example, significant benefits have been achieved in the way in which benzodiazepines (a sedative used for a wide range of purposes including for sleeping problems and anxiety) are prescribed in order to reduce risk of harm to service users.
- Enablement and support is a short term (up to six weeks) service which works intensively with people aged 16 and over to achieve the best outcomes with people. The ethos is to keep people motivated, engaged and to be as independent as possible. The service includes support from pharmacist technicians, occupational therapists and it has direct access to physiotherapists. These professionals work together to enable people to reach their potential and try and regain skills which they may have lost. Over the last 12 months, 85 % of people required either the same hours of homecare, less hours or no hours, following enablement.

MAXIMISING POTENTIAL AND MAKING EVERY MOMENT COUNT

Mr B lives in sheltered housing. He has recently begun to struggle to take care of himself at home and to maintain his social contact with friends. He has a diagnosis of dementia. His family have become increasingly concerned that his symptoms of dementia are worsening and he is forgetting to eat properly and is becoming isolated and depressed.

Mr B was referred to the Community Mental Health Team for Older People for further support. He was visited at home where he discussed his current difficulties. Mr B identified he was struggling with activities of daily living and had lost his confidence to make his own meals, to deal with finances and to go out to visit his friends at the bowling club. Mr B stated looking after himself was not a priority, as he felt there was 'no need' anymore.

The team spent time getting to know Mr B, allowing time and space for him to share his wishes and hopes for the future. Mr B told them that the bowling club had been a big part of his life, especially after his wife died and he missed the support he received. The team worked with Mr B to support him to return to the bowling club. A volunteer driver was arranged to take him and to return him home. The visits also coincided with a regular meal provided at the bowling club. Once Mr B's confidence increased, his friends at the bowling club arranged transport themselves to allow him to attend twice a week.

In addition, Mr B attended a lunch group and bingo in the sheltered housing complex which provided further social support. A support worker from the team worked weekly with Mr B to attend appointments and to assist him to set up systems to manage his finances.

- Our Strategic Housing Investment Plan (SHIP) sets out our plans to invest in housing developments for adults with particualr health and / or social care needs. It supports our ambition to deliver flexible models of support that enable people to live within their own homes where at all possible and receive the right support at the right time. Significant investment has been made in this area in recent years and this has led to fewer people living in institutional settings out with the city, which is often very costly. In partnership with Dundee City Council Neighbourhood Services and voluntary sector providers more than 40 units of housing with support were secured for adults with additional support needs over the last year. Between now and 2022, approximately 85 more units will be secured alongside suitable support services. There is a commitment to ensure that all new build housing provision has assistive/smart technology capabilities and this is reflected within our commissioning processes.

- Through service user consultation and working with other services the White Top centre has contributed to improving the quality of life for service users. This has been achieved in a number of different ways over the last year:

    - A widely accessible activity programme for people with a profound and multiple learning disability has been created. This provides a platform for service users to engage in their chosen activities and experience new opportunities. Joint working has been undertaken with Promoting a More Inclusive Society (PAMIS) to promote the inclusion of people with a profound and multiple learning disability in their local and wider communities.

    - An opportunity was created by PAMIS for service users to be involved in making an award winning film about having a profound learning disability. After this success some of the service users and staff were asked to feature in the up and coming PAMIS film called Profound.

    - Joint working with PAMIS and Tayberry Enterprise has led to the introduction of Sensory Storytelling within the service. This has been well received by service users and has provided them with a regular opportunity to be involved and explore new tactile and audio experiences. Tayberry Enterprise has also opened up the opportunity to have their lead percussionist visit the White Top Centre to provide an inclusive drumming experience.

- Allied Health Professionals, Community Learning Disability Nurses and Recreation Officers within the Learning Disability Team work collaboratively with a broad range of professionals, agencies, higher education organisations, advocacy groups, private sector staff, third sector groups, carers and volunteers across the city. They interact with service users and their carers in a variety of environments out with the home and traditional health or day service locations. Over the last year the following service areas continued to support people with a learning disability across the city:

    - **Speech & Language Therapy** - Speech and language therapists provide a vast range of training and ongoing support to over 20 learning disability care providers. Currently over 700 training places are offered each year across Tayside, on topics such as Makaton, Total Communication and Dysphagia. The service is also involved with supporting people with a learning disability to understand and contribute to complex communications through inclusive communication tools, subject matter translation, software programmes and `talking mats` based approaches. During the last year this has included supporting people with a learning disability to participate in the current NHS Tayside Mental Health and Learning Disability Redesign Transformation programme consultation.

    - **Nutrition and Dietetics –** Through the specially developed Healthy Eating, Health Living training programme and teaching resources, staff working for learning disability service providers learn the key skills needed to enable people with a learning disability to select and prepare a range of healthy foods; to promote the attainment of a healthy weight and to take regular exercise.

- **Community Learning Disability Nursing** – This team provides education and support to students, who have a learning disability and/ or autism, regarding their sexual and reproductive health at Dundee & Angus College as part of the students' curriculum. The team also provides individuals with specialist sexual health and parenting advice, education and support in tandem with mainstream services. Recognising that there are often barriers to communicating information about friendships and relationships, the nurses regularly attend evening discos and other social gatherings in order to interact with those furthest from engaging with traditional services. The team works in collaboration with the wider health team, care providers and third sector organisations to provide education and information regarding parents with a learning disability and also deliver Speak Easy classes in community centres and educational facilities.

- Working Health Services Scotland aims to provide vocational rehabilitation support for employees of small to medium sized businesses (up to 250 staff) and self-employed, who are struggling at work or on short term absence due to a health condition. This is delivered through a case management model and short term (up to 12 weeks) rehabilitation interventions, such as occupational therapy, physiotherapy or talking therapies. The service can also engage with employers to support return to work as required. Over the last 12 months 550 people were supported across Tayside, exceeding targets for the service.

- Fit for Work is a UK government initiative which provides support to employees who are struggling with their health in work. There is no restriction on the size of the company, but employees should be absent for four weeks or more and can be referred by their line manager or their GP. They will receive a detailed case management telephone assessment from a healthcare professional within 48 hours of referral. This looks at their health, work and any psychosocial difficulties which may be impacting on their ability to return to work. It is hoped that a return to work plan (replaces the need for a fit note) can be produced which guides both employee and employer on safe and effective return to work. Case managers can work with the employee for up to 12 weeks.

- Creative Engagement Through the Arts, is a developing non-medical therapeutic intervention that can operate alongside existing treatments by addressing psychosocial benefits (mood, confidence, self-esteem) associated with positive health and well-being. Tayside Healthcare Arts Trust (THAT) has been at the forefront of its development locally across a wide range of LTCs. It's nationally recognised work with stroke (ST/ART Project and ACES research) has earned recurring funding from NHS Tayside and partnership support from Dundee Contemporary Arts and others. THAT has for some years been demonstrating the applicability of this approach for other LTCs, particularly Dementia, Chronic Obstructive Pulmonary Disease (COPD), Parkinson's and Multiple Sclerosis (MS).

National Outcome 5: Reduce Health Inequality

Health and social care services contribute to reducing health inequalities

National Outcome 5 links to the following Partnership strategic priorities:

- Health Inequalities (Strategic Priority 1)
- Localities and Engaging with Communities (Strategic Priority 5)
- Carers are Supported (Strategic Priority 6)

Health inequalities are unfair and unavoidable differences in people's health across social groups and between different populations. They are determined by economic and social factors and the uneven distribution of wealth, income and power, not by individual choice. Health inequalities lead to a significant impact on people's health and life expectancy, but can be avoided or mitigated with changes to things such as socio-economic, welfare and public policies. There are however some things that are not within our control, such as age, ethnicity and genetics and to a degree, where we live, work, and learn. We may however, through partnership working, have a greater influence on some of these factors. We want people in Dundee to have improved health and to have equality of health outcomes irrespective of where in the city they live.

How well we are performing

Dundee had the 3rd highest premature mortality rate in Scotland in 2015, with 546 unexpected deaths per 100,000 people aged 75 and under. Historically, Dundee has always had a higher premature mortality rate than the Scottish rate and although the Dundee rate decreased between 2010 and 2014 it began to increase thereafter.

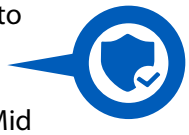
Dundee has high levels of deprivation with a widening gap between the richest and poorest communities. Overall Dundee is the fifth most deprived local authority area in Scotland, with only Glasgow, Inverclyde, West Dunbartonshire and North Ayrshire having higher deprivation. Six out of eight Dundee LCPP areas have higher deprivation than the Scottish average. Approximately half of those living in Lochee and East End live in the 15% most deprived areas of Scotland.

There is a higher percentage of people in Dundee living with one or more health condition than in Scotland as a whole. East End and Lochee are the LCPP areas with the highest levels of deprivation and they also have the highest rates of people experiencing multiple health conditions compared with the more affluent parts of Dundee and Scotland.

Dundee has the second lowest life expectancy in Scotland and although this has increased over the last ten years, it remains low in comparison to the rest of Scotland. In Dundee life expectancy is 77.6 years, whereas it is 79.1 years in Scotland as a whole. Life expectancy varies substantially by deprivation level and the occurrence of health conditions and disability.

The Dundee Citizen's Survey, which was last reported in 2016 established the public's views on general and specific aspects of life in Dundee, including; the home, neighbourhood, health, education, employment, community safety, financial issues, public services and satisfaction with the local authority. The analysis is separated into Community Regeneration Areas (CRA) (areas experiencing significant levels of deprivation) and non-Community Regeneration Areas (non-CRAs).

The survey asked respondents to rate their general health on a 5 point scale from very good to very poor. 61% of respondents from CRAs reported that their general health was very good, compared with 59% in non CRAs. Participants who lived in Fintry, Whitfield and Mill O Mains were the most likely to rate their health as 'very good' (68%) while participants who lived in Mid Craigie, Linlathen and Douglas were least likely (44%).



What we have achieved to deliver this outcome

- Keep Well uses anticipatory health checks to engage with targeted populations who are at higher risk of health inequalities. The targeted populations include, those aged between 40 and 64 who live within defined postcode areas, (i.e. those who live in the 20% most deprived postcodes in the city), and those who fall within a number of vulnerable groups including carers, those who have committed offences, the ethnic minority population, those who are homeless, gypsy travellers, and those who have a substance misuse issue (drugs or alcohol) as well as those serving a community based court order. In 2016-17 Keep Well delivered 2,071 health checks, of which 1,059 were delivered in communities to targeted vulnerable groups. A number of partners, including GPs, Community Justice Social Work and the third sector, are involved in engaging individuals from these key groups. Individuals are supported with a wide range of health, lifestyle and social issues after the initial health check. Evaluation demonstrates that the range of medical interventions, ongoing support and lifestyle changes delivered through Keep Well are having a positive impact on individuals. Keep Well may be contributing to considerable reductions in admissions to hospital and occupied bed days where Coronary Heart Disease was identified as the main diagnosis.

KEEP WELL

Engagement

Mr V attended a drop in cafe after seeing it advertised in his local library. He was a 44 year old man who was recently bereaved and had multiple health issues. The Keep Well Senior Nurse engaged with Mr V over several weeks, identifying what his priorities were for the coming months. Mr V was then referred to the Keep Well Associate Practitioner which allowed more time to be spent with Mr V to work through several of his problems. At this early stage in his journey, Mr V had been requesting GP appointments weekly and also calling NHS 24 at least four times weekly due to anxiety.

Keep Well health check findings

Mr V was very anxious about his health and reported that he had no faith in his GP as he felt that the GP just didn't care about how he was feeling. Mr V's blood pressure was slightly elevated on the few occasions it was checked and all his blood results were within normal ranges. The Keep Well Nurse was able to feed back the healthy blood results to Mr V which reassured him somewhat about his physical health.

Follow up care

The Associate Practitioner and Mr V worked out a plan for the next three months. She established what Mr V's interests were and found different organisations where these interests could be met. Mr V had a very poor diet and it was established that his cooker had broken the previous year and he had not replaced it. The Associate Practitioner was able to contact Transform and have a new cooker delivered within a week which encouraged Mr V to begin to eat a healthier diet once more. Mr V had also been sanctioned by Jobcentre Plus and did not know how to resolve this therefore the Associate Practitioner was able to assist Mr V with this. The CONNECT team also attended the drop in cafe and Mr V was able to seek support during these weekly drop in sessions.

Key Keep Well successes

Mr V had severe and enduring mental health problems and there was never going to be a 'quick fix' in this case. However, by providing intense support over several weeks and addressing many of the other problems which were affecting Mr V's life, this resulted in him attending his GP less frequently and also his contact with NHS 24 was decreased. Mr V has begun attending classes by himself and has started volunteering monthly at the drop in cafe.

- Dundee Healthy Living Initiative (DHLI) works with individuals living in deprived areas of the city to identify issues impacting on their health and supports communities to develop and implement interventions to address these. Examples of activities include accredited cooking skills and health issues in the community courses, volunteer led walking programme and community based health checks and relaxation sessions. In addition the DHLI supports local groups to become formally constituted and gain independent funding for activities.
- Social prescribing (delivered through the Sources of Support service) is one means of supporting self-management. It is an approach (or range of approaches) for connecting people with non-medical sources of support or resources within the community which are likely to help with difficulties they are experiencing (Friedli et al 2007). Three social prescribing link workers operate across four GP practices in Dundee and the majority of those supported live in the most deprived areas of the city. 141 people accessed Sources of Support during the last 12 months, of whom 2% were transgender, 49% were female and 49% were male. Of these 141 people, 89% had their goals fully or partially met, including support to access a range of services, which for many addressed mental health, housing and financial issues. The majority of people who accessed the service were aged 20 to 59 years old, unemployed / not fit to work, receiving welfare benefits and had mental and physical health issues. The Dundee Volunteer Centre was commissioned to develop and manage a volunteer component to the Sources of Support service to provide supported visits for patients. Also, a fast track system for referral to the Connect Team for money and benefits advice was piloted in one GP practice. More recently, additional funding was allocated to test a locality link worker model and to expand the range of referral routes into link worker support. This model is being tested in the Lochee LCPP initially.

SOCIAL PRESCRIBING SOURCES OF SUPPORT

Mrs S is married with a young family and had a career in teaching. She had what she describes as a breakdown resulting in being signed off long term from work. Mrs S was worried that she might lose her job and needed support to access benefits. She has a history of depression and anxiety stemming from childhood trauma, and was using alcohol to deal with this.

Mrs S received the following support from her link worker

- Support to access Tayside Council for Alcohol and hospital detox programme
- Referred to Connect and Shelter for money and benefits advice
- Referred to psychological therapies to help her deal with issues from her past
- Referred to Scottish Association for Mental Health Chrysalis project and Active for Life exercise on referral scheme
- Introduced to volunteer development worker

Mrs S engaged successfully with alcohol services. She feels unable to work at the moment and is in receipt of benefits. She has attended a range of community activities to provide structure, routine and social contact. Mrs S feels that engaging with the Sources of Support Link Worker gave her hope and saved her life. Mrs S is interested in a career change and hopes to become involved in volunteering. She still suffers high levels of distress and is on the waiting list for psychological therapies.

- Equally Well is a collaboration between the Partnership and Dundee City Council and aims to support frontline staff to adopt health inequalities and poverty sensitive practice. It offers a range of training sessions including Mind yer Heid Plus which promotes positive interactions with people at risk of poor mental well-being and health inequalities, and Poverty Sensitive Practice which focuses on reducing stigma for people living on a low income. Both sessions encourage staff to use a social prescribing approach to support people to access services and activities that can help tackle the root causes of their life circumstances and health status. Staff can also do this by accessing the My Wellbeing web pages on Dundee City Council's website.

- The Dundee Community Planning Partnership Prevention Framework includes a useful toolkit for staff to assess the extent to which they are using social prescribing as a route to improving service user outcomes and help them consider what more they could be doing to provide early interventions for those most at risk. A half day training session supports frontline staff to use the prevention toolkit as a practical aid to identify how health inequalities and deprivation may affect the people they are working with. The toolkit also supports staff to explore to what extent they are adopting preventative approaches already and recognise how they may be able to build on these. In the last three months of the year 135 participants undertook the training.

- The DD4 network is a multi-agency approach to supporting those who are furthest from work. An employability services review found that people wanted employability services and supports to be available and accessible in their local area. Following on from this the DD4 network has been established in Brooksbank and the Crescent, which are based in areas of multiple deprivation (the East End and North East respectively), for a pilot period of one year. In the last 12 months, 100 people have registered for support through the DD4 pilot. Of this group, 32% stated that health issues are their main barrier to gaining employment. Supports provided have included benefits, housing and health advice, food parcels, help to produce CVs and undertake

job searches, job matching and access to volunteering opportunities. A number of service users have gained employment or have gone on to access further training, education and volunteering.

- The Scottish Government's National Strategy for Community Justice states that

" Those who have been in the criminal justice system often experience higher rates of premature death, related to violence, accidents and suicide, and are more likely to face problems with mental health and substance misuse."

In response to the disproportionate incidence of negative health outcomes for people involved in criminal justice, a number of health staff have been co-located within the Dundee Community Justice Service (CJS) centre. This includes nurses who offer monitoring and treatment as part of statutory orders, such ad Drug Treatment and Testing Orders (DTTO) and nurses who offer a voluntary Keep Well service to male and female service users of CJS. As well as co-located nursing staff, Dundee CJS and the Partnership have strong established links to quickly refer CJS service users to community based services, such as dentistry and learning disability support.

National Outcome 6: Carers are Supported

People who provide unpaid care are supported to look after their own health and wellbeing, and to reduce any negative impact on their caring role on their own health and wellbeing.

Outcome 6 links to the following Partnership strategic priority:

- Quality of Life (Strategic Priority 4)

There is a significant level of unpaid care and support provided by family and friends for many people in Dundee who have health conditions, are frail due to older age or have other health and social care needs. The provision of such unpaid care can avoid the need for more formal interventions and is frequently delivered as part of packages of care and support, alongside services provided by the Partnership. This is particularly the case for those with very high level care and support needs who are being supported in their own homes or other community settings. The benefits of unpaid care for those who receive it are not just financial. For most people the support provided by families and friends meets many social and emotional needs and is the preferred option when considering alternatives to formal services.

How well we have performed

According to the 2011 census there were 13,072 unpaid carers in Dundee providing on average an estimated 360,000 hours of care each week. If such unpaid care had not been available those requiring support at home may have needed to seek more formal social care support. The cost of Dundee's home care service is approximately £15 per hour. Of the total number of carers in Dundee at the time of the 2011 Census, there were 3,909 who were providing more than 50 hours of care each week. Those who were receiving this level of care from family or friends may otherwise have been unable to continue to live in their own homes, and may have had to move to housing with care or to residential or nursing care, depending on the nature and level of their individual care and support needs. The costs of such provision are high and can require a significant financial contribution from the individual involved and/or their family, depending on individual circumstances and means and the type of resource identified. With the rising number of older people, it is anticipated that the number of unpaid carers in Dundee will grow and we know that there will be a need to 'scale up' the level of carer support accordingly.

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over, who provide unpaid care, if they agreed with the following statement:

"I feel supported to continue caring".

44% of Dundee respondents who provided unpaid care felt supported to continue in their caring role. This is slightly higher than the 41% of carers from Scotland as a whole who felt supported to continue in their caring role. There was variation in responses across GP practices ranging from 21% to 71.4%.

What we have achieved to deliver this outcome

- Carers and representatives from the Dundee Carers Partnership ran a successful city-wide advertising and media campaign culminating in a large scale city centre event in June 2016. The "What does a Carer look like?" campaign message highlighted that one eighth of people in Scotland provide unpaid care, with three-fifths of the population taking on a caring role at some point in their lives. The campaign ran for two months from early April 2016 and celebrated Dundee Carers Week by launching a free Carers Tea Party. Although this was a time limited campaign there are plans to further develop this initiative. As part of the campaign a website (http://carersofdundee.org/) and social media pages have been set up.

Carers Tea Party 2016

- Created as a result of consultation on the Dundee Mental Health Strategy, **"It's all about the break"** is a pilot scheme to support people who use mental health services and their unpaid carers to access new types of short breaks suited to their needs. The scheme is designed to lead to more opportunities for unpaid carers to enjoy a life outside their caring role by either providing them with a short break or giving them time to themselves so that they feel more supported in their caring role.

"It has been a privilege for us to see such a strong and creative partnership emerge from this process. It's great to know that a small investment of pilot funding will ultimately result in new short break opportunities for carers in Dundee and those they care for. We know that the right short break at the right time can make all the difference to the caring relationship, and this new project will be a life-line to many local people."

(Don Williamson, Chief Executive, Shared Care Scotland)

The co-production approach which has supported the development of the project has been described by evaluators as:

" an example of best practice, ensuring the meaningful engagement and involvement of carers, cared for people and service users in the design of the service."

Learning from the initial stages of the project will be used to expand its outcomes and eligibility criteria during 2017-18. The project will continue to offer a broad range of flexible and individualised breaks, consider putting in place supports to mitigate against barriers to taking a break, such as emotional, practical and medical support and enable conversations to take place with grant recipients to help them design or choose their break.

- The Dundee Carers Centre Short Breaks Service has revised its approach to service delivery and this is showing early signs of success. Despite an increase in referrals the waiting list is short and we have developed a better understanding of what is important to unpaid carers. A number of short breaks have been donated by local businesses including overnight hotel stays, restaurant meals, gym membership and therapy vouchers.
  Over the last 12 months, 347 people benefited from a short break and 241 short breaks were taken. Some of the people (117) who benefited were asked if the short break helped them to achieve outcomes which were important to them. Everyone who responded reported that the short break supported them to maintain or improved their health, their financial situation, their life balance and their emotional wellbeing.

SHORT BREAK BROKERAGE

Mrs B was referred to the Short Breaks Service by a member of the Dundee Carers Centre Adult Support Team as someone who would benefit from a break from their caring role. In the past Mrs B would have simply been referred directly to a specific service such as On the Spot.

Mrs B's daughter has physical and mental health problems. Mrs B also has her own health problems. Due to her daughter's varying needs she cannot make plans as she doesn't know when her daughter will need her support.

A support broker arranged to meet with Mrs B to chat about how to help her to have breaks from her caring role.

- It was discovered that Mrs B lacked confidence in her literacy skills and this was impacting on her overall wellbeing and ability to cope as a carer. The support broker was able to identify suitable literacy classes and helped Mrs B access these at no cost.
- It was also identified during the brokerage process that Mrs B really enjoys cooking and did not have a wide social circle. The broker was able to identify weekly cookery classes which are social as well as instructive for Mrs B to join and she was able to pay the small cost of this herself.
- Mrs B and her broker also applied for a grant of £200 which would cover 3 massage therapies and 3 trips to the theatre which could be used at short notice to suit Mrs B's caring role.

The brokerage process also identified a number of ways that Dundee Carers Centre could help this carer and provide long term sustainable outcomes to enable her to combine the role of carer with social, leisure and learning opportunities.

- To enable health and wellbeing checks to be promoted and embedded for carers over the age of 18 years, time was dedicated over the last 12 months to raise awareness of carers' health checks and the services offered by the Keep Well team. The Keep Well team have also attended events to engage with carers directly and ensured that information about carers' health checks is available on local intranet and internet websites. In particular, partnership working between Keep Well and Dundee Carers Centre has been enhanced. Workers at the centre are encouraging unpaid carers to attend for a health check appointment and dedicated health check sessions are available at the centre. Community based venues and appointments at alternative times are also now available. Many carers have been supported beyond the initial health check by the Keep Well Associate Practitioner. The Associate Practitioner has supported engagement with other services including community based activities aimed at having a positive influence on their physical health and/or mental wellbeing. Carer feedback is very positive of the added value of this support. Working in an integrated way with carers and agencies supporting them over the last year is beginning to have a positive impact on the number of referrals received.
- During the last year the Carers (Scotland) Act 2016 was passed by the Scottish Parliament. Within Dundee we have embraced this development as an opportunity to build on, strengthen and further develop local systems of support for carers. The Partnership has been working over the last year to prepare for the Act coming into force in 2018, working to co-produce our approaches with carers wherever possible. Some key activities undertaken during the year were:
  - The provision of manual handling training for carers to reduce their risk of injury as a result of caring.
  - The provision of learning and development activities for our workforce to enhance their understanding of carers' needs and the Act.
  - Testing new models for supporting carers within the service delivery area in which they live with the Carers Centre.
- In the last 12 months NHS Tayside and Dundee City Council have achieved Carer Positive status. This is an award presented by Carers Scotland to employers in Scotland who have a work environment where carers are valued and supported. There are three awards levels: Engaged, Established and Exemplary. Dundee City Council was recently awarded the first level "Engaged" Award and now intends to work towards meeting the criteria for the second and third levels of the award which will involve identifying employees who have caring responsibilities and the establishment of a Carers Support Network for Council employees. NHS Tayside has also received an "Engaged" Award. The certificate acknowledges the work NHS Tayside has done to support staff through the launch of a Carers Information Pack and the role of NHS Tayside's Carers Support Officer.

Dundee City Council staff - Carer Positive Award

National Outcome 7: People are Safe

People who use health and social care services are safe from harm

National Outcome 7 links to all the Partnership strategic priorities:

The protection of people of all ages is one of the most important responsibilities which all agencies in Dundee share. The Partnership is concerned with ensuring that health and social care services are of the highest quality and put the safety of people first, as well as ensuring that Dundee citizens are protected from harm from within the communities in which they live.

Clinical, care and professional governance is the system by which the Partnership is accountable for ensuring the safety and quality of health and social care services and for creating appropriate conditions within which the highest standards of service can be promoted and sustained. Our clinical, care and professional governance includes a focus on:

- information governance
- professional regulation and workforce development
- patient / service user / carer and staff safety
- patient / service user / carer and staff experience
- quality and effectiveness of care
- promotion of equality and social justice

There are well-established partnerships in Dundee that plan and co-ordinate a range of multi-agency supports and interventions to protect people of all ages. The Health and Social Care Partnership is an active leader and contributor within these Protecting People Partnerships.

- Adult support and protection
- Child protection
- Violence against women
- Multi-Agency Public Protection Arrangements (MAPPA) for high risk offenders who present a risk of harm to the public
- The prevention/promotion of a recovery focused response to drug and alcohol misuse
- Suicide prevention
- Humanitarian protection

Within the Dundee Community Planning Partnership there are strong links between the Protecting People Partnerships and the Community Safety Partnership. The Community Safety Partnership has a wider role and responsibility for promoting public safety and co-ordinating multi-agency activity at a community level and this includes working closely with the Dundee Community Justice Partnership.

How well we are performing

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over, who are supported at home, if they agreed with the following statement:

"I felt safe"

85% of Dundee respondents who were supported at home reported that they felt safe. This is slightly higher than the 84% of respondents across Scotland as a whole. There was variation in responses across general practices ranging from 60% to 100%.

In 2016-17 the Partnership actively participated in a range of responses to protect vulnerable people from harm. The Partnership has a lead role in the protection of adults at risk of harm, co-ordinating and contributing to adult support and protection interventions. In 2016-17 the total number of referrals to the Partnership for adults at risk decreased to 914 (from 1,246 in 2015-16). Whilst Police Scotland continued to be the biggest referrer of adults at risk, the number of referrals made by them reduced considerably from 1,074 in 2015-16 to 741 in 2016-17. These changes demonstrate the impact of focused work with referring agencies to enhance the quality of early identification and assessment of adults at risk.

The Partnership developed an Early Screening Group (ESG) to provide a multi-agency forum in which concerns about adults who are vulnerable and potentially at risk can be considered. In the last 12 months 500 referrals were discussed at the ESG providing opportunities for early intervention and prevention and contributing to the overall decrease in the number of adult support and protection referrals received. The majority of referrals made to the ESG were in relation to concerns about adults with mental health and substance misuse issues that have resulted in self-harm, suicidal ideation, suicide attempts or welfare concerns.

The Partnership contributed to the Multi-Agency Risk Assessment Conference (MARAC) process for high risk victims of domestic abuse. This process assists agencies to share information about the risk people experiencing domestic abuse face and to plan actions to help to reduce this risk and keep victims, and their wider family and friends, safe from harm. In 2016-17 there were 174 women discussed at MARAC (an increase of 14% from 2015-16). Over the last 12 months we have worked with partners to increase the number of women referred to MARAC by agencies other than Police Scotland. In the last year 76% of all MARAC referrals were made by non-police agencies (an increase of 25% from 2015-16). This is important as it helps to identify those most at risk and intervene to protect them at the earliest possible stage. A review of the MARAC process is in progress in order to; improve the way it operates, increase the safety of high risk victims of domestic abuse and extend the support available.

Dundee City Council's Citizen Survey, conducted in December 2016, asked a sample of Dundee citizens aged 16 and over their opinions on statements regarding vulnerable adults. 83% of participants said they would know who to contact if they had concerns that a vulnerable adult was at risk of being abused, which is a significant increase since the 2015 results (57%).

What we have achieved to deliver this outcome

- For the past two years the Making Recovery Real (MRR) partnership has been listening to people with mental health challenges and practitioners with the intention of transforming mental health supports and services. They have told us they want to see more roles for people with lived experience through peer support, peer education and learning. The response from people with lived experience has been such that we now have seven different groups locally (involving about 40 volunteers) and have employed a Peer Support Co-ordinator to co-ordinate this work. The plan is that these groups will generate 'stories' which will help improve services. MRR has provided an opportunity to open up wide ranging discussions about recovery and what it means for people and services. It has provided a platform for discussions, a safe space to bring together professionals and members of the community on equal terms, and a mandate for change. It has provided an opportunity to have a meaningful impact on the local agenda based on that discussion and given partners hope that recovery focused practice could finally be implemented.
- To ensure that Dundee City Council and Dundee Health and Social Care Partnership can effectively meet its statutory obligations a review of the Mental Health Officer (MHO) Service was undertaken.

The review identified 18 priorities around the themes of pursuing interventions with the minimal restriction on people's rights and freedoms wherever possible, service responsiveness, workforce development and capacity and quality assurance. A three year MHO Service Action Plan was developed and implemented over the last 12 months to maintain a focus on achieving the 18 priorities, National Standards for Mental Health Officers and Clinical, Care and Professional Governance requirements. Key achievements through 2016 – 2017 have been:

  - Last year the MHO Team members approached MRR with a view to exploring how they could link in with the initiative to help them share their discussions on possible improvements with people who have experience of using the service, about areas for improvement and how best improvements can be achieved. An event was held where people with lived experience of mental health challenges and of using the MHO services and MHO team members identified key areas for improvement and how they would work together to develop and test new ways of working. It was agreed this should not be a one-off discussion but a dialogue where people with lived experience can be engaged in on-going discussions about areas for improvement and how best improvements can be achieved.

  - Development of procedures relating to Adults with Incapacity and Mental Health Acts to support consistency of practice relating to these areas across the Partnership. It is planned to implement these procedures during 2017-2018.

- An ongoing improvement approach has been adopted, so that the Early Screening Group for concerns regarding adults at risk, supports a shift towards prevention of harm. As part of this an evaluation was carried out and action plan implemented to address areas of improvement identified. It is planned to implement a new approach to early screening during 2017-2018.

- We continue to implement the Safe and Together approach for working with families affected by domestic abuse. Safe and Together is an approach that has been designed to; keep families together, support the non-offending parent to look after their children and to address the behaviour of the perpetrators of domestic abuse. 41 front-line staff from a range of agencies in Dundee attended the four day training to become Safe and Together practitioners.

- We have appointed the Domestic Abuse Resource Worker to work with perpetrators of domestic abuse in a preventative approach. The focus is on perpetrators who have not yet been through the court system but would benefit from behaviour-change intervention to prevent the escalation of their abusive behaviour. The resource worker also provides advice and support to other staff working with families affected by domestic abuse.

- Over the last year the Dundee Violence Against Women Partnership (VAWP) has embarked on developing a co-ordinated response to commercial sexual exploitation and prostitution with a focus on a Routes Out of Prostitution approach and tackling the demand for prostitution. This included producing a revised statement on the approach to tackling position. The Inside Outside Exhibition was launched to raise awareness about the experiences of the women involved in prostitution. In a joint project with Dundee University the VAWP is conducting dedicated research which focuses on the experiences and needs of the women who are involved in prostitution and looking to identify what responses would be most effective to support the women to exit prostitution. Services will be restructured in line with the outcomes of the research project.

- The VAWP is focusing on raising awareness around the prevention of Female Genital Mutilation (FGM). This multi-agency work is being led by the Dundee International Women's Centre and focuses on the delivery of awareness sessions to relevant front-line staff.

BEING AND FEELING SAFE

Ms M lives alone in a first floor flat in Dundee. She has a diagnosis of dementia and has been living independently at home with support from staff in the Community Mental Health Team for Older People. Unfortunately, she has been struggling to light her gas cooker properly and her family have noticed a smell of gas in her home. A worker from the Community Mental Health Team discussed this with Ms M and her family. They agreed to a referral to her energy provider for a safety on/off valve for the cooker. This meant that the gas flow to the cooker could be turned off until a family member could be present to support Ms M to use the cooker safely. Ms M has been able to maintain her skills and independence in the kitchen and is able to continue to cook for her family.

- Starting from September 2016 the Adult Support and Protection Committee actively supported the national 'Take Five' campaign. The campaign aims to engage, empower and educate everyone on how best to protect themselves against financial fraud. It's main message is 'take five minutes - stop and think'. In Dundee, there has been ongoing work around financial harm within the multi-agency Financial Harm Group which reports to the Adult Support and Protection Committee. This group has worked closely and in partnership with the Dundee Community Safety Partnership, Trading Standards and Money Advice services to set up awareness raising events for the public, staff within services and elected members.

TAKE FIVE TO STOP FRAUD™

- Addressing the impact of drug and alcohol use on individuals, families and communities is an important area of work for the Partnership and the wider Community Planning Partnership. In 2015 the Dundee Alcohol & Drug partnership (ADP) established a network of Mutual Aid SMART Recovery groups across the city. The aim of establishing this network was to provide individuals and families affected by substance misuse the opportunity to participate and be supported by self-help groups based within LCPP areas. The groups are peer-led and firmly linked to the services that provide treatment, care and support to individuals and families. Recovery 'champions' have been specifically trained to organise and run the groups. This network offers the support individuals need in order to sustain their recovery from substance misuse, prevent relapse and receive support from their peers and communities. To date in Dundee there are:
  - 13 sites that are licensed to deliver SMART Recovery Groups and 9 local organisations are registered to deliver groups
  - 21 staff members and 7 volunteers who have been trained as Recovery 'Champions'
  - 71 individuals in recovery who regularly attend meetings across the city.

"SMART recovery is my weekly therapy to help me maintain my sobriety, although I only attend once a week I use the tools I've been shown whenever I need to".

"Coming to the SMART group really helps me, sometimes I feel I am so alone and cannot cope, this is when I normally relapse but having the group support and the tools helps me deal with situations before they stress me out too much, sometimes this means walking away and I now know that that is ok".

"…coming to group has changed my life; I'm now doing things for me. Living my life". "I feel stronger".

- Since 2014, three locality-based hubs have been developed to provide individuals and families affected by substance misuse with care and support. These hubs include; the Albert Street Hub, the Cairn Centre Hub and the Lochee Community Hub. The hub model of working ensures that local people affected by substance misuse and their families can have easier access to the services they need. The hub model means that people do not need to travel to the city centre to access treatment and support. These services are confidential, include specialist treatment services and a range of other supports people require to aid their recovery. Information from the last 12 months shows that people accessing the hubs have been supported to access dental, harm reduction, optician and welfare rights services, as well as foodbanks. The Dundee Alcohol and Drug Partnership is currently extending the Take-Home Naloxon programme to increase the safety of individuals at risk of overdosing through their drug use. This programme includes providing training to friends, families and staff to administer Naloxon in the event of an overdose and by doing so save a person's life
- Suicide Prevention is another area of focused work. Over the past year 112 individuals have been trained in Applied Suicide Intervention Skills (ASIST). Various activities were convened throughout suicide prevention week culminating in an event staged in the City Square in September which directly engaged with over 300 people.
- We developed a collaborative approach to No Recourse to Public Funds with partners across Dundee City Council, third sector and NHS Tayside to provide fair and consistent advice and assistance to those facing destitution. It is planned to fully implement this approach during 2017-2018. As a partnership with Dundee City Council, NHS Tayside and third sector we have supported families seeking refuge in Dundee through the Vulnerable Persons Relocation Scheme. Feedback from families and partners has been extremely positive.
- Through the Partnership's Integrated Care Fund, the Safe Zone Bus has continued to operate during the last year. This is a partnership initiative which aims to provide a place of safety that meets the needs of any person whose wellbeing is threatened by their inability to get home safely due to alcohol misuse, emotional distress or any other risk of vulnerability. The Safe Zone Bus is active every Friday and Saturday night in the city centre and is staffed by support workers and volunteers from Tayside Council on Alcohol and the British Red Cross. Over the last 12 months the Bus has provided people with advice and information, emotional support, first aid, warmth and facilitated safe contact with friends and family and / or a safe route home. A number of people benefitting from the Safe Zone Bus have been diverted from Accident and Emergency services and police services.
- We have worked with our partners in the Community Planning Partnership, Children and Families Executive Board to support the development of the Tayside Plan for Children, Young People and Families 2017-2020. This sets out the Partnership's commitment to working collaboratively with agencies that provide services to children, young people and families in areas such as parenting support, mental health, healthy weight, substance misuse, domestic abuse, support for young adults leaving the care system, support for young carers and support for young people with complex and enduring needs who are transitioning into adulthood.
- The Partnership has contributed to a strategic and operational multi-agency partnership approach to developing and implementing the Vulnerable Persons Relocation Scheme in Dundee. The outcomes have been positive to date with families stating that they feel more confident, empowered and less isolated. All families are accessing healthcare appropriate to their needs and are learning English so that they can access employment and further education.

'Dundee is great. I like to cook. I can find the right ingredients here for Arabic food. School is good for my children. Hospitals and doctors are good.'

'I liked Scotland even before I came here, but now I am here, I feel very welcome and happy..."

- The Partnership's Clinical, Care and Risk Management Forum provides opportunities for services to share and learn from each other. For example, during the last year mental health services have taken steps to reduce prescribing errors and changes have been made to enhance the Partnership's informed consent policy and approach to exit surveys. The Forum has also strengthened the Partnership's approach to learning from adverse incidents; ensuring that lessons learned are shared across service areas for action and improvement. For example, following learning from a Local Adverse Event Review, all staff from both the Centre for Brain Injury Rehabilitation and the Stroke liaison Service undertook "using positive behaviour to understand and manage challenging behaviour" training during the last year. This has meant that there is now a consistent team approach to the management of challenging behaviour and an ongoing approach to up-skill new staff joining the services. In addition, the Forum has developed a programme of reporting for individual service areas that will be implemented during 2017-18.
- We developed a collaborative approach to the implementation of the Scottish Manual Handling Passport Scheme with partners across Dundee City Council, third sector and NHS Tayside to ensure that our workforce and people who use our services experience safe provision of manual handling. It is planned to fully implement this approach during 2017–2018.
- Contracts for all externally commissioned services outline the Partnership's expectation in terms of adult support and protection and child protection and are explicit in terms of health and safety and moving and handling requirements. Information on health and safety matters is shared with providers as a matter of course including medical advice alerts which are issued from the Health and Safety Officer. Clear processes are in place for reporting any issues around individual safety and there are agreed procedures in place for identifying required improvement actions.

National Outcome 8: Engaged Workforce

People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

National Outcome 8 links to the following Partnership strategic priorities:

- Person Centred Care and Support (Strategic Priority 3)
- Models of Support / Pathways of Care (Strategic Priority 7)
- Engaged Workforce (Strategic Priority 8)

An engaged workforce is crucial to the delivery of the vision and aims of the Partnership. Workforce engagement helps create an environment where the workforce feel involved in decisions, feel valued and are treated with dignity and respect. It is only through an engaged workforce that we can deliver services and supports of the highest standard possible. Our direct workforce includes staff employed by NHS Tayside and Dundee City Council. However, we view the workforce of the Partnership as wider than this, including those employed by other statutory services, the third sector, social enterprise and the private sector who work with us to improve the wellbeing of people in Dundee.

How well we are performing

Over the last year the Partnership has rolled out the NHS imatter continuous improvement model. Imatter seeks to understand individual staff experience within their teams, allowing discussion about what is good (and to be celebrated) and what is not as good and needs improvement. All staff employed by NHS Tayside and Dundee City Council who work in Partnership teams have been offered the opportunity to participate in imatter. Although the data collection for imatter took place in May 2017 it asked employees to reflect on their experience of working in the Partnership over the previous 12 months (2016-17).

The overall employee engagement index score for the Partnership was 77%, with over 1500 staff members (75% of those working within the Partnership) responding. In general scores were high, with the majority of questions indicating that we should "strive and celebrate". Four areas were identified where we need to "monitor to further improve":

- I feel senior managers responsible for the wider organisation are sufficiently visible
- I have confidence and trust in senior managers responsible for the wider organisation
- I feel involved in decisions relating to my organisation
- I am confident performance is managed well within my organisation

75% of staff members said that they would recommend their organisation as a good place to work. High scores were also achieved for the following questions:

- I am clear about my duties and responsibilities
- My line manager is sufficiently approachable
- I feel my direct line manager cares about my health and well-being
- I am treated with dignity and respect as an individual
- I would recommend my team as a good one to be part of
- My work gives me a sense of achievement

What we have achieved to deliver this outcome

- Our Communications and Engagement Group has overseen corporate communications with our workforce during the early development of the Partnership. We have used a number of methods of engagement, including "News Matters" (our widely distributed staff newsletter), direct communication via e-mail, town hall events, NHS Tayside and Dundee City Council communication routes, social media, and our local press.
- Our Locality Managers, who are responsible for managing the delivery of health and social care services across our four service delivery areas, have used a number of different methods to bring together the teams that they are responsible for supporting. This has included large scale 'town hall' style meetings, visits to individual teams and services and utilising networks such as LCPPs. These approaches have enabled Locality Managers to engage in a two-way dialogue with employees to support the establishment of new ways of working and to identify areas of improvement for the future.
- We are creating more opportunities for our workforce to be engaged with the communities in which they work. Our Health and Well Being Networks bring together our workforce within the local community planning areas they are aligned to. The Partnership continues to be represented at each LCPP providing local community representatives with the opportunity to receive up-to-date information about the work of the Partnership, to raise any areas of concern and to work together to co-produce solutions.
- Our workforce has had access to a wide range of learning and development opportunities during the last year. Some examples include:
  - Transforming Leadership for Integration Programme which supports the workforce to design, implement and evaluate actions and test of change that contribute to how we work differently in an integrated way.
  - Learning Networks focusing on the Care at Home and Residential Care Workforce are self-directed events that support the workforce to come together to explore shared challenges around integration and to explore new ways of approaching these challenges.
  - Team and workforce development events for integrated teams who wish to explore a range of themes related to developing integrated approaches to improving and changing models of care / pathways. Examples of this throughout 2016-17 include supporting the Integrated Learning Disability Service and the MacMillan Improving Cancer Journey in Dundee.
- Within our Workforce and Organisational Development Strategy (published in June 2016) we have adopted a number of guiding principles to support our workforce to deliver on the ambitions of integrated health and social care. These locally created principles sit alongside existing legislative and clinical, care and professional governance requirements. The principles include: inclusivity and equality, visible leadership, collaborative co-production and reflective practice.
- We have begun a programme of development for IJB members with a session focused on ethical standards and code of conduct. This programme will continue over 2017-18 and has been designed to enable and support IJB members to undertake their role in overseeing and scrutinising the work of the Partnership. We have also developed an integrated approach to induction for the wider Partnership workforce which will be piloted over the next year.

National Outcome 9: Resources are used Efficiently and Effectively

Best Value is delivered and scarce resources are used effectively and efficiently in the provision of health and social care services

National Outcome 9 links to the following Partnership strategic priorities:

- Building Capacity (Strategic Priority 6)
- Managing our Resources Effectively (Strategic Priority 8)

At this time of fiscal constraint demand for health and social care services is increasing and this is particularly acute due to the scale of need in Dundee. Given the high levels of deprivation and health inequalities which exist and resultant high prevalence of multiple health conditions we cannot meet the rising demand for support by simply spending more. Doing more of the same is not an option. Together with providers we need to develop new and sustainable responses to people's needs.

How well we have performed

Emergency hospital care, including readmissions to hospital where the patient had previously been discharged within the last 28 days, is one of the biggest demands on the Partnership budget. Many hospital admissions are avoidable and often people either remain in hospital after they are assessed as fit to return home or they are readmitted to hospital shortly after they were discharged. You can read more about our performance in relation to emergency admissions and readmissions under outcome two in this report. In 2016-17 26% of Dundee's health and care budget was spent on hospital stays which was the third highest in Scotland.

The National Health and Wellbeing Survey asked a sample of Dundee citizens aged 18 and over, who are supported at home, if they agreed with the following statement:

"My health and care services seemed to be well co-ordinated".

76% of Dundee respondents who were supported at home agreed that their health and care services seemed to be well co-ordinated. This is slightly higher than the 75% of respondents across Scotland as a whole who agreed with this statement. There was variation in responses across GP practices ranging from 50% to100%.

Dundee has maintained a high proportion of services graded as 'good' (4) or better in Care Inspectorate Inspections. The Partnership is the sixth best performing in Scotland in relation to this measure of the quality of services. You can read more about the quality of health and social care services in section four of this report.

What we have achieved to deliver this outcome

- Throughout the last year the Partnership has undertaken work to redesign a number of services in order to deliver better outcomes for individuals and communities, enhance the quality and safety of services and ensure best value. Examples of this include:
    - Significant shifts in the balance of care have been achieved in Medicine for the Elderly and Psychiatry of Old Age services which have resulted in the closure of one hospital ward during the last 12 months, with a further ward closure planned by the end of 2017. This has been possible as the result of the development of more robust community based services. Some examples include; the development of an acute frailty team, the completion of anticipatory care plans, and creating links between the Medicine for the Elderly and Psychiatry of Old Age Teams. The polypharmacy work stream has reduced harm, waste and variation by allocating resources in both enablement and care home services. Housing with care has been further expanded with the development of two new sites. Day services have been remodelled which has increased the number of day opportunities in the community, as opposed to within traditional day centres.
    - The provision of supported and rehabilitative transitions from the Centre for Brain Injury Rehabilitation (CBIR) into the community by the Mackinnon Centre with a view to supporting earlier discharge from CBIR. This included enhancing the skills of the workforce within the Mackinnon Respite services, redesigning the care pathway for patients receiving rehabilitation services at the Royal Victoria Hospital acquired brain injury service and exploring better use of Mackinnon service resources to support individuals in the latter stages of their rehabilitation pathway.
    - Remodelling of the Chronic Obstructive Pulmonary Disease (COPD)Discharge Service to support more adults discharged from hospital. Over the last 12 months 496 people were supported. 80% of people were seen within five days of discharge from hospital and 83% of people were seen within four days of referral to the COPD Discharge Service. 65% of people received additional support to meet their clinical needs and data suggests that there is a reduction in re-admission rates (related to respiratory infection). In addition, Healthcare Support Workers were recruited to create increased capacity to support people with more complex health and social care needs, including people who have frequent readmissions.

COPD DISCHARGE SERVICE

Mr F was well known to the practice COPD nurse, however following multiple admissions he was referred to the COPD specialist nurse team to be placed on the housebound caseload. Mr F is an 81 year old man with COPD, low mood, high anxiety, who lives with his wife and there is no outside help and no family support.

From the first visit in December 2016 it was clear Mr F was not coping with his breathlessness and did not acknowledge he had a high anxiety level. He only felt safe when he was in Ninewells and surrounded by medical staff as he felt he was going to die. He had nine admissions to hospital and some failed discharges meaning that on average he was in Ninewells about once a month over the last 12 months.

Mr F's care was discussed, with an aim to setting achievable goals to help him cope with his illness and symptoms. His wife was involved in the discussion. The outcome of the first visit was to organise a nebulizer, home pulmonary rehabilitation programme and Roxburghe daycare. The team also agreed weekly visits from a COPD support worker for three weeks and from a specialist nurse in the fourth week.

Medication was added for use when Mr F felt his anxiety level was spiralling and he was unable to reduce his symptoms with relaxation and use of his nebulizer. He now mainly uses this medication twice a day but can use more often if required. Self-management plan discussions around recognising deteriorating symptoms, and when to commence rescue medications, was addressed and a rescue pack of antibiotics and Prednisalone was arranged for a home supply and a weekly dispenser for all other medications was requested from the practice pharmacist.

Since December Mr F has been in hospital once following a direct admission from Roxburghe daycare when he became unwell and was in hospital for one week. Since then Mr F has remained at home with no further admissions due to regular visits, sometimes twice a week, by the support worker. Mrs F calls when concerned about her husband and he is visited on the day, if at all possible, and admissions are avoided with this support.

Although this approach can be time consuming the additional capacity the support workers provide to the team have achieved an improved quality of life for Mr F, and his wife, and also prevented further admissions.

- A key factor in the effective and efficient delivery of health and social care is ensuring support is provided when it is needed and capitalises on opportunities when those who can be harder to engage are engaged with other partner services. For example, service users working with Community Justice , particularly on Community based orders, will be meeting regularly with staff and exploring what steps can be taken to achieve a reduction in reoffending through improving positive life choices. To build on a period of reflection, health staff are co-located within the Community Justice Service (CJS) centre and can be called upon to support health interventions, as and when needed. The Scottish Government's National Strategy for Community Justice' states that

" Every contact in the community justice pathway should be considered a health improvement opportunity."

Ensuring that workers from different disciplines (including CJS and the Partnership) communicate effectively and work together closely can help improve the health and wellbeing of service users, at critical moments it can also save lives as the following example illustrates :

CO-ORDINATED CARE

Ms C was involved with CJS through a Community Payback Order (CPO) with a Drug Treatment Requirement. The Drug Treatment nurse became concerned that Ms C appeared more depressed than ususal. A joint appointment was arranged with the supervising Social Worker, where Ms C assured staff she had no intention of harming herself. A further triangulation of information came when the TCA (Tayside Council for Alcohol) Mentor who worked with Ms C as part of the CPO, informed the nurse and social worker that another service user had spoken of Ms C expressing suicidal ideation. The Social Worker, as the co-ordinator of partner information, decided the concern was high enough to contact Police Scotland and request a welfare visit. When the Police called to Ms C's flat they found she was in the process of taking an overdose and the Police were able to ensure Ms C received emergency medical treatment and follow up at Ninewells. Workers may sometimes fear that service users will not welcome the Police being called but after Ms C recovered, she thanked the workers for their persistent concern and prompt action.

- The IJB has continued to demonstrate its commitment to securing best value across the Partnership through the development of their Transformation Programme and the establishment of a Performance and Audit Committee. The remit of the Performance and Audit Committee includes acting as a focus for Best Value and performance initiatives. The Performance and Audit Committee also considers reports from scrutiny bodies such as the Care Inspectorate and the Mental Welfare Commission in relation to the performance of health and social care services. During 2016-17, the IJB and Performance and Audit Committee have been presented with a wide range of reports and proposals which outline how resources have been and can be used more efficiently and effectively to achieve better outcomes for individuals. These include a report on Medicine for the Elderly Services which set out plans to reduce in-patient beds at Royal Victoria Hospital while reinvesting in more community and home based care services and a report on Discharge Management (from Hospital) Improvement Plans.
- In the last year the Partnership has developed a Transformation Programme which took into consideration additional investment from the Scottish Government. In order to achieve a balanced budget a range of activity to remodel services to achieve efficiency savings in 2016-17 and beyond has been undertaken. A key element of the Transformation Programme has been to use the full range of resources available to the Partnership flexibly, for example by carrying forward unspent resources to continue to test new models of care that deliver better outcomes for individuals.
- Within the Partnership there are a range of Strategic Planning Groups who are responsible for overseeing the planning and commissioning of services for specific populations and areas of service, such as mental health, learning disabilities, carers and substance misuse. Over the course of the last year these groups have been developing strategic commissioning statements for their areas of responsibility; including setting out how the Partnership intends to invest and disinvest in particular services over the long-term to meet its strategic objectives and improve outcomes for individuals and communities. You can see an example of one of these strategic commissioning statements on our website.
- In the last year we have published 'Shaping the Adult Health and Social Care Market in Dundee 2017 – 2021'. Our first market facilitation strategy is the start of a dialogue between the Partnership, service providers, service users, carers and other stakeholders about the future shape of our local social care market and how we can collectively ensure this is responsive to the changing needs and aspirations of Dundee's citizens. We currently make an annual investment of £249 million in health and social care services and need to make sure people can choose from a variety of providers and a range of support options. They must also understand what support is available and be able to make informed choices by having easy access to information about the quality, flexibility, safety and cost of services. As we move into 2017-18 we will implement the strategy to support us to develop services that are fit for the future.

THE QUALITY OF OUR SERVICES

4.0

In 2016-17 there were 141 services for adults registered with the Care Inspectorate in Dundee. This includes services directly provided by the Partnership, services commissioned by the Partnership from third sector and independent providers and services operating independently of the Partnership. Of these services, 110 were inspected during the year, of which 28 were combined inspections, where both the Housing Support and Support Services were inspected together.

33 care homes were inspected and of these inspections 6 services received requirement(s), 1 received an enforcement notice and 10 had complaint(s) upheld or partially upheld.

75 housing support or support services were inspected and during these inspections 8 services received requirement(s) and 6 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

2 nurse agencies and 1adult placement service was inspected. None of these services had any complaints upheld or partially upheld, enforcements or requirements.

This means that of the 110 services that were inspected during the last 12 months 87% received no requirements for improvement. The level of complaints upheld or partially upheld is similar to that of other Partnerships within our 'family group'.

A fuller list of the requirements made is available in Appendix 3.

Of the 18 services directly provided by the Partnership that were subject to inspection by the Care Inspectorate over the last year 89% received grades of 'very good' or 'excellent'. Further information about these inspections is available in Appendix 3. Whilst over the last year the quality of services directly delivered by the Partnership has in the vast majority of cases been very good we recognise the need to continuously maintain and further improve the quality of the services we deliver and to address any aspects of quality that fall below this standard.

In May 2016 Weavers Burn, a service consisting of 14 tenancies for people with a learning disability and / or autism who have complex needs which is directly provide by the Partnership, was inspected by the Care Inspectorate and received gradings of 'weak' and 'adequate'. A total of five requirements and five recommendations were made by the Care Inspectorate which the Partnership responded to with an action plan submitted to the Care Inspectorate. Over the last year the implementation of this action plan has resulted in an improvement in positive outcomes for people supported at Weavers Burn. There has been a reduction in challenging incidents, increased staff knowledge, skill, motivation and confidence in responding to perceived challenging behaviour and positive feedback from relatives of people using the service. Feedback from the Care Inspectorate also indicates that they view improvements in the service as having progressed well since inspection.

Key functions or services provided or commissioned by the Partnership were also inspected by Audit Scotland, Healthcare Inspection Scotland and Mental Welfare Commission. Requirements and recommendations are detailed in Appendix 3.

5.0 LOOKING TO THE FUTURE

Looking forward to 2017-18 we will continue to work towards the delivery of our strategic priorities, with a particular focus on:

- Strengthening our pathways, such as the falls pathway, to ensure that people receive support at the right place and time.
- Developing a better understanding of reasons for hospital readmissions within 28 days, and identifying appropriate supports to enable people to remain at home safely.
- Further developing health and social care support at home to enable more people to receive health support out with hospital.
- Further developing the market to increase choice of support which enables individuals to make the best use of Self Directed Support.
- Improving outcomes for individuals in communities by reducing inequalities and increasing healthy life expectancy.
- Improving the proportion of carers who feel supported to continue caring by implementing the requirements of the Carers Act and further developing the range of supports for carers.
- Developing service delivery area plans with local communities which reflect their priorities for health and social care over the next two years.
- Through our Transformation Programme, continuing to consider the opportunities to remodel services to ensure the best use is made of scarce resources in line with the Partnership's Strategic Priorities.
- Improving access to mental health and wellbeing support and improving pathways between community, primary and acute services for people who face mental health challenges.
- Strengthening the range of joint work with services supporting children and families to ensure a holistic, integrated response to issues such as substance misuse, domestic abuse, substance misuse, healthy weight and to transitions between children's and adult's services.

The Dundee Health and Social Care Partnership is committed to continuous improvement at all levels of the organisation and across all of our services. Whilst we have much to celebrate in terms of the progress we have made and outcomes that have been achieved during the last year, as described in this report, we know that there is more to do to realise our vision that

"Each citizen of Dundee will have access to the information and support that they need to live a fulfilled life".

APPENDIX 1

National Health and Wellbeing Outcomes

1. Healthier Living	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. Independent Living	People, including those with disabilities, long term, conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.
3. Positive Experiences and Outcomes	People who use health and social care services have positive experiences of those services and have their dignity respected.
4. Quality of Life	Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.
5. Reduce Health Inequality	Health and social care services contribute to reducing health inequalities.
6. Carers are Supported	People who provide unpaid care are supported to look after their own health and wellbeing, and to reduce any negative impact of their caring role on their own health and wellbeing.
7. People are Safe	People who use health and social care services are safe from harm.
8. Engaged Workforce	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
9. Resources are used Efficiently and Effectively	Best Value is delivered and scarce resources are used effectively and efficiently in the provision of health and social care services.

APPENDIX 2

Performance against National Health and Wellbeing Indicators

Indicators 1-9 are measured using the National Health and Wellbeing Survey disseminated by the Scottish Government every two years. The latest one was completed in 2015-16 and is due to be repeated in 2017-18.

National Indicator	2015-16 Dundee	2015-16 Scotland
1. Percentage of adults able to look after their health very well or quite well	93%	94%
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	88%	84%
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.	79%	79%
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	76%	75%
5. Percentage of adults receiving any care or support who rate it as excellent or good	84%	81%
6. Percentage of people with positive experience of the care provided by their GP practice	90%	87%
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	88%	84%
8. Percentage of carers who feel supported to continue in their caring role	44%	41%
9. Percentage of adults supported at home who agree they felt safe	85%	84%

National Indicator	2015-16 Scotland	2015-16 Dundee	2016-17 Dundee	2016-17 Scotland	Comparison with Scotland
10. Percentage of staff who say they would recommend their workplace as a good place to work	Not available	75%	75%	Not available	
11. Premature mortality rate (per 100,000 people aged under 75)	441	546	Not available	Not available	
12. Emergency admission rate (per 100,000 people aged 18+)	12,138	12,154	12, 411	12, 037	↓
13. Emergency bed day rate (per 100,000 people aged 18+)	122,713	142,407	136,059	119,649	↓
14. Readmission to acute hospital within 28 days of discharge (per 1,000 population)	96	121	125	95	↓
15. Proportion of last 6 months of life spent at home or in a community setting	87%	87%	87%	87%	
16. Falls rate per 1,000 population aged 65+	21	25	26	21	↓
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83%	88%	Not available	Not available	
18. Percentage of adults with intensive care needs receiving care at home	62%	54%	Not available	Not available	
19. Percentage of days people spend in hospital when they are ready to be discharged, per 1,000 population	915	832	755	842	↑
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	27%	26%	23%	↓
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Not available	Not available	Not available	Not available	
22. Percentage of people who are discharged from hospital within 72 hours of being ready	Not available	Not available	Not available	Not available	
23. Expenditure on end of life care	Not available	Not available	Not available	Not available	

Improved since 2015/16 | Stayed the same since 2015/16 | Worsened since 2015/16 | ↑ Better than Scotland | ↓ Worse than Scotland

APPENDIX 3

Statutory Inspections

CARE INSPECTORATE GRADINGS TO SERVICES DELIVERED DIRECTLY BY THE PARTNERSHIP 2016-17

Name of Service	Service Type	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
Menzieshill House	Care Home - Older People	07/11/2016	5	5	5	5
Janet Brougham House	Care Home - Older People	27/10/2016	5	6	5	5
Turrif House	Care Home - Older People	01/03/2017	5	5	5	5
Craigie House	Care Home - Older People	25/01/2017	5	4	5	4
White Top Centre	Care Home - Learning Disability	06/01/2017	6	6	6	6
MacKinnon Centre	Care Home - Physical Disability	15/02/2017	6	6	6	6
DCC - Homecare - Social Care Response	Housing Support Support Service Care at Home	01/09/2016	5 5	N/A N/A	5 5	5 5
DCC - Homecare - Locality Team and Housing with Care East	Housing Support Support Service Care at Home	24/03/2017	5 5	N/A N/A	5 5	5 5

Name of Service	Service Type	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
DCC - Homecare – Locality Team and Housing with Care West	Housing Support Support Service Care at Home	22/02/2017	5 5	N/A N/A	5 5	5 5
DCC - Homecare – Enablement and Support City Wide and Community Mental Health Older People Team	Housing Support Support Service Care at Home	08/12/2016	5 5	N/A 5	5 5	5 5
DSS Supported Living Team	Housing Support Support Service Care at Home	22/12/2016	6 6	N/A N/A	6 6	6 6
DSS Dundee Community Living	Housing Support Support Service Care at Home	04/11/2016	6 6	N/A N/A	6 6	6 6
DSS Housing Support Team	Housing Support	11/10/2016	5	N/A	6	5
Weavers Burn	Housing Support Support Service Care at Home	03/11/2016	2 2	N/A N/A	3 3	2 2

Name of Service	Service Type	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
MacKinnon Skills centre	Support Service – Other that Care at Home	07/03/2016	5	6	6	6
Oakland Centre	Support Service – Other that Care at Home	28/09/2016	6	5	6	5
Wellgate Day Support Service	Support Service – Other that Care at Home	25/02/2016	6	6	6	6

6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

() this signifies that the theme was not inspected therefore grade brought forward from previous inspection.

EXTERNALLY CONTRACTED SERVICES
CARE INSPECTORATE INSPECTIONS WHERE THERE WERE REQUIREMENTS 2016-2017

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
28/03/17	Caledonia Housing Association	Housing Support Service	4	N/A	4	(4)

Requirements (1)
The Provider must ensure in meeting this requirement that tenants can be confident that their individual needs are met and acted upon. By 1 August 2017 the provider must have all support plans updated. In order to comply with the legislation the service needs to change the support plan when the tenant's needs change significantly or every six months at the six monthly review.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
16/03/17	Crossroads Caring Scotland - Dundee	Care at Home/ Housing Support	3	N/A	3	3

Requirements (2)

- The Provider must ensure that personal support plans are reviewed with individuals and their relatives or representatives where appropriate at least six-monthly and more frequently if people's needs change significantly or they ask for a review.
- Supported people will experience a good quality care at home service that will help them meet their goals and outcomes in their everyday life. The provider must develop a system by which the manager of the service has comprehensive oversight of all aspects of the care provided. In order to achieve this, the provider must; develop an improvement plan which demonstrates how they will address, monitor and maintain progress toward improvements across the service as a whole, provide clear evidence of outcomes of quality assurance audits and views of service user/representatives and stakeholders contributing to continuous service improvement, ensure overall management oversight of the improvement plan with clear timescales of when progress is to be achieved stating clearly responsibilities for actions, ensure that the Care Inspectorate receives regular updates with regards progress toward identified goals.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
02/02/17	Carr Gomm	Care at Home/ Housing Support	5	N/A	4	(4)

Requirements (3)

- The Provider must ensure that medication is administered safely and recorded properly. They must; ensure that the correct medication is given at the correct time, ensure that the medication is taken, ensure that this is recorded and signed.
- The service user must ensure that it adheres to its conditions of registration with SCSWIS by ensuring that staff do not use a service user's home as an office base or as a venue for other staff meetings.
- The Care Inspectorate must be notified of any incident that has the potential to have serious implications on the health, well-being or safety of service users. The provider is required to ensure that notifications are made in-line with Records that all registered services (excluding childminders) must keep and guidance on notification reporting, available on the Care Inspectorate website.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
19/01/17	Blackwood Care (Margaret Blackwood)	Care at Home/ Housing Support	3	N/A	3	3

Requirements (4)

- The provider should ensure that all service users have an up-to-date personal plan in their homes.
- The service should ensure that where a person has a scheduled visit there are systems in place to ensure that this takes place and that if a visit is missed the service knows about it quickly and can take steps to ensure that person is safe and supported.
- The service should re-activate those practices which it previously undertook to support staff to ensure that they are carrying out good practice. These include team meetings, 1:1 supervision and observation of staff working in the community. This will ensure that the service is provided in a manner that promotes quality for service users.
- The service should review the procedure and practice for taking on new customers and consider the impact on existing as well as new customers.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
10/10/16	Avenue Care Services Ltd	Support Services- with care at home	4	N/A	4	3

Requirements (1)

- The Provider to devise, implement and fully embed robust quality assurance arrangements that evidence improving outcomes for service users.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
16/06/16 04/01/17*	Transform Community Development	Care at Home/ Housing Support	3	N/A	4	3

Requirements (3)

- To ensure the health and wellbeing of service users the provider must have a robust procedure for recording, reporting and analysis of incidents. To achieve this the provider must improve incident report forms to be clear about who is responsible for completing the incident report including dates and signatures, follow a standard process which allows for reporting actual events, impact on staff and other service users and strategies to avoid a repeat occurrence, consider whether a report should be made to other organisations such as the Care Inspectorate and other relevant professionals involved in the service user's support and timescales in which these should be made, consider whether the person's plans of support or risk assessments needs to be updated, ensure that any changes to a person's plan of support or risk assessment is made immediately and communicated to all staff, be quality assured by the registered manager, ensure post incident analysis takes place for significant events. These should be recorded and detail any further action required to prevent a re-occurence
- The provider must develop a robust adult support and protection policy which includes details of potential harm, staff responsibilities and local contact numbers.
- The provider must ensure that all notifiable incidents and accidents are reported to the Care Inspectorate as per guidance "Records all services (excl CM's) must keep and notification reporting".

*The follow up inspection held on 4 January 2017 was to ascertain if requirements had been met. Requirement 1 was not met. Requirements 2 and 3 were met. The grades remained the same as those awarded at inspection held on 16 June 2016.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
09/05/16 24/11/16*	Dudhope Villa & Sister Properties	Care at Home/ Housing Support	3	N/A	3	3

Requirements (4)

- In order to promote choice and autonomy, the provider must ensure that service users are provided with clear information relating to their financial affairs. Plans of support must fully detail the service user's income and expenditure .
- To ensure the health and wellbeing of service users, the provider must record each person's individual support hours within plans of support and have a system in place to ensure these hours of support are delivered.
- To ensure the health and wellbeing of service users, the provider must have a robust procedure for recording and reporting of incidents. To achieve this the provider must ensure all staff are aware of what would constitute a reportable incident, improve incident report forms to be clear about who is responsible for completing the incident report including dates and signatures, follow a standard process which allows for reporting actual events, impact on staff and other service users and strategies to avoid a repeat occurrence, consider whether a report should be made to other organisations such as the Care Inspectorate and other relevant professionals involved in the service user's support and timescales in which these should be made, consider whether the person's plans of support or risk assessments needs to be updated, ensure that any changes to a person's plans of support or risk assessments is made immediately and communicated to all staff.
- To ensure the service is delivered in a way which promotes choice, autonomy and enablement the provider should develop a systematic approach to service improvement including drawing up an action plan with timescales.

*The follow up inspection held on 24 November 2016 was to ascertain if requirements had been met. Requirements 1-3 were met. Requirement 4 was not met. The grades remained the same as those awarded at inspection held on 9 May 2016.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
10/08/16	Ballumbie Court	Care at Home - Private	3	4	3	3

Requirements (5)

- The provider must ensure that the Care Inspectorate is notified of all significant events promptly.

The following requirements were put in place on 14 October 2016 and 20 December 2016.

- The provider must make proper provision for the health, welfare and safety of people using the service. In order to achieve this the provider must; ensure that other professionals are involved in assessing the care and support to be provided, particularly where uncommon symptoms of pain are exhibited, ensure an effective system of communication between staff to ensure adequate assessment and care planning for people using the service, ensure that adequate continence promotion is assessed, planned and provided for people using the service, ensure that where additional observation of a person using the service is required, this is carried out as part of a planned process with clear guidance. If required, additional observation recording must be accurate and consistent.
- The provider must ensure that where concerns are raised by a Welfare Power of Attorney they are managed in accordance with the Complaints Procedure. The provider must, within 20 working days after the date on which the complaint is made, or such shorter a period as may be reasonable in the circumstances, inform the complainant of the action (if any) is to be taken.
- The provider must ensure that medication is managed in a manner that protects the health and wellbeing of service users. In order to do this, the provider must; ensure proper provision for storage of medicines, ensure that medicines are administered as instructed by the prescriber, ensure that a safe system is in place to accurately identify the person receiving the medication, demonstrate that staff follow policy and best practice about medication administration records and documentation.
- The provider must make proper provision for the health, welfare and safety of service users. In order to achieve this the provider must; ensure that people using the service have prompt access to other professionals when required and when their condition deteriorates, ensure that people using the service's condition is continuously assessed, including symptoms of pain and effectiveness of pain relief medication and food and fluid intake and output. Particularly during an acute episode of illness, ensure that the care plan fully reflects the needs of people using the service and how these needs should be met, ensure that record keeping is detailed and accurate.

*The follow up inspection held on 27 January 2017 was to ascertain if the requirement had been met. Requirements 1, 3, and 4 were met. Requirements 2 and 5 were not met. The grades remained the same as those awarded at inspection held on 10 August 2016.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
05/05/16	Helenslea	Care Home - Private	4	3	3	3

Requirements (2)

- The provider must ensure the premises are kept in a good state of repair. This means all staff must be aware of the reporting procedure for requesting repairs and maintenance of the building and equipment used by service users. To achieve this, the service should; ensure all staff revisit the repairs and maintenance procedure and can demonstrate their understanding through their practice. Areas of responsibility and accountability should be clearly shown within the guidance, ensure all staff are aware of the providers expected environmental standards for service users, ensure all staff are aware of bed and bathroom room checks and that these are carried out on a regular basis to ensure the personal environment of service users is maintained to a good standard, maintain clear and auditable records of all repair requested and completed.
- The care service provider must take steps to ensure that only staff who are registered with the Scottish Social Services Council (SSSC) or another recognised regulatory body, or who are newly recruited and are capable of achieving such registration within 6 months of commencing in post, may carry out work in the care service in a post for which such registration is required.

*The follow up inspection held on 31 January 2017 was to ascertain if requirements had been met. Requirement 1 was not met. Requirement 2 was met. The grades remained the same as those awarded at inspection held on 5 May 2016.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
28/04/16	Rose House	Care Home - Private	3	3	3	3

Requirements (2)

- The provider must demonstrate that they have developed and are implementing a safe and effective system for the management and administration of service users' medications. This must include (but is not limited to), the correct use of medication specific recording and monitoring of all topical applications, ensuring that where handwritten entries are made that these are signed for and that the authorisation for this entry or any amendments is clearly recorded, that as required medication protocols are developed to clearly guide staff as to their safe use.
- The provider must ensure that up-to-date environmental risk assessments are in place and that where a risk is identified that appropriate actions are taken to minimise such risks. Specific reference is made (but not limited to); radiators throughout the home and hot water outlets.

*The follow follow up inspection held on 24 January 2017 was to ascertain if requirements had been met. Requirement 1 was met. Requirement 2 was met outwith timescale.

As a result of an upheld complaint the following requirement was made:

The provider must demonstrate that the service has systems in place to ensure that the health needs of individual service users are adequately assessed and met. In order to do this they must; ensure that the personal plan includes clear and detailed guidance in relation to how specific needs should be met, ensure that support evidence demonstrates that specific needs have been met, ensure that all care staff have received training appropriate to the work they are to perform, particularly training in relation to dementia care, ensure that planned support is fully implemented for people with specific health needs, including oral care, ensure that managers monitor and audit health needs robustly.

The grades remained the same as those awarded at inspection held on 28 April 2016.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
19/01/16 (follow up)	The Bughties	Care Home - Private	2	(4)	(4)	2
13/10/16 (follow up)	The Bughties	Care Home - Private	2	(4)	(4)	3
14/04/16 (follow up)	The Bughties	Care Home - Private	4	4	4	4

Requirements (13/10/16) (2)

- The provider must ensure adequate staffing levels to meet the needs and choices of residents. The provider should keep records of the assessment that identifies the minimum staffing levels and deployment of staff on each shift over a four week period. This should take account of the physical, social, psychological and recreational needs and choices in relation to the delivery of care for all individuals. This should also take account of the physical layout of the building, staff training and staff supervision needs.
- The service must ensure that regular health and safety checks are carried out and recorded. Any remedial action identified should be taken to rectify repairs to the building and to equipment used by residents as soon as possible.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
24/10/16	Brae Cottage	Care Home - Private	2	2	2	1

Requirements (13/10/16) (5)

- The provider must ensure adequate opportunities for service users to partake in activity which is meaningful to them. In order to do this, the provider must:- make a detailed record of the social, recreational and psychological needs of each service user, ensure that service users' interests are taken into account when planning activities, ensure that activities are recorded and evaluated.
- The provider must ensure that: (i) Prior to admission, the service has assessed that they are able to meet the support needs of potential service users and that potential service users have the information necessary to make an informed choice about accepting the service offered.
  (ii) Ensure that staff have adequate information to guide them to the service users' individual support needs on admission to the home.
  (iii) Personal plans must state service users' individual, specific health needs and associated risks.
  (iv) Personal plans provide clear and accurate information and guidance for staff on how to meet these identified needs and risks. (v) There is clear and accurate information about consultation of residents, relatives and other health professionals.
  (iv) Accurate record keeping of specific interventions required and actions taken to support residents' safely.
- The provider must ensure that the laundry area currently in use is maintained and refurbished to a safe and suitable standard in order to allow staff to perform their duties and care for residents' laundry in a safe and clean environment. In order to do this the provider must undertake a review of these premises as a matter of priority and commence of programme of refurbishment and improvement. The provider must also undertake a full review of the infection control procedures to ensure that work practices reflect best practice guidance and equipment to allow them to safely undertake their responsibilities in the control of infection. In order to achieve this the provider must
  (i) Ensure all staff are trained and fully aware of and follow good practice principles in relation to infection control(ii) Ensure a detailed risk assessment is undertaken to identify and manage the risks posed
- The provider must demonstrate that it has followed best practice guidance in relation to safe recruitment practices and must not employ any person in the provision of a care service unless that person is fit to be so employed. This must include:
  (i) The development of an effective system to ensure that each candidate has undergone a satisfactory PVG check prior to employment within the service.
  (ii) The development of an effective system to seek and receive satisfactory references for each candidate and clear records of reasons where last employer references have not been received.
  (iii) Evidencing that evaluation of the skills, knowledge and experience of applicants is sought and records kept as part of safer recruitment practices.
- The provider must ensure all staff have access to regular planned training appropriate to the work they do and to meet the residents' needs.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
10/02/17	Wellburn	Care Home - Private	2	2	2	2

Requirements (8)

- The provider must develop care plans to offer staff clear direction in meeting each persons assessed care and support needs. The content should be person-centred and reflect the goals and wishes of residents in order to meet their needs and be reviewed regularly to ensure they remain valid. Staff must adhere to the stated frequency of monitoring aspects of health care identified in health assessments and in care plans. Care plans should direct staff to supporting documentation and this must be completed to ensure that planned care is delivered.
- The provider must ensure that medication is managed and administered safely and to the standard of best practice guidance, including 'Handling Medicines in Social Care' 2007 and the Care Inspectorate's Health Guidance 'Maintenance of Medication Records'.
- The provider must ensure that there is an appropriate system in place for carrying out and monitoring safety of the environment, maintenance and repair procedures.This must include (but is not limited to): developing environmental risk assessments and taking steps to minimise risks identified, carrying out regular and planned environmental audits, ensuring water safety is monitored, ensuring maintenance contracts are in place for specialist equipment such as hoists, baths, gas and electrical safety, ensure that any minor repairs are carried out timeously and records kept of this (including dating
- The provider must improve the care home's infection prevention and control arrangements by ensuring: laundry carts are used appropriately, personal protective equipment is available at point of use, waste bins are pedal operated (or risk assessed as appropriate), all staff are trained in and follow good infection control procedures.
- The provider must ensure that the environment is safe and service users are protected at all times. To ensure this Risk and COSHH assessments must be carried out on all cleaning materials used in the home, cleaning materials must be kept locked at all times, cleaning materials must not be left unattended in communal areas
- The provider must take steps to ensure all staff working in the service receive appropriate training which will equip them with the necessary skills and competencies required to meet the care and welfare of all the service users. The provider must ensure newly recruited staff are given a comprehensive induction and are supported by appropriate and experienced staff until they are assessed as competent.
- The provider must ensure that effective quality assurance systems are in place to enable the monitoring of: quality of care, support and outcomes experienced by service users, quality and safety of the environment, workforce quality and performance. The provider must ensure that there is development of the systems to ensure they are robust and effective so that identified actions can be demonstrated as being promptly met.
- The provider must ensure that all staff are registered with the appropriate regulatory body.

SERVICE PROVIDED DIRECTLY BY DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP
CARE INSPECTORATE INSPECTIONS WHERE THERE WERE REQUIREMENTS 2016-2017

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
25/05/16	Weavers Burn	Care at Home / Housing Support	2	No grade available	3	2

Requirements (5)

- The provider must ensure that each service users health, welfare and support needs are met in accordance with their assessed needs. In order to achieve this the provider must ensure that; there are suitably qualified staff, both in number and skill, on duty at all times, a process is in place to accurately assess the needs of each individual service user, all risks to each individual service users' health and welfare are accurately assessed and managed, the physical layout of the building (living environment) is taken into account in the management of risk to each individuals' health and welfare
- The provider must ensure that service users' personal plans reflect how staff will meet the health, welfare and safety needs of the person and that any specific guidance from other professionals and stakeholders must be reflected within each plan to ensure that staff have all the information required to support people safely and effectively.
- The provider must ensure that each service users' health, welfare and support needs are met in accordance with their assessed needs. In order to achieve this the provider must ensure that where a guardianship order is in place, that all information relating to the powers of the guardian are clearly recorded.
- The provider must ensure that staff supervision is carried out in line with the provider's policies and procedures and a system is in place to record when supervision sessions had taken place and when they were due.
- The provider and manager should ensure that the service has robust quality assurance processes and that audits and checks are completed within stated timescales and clearly evidence how any issues identified are to be addressed by whom and by when. The manager should sign these to evidence that they have been completed and issues are addressed.

6	Excellent
5	Very Good
4	Good
3	Adequate
2	Weak
1	Unsatisfactory

() this signifies that the theme was not inspected therefore grade brought forward from previous inspection.

HEALTHCARE IMPROVEMENT SCOTLAND REQUIREMENTS AND RECOMMENDATIONS 2016-2017

Inspection Date	Name of Org/ Service	Service Type	Quality of Care and Support	Quality of Care and Support	Quality of Environ-ment	Quality of Staff	Quality of Leadership & Manag-ement
May 2016	Monroe House	Independent Healthcare	4	4	4	4	4

Requirements (2)

- The provider must ensure that each service users health, welfare and support needs are met in accordance with their assessed needs. In order to achieve this the provider must ensure that; there are suitably qualified staff, both in number and skill, on duty at all times, a process is in place to accurately assess the needs of each individual service user, all risks to each individual service users' health and welfare are accurately assessed and managed, the physical layout of the building (living environment) is taken into account in the management of risk to each individuals' health and welfare
- The provider must ensure that service users' personal plans reflect how staff will meet the health, welfare and safety needs of the person and that any specific guidance from other professionals and stakeholders must be reflected within each plan to ensure that staff have all the information required to support people safely and effectively.

Recommendations (13)

- ensure that Healthcare Improvement Scotland is clearly referenced as the regulator for this service in the complaints material.
- ensure that all care plans show that patients and families are actively involved.
- explore ways to involve patients in staff recruitment and appraisal.
- review the format of care records, and ensure that patients' progress is easily trackable and that staff are aware of where information should be recorded and filed.
- ensure appropriate record of maintenance requests and actions
- ensure all staff complete mandatory health and safety training in line with its own policy
- ensure that emergency equipment is checked in line with organisational policy and that this is recorded.
- ensure that medication fridges are checked daily and temperatures recorded to ensure they are operating within required limits.
- ensure that clinical equipment such as sphygmomanometer, electronic scales and blood glucose monitoring machines are calibrated in line with the manufacturer's instructions.
- ensure that they continue to follow up the actions developed from the staff satisfaction survey.
- identify staff to lead in focus areas in the development of the two services to promote staff inclusion in the process for example décor and medication management.
- ensure that regular audit of medication documentation is carried out, in line with the planned schedule and used to identify and action areas for improvement.
- ensure that the medication policy is amended to reflect best practice in medication reconciliation and that staff receive education.

Action by Partnership

Care Inspectorate is supporting the production of an action plan and the contracts officer continues to attend feedback sessions.

MENTAL WELFARE COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2016-2017

Date of Inspection	Name of Org/Service	Service Type
10 August 2016	Monroe House	Independent Hospital

Requirements (3)

- Managers should ensure that the records of review meetings document clearly progress boing made to meet care goals.
- Managers should ensure that when patients have been supported to complete the 'My MDT' and 'My CPA' sheets, these sheets are filed with the rest of the documentation from review meetings.
- Managers should ensure that when s47 certificates are being completed, guardians are involved in the process of discussing and giving consent to the proposed treatment.

Date of Inspection	Name of Org/Service	Service Type
28 September 2016	Kingsway Care Centre	Independent Hospital

Recommendations (2)

- Managers should ensure that information about the locked door policy is available and clearly displayed at the ward doors.
- Managers should ensure that an environment assessment is undertaken and any necessary refurbishment work is completed as soon as practical.

Action by Partnership (2)

- The first recommendation has been fully actioned and information is now clearly displayed appropriately.
- An action plan is being prepared regarding ligatures and this will be escalated via the NHS Tayside Ligature Group.

APPENDIX 4

Glossary of Terms

Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include physiotherapists, dieticians, Speech and Language Therapists, psychologists, Occupational Therapists, podiatrists, audiologists, etc.
Carer	Someone who provides, or intends to provide, unpaid care for another individual (the "cared-for person"). This could be caring for a relative, partner or friend (of any age) who is ill, frail, disabled or has mental health or substance misuse issues.
Clinical Care and Professional Governance	A system to inform and progress the improvement of NHS services ensuring they are person centred, safe and effective and based on best available evidence and practice.
Community Regeneration Area (CRA)	A locality which has been identified for regeneration as a result of multiple deprivation.
Due Diligence	A process of enabling the organisation to identify the resources delegated to it and to quantify the financial, legal and operational risks associated with them to provide the necessary assurance that these can be managed effectively.
Emergency admissions	An unplanned admission to an acute hospital which occurs when, for clinical reasons, a patient is admitted at the earliest possible time after seeing a doctor.
Enablement	Services for people with poor physical or mental health to help them re-learn skills, or develop new skills, support them to be independent and improve their quality of life. In Dundee enablement is a short term service which is provided for a period of up to a maximum of six weeks.
Equality Act 2010	An Act of Parliament of the United Kingdom which brought together all anti-discriminatory laws including The Equal Pay Act 1970, The Sex Discrimination Act 1975, The Race Relations Act 1976, The Disability Discrimination Act 1995 and three major statutory instruments protecting discrimination in employment on the grounds of religion or belief, sexual orientation or age.
Equally Well	National Action Plan for reducing health inequalities in Scotland published in June 2008.

Ethnic Minority (EM) Group	The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race.
GP Clusters	The collaboration of a group of General Practitioners for the purpose of service improvement.
Health and Wellbeing Indicators	A suite of indicators which draw together measures relation to health and social care integration. These were developed in partnership with NHS Scotland, COSLA and the third and independent sectors.
Health and Wellbeing Outcomes	The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.
Home Care	Help provided directly in the service user's own home. Home carers are people employed to provide direct personal physical, emotional, social or health care and support to service users and are accountable for dealing with routine aspects of a care plan or service.
IJB	An Integration Joint Board was established in Dundee to oversee the integrated arrangements and onward service delivery. The Integration Joint Board exercises control over a significant number of functions and a significant amount of resource.
Intersectionality	When multiple identities intersect and create a whole that is different from the individual identities. These identities can include ethnicity, race, disability, sexual orientation and age
LCPP	Local Community Partnerships a groups of professionals and citizens work in partnership to deliver priorities regarding a geographical area.
Long Term Condition	Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.
Natural Neighbourhoods	54 small geographical areas where communities live which are aligned to the 8 Local Community Planning Partnership Areas in Dundee

Otago Falls A service delivery model which originated in Otago, New Zealand to support people who are at risk of falling.

Partnership Dundee Health and Social Care Partnership

Public Bodies (Joint Working) Act 2014 The Public Bodies (Joint Working)(Scotland) Act 2014 (the Act) requires NHS Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services.

Public Protection Committee Locally based multi-agency strategic partnership responsible for continuous improvement, strategic planning and public information and communication for public protection issues across the public, private and wider third sectors in Dundee and in partnership across Scotland. In Dundee the Adult Support and Protection Committee, Alcohol and Drug Partnership, Child Protection Committee, MAPPA Strategic Oversight Group (Tayside), Suicide Prevention Partnership, Refugee Partnership and Violence Against Women Partnership are considered to be part of the Public Protection grouping.

Service Delivery Areas The service delivery model of supporting people in communities in Dundee.

SMART flat A technology enabled property which supports people to live independently.

Strategic Priorities The eight priorities which will contribute to transformational changes in how integrated health and social care services are delivered in Dundee.

Dundee
Health & Social Care
Partnership

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