Dundee Health and Social Care Partnership

Annual Performance Report

2020 - 2021

Dundee Health & Social Care Partnership

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Foreword

Our Vision

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

This is the fifth Annual Performance Report for Dundee Health and Social Care Partnership and it sets out some of our key achievements over the past year.

2020 was an extraordinary year for the Health and Social Care Partnership, for our workforce and for people who use health and social care supports and services, carers and communities.

The impact of the COVID-19 pandemic; on the health and social care needs of the population, on how we deliver supports and services, on health inequalities on the health and wellbeing of our workforce and on unpaid carers has been substantial and wide ranging.

At a time when there was increased need to self isolate within staff groups and increased pressure on staff resources and our ability to maintain supports and services to individuals, Partnership services have responded dynamically and innovatively. They not only supported efforts to rapidly increase the availability of beds in the acute sector to respond to COVID-19 positive patients requiring hospital admission, but have also been integral to providing responses to COVID-19 positive people in the community, both within their own homes and within residential settings such as care homes.

As part of local partnership arrangements, by March 2021, we supported the administration of COVID-19 vaccinations to 87,043 people (71% of the 18+ population) and 188,211 PCR tests through the establishment of COVID-19 Vaccination Centres and Community Testing facilities.

This Annual Performance Report therefore reflects the range of work undertaken by the Partnership over 2020-21 to respond to the COVID-19 pandemic, as well as our ongoing workstreams to deliver the strategic priorities set out in our Strategic and Commissioning Plan 2019-22.

Despite the challenges, we maintained lifeline social care services to 3,186 people during the pandemic, including the scheduling of 1,146k hours of homecare. We have made progress in relation to more efficient and effective prescribing which has seen GP prescribing expenditure for Dundee reduce to below the Scottish average per weighted patient. We have continued to embed the personalisation of social work and social care supports, increasing the number of people receiving a Self Directed Support Direct payment by 17%. Keep Well, Health and Homeless Outreach, MARAC Independent Advocacy, Get on Track Course and the ASPEN project are just some examples of how we have continued to address the health inequalities gap in Dundee by using local data, listening to citizens and providing services which support people living with deprivation and also harder to reach groups. The establishment of the innovative Independent Living Review Team has promoted independence, enablement and supported self management, reduced carer support required and contributed to reductions in delayed discharge.

We could not have achieved this without the continued support from unpaid carers and our workforce, who have had to adapt to the changing and increased needs of a cared for population and have been required to be increasingly flexible, pro-active and innovative. As we continue to respond to the ongoing pandemic we are also looking to the future, working collaboratively through the Dundee Partnership (our community planning partnership) to plan for Dundee's recovery. In 2021-22 this will include reflecting on our learning from the pandemic response, continuing to monitor the impact of the pandemic on health and social care needs and inequalities in Dundee's population and consolidating our recovery priorities into our strategic and commissioning plans. We look forward to continuing to work with our staff groups, people who use our services, carers and wider communities to support recovery.

Councillor Ken Lynn, Chair
Dundee Integration Joint Board

Trudy McLeay, Vice Chair
Dundee Integration Joint Board

1.1 Who We Are

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 Partnership).

In accordance with the **Public Bodies (Joint Working) (Scotland) Act 2014** ('Public Bodies Act'), an Integrated Strategic Planning Group ('ISPG') established by the IJB, developed the second Health and Social Care Strategic and Commissioning Plan ('Plan'), which was effective from 1 April 2019.
Our Plan describes our strategic priorities for the next three years and the key actions required to deliver on our ambitious vision for the city. The Plan represents the knowledge we have gained through our ongoing engagement with communities, people who use Health and Social Care services, their families and with carers.

Our Plan describes what has been achieved so far. It also outlines what still needs to be done to arrange services in a way that helps Dundee citizens receive the right information and support at the right time, to live a healthy and fulfilled life in the way they want.

Our Plan is a critical companion document to other plans such as the **City Plan for Dundee 2017-2026** and the **Tayside Primary Care Improvement Plan**. Success can only be achieved by our continued joined up working with partner organisations. As a Partnership, we are emboldened by the new vibrancy felt across the city and are determined to play our role in realising the full potential of each Dundee citizen by enhancing individual health and wellbeing.

The 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.
Additionally Dundee, Angus and Perth and Kinross Health and Social Care Partnerships have mutual hosting responsibilities. Hosting arrangements were agreed for highly specialist or area wide services.

On behalf of the three Tayside Health and Social Care Partnerships, Dundee hosts and leads the planning and delivery of a number of services such as sexual and reproductive health, specialist palliative care, the Centre for Brain Injury Rehabilitation, medical advisory services and nutrition and dietetic services.

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 Health, Care and Wellbeing Executive Board, Children and Families Executive Board, Community Safety and Justice Executive Board and Public Protection Committees.

The vision of the Partnership is:

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

The vision sits alongside Scotland's long term aim for people to live longer, healthier lives at home or in a homely setting.

The Scottish Government has 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 you can also find a full list of the outcomes in appendix 1.

To deliver our vision and the National Health and Wellbeing Outcomes, the Strategic and Commissioning Plan 2019-2022 revised the Partnership's Strategic Priorities. The main change from the previous plan is the focus on the delivery of four of the previous eight strategic priorities: Health Inequalities, Early Intervention and Prevention, Locality Working and Engagement with Communities, Models of Support and Pathways of Care. The four remaining priorities from the 2016-21 plan: Person Centred Care and Support, Carers, Building Capacity and Managing Resources Effectively are all now embedded in the Health and Social Care Partnership's everyday work.

You can read more about how we identified our Strategic Priorities and what we plan to do to achieve them, between now and 2021, in our **Health & Social Care Strategic & Commissioning Plan 2019-2022.**

1

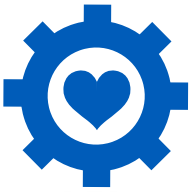
Health Inequalities

2

Early Intervention Prevention

3

Localities and Engaging with Communities



4

Models of Support/ Pathways of Care

Novel Coronavirus (COVID-19)

Coronavirus is an infectious disease caused by severe acute respiratory syndrome coronavirus 2. It was first identified in December 2019 in Wuhan, China and has since spread globally. The World Health Organisation declared the outbreak a pandemic on 11 March 2020. The first confirmed case of COVID-19 in the UK was on 29 January and the first confirmed case in Scotland was 2 March 2020 in the Tayside area.

The first wave of infection endured until June 2020 and the second wave of infection began mid-October 2020 and continued into early Spring 2021. The COVID-19 pandemic has been the biggest public health challenge facing society, including our health and social care system, in our lifetimes.

At 31 March 2021 there had been 203,555 confirmed cases of COVID-19 in Scotland; 13,358 of which were in Tayside and 6,407 of which were in Dundee. There were over 300 deaths of Dundee residents. (based on deaths where COVID-19 was mentioned on the death certificate) (https://www.nrscotland.gov.uk/covid19stats).

The impact of the COVID-19 pandemic on the health and social care needs of the population, how we deliver supports and services, on health inequalities and on the health and wellbeing of our workforce and of unpaid carers has been substantial and wide ranging. However, data and modelling information about the impact of the pandemic beyond acute hospital settings is limited and a full understanding of the short, medium and long-term impact of the pandemic on health and social care needs will not be ascertained for some time to come.

Services delegated to the Partnership form a critical part of our overall health and social care system, particularly the wide range of community-based health, social care and social work supports and services. Partnership services have not only supported efforts to rapidly increase the availability of beds in the acute sector to respond to COVID-19 positive patients requiring hospital admission, but have also been integral to providing responses to COVID-19 positive people in the community, both within their own homes and within residential settings such as care homes.

Essential services have been maintained, including face to face contact with service users and patients, and intensive work was undertaken to upskill and train to support redeployment of colleagues from other sectors. A range of services and supports have been rapidly redesigned to enable continued operation in the context of social distancing regulations and public health advice.

The Partnership's contribution to staff and public COVID-19 vaccination programmes, as well as additional activity required to respond to annual winter pressures (including Flu Vaccination and disruption due to poor weather), represent significant additional elements of the second wave response. In addition, the Partnership has made a significant contribution to wider partnership efforts to respond to community support needs, such as responses to shielded people, food distribution and a range of public protection responses.

At the time of writing this Annual Report, COVID-19 remained prevalent in the population, with numbers beginning to rise following the easing of lockdown restrictions. The vaccination programme is continuing and demands on acute and community services are being closely monitored.

1.2 How We Measure Our Performance

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 individuals, carers and families underpins everything that we do.

During 2020-21 the Performance and Audit Committee (PAC) of the Integration Joint Board (IJB) continued to be responsible for scrutinising the performance of the Partnership in achieving it's vision and strategic priorities, including overseeing financial performance and other aspects of governance activities. In common with other governance groups, due to the pandemic meetings of the PAC were suspended from March 2020 until September 2020, at which point they resumed on a virtual basis.

Since September 2021 the PAC has received quarterly local performance reports, including benchmarking data from other Health and Social Care Partnerships across Scotland. 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 eight comparator Partnerships. Dundee is placed in a family group along with Glasgow, Western Isles, North Lanarkshire, East Ayrshire, Inverclyde, West Dunbartonshire and North Ayrshire.

You can see the Partnership's quarterly performance reports on our website.
https://www.dundeehscp.com/publications

At the height of the pandemic, priority given to reducing demand on unscheduled care temporarily shifted as Health and Social Care Partnerships adapted processes, procedures and pathways in order to prevent spread of the virus and to maximise hospital capacity to treat COVID-19 patients safely and effectively. This adds a level of complexity to the indicators monitored since 2015/16 to measure how Partnerships are performing towards 'shifting the balance of care'. Whilst we are monitoring and scrutinising performance quarterly, we recognise that indicators where processes and pathways were affected by the pandemic should be treated with caution and viewed alongside whole system pathways and processes when scrutinising performance.

The PAC requested additional analytical reports in areas where performance was poor, such as readmissions, complex delayed discharges and falls, to support an improved understanding of underlying challenges and the development of more detailed improvement plans. The PAC also received a Performance Report from Dundee Carers Partnership.

Over the last 12 months individual teams and services have adapted their approach to performance management and self-evaluation to reflect the pandemic context. Significant focus has been given to aspects of service delivery such as infection control and workforce sustainability and additional information has been captured across internal and external services to monitor the impact of changing models of service delivery. In some areas, such as the care home sector, additional requirements have been put in place on a national basis by Scottish Government, including data collection and reporting.

Clinical Care and Professional Governance (CCPG) 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. The Framework for CCPG within integrated services is set out in the agreed framework – Getting It Right for Everyone: Clinical, Care and Professional Governance Framework. CCPG relies on all of these elements being brought together through robust reporting and escalation processes using a risk management approach to ensure person-centred, safe and effective patient care. This has been critical throughout the pandemic period to support the safety of people who use services and of the workforce. CCPG considerations have been central to managing the adaptation of existing services in response to public health restrictions and enhanced infection prevention and control measures, as well as to the development of new services and supports directly responding the new health and social care needs arising from the pandemic.

The Partnership has been part of and has contributed to the statutory Best Value Audit of Dundee City Council which was published in September 2020. The Accounts Commission is the public spending watchdog for Local Authorities and is responsible for assessing Best Value. The Council's audit focused on their vision and strategic direction, performance, planning for use of resources, delivery of services with partners and continuous improvement. The Accounts Commission found that whilst the Council and its partners have a clear and ambitious vision for Dundee, that there is an need to accelerate the pace of change in addressing complex and deep-rooted challenges such as poverty and drug and alcohol use. The Commission also noted risks in relation to the financial sustainability of the IJB and the likelihood that this would be further exacerbated by the impact of the pandemic.

1.3 How We Promote Equalities and Human Rights

The Partnership is committed to embedding the principles of fairness, equality and human rights in the planning and delivery of all our responsibilities. The implementation of the Equality Act (2010) supports our aim to reduce the impact of protected characteristics as well as poverty and poor social circumstances for people who need to access our services, their carers, our workforce and our communities. This is enhanced by our focus on reducing health inequalities and supporting efforts co-ordinated by the Dundee Fairness Commission across the Local Community Planning Partnerships to tackle deprivation and promote fairness.

The IJB is directly subject to the Public Sector Equality Duty and is responsible for delivering on its own Equality Outcomes. We work in partnership with Dundee City Council and NHS Tayside to ensure compliance with the Equality Act. All Public Bodies are committed to the delivery of the Equality Act across Dundee; this has particular importance as our workforce is employed by Dundee City Council, NHS Tayside or through commissioned organisations in the Third or Independent Sector. We have continued to work alongside all of the partners who employ our workforce to promote fairness and comply with our equality duties.

The Fairer Scotland Duty placed a legal responsibility on IJBs to 'pay due regard' to how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions. The continued commitment within the Partnership's Strategic and Commissioning Plan to addressing health inequalities supports our progress towards fairness and equality of outcomes.

The Partnership's existing equality outcomes were reviewed to reflect the desired outcomes of people with Protected Characteristics and those affected by poverty. The outcomes were aligned with the revised outcomes published by Dundee City Council and NHS Tayside in 2017. This resulted in the publication of our Equality Outcomes and Mainstreaming Framework 2019-2022.

Our **Equalities Outcomes and Mainstreaming Equalities Framework** sets out our priorities for addressing equality issues. We monitor and report on our progress against each of the agreed equality outcomes, refreshing equality outcomes as required.

At the end of 2020-21 we published our statutory Equality Mainstreaming Report 2019-2021 (https://www.dundeehscp.com/sites/default/files/publications/dhscp_equality_outcomes_framework_2021_publication.pdf) which gives information about how Dundee Integration Joint Board (IJB) is mainstreaming the equality duty and achieving the equality outcomes that were set in 2019. The report provides an overview of some of the positive progress that has been made over the last two years, as well as identifying priorities for further progress and improvement in 2021/22. Key content from the report is also reflected within this Annual Performance Report.

We have continued to contribute to the British Sign Language (BSL) plans of our partners in Dundee City Council and NHS Tayside and we will continue our work to ensure we meet the needs of BSL users in the best possible way.

1.4 How We Engage and Communicate with Our Stakeholders

Throughout 2020-21 we continued to work in partnership across the city, Tayside and nationally. The constraints of lockdown and the impact of ongoing limitations and restrictions have meant that our usual partnership and engagement practices have been restricted and effort has been directed at finding new ways of communicating and hearing from Dundee Citizens and their Carers. We have maintained our commitment to understanding the needs of individuals, families and carers in different geographic communities and communities of interest in Dundee. We have also valued the efforts and energies that our workforce and our partners have extended to hear from and keep in touch with as many people as possible during this time. It has been more important than ever for us to recognise that meaningful engagement and participation requires us to take account of their individual and collective characteristics.

We recognise that engagement is better done in partnership, taking advantage of expertise, resources and relationships which exist across our communities to best listen to those who need and make use of our services and supports. We have continued to work towards the Vision in the Participation and Engagement Strategy approved by the IJB in 2019.

Ensuring that the voices of the citizens of Dundee are heard and listened to, to improve their health and wellbeing and the quality and delivery of health and social care services.

We have joined with others in Dundee Partnership to learn more about how the Pandemic has impacted them and recognise that isolation has had a significant impact on wellbeing, as have money issues. We anticipate learning more about how people have been affected and the positive lessons we can draw from this. As we recover, we anticipate supports and services resuming and being reshaped to best meet their current needs as well as co-producing responses that will mitigate this impact and improve outcomes for people who use our services, their families and carers.

The Participation and Engagement strategy sets the broad principles by which we engage with patients, service users, their families and carers and our workforce. Throughout the pandemic, although restricted, our services have continued to engage directly with individuals, their families and carers to hear their views on how to improve service delivery; face-to-face focus group activities have been very limited. We continue to use a range of engagement methods including surveys, customer questionnaires, education/information sessions, telephone and virtual feedback and interviews.

We have embedded many of the actions and activities identified through the Coalition of Carers in Scotland Best Practice Standards for Community Engagement. We have also continued active involvement of carer and service user representatives on the IJB and other strategic planning groups.

Across all services and supports in Dundee we listen to and work with service users and carers in accordance with the principles in the Health and Social Care Standards . In particular **Standard 2- I am fully involved in all decisions about my care and support**. Services are expected to evaluate their performance under the standards and evidence this for inspections by regulatory bodies.

We have made progress towards reducing the impact of social isolation for individuals and their carers and have been able to give direct support with obtaining digital devices as well as given (often virtual) support to use them. For example, Dundee Carers Centre was able to redirect some Carers Act Funding towards making sure all young carers known to them in early/mid 2020 had access to an appropriate digital device. Other service users, patients and carers have benefited from support from Connecting Scotland funding sourced by local organisations for individuals who are: digitally excluded, and on a low income, and at risk of social isolation and loneliness.

As well as providing one-to-one and groups support online and by telephone Dundee Carers Centre developed "Virtual Hubs" sessions via Facebook Live, these have proved highly successful with carers and workforce across Dundee and further afield.

A number of engagement surveys were disseminated during 2020 for both carers specifically and Dundee citizens in general. Findings of these surveys have been included under the Strategic Priority – Localities and Engaging with Communities section of this report.

2.0 OUR RESOURCES

2.1 Where Our Resources Come From

The Partnership's 2020-21 integrated budget for adult Health and Social Care services was confirmed at the IJB's meeting held in August 2020 (having been deferred from March 2020 COVID-19 pandemic lockdown restrictions). This budget consisted of resources delegated to the Partnership by Dundee City Council and NHS Tayside to support the delivery of adult Health and Social Care services.

The budget settlement from Dundee City Council for 2020-21 included an uplift for inflation of £nil, other net budget increases of £232k and additional funding from the Scottish Government of £2,799k for the implementation of new legislative and other national policy requirements and financial commitments, including further implementation of the Carers Act, the uprating of free personal care for under 65s, further payment of the living wage, and increases in free personal and nursing care payments.

The NHS budget settlement included an uplift passed on directly from the Scottish Government of 3.0% to fund general increases in expenditure.

In addition to the budget settlements from Dundee City Council and NHS Tayside, additional Scottish Government ring fenced funding was provided during the year to support national initiatives for Primary Care Improvement, Mental Health Action 15 and Alcohol and Drug Partnerships, as well as provision to support additional expenditure incurred by the Health and Social Care Services in relation to the COVID-19 pandemic response.

Set within this financial context are services which face increasing levels of demand to support vulnerable people in Dundee. This includes the demographic impact of an increasingly frail population, prevalence levels of people with a disability, mental health and substance misuse problems and levels of demand for GP prescribing. The culmination of these factors resulted in a projected budget shortfall of £2,341k in resources in the Health and Social Care Partnership's 2020-21 budget at the budget setting stage. The IJB considered and agreed to a range of savings and interventions which would be applied throughout the year in order to balance the budget.

This section of the report sets out how the Health and Social Care Partnership performed in relation to these challenges throughout 2020-21.

2.2 How We Have Used Our Resources

This section links to

National Health and Wellbeing Outcome 9: Resources are used effectively and efficiently in the provision of Health and Social Care services and Dundee City Best Value Theme - Use of Resources.

The IJB has a duty of Best Value, by making arrangements to secure continuous improvements in performance, while maintaining an appropriate balance between quality and cost. In making those arrangements and securing that balance, the IJB has a duty to have regard to economy, efficiency, effectiveness, equal opportunities requirements and to contribute to the achievement of sustainable development. Following a self-assessment, the IJB can evidence it has in place a clear strategy to support the delivery of best value through its governance framework and budget setting process.

With the backdrop of a significantly challenging overall financial settlement as noted in section 2.2, Dundee IJB received regular financial monitoring information throughout 2020-21 which continued to highlight the range of pressure areas and services which were likely to over or underspend throughout the financial year. These overspend areas included the continued challenges of meeting the demographic demands of an increasingly frail population, reducing delayed hospital stays resulting in further investment in community-based Health and Social Care services and the impact of pressures on the mental health inpatient service.

The COVID-19 pandemic had a significant impact on Health and Social Care Services throughout the year, with some services having to temporarily stop due to national guidelines and others needing to be enhanced or developed to support local residents, patients, service users and providers in different ways. The financial impact to support the additional remobilisation and recovery work amounted to £10,271k of additional expenditure, and this has been funded from additional Scottish Government non-recurring allocations during 2020-21.

The overall financial performance consisted of an underlying overspend of £1,387k in Social Care budgets (overspend of £6,073k in 2019-20) and an underlying underspend of £3,482k in NHS budgets (underspend of £266k in 2019-20) resulting in a net surplus of £2,094k.

The actual expenditure profile for integrated Health and Social Care services for 2020-21 is shown in the table below:

Service Type	2020-21 Net Expenditure/ (Income) £000	2019-20 Net Expenditure/ (Income) £000	Increase/ (Decrease) £000
Older People's Services	85,756	78,086	7,670
Mental Health	22,761	21,062	1,699
Learning Disability	37,401	35,448	1,953
Physical Disability	8,133	8,672	(539)
Substance Misuse	6,825	5,256	1,569
Community Nurse Services/ AHP*/Other Adult	17,351	15,128	2,223

Community Services (Hosted)	11,842	10,776	1,066
Other Dundee Services/Support/ Management	3,251	4,875	(1,624)
Prescribing	31,053	32,406	(1,353)
General Medical Services (FHS**)	28,136	26,687	1,449
FHS - Cash limited & Non Cash limited	22,174	19,216	2,958
Total Costs of Operational Services during the Year	**274,683**	**257,611**	**17,071**
IJB Operational Costs	329	294	35
Acute Large Hospital Set Aside	17,608	18,172	(564)
Total Cost of Services	**292,620**	**276,077**	**16,542**
Delegated Budget*	(305,957)	(273,803)	(32,154)
(Surplus) or Deficit on Provision of Services	**(13,337)**	**2,274**	**(15,612)**

*AHP - Allied Health Professionals

** FHS - Family Health Services

All above figures are subject to change following completion of the audit of the accounts. Final audited accounts will be available by the end of November 2021.

The summary of this financial performance is shown below:

Financial Performance Summary

	2016-17	2017-18	2018-19	2019-20	2020-21
Total Spend	£254.5M	£257.5M	£263.1M	£276.1M	275.1M
Health Service - Hospital In-patient	£44.7M	£40.4M	£42.1M	£43.6M	£43.1M
Other Social Care Services	£64.4M	£71.1M	£72.6M	£76.4M	79.4M
Other Health Care Services	£116.2M	£115.2M	£117.5M	£123.2M	£116.6M
Care Home and Adult Placement Social Care Services	£28.0M	£29.5M	£29.5M	£31.5M	£34.6M
Supporting Unpaid Carers	£1.2M	£1.3M	£1.4M	£1.4M	£1.4M

You can read more about our financial performance in our Unaudited Annual Accounts 2020-21, with the Audited Accounts available by the end of November 2021.

Reserves:

The financial performance of the IJB during 2020-21 resulted in a shift in the reserves position from £492k at the start of the year to 13,829k at the end of the year. The majority of this balance, £11,735k, relates to ring fenced funding which will be invested in the purposes for which they were intended during 2021/22 (i.e. Primary Care Improvement Plan, Mental Health Action Plan, Alcohol and Drug Partnership Funding and ongoing COVID-19 remobilisation and recovery). The remaining £2,094k will be uncommitted at the start of 2021/22.

Shifts in Resources:

Over the last 12 months, the IJB has continued to invest additional resources in social care and community-based services across client groups while redesigning services to reduce spend on the hospital bed base and care homes in line with its Strategic Plan. This has resulted in a continued decrease in delayed discharges from hospital and emergency bed days which had enabled NHS Tayside to release £1m of resources to Dundee Integration Joint Board as part of the 2020/21 budget agreement for reinvestment in community-based services.

3 OUR PERFORMANCE

This section describes and analyses our performance. In previous reports we presented our performance under 9 National Health and Wellbeing Outcomes and cross referenced these to local and national indicators, Dundee Strategic Priorities and Best Value Themes. In this report we have reorganised our focus to have a more direct connection with the 4 Strategic Priorities as set out in the Dundee Strategic and Commissioning Plan 2019-22. We have organised our Performance under these 4 Strategic Priorities and the performance and actions reported, link across to each of the 8 Best Value themes and 9 National Health and Wellbeing Outcomes.

Under each Strategic Priority we have described some of the key developments over the last year and any evidence of impact on health and social care needs and outcomes. This is not intended to provide a comprehensive overview of all of the work that has been undertaken during 2020-21. The examples we have included demonstrate pandemic specific responses, adaptions to existing services and supports in response to the pandemic and non-pandemic improvement activities where these have been able to continue over the last year.

3.1 Strategic Priority 1 - Health Inequalities

Our Ambition:

Health inequalities across Dundee will reduce so that every person, regardless of income, where they live or population group, will experience positive health and wellbeing outcomes.

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 to have improved health and to have equality of health outcomes irrespective of where in the city they live.

Dundee had the 3rd highest premature mortality rate in Scotland during calendar year 2020, with 604 unexpected deaths per 100,000 population aged 75 and under. This is an increase of 11.4 % from 2019.

Dundee has high levels of deprivation with a wide gap between the richest and poorest communities. Overall Dundee is the fifth most deprived local authority area in Scotland. Seven out of eight Dundee LCPP areas contain postcodes which are of the most deprived in Scotland. More than half of those living in Lochee, East End and Coldside live in the 20% most deprived areas of Scotland.

55,840 (37.5%) people in Dundee City live in a datazone within the 20% most deprived in Scotland. (Scottish Index of Multiple Deprivation 2020)

A higher percentage of people in Dundee live with one or more health condition than in Scotland as a whole. East End, Coldside 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.

In Dundee life expectancy is 74.0 years for males and 79.2 for females, whereas it is 77 years in Scotland as a whole for males and 81.1 for females. Dundee has the second lowest life expectancy in Scotland for males and third lowest for females. Life expectancy varies substantially by deprivation level and the occurrence of health conditions and disability. Healthy life expectancy is used to understand how many years in 'good health' a person will live. In Scotland as a whole, males are expected to live 61.7 years in good health and in Dundee men are expected to live 56.8 years in good health. In Scotland as a whole, women are expected to live 61.9 years in good health and in Dundee women are expected to live 57.9 years in good health.

Local data provides strong evidence of the high levels of deprivation in Dundee. Evidence across a range of issues such as attainment, health, mental health and substance misuse highlights a strong correlation between poverty and poorer life outcomes 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 lifestyles associated with deprivation. Looking after their own health may be more difficult for people with long term conditions including mental illness and disabilities. The combined effects of these are evidenced by the increased demand and usage of Health and Social Care services.

The short, medium and long term effects of the pandemic has further exacerbated the already high health and social inequalities in the city; reduced income as a result of job loss, reduced working hours and furlough. With unemployment predicted to rise in the medium term, this insecurity may accelerate. Personal debt has escalated during the crisis, potentially trapping households in unmanageable debt and poverty in the future.

How We Performed

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

Health & Social Care Experience Survey 2019/20

Dundee

Scotland

"How good is your health overall?"

Dundee Citizens Survey 2019

The Dundee City Council's Citizens Survey is completed annually, however was not undertaken in 2020 due to the pandemic. There was a drop in the % of people who reported that their overall health is very or fairly good from 83% in 2018 to 77% in 2019.

The Dundee Citizens Survey is analysed by ward and Community Regeneration Area (CRA) shows that respondents who lived in Fintry, Whitfield and Mill O Mains (56%) were most likely to rate their health as 'very good' while respondents who lived in Mid Craigie, Linlathen and Douglas (39%) were the least likely.

Despite Dundee citizens giving a positive response to how good their health is and being able to look after their own health, emergency admission 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 2020, for every 1000 people in Dundee who were aged 18 and over, there were 118 emergency admissions. This is higher than the Scottish rate and was the 12th poorest performing Partnership in Scotland, out of all 32 Partnerships.

The 2020 rate is lower than the 125 in 1000 people reported in 2019, however this is a result of the emergency response to the COVID-19 pandemic.

Emergency admission rates vary across the city. The highest emergency admission rate was in East End (162 admissions per 1000 people) and the lowest rate was in West End (81 admissions per 1000 people). There is also high variation between the neighbourhoods within each LCPP. When we analysed this data by whether an admission was due to COVID-19, the LCPP trend was the same however the rate was slightly lower. (Source: NHS Tayside, Business Support Unit)

During calendar year 2020 emergency admission performance was slightly higher in Dundee than across Scotland and Dundee was the second best performing Partnership in the family group, of eight Partnerships, that it is aligned to.

The Engage Dundee survey took place online during August 2020 and was a partnership between Dundee City Council Community Learning and Development section, the Partnership and NHS Tayside Public Health Directorate. It was circulated widely across a number of digital platforms and limited paper copies were made available through some local teams and voluntary sector partners. The survey aimed to explore the impact of the COVID-19 pandemic on Dundee's citizens, particularly in determining whether individuals had accessed specific services during lockdown, their experiences both positive and negative, whether there had been impacts on mental health and wellbeing and in what ways, any positive developments over the lockdown period, and to help assess the priorities of individuals, families and communities going forward.

Findings show that the most commonly used services during lockdown were: GP services (61.5%); websites/self-help resources (46%); mental health advice/support (32%); physical health advice/support (30%); food parcels/delivery (29.2%); and money/benefits advice and support (23.5%).

There were varying degrees of satisfaction expressed for using services; highest was for websites/self help resources (78.9%), food parcels/delivery (76.2%) and GP services (69%), and lowest for employment advice (40.2%) and substance use/alcohol support (16.3%).

The survey explored whether respondents were experiencing specific difficulties and the most common responses were for mental health (37%), healthy lifestyle (31%), family/household relationships (18%), physical health (18%), and income/money (20%).

Many respondents felt there had been positive developments due to lockdown/ COVID-19 restrictions. 57.7% reported less traffic, 41.5% reported spending more time with their family, 30.2% made more use of green space, and 28% exercised more.

Further analyses explored the variation in responses and experiences within the different categories of respondents; that is, age group, employment status, in receipt of welfare benefits or not, and living alone or with others. Significant inequalities across a range of indicators became apparent in these analyses, most notably for specific age groups, carers, long-term sick or disabled, the unemployed, people on benefits and those who live alone.

Results from this and other surveys show emerging themes regarding the impact of the pandemic during and moving out of lockdown. The most common themes across the surveys related to reduced access to services, the day to day challenges of lockdown measures, uncertainty and concerns about the ongoing nature of the pandemic, social isolation, mental health impacts more broadly, and financial and job insecurity. For many, the issues were interconnected and for some the pandemic had exacerbated what were already difficult life circumstances.

Results suggest that accelerated efforts should be considered by a wide range of partners to mitigate effects for those in most need whilst building resilience for individuals and communities to provide responses themselves. Suggested actions for partners moving forward are:

- disseminate the findings across the system, acknowledge the disproportionate effects of the pandemic on particular populations groups,
- use the data to influence recovery planning,
- involve local people in identifying solutions and setting priorities, and consider any rapid responses that can be implemented to alleviate difficulties.

The Get on Track course was developed by the Community Health Team to help address issues arising from the COVID-19 pandemic. Staff became aware of a wide range of challenges being encountered by indiviuals through their engagement with local people over the telephone, in settings such as foodbanks, and as evidenced through the findings of the Engage Dundee survey completed by over 800 residents. The survey showed that the pandemic was having a profound impact on the mental and physical health and wellbeing of residents, their social connections and sense of security, and the material circumstances of their lives.

Dundee had the highest rate of drug related deaths and the fourth highest rate of alcohol deaths in Scotland when calculated over a 4 year period from 2016-20.

Dundee had the highest suicide rate in Scotland when calculated over a 4 year period from 2016-20. 38% of Dundee carers reported having to reduce or give up hours in employment due to their caring commitments (Dundee Carers Engagement, 2020). 67% of Dundee Carers reported negative financial impact as a result of higher household expenses.

Samaritans reported that mental ill-health was the most common concern during the year since restrictions began, and increased slightly compared to last year. The mental health of people with pre existing mental health conditions appears to have been affected most. Finance and work concerns were strongly associated with concerns about the pandemic, with concerns about potential and actual job loss strongly linked to fears about the future.

What we have achieved to deliver this Strategic Priority

Community Health and Housing

- The Community Health Team produced an online directory of real-time service changes during lockdown covering public, voluntary and private sector. The development of a telephone support system for Community Learning and Development staff to enable them to support callers struggling to cope by connecting them with a wide range of services including the Council's Firmstep system.
- Social Prescribing Link Workers (Sources of Support) moved to telephone/online support during the pandemic and extended their coverage to an additional nine GP practices. This means that all practices in Dundee City now have access to link worker support.
- Housing First is an internationally recognised programme to provide intensive support to participants to encourage independent, community living. It is aimed to break the 'revolving door' of homelessness and introduces a network of partners to empower participants to take control of their lives. At 31 March 2021 there were 100 participants on the programme. The programme's sustainment rate is 89%, which is higher than the national rate. The Housing First Dundee Pathfinder will come to an end on 30 September 2021, and the participants will be offered support from alternative support providers including the Housing Support Team, who operate under the internationally recognised principals of Housing First. Within the above time period the programme has developed an exit strategy to ensure that the mainstreaming of the service is as seamless as possible for the participants, as well as providing the wrap-around support that had been provided over the previous two years.

Sources of Support:

Mr O - Key Issues

- Homelessness
- Low mood
- Anxiety
- Recovery from substance use
- Food poverty
- Employability support

Housing Issues

Mr O became homeless due to a relationship breakdown, at the height of the COVID-19 Pandemic. He was referred in to Sources of Support by his GP, as he had presented to them feeling overwhelmed.

He had no idea how to navigate through the homeless process, and could not access housing support until he had a tenancy. His Link Worker helped Mr O through the homeless application process and to secure temporary accommodation.

Financial Issues

Although this new temporary accommodation was more affordable, it was also unfurnished. This meant Mr O had no fridge, freezer, cooker, washing machine, bed or sofa. His Link Worker liaised with local community agencies to access furniture, and also helped Mr O apply successfully for a Community Care Grant.

Mr O now lives in a comfortable, affordable home with his own furniture and new white goods which will go with him when he moves into his own permanent tenancy.

Mental Health Support

Throughout this difficult time of transition, Mr O also faced other challenges including family illness, the unexpected loss of his job as a result of the pandemic and relationship problems. Mr O struggled with high levels of distress and anxiety and his Link Worker provided self-help resources and emotional support to help him, while he awaited assessment.

The Role of the Link Worker

Although the presenting issue was initially homelessness, the Link Worker was able to support Mr O through the other issues that arose in the course of their work together. This holistic approach included supportive, encouraging conversations, ensuring Mr O had access to mental health support by providing access to free online resources that he could work through at home and also linking him in with addiction support services, as he was in recovery and did not want to relapse due to the stress and turmoil that he was going through. Mr O engaged well with all the support offered, started a college course, and looks forward to moving into his own permanent home. Most importantly he feels empowered and well-equipped to deal with any future issues that may arise in a positive way, as he feels he now has the tools required.

- During the pandemic, Keep Well/ Health and Homeless Outreach Team nurses worked in partnership with community workers and third sector organisations at food distributions points where money advice, mental health and wellbeing leaflets and other information was inserted into food bags. The nurses also worked in partnership with the Housing Options Service due to the increased demand for Temporary Accommodation during the pandemic, and accessed funding for wellbeing packs to drop off at people's homes and undertake assessments at the same time.
- The Get on Track course was offered in five community centres once restrictions had lifted and used a range of activities to explore topics. The aim was to build the capacity of participants to cope with and address their own needs by working together, supporting one another, learning new skills, and accessing information. Group members could opt to participate in all or selected parts of the course and were able to progress onto the accredited Health Issues in the Community Course if they wished to. Sessions included: Getting to know one another; Looking after yourself; Knowing where to go for support; Making informed health choices; What influences our health and wellbeing; and, Taking control.

  Participants said...

I was so nervous about doing this course but my Community Nurse assured me that it would be friendly and welcoming… it was really good, we covered some really interesting subjects. It was so good to speak with adults again, I had been at home with my 7 year old and he has a learning disability.

Lochee Ward Group

I have had problems with alcohol and I struggle to find things to do. The course on a Monday afternoon was helping me to meet other people and talk about normal things. It was helping me keep motivated. I really hope it can start again as I have missed the support and direction that it gave me.

Coldside Ward Group

The Get on Track course is excellent, I have enjoyed all of the sessions especially the one that was about mental health. I suffer from stress and anxiety, it was reassuring to hear others talking about their issues. It made me realise that I wasn't the only person that was struggling.

Coldside Ward Group

The courses were suspended once restrictions were reintroduced; however, plans are in place to re-establish the courses as soon as it is permitted to do so.

Health and Homelessness Outreach Team (HHOT)

Links with National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
7. People who use health and social care services are safe from harm.

Mr K is a 40+yr old male with a long history of illicit drug use and mental health concerns. He has lived in the same community all his life and although he had support from family and friends and was in employment this changed due to his addiction and criminal activities.

In his late teens he sought help for his addiction and was prescribed Methadone. Mr K found it difficult to adhere to his treatment and despite being given support it was decided clinically that it was no longer safe for him to be prescribed Methadone and the treatment was terminated. Mr K has been in jail periodically due to drug related crimes for the past 20 years. After liberation from his last custodial sentence he was placed in homeless accommodation.

Mr K engaged with Parish Nurses and was referred to the mental health nurse from the Health and Homelessness Outreach Team (HHOT). On assessing Mr K's needs, the nurse found that he had anxiety due to being in a homeless hostel in an area of Dundee where he had no support network. He was struggling to attend welfare benefit assessments and was confused about medication. He was finding travel difficult and wished to apply for a bus pass. The HHOT nurse liaised with Positive Steps and together they helped Mr K to access a bus pass, which ensured he could attend a pharmacy for his prescription.

During lockdown, the HHOT nurse kept in touch with Mr K and arranged a joint visit with a Parish Nurse. The nurses contacted the GP Surgery to arrange a full medication review resulting in Mr K no longer being prescribed medication he did not need. This resulted in him feeling better physically. Mr K was refused Personal Independence Payments and the nurses are supporting him to cope with this decision and submit an appeal.

The nurses continue to visit Mr K fortnightly and provide regular updates to Positive Steps. They have also contacted the Dundee City Council Temporary Accommodation Team to support Mr K with his request to be housed in the area of Dundee where his support network lives.

Protecting People

- The MARAC Independent Advocacy (MIA) Service has progressed significantly in reaching service users who are at high risk of harm from domestic abuse and it provided a service for 489 referrals during 2020-21. Activities undertaken were designed to assess and reduce risk, to provide practical and emotional support and to ensure access to advice, information and support tailored to individual needs.

  These activities included:

  - Home visits carried out in the first quarter of the year, where appropriate and safe or alternative safe venues were arranged to provide face to face advocacy and support.
  - Victims supported to attend and engage with, e.g. GPs, solicitors, schools and other agencies that women found particularly difficult to engage with. During lockdown, such support was through digital means, with workers sharing information appropriately to make it easier for service users to engage with others without having to tell their story repeatedly.
  - Targeted work to specifically support service users to engage and access the new direct access clinics through the Integrated Substance Misuse Service (ISMS). This was more challenging during lockdown as these clinics closed, however they continued to liaise with ISMS to ensure safe arrangements were put in place to enable service users to access a service.
  - Advocacy and support carried out remotely. Client engagement rates were high, with less need for proactive outreach. This was undoubtedly due to MIA being able to assist clients financially. Barnardo's administered the Scottish Government wellbeing fund and also hardship funds provided by the National Lottery. Increasing numbers of service users experienced financial pressures during this time period. Change in benefits and increase in costs of food has increased the impact of poverty. Between 16th March and end of September, Barnardo's distributed over £8,500 through the FORT system to service users in our domestic abuse services and prison mentoring service who were severely financially impacted by COVID-19. An additional £2000 was also used to purchase supermarket vouchers, mobile phones/top ups and bus passes/taxi vouchers, from the hardship fund monies provided by Big Lottery, for use by vulnerable service users.

  Outcomes of victims and their children affected by domestic abuse who were supported by the MARAC Independent Advocacy (MIA) Service:

  - 94% have a reduced assessed risk of harm
  - 87% report increased feelings of safety
  - 94% report improvements in physical and mental wellbeing
  - 98% accessed local networks of support and relevant agencies to improve their social capital
  - 76% supported to be in safe accommodation
  - 92% accessing appropriate services to ensure multiple needs are met
  - 94% reported their views being heard
  - 99% reported increased feelings of control

  - The Dundee Women's Aid Aspen project recognised the value of having a Clinical Psychologist where specialist case consultation can be accessed, and treatment plus training can be accessed quickly. The case has been made for the position to be funded permanently and this has now been taken forward by the Partnership thereby securing the specialist provision for women who experience a range of health inequalities due to their experiences of trauma and homelessness. This will allow continuity of service and opportunities to expand the service.

- The recognition of the value and success of the ASPEN specialist provision has been extended to Dundee Women's Aid Children and Young People's service. There has been growing recognition of the complex needs of children and young people who have experienced domestic abuse and how these traumatic experiences impact on the child or young person's wellbeing and education. Shared learning led to a funding bid to employ a 0.5wte Clinical Psychologist to work in partnership with Dundee Women's Aid Children and Young People Team and CAMHS. This bid has been successful and monies have been awarded. ASPEN, Dundee Women's Aid Children and Young People Team, CAMHS Clinical Psychology and Dundee Educational Psychology Service (DEPS) continue to work in partnership to shape and support this pilot project. This has the potential to significantly reduce the impact of trauma for children and young people, including early intervention and prevention to reduce the likelihood of poor health outcomes in the future.
- Dundee Independent Advocacy (DIAS) service was successful in a bid to the Alcohol and Drug Partnership to create a new substance user independent advocacy post as a test of change over a 2 year period.

  There are 2 main parts to the role

  - Directly supporting people with substance use to have their voice heard and be the conduit between the person and services (both statutory and third sector) that are involved with the person.
  - To raise awareness of the benefits of seeking independent advocacy support at an early stage in a person's recovery process, often when non-engagement is high, to all staff within statutory and third sector organisations that support people with substance use. There will be an element of winning over the "hearts & minds" of some staff to see the wider benefits of advocacy to all involved, for example validating their own professional service and how it helps the recovery process be person centered at all times.

  Although DIAS has supported people who have substance use prior to this designated post it has been limited both in terms of sustainability of resource when there is non- engagement, and to the reach of services such as non-fatal overdose teams. It has also allowed DIAS to be directly involved at a strategic level, helping shape and influence support services with people with substance use and their families.

Substance Use

- We have listened to and shared the findings of Dundee Drugs Commission and the Tayside Mental Health Inquiry. Following the sharing of these reports, plans have been initiated to make changes to increase positive outcomes for people in Dundee and those who care for and support them.
- The Injection Equipment Provision Harm Reduction Service was awarded £500 by the Scottish Government's Supporting Communities Fund to hand out 100 hygiene packs to people who access the service and during outreach. These packs consisted of: a reusable purple duffle bag, two reusable face masks, hand sanitiser, 2 in 1 shampoo and conditioner, tooth brushes and toothpaste, a face cloth, a pack of razors, deodorant, hair brush, bar of soap and a lip balm. These packs allowed those facing financial hardship during the COVID-19 pandemic to continue practicing good hygiene.
- Prior to lockdown, We are With You developed a weekly recovery group programme which had been well attended and is starting up again. Activities include hill walking with Ancrum Outdoor Centre, cycling, allotment gardening, fitness with Street Soccer and walking with the Keep Well team.

When I first reached out to WRWY, I was on a downward spiral that was only going to end one way. A year later with frequent check-ins , I am a new person, quite literally saved my life. I still have down days but when I think of relapsing I go back to the advice given to me and that stops me doing anything silly. The best move I ever made was to make contact with WRWY. They gave me the tools I needed to succeed and stay sober and I will always be grateful.

Feedback from person supported by WRWY

- For several years the R&R (Restore & Revive) recovery café has run a Christmas toy appeal which distributes toys to families who otherwise may not be able to provide a Christmas for their children.

R & R Cafe
Revive & Restore

This past Christmas, although the R&R was closed due to COVID-19 they were still able to provide toys to 134 children within Dundee.

City Church Dundee kindly offered the use of their main auditorium and the recovery worker planned the event, ably assisted by R&R volunteers, who have lived experience of substance use and operate the café when it is open. The volunteers came together specifically for this event and their contribution demonstrated the progress they have made in their recovery journeys.

Family members were also extremely grateful as can be seen by the comments below.

Hi, My name is ** I'm 30+ years old, I have 2 kids. This year for kids has been the worst ever, I came to help yesterday and the lovely people I've met at the Friary to help bring toys for all the poor kids after this bad year. I'm so happy as I've had a very warm welcome and I thank all these volunteers etc. If it wasn't for the group my kids wouldn't have got as much for Xmas as I have very bad financial difficulties. I'm so grateful of what these people have done for me and my 2 kids. I can't stress enough how lovely everyone is here at the Friary. So thanks everyone and God bless everyone for the help as my kids didn't have much but I'm so grateful, thanks everyone, you are amazing people.**

The Recovery Café is empowering volunteers with lived experience to develop new skills, increase their self-esteem and be part of their community. After the toy event several of the volunteers felt confident enough to take part in CrossReach's internal volunteer training course.

Using Information for Improvement and Service Planning

- We have published Locality Profile information about the people who live in each of the eight Community Planning Partnership areas. This information helps inform planning in these areas and supports us to analyse if progress has been made towards the Partnership outcomes for people living in these areas.
- The IJB Performance and Audit Committee receive regular Performance Reports, with statistics comparing Dundee with other areas and including differences in Local Community Planning Partnership areas. This information is analysed and comparisons made between areas of deprivation regarding important statistics like: Emergency Hospital Admissions rates; number of bed days; and amount of Delayed Discharge. This information informs plans to address health inequalities.

3.2 Strategic Priority 2 - Early Intervention and Prevention

Our Ambition:

Enhanced community based supports are enabling people to take greater control of their lives and make positive lifestyle choices that enhance their health and wellbeing and reduce the need for service based interventions.

By working with people earlier, we can reduce the incidence and impact of ill health. We believe that a focus on prevention and early intervention is a positive choice, which will reduce the need for more intensive or acute support at a later time. It is by prioritising early intervention and prevention that we improve outcomes in the longer term, more effectively manage demand for services and release resources to where they are most needed.

Local people tell us that they want support to live independently and when possible want to be supported at home or in a homely setting. They prefer to live at home rather than be in a care home or hospital. We know that if needs can be met at home then the hospital environment is not the best place to provide long term care.

How We Performed

Health & Social Care Experience Survey 2019/20

"I was supported to live as independently as possible."

Dundee

Scotland

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

Dundee

Scotland

Dundee has a high rate of readmissions to hospital, where the patient had been discharged within the last 28 days. In 2020 14.6% of people discharged from hospital following an emergency admission, were readmitted within 28 days. (Public Health Scotland) Dundee has the second highest 28-day readmission rate in Scotland. We have compiled in depth analysis to understand reasons for this and whilst we realise that we need to improve the number of people being readmitted, we also know that the way we record readmissions differs to other Partnerships and this further inflates the rate. We are working with colleagues in NHS Tayside to agree a solution to this.

Despite a high rate of readmissions to hospital, the number of bed days lost to delayed discharges for people aged 75 and over is 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 2020-21, for every 100 people aged 75 and over, 32.4 bed days were lost due to a delayed discharge. This is an improvement on the 2019-20 figure, when there were 44.5 bed days lost for every 100 people aged 75 and over. In 2020-21 Dundee was the 12th best performing Partnership in Scotland. (Public Health Scotland)

There is variation between the number of bed days lost to a delayed discharge across LCPPs.

People aged 75 and over who live in North East LCPP contribute to the largest rate of standard delayed discharge bed days for all reasons. For every 100 people aged 75 and over living in North East there were 23 bed days lost in 2020-21. The lowest standard delayed discharge bed day rate was in Strathmartine where for every 100 people aged 75 and over there were 12 delayed discharge bed days used.

People aged 75 and over who live in Maryfield LCPP contribute to the largest rate of complex delayed discharge bed days for all reasons. For every 100 people aged 75 and over living in Maryfield there were 23 bed days lost in 2020-21. The lowest complex delayed discharge bed day rate was in Strathmartine where for every 100 people aged 75 and over there were 5 delayed discharge bed days used.

There are a number of preventative and rehabilitative supports available in the community and one measure of this is the extent to which the Partnership is maintaining people with long term care needs in the community. Home care is one of the most important services available to partnerships to support people with community care needs to remain at home. This indicator measures the number of adults who are 65 and over receiving care at home as a percentage of total number adults needing long term care. Using the most recent national data available for 2020, 59.5% of people in Dundee aged 65 and

over with long term care needs were receiving personal care at home. This is slightly lower than the Scottish figure of 62.9%.

Despite many 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 aged 18 and over remain higher than most other Partnerships. Dundee has a high rate of emergency occupied bed days for all hospital specialties – acute and mental health, although there has been a substantial reduction (15%) between 2019-20 and 2020. (Public Health Scotland) This is a positive change, meaning that, on average, for every 100 people in Dundee 97 bed days were occupied during 2020, compared with 115 bed days occupied in 2019-20. Despite this improvement, during calendar year 2020, Dundee performed more poorly than the Scottish average and was the 15th poorest performing Partnership in Scotland, out of all 32 Partnerships. Whilst performance in Dundee is poorer than the Scottish average, when assessment is made alongside the other 'family group' Partnerships performance is more positive. In 2020 Dundee performed best out of all family group partnerships it is aligned to.

Emergency bed day rates vary across the city. The highest emergency bed day rate was in Lochee (119 bed days occupied per 100 people) and the lowest rate was in West End (71 bed days occupied per 100 people). There is also high variation between neighbourhoods within each of these LCPPs.

COVID-19 hospital admissions are necessary and unavoidable and cannot be influenced by the Partnership's Strategic Priorities. As part of our quarterly performance reporting we have tracked and analysed emergency admission and bed day rates across LCPPs with data separated by COVID-19 and non COVID-19 admission reasons. Trends show a more positive trend and similar pattern across the data that excludes COVID-19 admissions. (NHS Tayside Business Unit).

The Pandemic has affected the proportion of people who received a minimum of 12 months post diagnostic support following a diagnosis of dementia. Between 2015/16 and 2019/20 this proportion was always over 97%, however during 2020/21 this dropped to 61%, which is slightly lower than the 68% for Tayside.

What we have achieved to deliver this Strategic Priority

Protecting People

- Dundee City Council has signed up to the Make a Stand pledge, which was developed by the Chartered Institute of Housing, in partnership with Women's Aid and the Domestic Abuse Housing Alliance, to encourage housing organisations to make a commitment to support those suffering domestic abuse and to intervene early. As a result of that commitment, the Housing and Communities Service have now developed a policy to support those experiencing domestic abuse in council housing in our city. This policy was approved by Elected Members on 16 November 2020. Since then, an oversight group to roll out the actions required was developed across services which included:
    - Rent Recovery
    - Customer Services
    - Construction Services
    - Housing Support
    - Housing Options and Lettings
    - Quality and Performance Unit
    - Violence Against Women Partnership
    - Dundee Women's Aid
    - Anti-Social Behaviour

- As a landlord, Dundee City Council regards domestic abuse as wholly unacceptable behaviour which will not be tolerated in their council houses. Therefore, to reflect this, the Scottish Secure Tenancy Agreement was amended to include a new clause, emphasising that domestic abuse will not be tolerated and detailing the implications for anyone perpetrating domestic abuse in council houses. In addition, since approval of the policy, an online training resource is being rolled out to staff who may witness/come in to contact, but not directly deliver intensive support and also for staff who will directly support and assist those who engage with the services.
- In Dundee, the Trauma Steering Group was initially set up to undertake a mapping of the Dundee City Council and Partnership workforce against the National Trauma Training Framework but has evolved to take a broader remit to develop and support the implementation of an action plan around organisational change relating to trauma informed leadership and trauma informed practice. Prior to COVID-19 we had submitted a successful bid to the Scottish Government to pilot a focus on trauma training for our strategic and senior management teams and develop the concept of professionals with lived experience. There are three key areas of work identified by the steering group which are as follows:
    - Ensure that the National Trauma Training Framework is delivered and implemented in Dundee. The National Trauma Training Framework will entail specific trauma training at informed, skilled, enhanced and expert levels.
    - Build an action plan around ongoing organisational change relating to trauma informed leadership with a focus on developing the concept of professionals with lived experience. Focus on strategic and senior management within multi-agency public protection and community planning leadership groups and the local authority.
    - As both a cause and consequence of culture change, professionals within the workforce with lived experience of trauma are able to contribute and co-produce services and strategy.
    - A draft action plan has been developed detailing priority actions under each area of work.

A number of tests of change (trauma informed and responsive culture and practice) are in progress and the Trauma Steering Group will provide support for these tests of change and intends to organise future learning and review events as the tests progress to ensure we evaluate and learn as we go to inform further expansion to a whole systems change.

The initial resource offered by the Scottish Government as part of our bid consisted of training input and support from NHS Education Scotland to deliver Scottish Trauma Informed Leadership Training (STILT) to our Chief Officers group and other strategic and senior personnel between January to March 2020. This was cancelled due to the emergence of COVID-19 but was delivered at the end of 2020 / start of 2021 through a virtual approach.

- The Commercial Sexual Exploitation Working Group of the Violence Against Women Partnership has been an active and well-attended group. Key activities have included:
    - Development of a fast track sexual health pathway for vulnerable women.
    - Development of multi-agency guidance for supporting people involved in commercial sexual exploitation (CSE) which was launched in January 2021. https://www.dvawp.co.uk/professional/guidance-documents
    - The Protecting People Team have continued their collaboration with the University of Dundee on PhD research looking at the barriers women face to exiting prostitution. The first stage of research involved interviews with practitioners whose role brings them into contact with women involved in prostitution whether or not the support they give is around prostitution specifically. The practitioner interviews revealed concerns around the way they were currently working with women experiencing CSE. These concerns included feeling alone, feeling like there was no cohesive strategy, lack of clarity on organisational standpoint and concerns about saying the

wrong thing or offending. These initial findings were fed back to the CSE working group who responded by collaborating on the production of Dundee Multi-Agency Guidance for supporting those experiencing CSE. To accompany this guidance there has been ongoing knowledge exchange events where practitioners are introduced to CSE and introduced to some ways they may wish to apply the guidance in their own work. Practitioners attending these sessions said:

Such a challenging topic – but I'd feel much more confident working with CSE

I learnt new things which I had not considered and it will help me to signpost to the relevant organisations to help women

The Scottie Project

Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
7. People who use health and social care services are safe from harm.

The Scottie Centre Project was formed in July 2019 to increase the support locally for women who are involved in commercial sexual exploitation. To effectively help these vulnerable women, whilst balancing community concerns, a focused partnership approach was formed by We Are With You, Maryfield Community Police Team and the Maryfield NHS Keep Well Team. Supported by Vice Versa, The Scottie Centre Project offers women a safe place to drop-in and access a range of supports including substance use, health assessments, benefit and housing advice. They also have access to food and toiletries, sanitary products, condoms and clothes.

The project is open access with no referral required and the woman can drop in by themselves. The project is open from 6.30pm-10.30pm - currently on a monthly basis. Prior to COVID-19 the project was becoming busier through word of mouth of the women who accessed and seeked support. Pathways were being developed with Dundee Drug and Alcohol Recovery Service and Brooksbank (Benefit Support) to increase the support and access into other services.

The project has now been running for two years and the support remained available throughout lockdown. The Scottie Centre closed for a period but support was still provided to the women as and when required from the same staff team. The focus now is to increase the drop-ins to bi-monthly and design opening hours around other services the women might attend, further increasing the accessibility of the service.

The Gendered Services Group (which reports to the Alcohol and Drug Partnership (ADP) and VAWP) has carried out a number of activities relating to services for women and has a remit to take forward actions in the ADP Action Plan for Change relating to gendered approaches (Recommendation 15 from the Dundee Drug Commission report - Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning).

Following research carried out in Dundee during 2019 we have been able to fund a Gendered Services development post, through the CORRA fund. The project aims to work with services to improve their gendered approach and responses to women in the city

The Gendered Services Project

Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
7. People who use health and social care services are safe from harm.

The Gendered Services Project is a two year project that began in September 2020. The project aims to encourage a gender mainstreaming approach to service delivery, specifically focussing on substance use services and homelessness services. The outcomes of the project are:

· Improved quality of service is provided to women
· Increased accessibility of services for women
· Increased capacity and ability of services to respond to women

The project is working with women with lived experience to shape the project and we now have around eight women with complex needs who regularly engage. The group has met to discuss the barriers they have experienced when trying to engage with services, and to talk about what makes a service more accessible. The input from the group members will be incorporated into a self assessment tool which will be used with services to identify gaps in service delivery and any gaps in understanding of a gendered approach for staff. The project has experienced delays due to the pandemic, especially when trying to recruit women with lived experience. We have done our best to be flexible in the ways in which women can participate. This has involved the use of online meetings, one to phone or video calls, email discussions and the use of online whiteboard tools to encourage collaboration. The ability to be so flexible in our approach has increased the engagement with women, and has provided us with a richer understanding of the barriers that women face in Dundee.

Over the remaining project delivery period, we will identify gaps in knowledge or support needs with services, the project will source training if needed, provide gendered approach training if required, advise on policies and procedures, and support services when they apply a gendered approach to service delivery. The project also aims to recruit champions within services who will continue to promote the need for a gendered approach with their colleagues and leaders. It is hoped that this approach will make the project sustainable.

Children and Families

- As part of our approach to gendered services we have engaged with women where there is significant adversity and vulnerability. Our multi-agency New Beginnings team (social work, midwife, mental health nurse, drug and alcohol recovery nurse and learning disability nurse) supported 38 babies to be cared for by their parents at home. In 31 of these families the child was placed on the Child Protection Register pre-birth due to concerns about significant risk however the team were able to work with the families to reduce these risks. We have also worked in partnership with Tayside Council on Alcohol (TCA) and PAUSE UK to support 22 women who have experienced the removal of 2 or more of their children. Most of the women were vulnerable due to mental illness or substance use issues and the program has supported them to achieve greater stability and connections with their families.
- PAUSE Dundee are working with 22 women. During the challenging lockdown period, the team has continued to work extremely hard to provide support, and the women on the programme have demonstrated high levels of resilience and engagement. No women dropped out of the programme, however one woman passed away. The first women to graduate from the programme began their transitions in February 2021, with the majority of transitions due to be completed by May.
  The women working with PAUSE Dundee are making excellent progress towards their goals. Examples of this include:
  - two women are attending college and have been supported by their practitioners to improve their digital literacy;
  - one woman has begun a volunteering opportunity with TCA;
  - three women have attended job interviews;
  - one woman is attending a weekly walking group independently;
  - the community are being supported through their grief and loss with three women now using memory boxes to record their experiences and memories.

Communication

- During the pandemic, The Protecting People Team has taken a lead, with Dundee City Council communications team (alongside NHS and Police Scotland communications teams) to ensure key messages are reaching the public. Leaflets with key protection messages for women who are involved in commercial sexual exploitation were developed. An accessible, symbolised version of public communication around domestic abuse has been produced with support from the NHS Speech and Language Therapy Department, Adult Learning Disability and Mental Health Service and Dundee Health and Social Care Partnership. Updates have also been made to the Protecting People website, including the violence against women section being significantly enhanced in January 2021 www.dvawp.co.uk
- COVID-19 information was sent out by the Community Learning Disability Nurses (CLDN) Dundee that was easy read during the changing face of restrictions. The team also worked jointly with the COVID-19 vaccination team to ensure safe and timely vaccinations were administered.

Substance Use

Alcohol Counselling Service

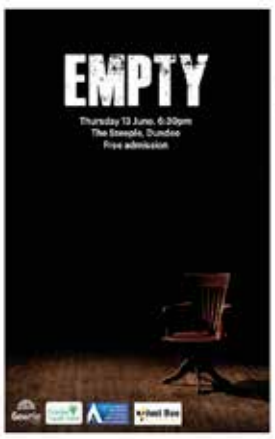
Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
7. People who use health and social care services are safe from harm.

Mrs H was struggling with alcohol dependency and suicidal thoughts. In the past she had her own business, but now middle aged she finds herself unemployed, alcohol dependent and her health is suffering. She has engaged with counselling for six months and finds it helpful to talk over her issues and process feelings she has held onto from childhood. Her mother was also alcohol dependent, and they spent most of her life apart, although reconnected when Mrs H was in her 20's. Sadly her mother died after a year and this left her feeling abandoned again in the same way she felt as a child. Over the years her drinking began to increase and she tried to suppress the emotional pain and was always trying to help others. She has come to understand a pattern of behavior and the dangers of people pleasing.

Mrs H is being supported to work on her thought processes and feelings using a person-centered approach and Cognitive Behavioural Therapy. There have been additional complications because of her health issues and associations which has led to feeling of shame which has felt unbearable at times and there have been some relapses. This process is taking time and we will continue to provide support until Mrs H is ready to engage in the wider community as lockdown lifts.

- Funding was awarded from Dundee Youth Fund to deliver an interactive performance to young people living in Dundee, challenging the consequences of substance use.
  Peer educators working alongside staff from Young Peoples Drug and Alcohol service and Just Bee Productions have developed a play that focuses around the current issues facing young people living in Dundee based on feedback received. There is a strong focus on current trends such as cocaine and ecstasy giving a realistic look at the impact on individuals, families and communities challenging stigma and breaking down barriers to seeking support and advice. The aim is to deliver this in schools across Dundee with a view to securing additional funds to have a wider roll out across Tayside. (delivery of the play has been on hold due to the COVID -19 pandemic).



Alcohol Counselling Service

Links with National Health and Wellbeing Outcomes

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During the pandemic the office has been open at certain times for new clients to be assessed and some clients have been opting to have telephone assessments. Part of the assessment process is to ask clients about their mental health and they are then triaged. Clients identified as high risk and who possibly have suicidal ideation are given priority in being allocated to a counsellor.

Mr C was identified as high priority as he suffered from depression and had attempted suicide several times. These attempts always happened when he had been drinking to excess so he, and his partner, decided it was time to do something about it. He is in his early forties and lives on his own but has a partner who lives elsewhere. He is trained as a chef and had been doing agency work but that had dried up due to the pandemic so he had a lot of time on his hands and was feeling a bit bored and depressed so the temptation was there to sit and drink.

Mr C explained that he had started drinking as a young teenager, but not to excess. He had been married but that broke up acrimoniously a few years ago and that is when his drinking started to become a problem. His habit was to binge for 3-4 days then spend the next few days recovering and then start again. We estimated that he was consuming, on average, in the region of 100 units a week. This puts him into the "dependent" category so we talked about the possibility of him trying detox again. The counselling process gave him the opportunity to reflect on his life and consider the pros and cons of drinking. He also consulted his GP and had his medication for depression reviewed. After a few weeks he reported that his mental health was improving and he had started going out walking every day. He was managing to cut down on his drinking and was able to stop after a few cans instead of carrying on until he passed out.

Mr C, with the help of his partner, is now managing to control his drinking and is keeping up the habit of going for daily walks to increase the feel good hormones in the brain and lift his mood.

The support Mr C received was carefully reduced as he became increasingly independent and he now only requires fortnightly telephone consultations.

- Prior to November 2019, individuals who experienced non-fatal overdoses (NFODs) in Dundee were formally discussed once per week by the Early Screening Group. Often those individuals were followed up after an extended delay, were difficult to contact or did not fit the criteria for follow up by Adult Protection, and the group thought a more robust response that met more often would be appropriate. It was initially intended as a six-week "Test of Change" that sought to improve the coordination of the various organisations responding to a NFOD. This joined-up, acute response continued and has developed into what we now call the Non-Fatal Overdose Response. The Dundee Non-Fatal Overdose (NFOD) Rapid Response Team was developed, implemented and evaluated. This is a multi-agency virtual team that meets every week-day to discuss all the known NFODs and develop a safety plan for each individual that has experienced a NFOD. A team of assertive outreach workers are linked to this response and aim to make contact with the individuals within 72 hours of the NFOD. The work of the NFOD Rapid Response team has been evaluated and a working group was set up to progress the recommendations.

  25 professionals responded to the online survey (out of 36 who were invited). Stakeholders were asked about a) their views on the current NFOD Response provision and delivery, b) perceived impact on partnership working and outcomes for individuals who have experienced an overdose, c) perceived barriers and gaps to delivering the NFOD Response, and d) potential NFOD Response developments.

  - 88% of respondents either somewhat agreed or strongly agreed that *'the NFOD Response adopts a person-centred approach to care that is tailored to people's needs and circumstances'*
  - 96% somewhat agreed/strongly agreed that the NFOD Response has *'Allowed individuals who have experienced a non-fatal overdose to have quick support and access to services'*
  - 88% either somewhat agreed or strongly agreed that the NFOD Response has *'Increased professionals'* ***confidence*** *to work in partnership to address non-fatal overdoses and support individuals at risk of subsequent fatal overdoses'*
  - 84% either somewhat agreed or strongly agreed that the NFOD Response has *'Increased professionals'* ***understanding and skills*** *to work in partnership to address non-fatal overdoses and support individuals at risk of subsequent fatal overdoses'.*
  - 88% agreed/strongly agreed that the NFOD Response has '*Improved joint working across the Partnerships-NHS, Police, Local Authority and other agencies*' and 76% thought it has *'Made decision-making easier and faster'* (76%).
  - 80% of respondents agreed or strongly agreed with the statement: '*the NFOD Response has 'Improved monitoring and understanding of the impact of services to prevent and address non-fatal overdoses'*

Miss M called the Cairn Centre today at lunch time – the call was missed so she left a voicemail asking us to call her back. By the time I phoned back she had the issue sorted but wanted to let us know that she has left the house with the dog today, she is now back in her own house. She didn't have electricity and that's why she contacted us but she now has this sorted out (with help from her ex partner). She has passed on her thanks for staff supporting her with the taxi, the mental health appointment went really well, she is going to engage with them, she said it feels like she's been in a trance but has now woken up and is going to start engaging with them. She wanted to pass on that the visit really benefitted her and she wouldn't have made this step without the staff support."

International Overdose Awareness Day

- Hillcrest Harm Reduction Team, Police Scotland and NHS Tayside worked together to raise awareness and reduce stigma around drug related deaths. 12 members of the public were trained and supplied with Naloxone.
- During 2020 NHS Tayside announced that Tayside has become the first region in the world to effectively eliminate Hepatitis C. In 2009, in partnership with NHS Tayside, Hillcrest Futures introduced Dried Blood Spot Testing to test for viral antibodies to further support individuals alongside harm reduction and safer injecting advice to identify people with active Hepatitis C infections and initiate them onto treatment.

Care at Home

- The Care at Home Team has been working in partnership with the Independent Living Review Team. The sharing of the skills and knowledge by physiotherapists and occupational therapists with frontline staff has been beneficial whilst supporting individuals in their home. This service works in conjunction with Care at Home and focuses on a functional assessment along with reviewing and supporting individuals. This is an excellent example of partnership working and enables individuals to reach their maximum potential.
- Staff from the Community Mental Health Teams for Older People created the 'Stay at Home, Stay Safe and Have a Cuppy' packs. The packs included seated exercises, seated yoga, word searches, quizzes, colouring pictures and pens, poems, carer stress tips and life story questions. They also contained a coffee sachet, some tea bags and a biscuit to encourage people to make time to do something nice in the day.

Activity Support Worker Jodie Milne with a selection of donated activity items. (The Evening Telegraph, May 2020)

Community Mental Health Team Older People East Team Lead, Christine Davidson, said:

As an occupational therapist I was acutely aware of the impact lockdown could have on our patients and carers. I was keen that as a service we would try and help people to stay as active as possible during this time. Social isolation among older people was already a huge issue before the coronavirus crisis and the lockdown has made life even more difficult and isolating for this vulnerable group. I would like to thank our support workers in the Community Mental Health Team Older People as they have really pulled together and worked incredibly hard to gather donations, find suitable activities and to put it all together and also arrange to get them delivered. We would not have been able to prepare these packs without the generous donations received from local businesses and members of the public. Everyone has been so kind and we really appreciate all the donations we have been given. In these difficult times we hope the activity packs are one way that we can let people know we are here for them and they are not forgotten.

Care Homes

- During lockdown, staff at Turriff House developed a comprehensive activity programme involving residents, families and staff. This ensured that residents not only coped during the pandemic but thrived despite the challenges. Some examples included a chatty cafe for residents to have a virtual cafe catch up via video call, a socially distanced fundraising 26.2 mile mad March marathon (relay style over a few weeks) including Olympic style torch and staff dressing up "118 style", pen-pal letter writing between residents and St Clements Primary which led to virtual maths and english classes led by the residents, washable Christmas decorations and an outdoor Christmas Market which served German sausage, churros and hot chocolate and a 'Strictly' style (singles) dancing competition.

Discharge from Hospital

- Ensuring patients are safely discharged from hospital as soon as they are well is a priority for the Partnership. We know that unnecessary hospital stays can have a negative impact on some people and we want to avoid this, whilst ensuring that there is support and services in the community to care for the patient. Although Dundee continues to perform well in relation to the 2015/16 delayed discharge benchmark, and has been amongst the top performing Partnerships in Scotland there was a deteriorating picture regarding standard delays. During 2017/18, the introduction of the 'Discharge to Assess' model enabled the majority of patients to be discharged on their Planned Date of Discharge as the assessment of their needs could be undertaken in a community setting. The greater accuracy of this assessment has enabled more patients to remain in their own homes on a long-term basis and demonstrated a reduction in the need for care home placements. However, this has also resulted in an increased requirement for social care. In order to address this, there is a need for a further improvement in discharge pathways which maximise the resources available and promote better outcomes for patients.

A number of improvements have already been made including:

- A locality modelling programme to ensure best use of existing staff resource across the Partnership. This will create multi-professional teams based within geographical localities, thereby reducing duplication and maximising efficiencies. This will support workforce remodelling and create staff resource to undertake the social care review function more robustly. A barrier to this is the increasing vacancy levels within both care management and community nursing teams.
- The Home First strategic programme is now underway. This aims to reduce barriers between urgent care services in the community and create a whole systems pathway for frail older people which ensures they can receive care and treatment in community settings wherever possible. This will support reduction in hospital admission, and will expand the Dundee Enhanced Community Support Acute model into a Hospital at Home service. This pathway will be focussed on community rehabilitation in order to promote independence and has replaced the previous 28 bedded Intermediate Care Unit which was closed in March 2020.
- The implementation of the Eligibility Criteria for social care is now complete and staff across the Partnership have been briefed. This will provide a clearer framework for allocation of social care resource with the aim being to only provide this service to people with a critical or substantial need. In tandem with the developing community rehabilitation focus through the development of the Independent Living Review Team, as well as stronger links with the Third Sector, this is designed to reduce reliance on traditional social care services over time.
- Winter Pressures monies were used to expand the existing 'Discharge to Assess' model over the winter. The success of this model has provided evidence that earlier discharge from hospital and minimal moves whilst an inpatient, creates better outcomes particularly for frail, older adults. Now that this approach is fully embedded, the next stage of development is to target inpatient rehabilitation alongside this resource within the acute hospital to ensure patients can return home safely on their Planned Date of Discharge. Whilst this may slightly increase the length of stay within acute hospitals, the aim is to reduce whole system length of stay while improving outcomes for individuals. The Acute Medicine for the Elderly Unit continues to support good quality frailty assessment and early discharge for frail older adults, and the Home First project is now focussed on developing a similar model in the community.
- Following a delay due to COVID-19, the 8 bedded unit within Turriff House has now been opened as a 'step down' alternative to inpatient psychiatric rehabilitation for older people.
- Advanced practice models are now being developed to support the community hospital and urgent care services in the community. This will complement the Primary Care Improvement Plan, specifically in relation to the proposal to develop urgent care around the existing GP cluster model.
- The Care Home Team continues to undertake development work with local care homes as a means preventing admission to hospital when appropriate and a further Nurse Consultant post is in the process of recruitment to support this.
- Frailty assessment is now fully embedded within the Surgical and Orthopaedic inpatient pathways which is contributing to reduced length of stay, however will initially impact on demand for services to support discharge.

3.3 Strategic Priority 3 - Locality Working and Engaging with Communities

Our Ambition:

People can access services and supports as close to home as possible, with these services and supports responding to the specific needs of the local community.

Dundee has a strong ethos of working in partnership with communities and the people it supports. The following factors impact on the way in which local services are accessed by the population within Dundee:

Geography of Dundee – Dundee occupies a small geographical area (approximately 60 km2). The city's compact size, coupled with a tradition of community activism, creates positive opportunities for collaboration between our workforce, communities and people using services and carers and means that any specific sites of service delivery will be relatively accessible to the whole population.

GP registration – in Dundee, GP registration does not correlate with area of residence and therefore, in most instances, it cannot be assumed that GP surgeries are responding to the needs of the local population. In addition, practices within Dundee have over 20,000 people registered who do not live within the city boundary.

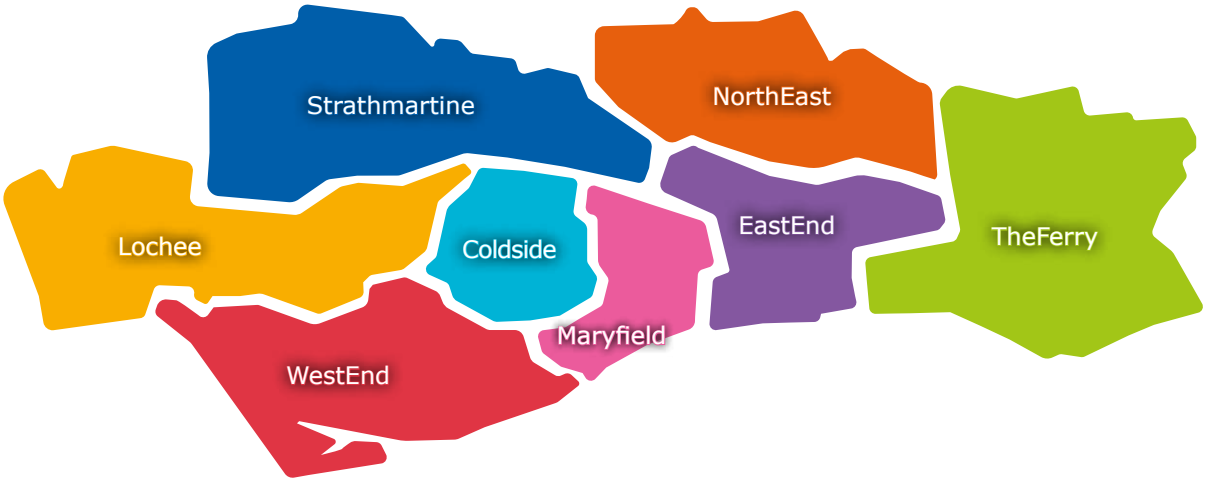
Definitions of community – Dundee's communities do not necessarily identify with the locality designations ascribed to them by the Council's administrative boundaries, with distinctive community identities existing within and across localities.

The Partnership follows a 'locality model' approach to delivering services within the city to ensure that services are targeted to meet the needs of individuals and their carers. The approach also helps to support 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 it's 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 Partnership is an active partner in Local Community Planning Partnerships.



The four 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. 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.

As well as reporting on our activity in different geographic localities this section also provides information about our responses to communities of interest or who have shared characteristics / health and social care needs. This includes developments in relation to communities of people who have protected characteristics under the Equality Act 2010.

How we performed

Health & Social Care Experience Survey 2019/20

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

Dundee

Scotland

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

Dundee

Scotland

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

Dundee

Scotland

"I felt safe"

Dundee

Scotland

"I agree that my health and social care services seemed to be well co-ordinated"

Dundee

Scotland

This information suggests that experience of care appears to be positive.

Across Dundee unpaid carers provide a significant level of care and support for family and friends who have health conditions, a disability, a mental health condition or substance misuse issues, are frail due to older age or have other health and social care needs. For most people this support is the preferred way of receiving support and meets many social and emotional needs as well as providing practical help. The provision of such unpaid care can avoid the need for more formal interventions for some and for others unpaid care is 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. Carers make an immeasurable contribution to the lives of the people they care for and although we know that it would be impossible to replace the quality of care and support given by someone who is not paid to be in your life we also acknowledge that there would be huge financial cost to us all if we were to attempt to replicate the care and support they give.

The most recent Census (2011) asked people whether they look after, or give any help or support to other family members, friends, neighbours or others because of either long term physical and/or mental ill-health, disability or challenges related to old age. The definition did not include paid employment.

In 2011, 13,072 people identified themselves as being a carer; this was 8.9% of Dundee's population at the time. Local intelligence estimates that this number is now significantly higher, particularly due to the pandemic when national statistics suggest a huge increase in the numbers of carers as well as in the roles and responsibilities they have taken on. It is thought that many of these carers will remain in this role after services and supports are resumed.

The Citizen Survey for 2019[2] was completed by 1300 Dundee residents. The key findings reported that 23% of households with at least one member who had some form of long-term health problem or disability also had at least one member of their household who was providing unpaid care and support for someone else. This is a significant increase from the 4% of households reported in 2018.

Of the households where someone provides unpaid care, the majority said this person who provides care or support was aged 18 or over (99%, 89% in 2018). 40% said they or others in their household have accessed information, services or support to help them manage their caring role. This is consistent with the 2018 survey results (41%).

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. Carers sustain, maintain and contribute to the quality of life and health and wellbeing of the people they support. Depending on the nature and level of their individual care and support needs some of those who receive a significant level of care from family or friends may otherwise be 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, or have experienced serious impact on their health and wellbeing. With the rising number of older people and increased complexity of needs of people with disabilities remaining at home, 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.

There has been a body of national research completed to measure the impact of the pandemic on carers.

Health & Social Care Experience Survey 2019/20

"I feel supported to continue caring"

[2] Dundee City Council City Wide Citizen Survey Report 2019

The results are consistent and show that unpaid carers are struggling to cope, have not had a break for a long time and are worried about the lack of services that will be available to them, and the person they look after, following the pandemic. 72% of unpaid carers reported poor mental health, and the same percentage (72%) said their physical health had deteriorated. There has also been an increase in the number of people who are caring for someone they didn't care for prior to the pandemic and for those who continued their caring role, 33% reported giving more help to people they helped previously. Those aged 45 to 54 were the most likely group to provide support - 60% of this age group reported doing this. Women were more likely than men to provide support, as were those with dependent children.

In late September 2020 to mid-November 2020, we launched local engagement work with carers and workforce supporting carers to better understand the impacts of the COVID-19 pandemic. The consultation involved engagement with carers, young carers and the wider workforce.

Data collection included two online surveys, a carer's survey and a workforce survey, and 5 focus group discussions with adult carers and one focus group held with a group of young carers, all focus groups were facilitated by support organisations in the City.

- Online local survey for carers -116 unpaid carers completed the online survey
- Online survey for local workforce –37 individuals completed the workforce survey
- Carer Focus Groups - 41 carers participated in the focus group discussions

The findings report https://carersofdundee.org/workforce/carers-partnership/#report has identified several recommendations that require consideration and action to ensure outcomes are met for carers in the City. The Dundee Carers Partnership has dedicated workstreams to develop proposals based on the finding areas to initiate targeted work activity to deliver improvements to better support carers in Dundee.

Findings revealed the following:

- The majority (84%) reported an increase in the amount of care provided since the start of the Pandemic
- A high proportion (63%) of carers were struggling to balance commitments alongside the caring role
- 38% had to reduce or give up hours in employment due to their caring commitments
- Negative impacts on physical, mental, and social wellbeing (84%) and feeling socially isolated (60%)
- The majority were feeling more worried and anxious about the future (82%)
- The financial impact on carers as a result of higher household expenses (67%)
- Half of carers (51%) were unable to get support through accessing resources to improve their own wellbeing, whilst just over one third (35%) had been able to access this.

More positively, the engagement also identified areas that were working well for carers to build upon for future, including:

Community groups and voluntary sector organisations continued to provide essential support to carers during the pandemic, many utilising digital technology, which carers found invaluable in helping them cope during this period.

Carers also benefited from local networks in the community and neighbour support during this period.

It was recognised that these initiatives should continue to be promoted, whilst also finding other solutions for people who cannot access online information/digital engagement opportunities to ensure information and support is available in a wide range of accessible formats.

746 service users participated in the Care At Home COVID-19 Survey

99% of service users felt the service was good, very good or excellent during the pandemic

98% of service users felt the support offered/given by emergency responders was good, very good or excellent

79% of service users felt safe and confident in the SCRS team in relation to wearing PPE

99% of service users felt the way in which SCRS staff respected their wishes and preferences was good, very good or excellent

99% of service users felt the way in which SCRS respected their dignity was good, very good or excellent

Service users used words to describe the Care at Home service during the pandemic:

What we have achieved to deliver this Strategic Priority

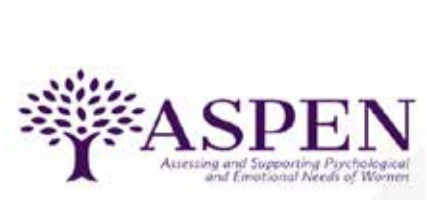
Unpaid Carers

- Dundee Carers Centre is working in all eight localities and has established locality teams and has worked with carers and workers to develop locality plans. https://dundeecarerscentre.org.uk/services/locality-work/
- Dundee Carers centre continued to support unpaid carers via the virtual hub, launch of the e-learning portal Carers of Dundee, the introduction of shopping cards and the provision of safe and innovative forms of short breaks. How we support carers continues to be informed by the Engagement Surveys and Focus Groups which carers were invited to contribute to.

Home First

- The Partnership is working to develop cluster focussed urgent care teams – bringing together Dundee Enhanced Community Support Acute (DECSA). Enhanced Community Support (ECS) nursing teams, Care Home Urgent Care Teams, Primary Care Urgent Care, care co-ordination, AHP and pharmacy services under the banner of "Home First". We have developed a single point of referral for ECS and DECSA and are working to develop an Urgent Care Triage tool and common assessment documentation.

Protecting People



- Dundee Women's Aid's ASPEN project aims to focus on engaging "harder to reach" women. The service criteria focusses on women who are homeless, or are at risk of homelessness, have experienced trauma (most often in a variety of forms, including victim of commercial sexual exploitation or trafficking, throughout their lifetime, rather than a single event) and have a range of complicated factors including significant mental health difficulties, high levels of trauma symptoms, unhealthy or harmful coping strategies including substance use, self-harm, suicidal behaviour, offending behaviour. Where someone has shown evidence that they are able to engage with conventional, mainstream services, their care will be directed towards those services, leaving ASPEN to provide assertive engagement to women who simply cannot access mainstream services, including GPs, due to the complexity of their difficulties. Typically engagement is a slower process, with missed appointments being tolerated for much longer than many mainstream services which adopt a discharge policy after two-missed appointments. A variety of engagement methods are used, including face to face alongside another worker, telephone, text or video appointments. The length of appointments is also adapted to suit the individual's needs, for example some women may want to start with shorter, less formal meetings which are extended over time, once trust and therapeutic rapport develops. Some women may need contact multiple times in a week or some may feel the need to be in control and access the service more sporadically, but knowing that they will be responded to as required in a time of need. This is a truly trauma informed way of responding – flexibility of response is one of the keys to ASPEN's success.

Dundee Violence Against Women's ASPEN Service

Links with National Health and Wellbeing Outcomes

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

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

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

Miss J was referred to DWA's ASPEN service a few weeks after a very serious assault. Whilst clinical recommendations are that intervention is not offered within the first three months of a traumatic incident (as most symptoms of acute trauma resolve within this time frame) a decision was made to prioritise offering Miss J support due to the high levels of distress that she was displaying. Psychological support was led by Miss J's needs and requests moving from initially daily, down to three times a week, then twice a week, then weekly, now fortnightly. Interventions have included empathic listening, provision of psychoeducation regarding normal responses to trauma, psychological formulation, behavioural activation, and cognitive restructuring. Liaison with multiple services has also been a key factor in working with Miss J successfully. Extensive liaison has been undertaken with Police Scotland, Procurator Fiscal Service, surgical services at Ninewells Hospital, GP, Community Mental Health Services, Housing, Families Outside, MIA and TDAS. In addition liaison was undertaken with Scottish Women's Aid regarding media reporting of the case, which culminated in two national tabloids being directly challenged on their reporting standards. Whilst much remains problematic and worrying for Miss J, her functioning and wellbeing has improved significantly, with her now actively completing an Open University course and making positive plans for her future. Miss J's case represents the importance of a co-ordinated, specialist approach focussing on early intervention and prevention work, whilst also demonstrating locality and community engagement that is unlikely to have been as successful without DWA's APSEN service leading the response and care of Miss J.

Children and Families

- Non-medical prescribing nurses have been appointed who are based with Children and Families Teams: this approach supports the focus on the health and wellbeing of families and ensures parents can access fast and well supported treatment for drug use. This approach also increases the joint working between the specialist adult substance use service (DDARS) and children and young people's services.

Dundee Violence Against Women's ASPEN Service

Links with National Health and Wellbeing Outcomes

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

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

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

Mrs P was known to DDARS with an active methadone prescription and was on the caseload of one of the locality nurses. The nurse worked closely with Mrs P as her son was being supported by the social work team. Mrs P was seen every 4-6 weeks for testing and relapse prevention work. Mrs P's choices of drugs were illicit street Valium and illicit Pregabalin or Gabapentin. Regular team around the child (TATC) meetings were organised by the social work team and Mrs P's son's case was closed due to her evidencing stability and therefore reduced risks and concerns towards her son.

Mrs P was then placed onto the unallocated list within DDARS and her nurse started her new role as a locality nurse within the children and families service as part of a pilot.

2020

Information was shared with Mrs P's previous social worker and her nurse via Police Scotland regarding concerns that she had been subjected to a traumatic incident and it was deemed that it was unsafe for her son to remain at home. Mrs P's son was placed with a kinship carer until the social work team assessed the situation further.

As Mrs P's nurse was now a locality nurse she was then able to attend Mrs P's house with the social worker. This was highly beneficial as both workers knew Mrs P well. The social worker and locality nurse worked jointly to assess the situation and provide intensive support. Mrs P has become more stable; the level of risk has been reduced and her son is back living in her care. Mrs P is now illicit free from Gabapentin and Pregabalin and is working towards being illicit free from Diazepam. The locality nurse and the social worker continue to work jointly to maintain stability.

Interventions

- High level of support to Mrs P to enable her to be illicit free from Gabapentin and Pregabalin
- Relapse Prevention work
- High level of therapeutic support from locality nurse to Mrs P
- Immediate crisis response and continuity of workers

Outcomes

- Mrs P now stable mentally and physically
- Son has returned home full time
- Mrs P more supported by DDARS while dealing with trauma and able to seek additional support from other services promptly.

- We completed a test of change in the Lochee surgery to develop a shared-care approach between Primary Care and Dundee Drug and Alcohol Recovery Service (DDARS) which has resulted in the appointment of GPs who will work directly with the DDARS. We have increased the availability of Take Home Naloxone in Dundee, with more organisations issuing Naloxone kits to individuals
- In partnership with Tayside Council on Alcohol and a host of agencies, the Safe Zone bus returned to Dundee's streets in May 2020. The bus offers support out with normal hours to anyone in need. As well as general welfare there is access to harm reduction including Naloxone. Crisis work can be supported and there is an established pathway for the staff and volunteers on the bus to refer into specialist agencies.
- We Are With You (WAWY) and Hillcrest are now following locality working when delivering substance use services. Each organisation is now located in a different part of the city (East and West) and attached to a specific locality team within DDARS.
- Hillcrest provided local drop-in at various locations in City Centre and West Dundee. They had a presence at Lochee Hub, Charleston Community Centre, Kirkton Community Centre and Dundee West Church. They provided drop-ins including a women only one. They also had a regular presence in Lochee High Street to support people attending local pharmacies – providing emotional and practical support including lunch bags (social Byte) and Injection Equipment Provision (IEP) and Naloxone. This was well accessed by locals as a street advice hub and locals have been very appreciative of this advice point with consistent workers offering support. Through this street advice hub Hillcrest supported people to get in touch with other agencies including ISMS, GP surgeries and the Department of Work and Pensions (DWP)

Hillcrest Futures Harm Reduction Team with their Integrated Care Award

- Hillcrest has delivered recovery and harm reduction services from its base at The Cairn Centre. Prior to the pandemic, the recovery café drop-in provided food, support and advice to many people – both in recovery and requiring crisis support. Through a hub model with partners Hillcrest offered advice on housing, benefits, health, Naloxone distribution, Blood Borne Virus testing and treatment as well as services such as Optometry and Dentistry. These services were provided to people who would not access mainstream service in other locations. During COVID-19 lockdown Hillcrest was only able to provide essential IEP and harm reduction service at The Cairn Centre which reduced the face-to-face recovery work but telephone support was provided and recovery support provided to people in community pharmacy, during delivery of Opioid Substitution Therapy and also via phone. Later online mutual aid was introduced. They provided people with mobile phones and data so that we could keep in touch with them and they had a means of accessing further support and contact

with others. This included people coming out of prison. Hillcrest also provided harm reduction assertive outreach throughout the first COVID-19 lockdown. The Harm Reduction Team has made 447 visits. 171 were as a direct result of a near fatal overdose and the remaining 276 were seen opportunistically or referred via an external agency. The average age of individuals supported is 34 -42 years old which is consistent with the high risk age group the model is targeting. 22 phones and top-up cards have been given to those without access to a phone who need to be in contact with services.

- Inclusive Cities Events are aimed to celebrate recovery, make it visible and to challenge stigma and promote inclusion for those who have experienced personal, family or community substance use. They give people the opportunity to showcase their talents and experiences through creative arts in a venue that many may feel initially disconnected from. We aim to host regular Inclusive Cities Events both at the V&A and other venues across the city. We hope that the Inclusive Cities 'brand' will become well known and synonymous with inclusion and connection for all Dundee citizens regardless of their background, talent or current circumstances. Attendees had the opportunity to find out more about the drug and alcohol services offered by the charities. Poetry and art work created by people with lived experience of substance use were also exhibited. Feeling part of a community can have a significant positive effect on someone's recovery journey. Being part of Inclusive Cities events and showcasing their creative abilities help people feel less marginalised, improve self-esteem and provide hope.

In the past I have felt unable to access community facilities as I believed I would not be made to feel welcome. It was really great to go to the V&A. I never thought that this was a place for me to go to, however I was made to feel welcome

I can't believe my work is being shown at the V&A, this is something I never imagined would happen to me

Hillcrest at the Cairn Centre

Links with National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

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

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

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

Mr M has been attending the Cairn Centre regularly since he returned to Dundee to have ulcerated wounds on his legs cleaned and dressed, as well as collect Injection Equipment Provision. Over the past few months, it has become apparent that there is a significant deterioration in Mr M's mental wellbeing, leading to a marked increase in risk taking behaviour, which in turn has resulted in him appearing on the Non-Fatal Overdose Multidisciplinary Team Call for three incidents, all within less than 36 hours of each other. As a single male over the age of 35 years, Mr M is in a high risk group for drug related injury and death.

Mr M's Journey

- Mr M stopped engaging at Eagles Wings meaning he was receiving no support
- Mr M is considered to be at elevated risk of serious illness and death associated with COVID-19
- Mr M's injecting frequency of heroin had increased to 0.5g Heroin, 3-6 and more times a day
- Following a breach of his occupancy agreement Mr M became homeless
- Mr M's on-going substance use increased, poor sleep, poor diet, no income, leg wounds, and minimal support, meant he was at an extraordinarily high risk of overdose
- Mr M was known Hepatitis C Virus (HCV) positive but non engager with treatment interventions
- Mr M was supported to commence an Opioid Substitution Therapy prescription and he was accompanied to his first appointment
- Over the course of the month, Hillcrest Futures staff secured clothing provisions so that Mr M could promote the healing of his wounds
- Hillcrest liaised with Positive Steps to set up transition into a Network flat and he was supplied with a mobile phone to stay in regular contact for support
- Food bank referrals and electricity top up facilitated by Hillcrest Futures supported Mr M moving into his accommodation
- Mr M was supported to speak with NHS Harm Reduction Nursing team at the Cairn Centre regarding HCV treatment then Mr M dropped in on his own accord and started treatment the following week and was cured after 6 weeks
- Mr M's risk taking behaviour immediately decreased and a change in his behaviour and outlook was clear. He is continuing to try and stabilise on a prescription and reduced his heroin use to 0.5grams, 1-2 times a day

- Positive Steps Assertive Outreach service has been especially successful in targeting overdose prevention interventions towards a "hidden" population of individuals at significant risk of drug related death. The service proactively identifies high risk individuals by conducting visits to street begging sites and homeless accommodation, as well as working with Dundee Drug and Alcohol Recovery Service to re-engage individuals who have recently stopped attending their service. Over one third of individuals who the service engaged with were not in treatment, and thus would have otherwise had limited access to co-ordinated, holistic support regarding their substance use. Furthermore, 71% were male and 36% were aged 41 or over. This group is considered particularly "hard to reach" as many have repeatedly cycled in and out of services, and frequently have complex health needs associated with age. Engaging effectively with this group therefore necessitates innovative, flexible and truly relational approaches. Over a 4 month period, 19 individuals were keen to be referred into treatment. The service effectively addresses the needs of older men and those disengaged from treatment; populations at highest risk of death from overdose. This is currently operating in the East of Dundee. We have sights at Whitfield , Albert St and Douglas. This provides easy access to all residents in the East of Dundee.

Primary Care

- We continued to work towards actions in the Primary Care Improvement Plan (PCIP) and increased the support to General Practices by providing community supports such as Community Care and Treatment Services, First Contact Physiotherapy, Social Prescribing, improved diagnostic pathway for adults with autism, follow up service for people discharged back to GP care by the Community Mental Health discharge hub, the Advanced Practitioner role across Community Mental Health Teams to assess and prescribe and the Community Health Online Directory. We have also made improvements to urgent care referral routes and pathways and developed cluster Home First teams.
- The First Contact Physiotherapy (FCP) Service has now recruited posts within the original PCIP 3 year plan. The COVID-19 pandemic has changed how the service is delivered, with initial contact by phone, supported by video or face to face consultations, and from more centralised venues. All practices have been able to book into FCP as part of support during the pandemic. Insufficient capacity issues have emerged, however, with demand appearing to significantly exceed the capacity of the service. We are currently reviewing the service to consider how it remobilises and develops the model. We have not yet agreed what a full service is; recognising it is not possible that every MSK presentation to General Practice can or should be seen within a FCP service. There is agreement we need to increase capacity and will review the impact on other linked services to consider how resources can be released to support this aspect of care.

Day Support

- Feedback regarding Wellgate Day Support

- Tayside Adult Autism Community Team (TAACT) liaise and interact with third sector organisations (e.g. Autism Initiatives) to support their proposals for development of a Tayside wide service. They also liaised with Citizens Advice to ensure community support was available prior to the launch of developmental questionnaires pre initial assessment.

The Friary – A therapeutic environment for recovery in the city

Recovery@ The Friary is open every Tuesday & Wednesday

Woodworking area at Recovery@ The Friary

Learning Disabilities

You are the go to person to ensure anything that I say to the client they understand. You are able to see if they understand and how you speak to them they can understand" Complement received by the CLDN from another professional

Community Learning Disability Nursing (CLDN) Dundee

Links with National Health and Wellbeing Outcomes

2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
7. People who use health and social care services are safe from harm.

Miss E had a mild learning disability and was homeless and pregnant. She was staying with her sister whose own tenancy was in jeopardy due to this. Joint working with a Children's Social Worker, Housing department and CLDN, meant we were able to secure immediate network housing for Miss E. Her sister, who was also vulnerable, could then continue with her tenancy.

Miss E was not long into her tenancy when there were issues surfacing with regards to exploitation from various apparently undesirable associates. The First Contact Team became involved due to this to look at the concerns for Miss E as she was vulnerable and was potentially being exploited.

Miss E has an appointment to see the Consultant Psychiatrist in Learning Disability to assess her capacity to make decisions regarding her associations.

Service Users from Wellgate Day Support enjoying outdoor activities

Mental Health

Dundee Community Mental Health Services

Links with National Health and Wellbeing Outcomes

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services

The patient was transferred from another area to the Community Mental Health Team (CMHT). On transfer to CMHT the patient was allocated to a Community Mental Health Nurse (CMHN).

On the first meeting it was identified that person had moved to live in Dundee with a family member in a 1 bedroom flat with another room being shared by 3 family members, having to sleep on the floor.

With the patient's agreement, the nurse contacted the Social Work team who arranged a joint meeting with the patient, the CMHN and the social worker. From the meeting the agency `Shelter` got involved to support the patient to gain options for appropriate accommodation.

Dundee Adult Psychological Therapies Service

Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Mrs A was a 50+ year old lady referred to the Dundee Adult Psychological Therapies Service by her GP for anxiety. Mrs A was diagnosed with social anxiety and low self-esteem and she often had thoughts such as "I am stupid" and "others will be judgemental". Having recently retired she had become increasingly withdrawn and avoided social situations. Mrs A had tried psychological therapy 5 years ago but struggled to engage and she was offered a place at the virtual Building Confidence Group. The group includes 10 weekly 2 hour sessions with a follow up 7 weeks after. It uses a Cognitive Behaviour Therapy approach and is hosted on a virtual platform – 'The National Video Conferencing Service'. Initially Mrs A was reluctant to attend due to anxiety and was apprehensive about using the technology. However, she actually found the system really easy to use and although initially she only wanted to have part of her head visible on camera and talked only occasionally: over time this became easier. Mrs A began to feel more confident to contribute to the exercises, was able to show her face on camera, provided advice to other group members, made jokes and chatted during the break. Mrs A was also able to attend the group even after she was contacted by Track and Trace when she had to self isolate for 10 days. At the end of the group Mrs A said "I would not have attended if this was in person, I'm happy I got this opportunity". At the follow up, group members were planning a social meet up once Covid-19 restrictions lifted.

Home Care

- During 20-21, 1762 people received a Home Care service and 1,146 thousand home care hours were scheduled. During the pandemic, home care services continued to be provided in localities and care workers frequently made community connections with service users and shared information about local initiatives and activities.
- Within each household of the Chinese community there are laminated sheets from the Social Care Response (SCRS) service with symbols in Chinese and English, with numbers attached to each possible answer. SCRS staff have the same sheets in the control room but in reverse (Chinese to English). These sheets are used to overcome language barriers and communicate with the service user by referring to symbols and numbers to represents the type of support required.

Young People

The Corner

Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

A young person attended the Corner for emotional wellbeing support. After a Corner assessment, it was agreed for the young person to access The Corner counselling service. As well as the young person being offered counselling, the Corner counsellor also offered additional support to the young person's parents. This included speaking to the parent's outwith appointment times and being on the end of the phone when times were difficult. The support offered to both the young person and her parents made a significant difference to the wellbeing of the whole family. By being offered additional counselling support and advice and by working together the young person and parents are in a better place and are now more hopeful for the future.

Email from a parent (with consent)

"Our world started to crumble around us when our daughter unfortunately succumbed to anxiety just after her birthday last year and after advice from our GP, we called The Corner for help.

The Corner counsellor came to our rescue and I will always be indebted to this lovely lady. She not only reached out to help our daughter, our most precious thing, immediately, but she helped my husband and I also, especially me.

As we spiralled downwards over the next few weeks because of our daughter's ill health, on her and my darkest days, the counsellor was only a phone call away. She always made time to talk to our daughter, in a way that helped her.

At my very low points, so desperate, the counsellor lifted me with her wise words of encouragement.

Six months on, we are still dealing with our daughter's anxiety but there are now days that she laughs and I believe the counsellor is the key person who has given our daughter the motivation to step back into life again, which she is trying really hard to do.

We don't know what the future holds but at this stage, we have a small amount of hope.

I would like to thank all the staff at The Corner, for the unbelievable work that they do and very special thanks to the counsellor".

The Corner staff at their core, are kind and they listen non-judgmentally. Empathy and care build the foundation of their work, not to mention the huge breadth of skills, knowledge and expertise that the staff have. Online interviews, one-to-one and counselling have the same warmth and inclusion of face to face and the video platform is easy to understand. Everything comes with a few technical difficulties, however, they are quick to solve and ever improving.

The Corner window displays

- To help reduce health inequalities experienced by young people, a digital content officer was recruited in late 2020, with an aim of improving the Corner's digital media presence. The Corner's website was launched in January 2021 and the number of followers on The Corner's social media platforms (Facebook, Instagram and Twitter) have increased. The most engaged posts included suicide prevention, World Bipolar Day, Stress Awareness Month and our Wellbeing Boxes being delivered to young carers. The number of young people accessing the Corner is also increasing and increased 300% between January 2021 (66) and March 2021 (187). To mark Young Carers Awareness Day, The Corner has teamed up with the Dundee Carers Centre to provide every young carer in Dundee with a Wellbeing Box.

  Launched in February, The Corner Wellbeing Boxes contain items such as a stress ball, a mindfulness colouring book and various leaflets to use if people are feeling upset or anxious, to help them relax and to promote positive mental health and self-care. Dundee Health and Social Care Partnership has provided the project with additional funding to provide all young carers living in Dundee with a box.

Health Outreach Officer at The Corner, Caroline Millar said,

"Thanks to the Dundee Health and Social Care Partnership we have been able to double the amount of young people benefiting from this initiative to ensure that all young carers will receive a box."

We understand that young people are increasingly worried about their future and some are facing many stresses during lockdown so we hope these boxes will help them focus on their own wellbeing……The boxes will be distributed in the coming weeks and we thought this initiative was a brilliant way to mark Young Carers Awareness Day."

The box was really helpful - it could help a lot of other young people and help them with their mental health and lift everyone's mood

Feedback from recipient of box

Hello, everyone at The Corner Dundee. I just want to drop a line to say thank you so much for my daughter's 'you got this' box. It means so much to receive an act of thoughtfulness and kindness in these trying times. Your wonderful service hasn't gone unnoticed

Feedback from a Parent via Twitter @ TheCornerDundee

The box is fantastic, I was really surprised with everything in it, I thought it was amazing.
Box is amazing, I cried, thank you so much

Feedback from recipient of box

Kieran Drugan, Team Leader Dundee Carers Centre said,

"This is a fantastic idea and I'm sure the Wellbeing Boxes will be gratefully received by young carers across the City. We have identified more than 700 young carers through schools, colleges and communities and they all will receive a wellbeing box."

- It was recognised that young carers unlike older carers do not currently receive a "health check" to establish emotional, physical and other concerns experienced by young carers. This has led to conversations with key partners about how to redress this imbalance with this vulnerable group and subsequently a further funding bid to develop a "Transition Health Session, Young Carer's Health Check and Follow Up" programme to build links, relationships and deliver health checks for all identified young carers across Dundee is to be submitted. This funding has been central to many developments and positive improvements to the service for Young Carers such as: The Corner assessment undertaken with all young people includes a Young Carers section, to identify young carers and establish and address unmet need. The Corner is now Carer Aware and now has a Carers Charter and worked in collaboration with CAMHS, Dundee Carers – Family Feelings group.
- The Humanitarian Team is creating content for the 'new Dundonian' tab within The Corner website and includes the Scottish Refugee Council link and the Dundee Resettlement group link which offers support to refugees. A Google translate function has been created and is now available on The Corner website. Information leaflets have also been created and have been adapted for different languages.

  45 Health and Wellbeing Boxes were delivered to young refugees, contents including; pencils, mindfulness colouring books, hug in a mug, aromatherapy fragrance, Lush products, healing crystal, stress balls, fidget spinner, bubbles, mints, lip salve, thoughts diary, and positive

affirmation cards. This Box is a resource for young refugees to use to improve their mental health and wellbeing in times of stress. A referral form for further Boxes is available on The Corner website.

Local young person from the Hope Humanitarian Group receiving Wellbeing Box delivered in partnership with local CLD Youth Work Staff

Staff training at The Corner for Purple Friday- part of LGBT History Month

3.4 Strategic Priority 4 - Models of Support, Pathways of Care

Our Ambition:

People will live more independently at home for longer, supported by redesigned community based, person centred services.

The Kings Fund Report **Reimagining Community Services - Making the most of our assets** published in 2018, notes that "A radical transformation of community services is needed, making use of all the assets in each local community wherever these are to be found, breaking down silos between services and reducing fragmentation in service delivery."

We recognise the need to continue to improve the way that people move between large hospitals and the community, how we would redesign models of non-acute hospital-based services and re-invest in community-based services including our response to protecting people concerns.

How We Performed

Encouraging people to have choice and control over the services and supports they receive underpins this strategic priority. The table below shows that the number of people who received Self Directed Support options 1 and 2 has increased consistently since 2015-16. The amount spent on delivering services and supports under options 1 and 2 increased considerably from around £1.8M in 2015-16 to around £6.5M in 2020-21.

Self Directed Support – Options 1 and 2

	2015-16		2016-17		2017-18	
Option	**No. of people**	**Cost (£)**	**No. of people**	**Cost (£)**	**No. of people**	**Cost (£)**
Option One Total	58	928,673	60	1,087,024	74	1,522,411
Option One - Adults only	50	865,451	52	1,016,659	65	1,413,326
Option Two	22	96,279	30	308,726	39	287,817
	2018-19		**2019-20**		**2020-21**	
Option	**No. of people**	**Cost (£)**	**No. of people**	**Cost (£)**	**No. of people**	**Cost (£)**
Option One Total	103	1,875,293	122	3,432,428	143	3,782,570
Option One - Adults only	79	1,640,765	81	2,701,004	88	2,682,716
Option Two	70	613,366	161	2,062,732	123	1,663,544

What we have achieved to deliver this Strategic Priority

Community Health and Care

- We received funding and support from Healthcare Improvement Scotland for the development of Hospital at Home service. (£160k until March 2022) This has allowed expansion of the team, increased medical input and recruitment of a healthcare assistant post.
- Across the Urgent Care Service we have improved patient pathways including widening referral routes and creating smoother pathways to and from the service and we have improved co-ordination of social care support via the co-ordinator role

Feedback via Care Opinion regarding Urgent Care service:

The lead nurse practitioner ....was excellent in keeping in touch with family and explaining everything she was putting in place. Thanks to (the nurse practitioner) and the team he was able to spend his last days at home surrounded by family.

have to say that this team went over and above their duty of care more than I could have expected. All necessary tests were carried out at home and they were just a phone call away if needed!

The care that (the team) provided was so thorough and professional, yet always compassionate and respectful. To say that they went the extra mile would be an understatement. Telephoning on their days off and keeping us well informed of our Mum's situation, their treatment, and how they were juggling medications to best treat her complicated needs. We had no idea that this care was available in Dundee, and we were so relieved to be referred to them. They undoubtedly saved Mum's life, giving her a little more time with us, and they gave us comfort and peace of mind. The family owe them so much, we cannot speak highly enough of them and the care they have provided.

In my opinion there should be more of these teams set up throughout the NHS Scottish regions. It saves the stress of hospital admission which can sometimes affect a patients recovery especially when there are conditions that can be treated safely and effectively within the home environment but need that little bit more input than a GP can provide.

The team showed not only great care and kindness to my father but to the family. Having the DECSa team in our home instead of a clinical environment helped to make the situation a lot less stressful.

- There is a growing number of older adults whose needs cannot be accommodated within the current local care home resource and for whom more complex discharge planning is required. There are plans to remodel local authority care home provision which will ensure older people with the most complex needs receive appropriate care and support, however progression of this has been delayed due to COVID-19.
- The Pelvic & Obstetric Physiotherapy Team (POP) have worked with primary and secondary care colleagues and the Transforming Outpatients Team to develop the Urogynaecology pathway and proposed new guidelines for referrers. This promotes and encourages self-management of urinary incontinence at an early stage. The new pathway has led to higher referral rates and more patients redirected into the physiotherapy service due to enhanced gynaecology vetting and implementation of the new pathways. The POP team cover both Dundee and Angus patients and have received investment to reduce the significant waiting list the new pathways have contributed to.
- The plan is to develop patient friendly digital resources (online patient information, links to pertinent sites, instructional videos and potentially app development) that can be utilised at all stages of the pathway (Obstetric MSK, Male & Female Pelvic Health, Prostate Rehab, Section School). Information will also be accessible to aid improved public health. It is anticipated that these resources will improve access to information for patients and may reduce the number of unnecessary referrals into the service. Timely access to resources will be supported by clinicians sending patients (digitially if possible) the right information when assessing referrals, therefore enabling patients to self-manage whilst waiting for an appointment. It will also allow patients who may find it hard to attend clinics an opportunity to access information to help their condition.
- In February 2021, representatives from Allied Health Professions across all three partnership areas, the Tayside Orthopaedic Service and other important stakeholders met to embark on an improvement project. The project acknowledged there are increasing pressures on hospital outpatient departments to provide timely medical and Allied Health Care for an increasing numbers of patients with orthopaedic/musculoskeletal (MSK) complaints. AHPs are integral to the efficient management of outpatients within NHS Tayside, and as per the Tayside MSK pathway, patients should be directed to AHP services as first line management for MSK problems. In light of recent developments in management of primary care patients, e.g. introduction of First Contact Physiotherapy, and because the MSK pathway was last reviewed in 2013, it was agreed the project would undertake a thorough review of the whole service in order to ensure the best patient outcomes and experience. Furthermore, developments in managing patients virtually during the COVID-19 pandemic, including multi-disciplinary team communication and support will be factored into any future service model. An analysis of current staffing, DCAQ and mapping of desired patient pathways is being reviewed. Referral guidance for all sub-specialities developed, utilising IT solutions to ensure they remain accessible, relevant and reflective of any changes in evidence base and practice. Criteria to measure success of the project will be agreed with support from the NHS Tayside Improvement Team.

Care Home and Treatment Service

Links with National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

"At the beginning of last year I was referred to the Dundee Home Care and Treatment Service. For many months I had daily dressings carried out in my home since I was shielding. My care was then taken over for a very short time by the District Nursing Team before being returned once more to the Home Care and Treatment Service. At this point I started to attend the Crescent at Whitfield for my dressing the frequency of which was slowly reduced from daily to weekly. Fortunately I no longer require dressings but must have received care from this team for about a year so I got to know them quite well!

Each & every member of this team were excellent. They were knowledgeable, supportive & clearly very experienced & expert in the service they provided. For many months they were my only contact with the world outside & they helped me remain mentally well. They were clearly busy but I never felt rushed or a nuisance. At one point I was struggling with making a decision whether to have major surgery during a pandemic. My surgeon made it very clear about the risks should I contract Covid post op & it was not therefore a decision to be taken lightly. The nurses in the Home Care and Treatment team listened to my concerns, supported me when I was distressed & very gently helped me to reach a decision on surgery. I will never be able to thank them enough for their support. They also seemed like a happy team and one which was fulfilled by their role.

I should also say the staff who manned the telephone lines were always professional & helpful including fitting me in to have bloods taken rather than have to attend at another time. They looked for & found solutions & were willing to be flexible. The Phlebotomist at Whitfield was also excellent & one of the few people who always got a vein first time - & believe me that is rare.

Anyway hopefully I've made it clear how much I valued & respected this entire team."

- Tayside Adult Autism Consultancy Team (TAACT) has reviewed the diagnostic pathway for Primary Care referrals, resulting in developmental information being gathered in advance of first appointment. This reduces the number of sessions required and is in line with other similar services nationally.
- The NHS Tayside Chronic Pain Service Improvement Group was established to work collaboratively and use a quality improvement whole systems approach to advise on the delivery of safe, person-centred and cost effective care to patients living in Tayside. Through this work the group continues to implement chronic pain pathways within NHS Tayside that are aligned with the Scottish Chronic Pain Service Model (https://www2.gov.scot/Topics/Health/Services/Chronic-Pain).

  As part of this group, the Clinical Health Psychology Service has been able to work more closely with the Tayside Pain Service to establish new patient pathways through funded Clinical Psychology posts integrated within the Pain Service. The service continues to develop with both new post holders in place in January 2021. A new patient pathway will allow service delivery in line with the Scottish Chronic Pain Service Model where patients can access input from psychological care as part of multidisciplinary treatment within the Pain Service.

Prior to the establishment of this pathway, patients wishing to seek psychological input for symptoms of chronic pain accessed psychological therapy via the General Physical Health Service within the Clinical Health Psychology Service. Providing integrated care together with other health professionals was challenging as patients may have been discharged from the Pain Service by the time they were offered an appointment. Patients also tended to be referred to Clinical Psychology when they had received all other healthcare interventions. The new pathway will allow patients to receive psychological care earlier in their care.

The new pathway will also allow for the delivery of a Pain Management Programme (PMPs) provided by Clinical Psychology, Physiotherapy and Specialist Nurses. Finally, this new pathway will also allow for a tiered service delivery model of psychological therapy by further aiding multidisciplinary team members to deliver psychologically informed care to individuals living with symptoms of chronic pain.

- At the start of the pandemic there was a request from the Scottish Government to set up community COVID-19 assessment centres to focus on assessing people in the community who may have COVID-19. This would allow assessment in an environment which minimised risk to staff and patients. There were several pathways after assessment, including advice for self care, a treatment plan, both for COVID-19 and other illnesses, and referral of those who are acutely unwell requiring admission. The Community Covid Assessment Centre (CAC) involved a wide range of partners, including the Partnership, Out of Hours Service, Paediatric Service and General Practice Teams. Initially 5 centres were opened in Dundee, Perth and 3 sites in Angus. The CAC is now managed alongside the Out of Hours Service. Additional salaried staff have now been employed on fixed term contracts, supported by Out of Hours and General Practice staff.

  Tayside opened the first centre in Scotland, with the base in Dundee, with the other centres opening within 2 weeks. The centre was staffed by General Practitioners, Advanced Nurse Practitioners, staff from Out of Hours Service and a number of staff who returned from retirement to support the service in a range of roles. Redeployed staff from the Dental Service also provided significant staffing. The service included telephone triage as well as face to face assessment. It was also developed to allow support for daytime work if a practice or practices had to close due to COVID-19.

  The model developed in Tayside has been effective in managing this group of patients in a drive through centre. The Dundee site has stayed open to provide a service to those who it is not possible to see in general practice, but is mainly focussed on those in Dundee. Numbers are now much smaller, but staffing and sites reduced to reflect this, but it has the ability to flex up if required. It has been a huge commitment which has worked because of the input of a wide range of partners, with really strong leadership from across primary care in Tayside. It has had a key role in supporting General Practice and in managing care to minimise admissions to hospital during this challenging time.

- In line with other services general practice had to adapt its model of care delivery overnight to minimise face to face contact, while also dealing with significant demand from patients with possible COVID-19. It has been a challenging year as processes have changed and evolved with phases of lockdown. Patients are predominantly now given an initial assessment by phone and either supported on that initial call, or given a subsequent appointment by video call or face to face where required. Practices all developed "hot rooms" to see those who might have COVID-19 in practice, where they could not be assessed in a car at the CAC. There was a huge rise in Near-Me video consultations, although this was more marked in some practices than others, and has reduced with time. The increased use of technology has been welcomed by many patients, with access to advice and support through a range of routes in a way that was not as well established prior to COVID-19.

  The workload for GPs has increased overall, particularly as they support people to manage their condition while they wait for assessment, treatment and intervention in secondary care. This pressure is likely to continue to increase. Balancing this with remobilisation is challenging at the current time.

- The use of online supports has resulted in a huge reduction in travel time and an increase in the number of multi-disciplinary team / referral / consultation meetings able to be attended. As a result, all Allied Health Professionals can now network with a wider group of colleagues both locally and nationally with less time taken from clinical services.
- The Physiotherapy Team used the initial drop in face to face contact in order to review and implement the National Physiotherapy Guidelines for Learning Disability Physiotherapy Services. This has incorporated a benchmarking system and the themes covered chimed well with the 4 Strategic Priorities as laid out in the Dundee Strategic and Commissioning Plan 2019-2022. Physiotherapy staff were able to grasp new learning opportunities, this included one support worker commencing her Physiotherapy degree Pathways of Care course.

Mental Health

- The Dundee Community Mental Health Services Discharge Hub was created at initial stages of COVID-19. This centralises all Carseview, Murray Royal Hospital and Crisis Team discharges for residents of Dundee. The Hub provides a consistent and streamlined process of discharge and an improved quality of care and patient experience post discharge. This is a "wrap around service" for people who have been referred to the CMHT and is also a follow up service for people who are discharged back to the care of their GP or other services including Integrated Substance Misuse Services. This service is operational 6 days per week including public holidays.
- Community Mental Health Nursing and medical staff altered their normal working patterns and have been operational on public holidays due to perceived effects of COVID-19 and the restrictions placed on people.
- The Dundee Community Mental Health Service introduced the Advanced Practitioner role across Community Mental Health Teams so that their prescribing/assessing skills would reduce the pressure on medical cover.

Community Mental Health Referral Hub

Links with National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Miss R was referred to the Community Mental Health Referral Hub with anxiety and low mood. The Hub offers a new way of working and allows Peer Support Workers, Psychological Therapies, Community Mental Health Team and AIDARS to meet together to discuss mental health referrals and agree on the best service to meet the patient's needs.

It was thought that Miss R may benefit from the new group interventions being delivered within the service and was invited to attend a core skills cognitive behavioural therapy group. Due to COVID-19 this group was being delivered remotely. Miss R attended and benefitted greatly from the group with a noted reduction in anxiety and mood on measures post group. She had two further sessions within Psychological Therapies to look at goal setting for the future.

Due to not working and lack of activity maintaining her mood, she was signposted to Voluntary Action Angus and she began volunteering locally. She has also started to engage with the Penumbra service.

- The community mental health teams enhanced the support worker role in their teams to ensure that increased practical, social and emotional support was more readily available for people with mental health needs living at home. This has allowed more individualised support plans and greater access to personalised supports.

Community Mental Health Team Older People

Links with National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
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3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Mr G is a 78-year-old man who lives alone with a mental health diagnosis. He was referred to the team for assessment and support for his mental health. Mr G had chosen not to engage with support services in the past. He was found to be living in poor conditions and socially isolated. A support worker worked alongside the multi-disciplinary team to build a relationship with Mr G with the goal of improving his quality of life. To date the support worker has worked at Mr G's pace to achieve a variety of changes including his house being thoroughly cleaned and redecorated, accessing supports such as Foodtrain and engaging him with social support groups once a week. Mr G feels he now has a better quality of life and knows he can access supports on his terms.

Social Care Response

- The Social Care Response Service (SCRS) is an emergency support service that operates 24 hours per day and one of their high priority calls is attending to those who have fallen at home, supporting emergency services and preventing unnecessary admissions into hospital. SCRS have referred a significant amount of service users to the falls test of change (224 people were referred during December 2020 and January 2021). The COVID-19 pandemic has had a significant negative effect on individuals health and wellbeing. During lockdown, most people spent more time at home and were less mobile. They had fewer visitors and fears and anxieties around catching COVID-19 may also have had a negative impact on that persons mental health and stimulation, resulting in further physical inactivity. All of these factors greatly increased the risk of some people falling at home. Within the Partnership there were some changes to the delivery of care which could also impact people falling at home, such as (i) an overall increase in demand for community-based services; (ii) the profound and complex needs of service users and increase in the demand for multiple visits throughout the day (iii) the focus and drive of less reliance on care services due in part to eligibility criteria changes and resource issues elsewhere in the system. We are starting to see signs that this service could have a profound impact on service users. SCRS have around 7000 service users they support in Dundee, with varying levels of need, a high proportion of these individuals are not known to wider Partnership teams, so this test of change has highlighted how important it is to have a needs led assessment in relation to the fall and

factors contributing, with the intention of trying to prevent further falls. Those referred to the test of change were also referred to occupational therapy for a wider assessment in relation to aids and adaptations, nutritional advise, podiatry needs explored or falls leaflets left with them for support in the future.

Social Care Response

Links with National Health and Wellbeing Outcomes

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4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Mrs H is over 90 years old and lives at home with her husband and has been using her alarm system with Social Care Response Service since 2015. Mrs H has seen a deterioration of her health over the last year, with declining mobility and a significant number of falls. Emergency responders were called 26 times over a four month period. With the support of the emergency responders and control room advisers a referral was made to the falls project support worker who was able to assess Mrs H and support her in a full assessment of need, with the outcome being Rehab/Physio support. The outcome was a big reduction in the number of times Mrs H would fall.

Feedback regarding the Falls Test of Change:

The Falls Test of Change has had an instant impact due to the high level of referrals that came through the service. People who were frequently falling went on to have an assessment followed up with the relevant interventions. The data collected from this Test of Change enables us to see that there's been a significant impact on these people where they are no longer calling SCRS. This service has the potential to be developed and rolled out to other frontline services

Although this project has only been running for a matter of months, the feedback and outcomes given by the support worker enables us to be better informed and able to support individuals better and it links key areas within the partnership, such as OT and Physio

The care given to my mother was a lifeline. Community alarm supported her with respect and dignity at every visit. Not only did they reassure and support her they also helped support me when I was finding things difficult when mum was poorly or had fallen. Mum has sadly passed away but you made her final few days dignified.

The way the controller handled the call to my mother was excellent from start to finish, reassuring her at every step and also the care given to my mother was again excellent.

I have just had the pleasure of seeing your service first hand when my father-in-law had a community alarm installed. The installer was a credit to your service and her people skills with my father-in-law who has advanced dementia were excellent.

I felt this service was incredible and a great support to my mum in accessing services and staying connected.

- The Technology Enabled Care Service is based within the Social Care Response Service (SCRS) and has expanded and developed over the last 2 years. We have introduced a team of Technology Assistants along with a line manager who will keep the service up to date with new pieces of equipment and will lead the transition from analogue to digital technology. This service quickly recognised that many carers had to have time off work to make themselves available for pieces of equipment to be installed in their loved one's homes. This service has not only increased in size but also works 7 days per week and up to 8pm in the evenings to support service users and carers.
- All social care staff now have their own e-mail account and many have been issued with a mobile phone. This has enhanced our communication with staff working in the community. Staff now receive information, publications and 'all staff' information in a timely manner. Social Care Organisers previously had to visit complexes and print off information for each worker so this development has made the service much more efficient in many ways.

Multi-Agency

Links with National Health and Wellbeing Outcomes

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2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Mr A is a 70+ year old male who lived alone when he was seriously injured in a house fire.

Mr A has a learning disability making his understanding and processing of events difficult to comprehend. The trauma of the fire left him with severe anxiety and medical interventions proved challenging. Following a period of time in hospital where he underwent critical medical interventions followed by rehabilitation to learn to walk again, Mr A was moved to a Step Down flat ahead of him moving into his own accommodation in a Housing with Care setting.

Mr A's transition to his Housing with Care accommodation was challenging for him and he required a high degree of interventions from other health care professionals, particularly due to his obesity. This in turn impacted on his mobility, and on occasion, it took several care workers to turn him in bed. During the night, Mr A would become very agitated and was reliant on Social Care Response Service (Community Alarm) for reassurance.

In order to support Mr A to live as independently as possible a multi-disciplinary support plan was developed.

District Nurses visited every morning to dress his legs and administer his medication in liquid form as Mr A had developed a swallowing problem through smoke inhalation. Community Dentist visited and Mr A received a new set of dentures which made swallowing easier.

Speech and Language Therapy (SALT) then became involved and Mr A was placed on a pureed textured diet along with thickened fluids.

These interventions affected Mr A's mood and it took a long time before he began to establish a trusting relationship with the care team.

At this juncture, the SALT Therapist/Dietician worked closely with the Bield kitchen staff and care team as charts were to be completed and Mr A was to be supported when eating.

To make his mealtimes pleasurable, Mr A was supported by a Clinical Psychologist from the Psychological Therapies Service through the Learning Disabilities Section. Although the Psychologist had never met Mr A, she was able to send simple distraction techniques and breathing exercises.

This was very effective and was the turning point for Mr A. He gradually lost weight and his legs began to heal. He was then able to walk with the aid of his frame. At this point the Community Rehab Team became involved and worked with Mr A on a weekly basis until he gained confidence and latterly took his first steps outside his flat.

It was not too long before Mr A could walk to the dining room and share the company of others at lunch time and eat solid food again.

Mr A now has a fantastic relationship with his care workers, and they oversee all aspects of his care from medication to the maintenance of his legs which have healed well.

Care and Protection Team, Aberlour and Children 1st Pilot

Links with National Health and Wellbeing Outcomes

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.

As part of the Alcohol and Drug Partnership Children and Families Working Group, and under section 8 of the Substance Use Action Plan "Keep Children Safe from Substance Use and its Consequences", it was agreed to create a pilot between the Care and Protection Team, Aberlour and Children 1st. A number of cases were identified which required an Initial Assessment due to substance misuse issues which were affecting parenting. The pilot was for Aberlour or Children 1st to complete the Initial Assessment. It was anticipated this would encourage families to engage with the voluntary organisations and create some additional capacity within the Intake Service.

It quickly became apparent that the majority of families would agree to work with the voluntary organisation and then not engage with them once Social Work closed the case. It was vital that the children were provided with the correct level of input and not closed with no change. As these were children on the brink of falling into the child protection process. The solution to this was to identify a social worker within the duty team to do the introductory visit and thereafter be the identified social worker who would remain the single point of contact for the worker from Aberlour or Children 1st.

Of the eleven families referred into the pilot:

- only one resulted in no further action/case being closed following the assessment.
- six resulted in ongoing support being provided by either Aberlour or Children 1st following assessment.
- In all of the above cases, Aberlour or Children First provided Intake with a written Initial Assessment which was recorded in Mosaic and uploaded as an attachment.
- Four families were returned/reopened by social work.
- Two of those families had Child Protection issues, which resulted in the cases going to Initial Child Protection Case Conference and the children's names being placed on the Child Protection Register.
- One case returned to social work due to a new referral, which appeared to be of a child protection nature. An Initial Assessment was completed by social work, with the outcome of ongoing support provided by Children 1st.
- One was returned due to non-engagement by the family, which resulted in an Initial Assessment being undertaken by the Care and Protection Team, with no further action as a result of that.

Achievements

- All of the cases identified in this pilot have been appropriate and the majority have resulted in ongoing support being provided to the family by Aberlour or Children 1st.
- The families and children at a point of crisis have been provided with a high level of support that has benefited them all.

- In the two cases that went to Initial Child Protection Case Conference, Aberlour and Children 1st attended and contributed to the meeting. The children's names were placed on the Child Protection Register and the voluntary organisation continued to provide support and were part of the child protection plan.
- The test of change has contributed to stronger positive links between the Care and Protection team in social work and Aberlour and Children 1st.
- The number of cases within this pilot is small in comparison to the number of referrals that are dealt with in the Care and Protection Team but has resulted in creating some additional capacity within the Intake Service.
- The most important outcome is that children's situations have improved, they are getting their needs met and are safe.

Following involvement in the Test of Change pilot, there have been many notable benefits, positively impacting 3rd sector partners and the families who have been supported within the pilot.

- Strengthened Partnership Working
- Supported learning opportunities when practitioners worked alongside duty workers. They gained a better understanding of the day to day processes on safeguarding responses within Dundee. This created further understanding and promoted shared thresholds surrounding risk and risk management. Practitioners spoke extremely highly of this opportunity.
- For families, it has encouraged positive engagement and demonstrated positive experiences of agencies working in partnership to provide required support and reduce risks allowing families to thrive together.

Feedback from supported families about the service they received from Aberlour:

I didn't want social work involved for my child coz I had them when I was younger, so it was better for us to work with Aberlour, but I didn't really know what they did but once I got to know the worker, it was good, cos they helped us as a family and they didn't make me feel judged.

I just can't thank your staff enough

If we have needed anything I knew you are only a phone call away

I feel you really made sense. I felt listened to and respected. We were really happy with how the assessment was done and felt if we weren't sure, we could ask you. I feel like you really did help us.

Adult Support and Protection

The COVID-19 pandemic impacted on the protection and vulnerability agenda as a result of self isolation and reduced support to vulnerable adults and families.

Adult Support and Protection remained a statutory duty of councils, health boards, police and others to support and protect adults at risk of harm. The Coronavirus Act 2020 did not affect these duties, especially the identification and referral of adults at risk of harm, subsequent inquiries, investigations, Protection Planning or Protection Orders and multi-agency co-operation to support these activities.

Throughout the COVID-19 crisis, it has been particularly important to safeguard adults with care and support needs. They may be more vulnerable to abuse and neglect as others may seek to exploit disadvantages due to age, disability, mental or physical impairment or illness.

In response to COVID-19, the partnership recognised that protection remained a key priority during the pandemic and along with our key partners, we continued to offer the same level of oversight regarding these duties.

These included:

- Additional monitoring and oversight on a multi-agency basis was introduced with weekly meetings and data collection and analysis.
- Updating of operational guidance to accommodate situation.
- A focus on a multi-agency corporate "Risk Register" in respect of Protecting People.
- Executive Groups/Chief Officer Groups for Public Protection increased the frequency of meetings to support their responsibility as guardians of collective public protection governance, assurance and culture to proactively provide additional support.
- Information shared electronically and via newsletters to raise awareness and ensure staff remain vigilant
- Scottish Government supplementary Adult Protection Guidelines shared
- The Mental Welfare Commission guidance in response to COVID-19 to support practitioners was shared across a variety of platforms

The number of adult concerns reported to the Partnership have continued to increase on last years figures although the vast majority of these (81%) did not meet the definition of an adult at risk. A further 16% were supported by actions other than adult protection and the remaining 3% were progressed by actions in accordance with the Adult Support and Protection (Scotland) Act.

Police continue to be the main source of reported concerns although we have continued to see a rise in referrals from NHS colleagues. This is considered a positive development as it demonstrates greater confidence in partners ability to recognise and respond to an adult potentially at risk.

There has been a focus on developing key areas of Adult Support and Protection, primarily;

· Support and training for the role of Council Officer.

· The piloting of new models of screening and risk assessment.

· The appointment of Nurse Advisors within the NHS Adult Protection Team.

As we move forward, there will be a need to review and analyse the impact of these development on vulnerable adults.

4 Our COVID-19 response

A timeline of the pandemic response delivered by the Partnership in collaboration with other community planning partners during waves 1 and 2 was presented to the Dundee Integration Joint Board on 25 August 2020 and 21 April 2021. The timelines describe the Partnership response regarding governance, leadership, service provision and service user and staff safety. This can be viewed here https://www.dundeehscp.com/publications/ijb and provides a comprehensive overview of the range of activity the Partnership undertook to maintain lifeline services, establish new COVID-19 services and supports, support other partners across wider health and social care and community planning systems and to protect the health and wellbeing of the health and social care workforce.

Some of the key developments that the Partnership delivered as part of the COVID-19 response are highlighted below:

- As part of local partnership arrangements we have to date, supported the administration of COVID-19 vaccinations to 87,043 people (71% of the 18+ population) and 188,211 PCR tests through the establishment of COVID-19 Vaccination Centres and Community Testing facilities.
- Maintained lifeline social care services to 3186 people during the COVID-19 pandemic, including the scheduling of 1,146k hours of homecare.
- During the pandemic the existing good links and support systems from the Partnership to care homes was enhanced. The recognition that this period was extremely challenging and worrying for care home staff, residents and families was apparent. In Dundee we were able to draw on our existing care home team which comprises of social workers, mental health nurses and general nurses to ensure each care home had a link member of staff to speak with. This service was also expanded to weekends to ensure daily support if required. A central, regularly updated email information system was set up to ensure relevant information and guidance was shared. Prior to the pandemic there was a Dundee Care Home Provider's Forum Meeting which was held monthly. These were increased to weekly throughout the pandemic to ensure care homes were able to hear up to date information and discuss concern. We established a daily, then twice weekly safety huddle meeting to ensure that a local oversight was kept to ensure that any concerns or supports requirements were responded to.

Wellgate 'Box of Tricks'

- Community Care and Treatment Service adapted their clinic based services to visit shielding patients at home to deliver wound care and phlebotomy services.
- The Mental Health and Learning Disability Allied Health Professionals used MS Teams to communicate with individuals in lieu of `face to face` appointments. For example Speech and Language Therapy utilised MS Teams to provide an Augmentative & Alternative Communication (AAC) therapy group for people with a range of learning disabilities and associated physical issues which would otherwise not have been able to meet due to COVID-19 related restrictions. This method of communication has also provided peer support for both service users and carers which might normally have been hard to achieve.
- The First Contact Physiotherapy (FCP) Service continued to be accessed directly by GPs. However the pandemic changed how the service is delivered, with initial contact by phone, supported by video or face to face consultations, and from more centralised venues.

Wellgate 'Box of Tricks'

- Wellgate Day Support introduced a timetable of COVID-19 friendly initiatives including remote music therapy sessions, speech and language therapy video sessions and outreach work. Makaton packs and various games and outdoor large games were shared with service users to support activities in their own home, a guitar from Wellgate was delivered to a service user to support music activity and a "Wellgate box of tricks" was delivered. These were individualised packs including pots to decorate and a competition to grow a sunflower, including seeds, craft packs, embroidery, knitting, face masks, word search books, postcards/decoration items to design a card to send to a friend, time capsule and a keep in touch leaflet.
- A collaborative project between the music therapist and physiotherapy support and recreation staff saw the creation of a series of YouTube based exercise to music sessions. These sessions were aimed at a range of individuals supported by the learning disability and mental health teams and became a vital means of support to a large number of individuals. Family carers whose loved ones were unable to leave home due to the COVID-19 related closure of their day service supports, found this to be an invaluable respite in their daily routines.
- The `Positive Notes` Learning Disability choir, led by the Occupational Therapy service positively embraced the move onto an online platform as a means of continuing to sing together.

- Occupational Therapists, who were unable to carry on all their group work with people with learning disabilities, created a range of art and craft based resources which they delivered on a weekly basis to individuals in their home environments. This provided vital practical opportunities for individuals to maintain their activity and cognitive engagement levels whilst also providing `mask to mask` contact between therapists, support workers and family or paid care staff.
- The CARES service (COVID-Related Advice on Rehabilitation, Enablement and Support) has been a rapid development in direct response to emerging need. This remote access service offers direct access for anyone experiencing symptoms which are common after COVID-19.
- The community learning disability nurses also adapted their service during the pandemic by providing nursing cover on public holidays and offering garden visits and 1:1 sessions instead of group work, where people did not wish to communicate using Near Me.
- The Corner provides holistic, person-centred, services to young people, including sexual and emotional health support, counselling and crisis support. The development of the new website www.thecorner.co.uk offers young people several new platforms including an up to date range of information, a live chat function, online booking system and live Near Me video chat link. In a year when young people have been more isolated and limited than ever this has allowed us to offer a full range of services using online and telephone platforms. During recovery they are now working on integrating face to face services and an online presence to continue to offer young people a diverse and responsive service.
- Further developed and strengthened our support to third and independent sector providers to support them to continue to operate safely throughout the pandemic and to support ongoing sustainability through national financial support arrangements.
- Developed a Partnership staff wellbeing framework and worked with partners in Dundee City Council and NHS Tayside to develop a range of supports and responses to respond to workforce health and wellbeing needs arising from the experience of working through the pandemic.
- Continued to support victims of domestic abuse and understand the effects lockdown and the pandemic has had on families. This includes a range of activities in partnership with Neighbourhood and Children and Families Services to enhance mainstream services responses to women, children and young people.
- Ensured that people in vulnerable care groups are supported when they attend their appointment for a COVID-19 vaccination by supporting the organisation and development of the local vaccination centres and community testing facilities. For example, the Community Learning Disability Nurse organised a secluded area to support the needs of some people with a learning disability.
- In order to ensure key messages reached the community during the pandemic; leaflets with key protection messages for women who are involved in commercial sexual exploitation were developed and an accessible, symbolised version of public communication around domestic abuse was produced.
- Continued to support unpaid carers via the virtual hub, launch of the e-learning portal Carers of Dundee, the introduction of shopping cards and the provision of safe and innovative forms of respite. How we support carers continues to be informed by the Engagement Surveys and Focus Groups which carers were invited to contribute to.

Responding to the COVID-19 pandemic also meant that the Partnership faced a number of challenges:

- The need to rethink and plan how we deliver services and communicate in order to maximise safety during the pandemic, including the use of outdoor space and digital methods of communication. The closure, suspension and moving online of many services meant that they were less accessible to some people who under usual circumstances would have been able to benefit in a number of ways, such as improving social connections and tackling loneliness.
- The increased frailty and reduced mobility of many citizens caused by isolation and reduced opportunities to socialise and take part in activities away from the home has increased the demand for support and services.
- The increased need to self isolate within staff groups, particularly within social care teams has increased pressure on staff resources and our ability to maintain supports and services to individuals.
- The increased requirement to support staff at a time when stress levels and workload was heightened and office bases were closed and home working was expected.
- COVID-19 restrictions and lockdown have had a significant impact on service users, who have been at increased risk of 'hidden harm' and there has been increased difficulty in reaching already 'hard to reach' groups due to pandemic restrictions. For example, restrictions on face to face peer support/ self help and lived experience work had to be mostly postponed or conducted virtually.
- Continuing to focus on long-term strategic priorities and improvement activities at the same time as delivering a reactive response to the pandemic.

During 2020/21 our recovery planning work incorporated learning from the pandemic, the challenges we faced during the pandemic response thus far and from changes made to services and supports over the last 12 months. Our recovery plan aims to address three critical elements:

- scalable and sustainable plans for context where we are 'living with COVID-19', including further potential surges in COVID-19 cases and peaks of demand;
- medium-term recovery planning over the next 12-month period; and,
- re-setting our strategic vision and priorities post COVID-19 in partnership with people who use our services, their carers and our local communities.

The Recovery Plan continues to recognise that recovery may not be a linear process and may involve movement both forward and backwards through planned recovery phases and actions.

During 2021/22 our priority is to begin the process of aligning our recovery priorities and the strategic priorities contained within the Partnership's Strategic and Commissioning Plan.

Complaints

In 2020-21 a total of 39 complaints were received regarding social work and social care services provided by the Partnership. Over half of the complaints (54%) were resolved at the first stage of the complaint process, frontline resolution. For 61% 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 and these are categorised below.

Complaints regarding Social Work and Social Care services

Top 5 Complaint Reasons
Treatment by, or attitude of, a member of staff
Delay in responding to enquiries and requests
Failure to meet our service standards
Failure to follow the proper administrative process
Dissatisfaction with our policy

For 21% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

In 2020-21 a total of 102 complaints were received about health services. 33% of complaints were resolved at the first stage of the complaint process, frontline resolution. Most complaints (51%) were responded to and resolved within the target timescales which has continued over the last two years.

Complaints regarding Health Services

Top 5 Complaint Reasons
Attitude and Behaviour
Communication (oral)
Competence
Date or appointment
Clinical treatment

For 76% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

Compliments

The Partnership also regularly receives compliments from the people who use our services, their families, carers and other professionals.

This compliment was received about Dundee Enhanced Community Support Acute Service:

"After being discharged from hospital, after a severe bout of pneumonia, my 80 year old mother still had a few health issues that needed to be dealt with from her GP after she got home. Her GP decided that it would be more beneficial that she were referred to the Dundee Enhanced Community Support Acute Team (DECS-A) who have the experience to deal with elderly adult conditions. This team was set up a couple of years ago to treat patients who needed a more clinical input than a GP can give but really don't have the need to be admitted to hospital as they can be treated just as effectively at home. I have to say that this team went over and above their duty of care more than I could have expected. All necessary tests were carried out at home and they were just a phone call away if needed. In my opinion there should be more of these teams set up throughout the NHS Scottish regions. It saves the stress of hospital admission which can sometimes affect a patients recovery especially when there are conditions that can be treated safely and effectively within the home environment but need that little bit more input than a GP can provide."

This compliment was received about one of our Community Support team:

"My 85 year mother received great service from the Dundee Enhanced Community Support Acute Team. The nurses /doctor were all very friendly and helpful could not fault them they made a big difference to my mother just a pity it had to stop. 10 out of 10 thank you very much."

This compliment was received about the OT team:

"I would like to thank you, on behalf of my mother, for having the steps and hand rail installed for her. What a difference it has made to her already. The communication and service was excellent and work completed quicker than expected. Wishing you a Merry Christmas and a big thank you once again."

Inspection

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.

Services for adults registered with the Care Inspectorate in Dundee include services directly provided by the Partnership, services commissioned by the Partnership from the Third Sector and independent providers and services operating independently of the Partnership.

Advice from Directors of Public Health in Scotland was that Care Inspectorate inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted their presence in services unless necessary.

This approach resulted in the majority of services not being graded as normal and retaining the grades they had last received. Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches to ensure services were supported and operating well throughout the pandemic.

The Coronavirus (Scotland) Act, introduced by the Scottish Government on 31 March 2020 to respond to the emergency situation caused by the COVID-19 pandemic came into force on 7 April 2020. Within the Act are provisions which affected the work of the Care Inspectorate, the providers and services they work with, and individuals experiencing care.

In order to robustly assess arrangements to respond to the COVID-19 pandemic, inspections required to place particular focus on infection prevention and control/PPE (Personal Protective Equipment), well-being and staffing in care settings. A key question to augment existing frameworks was developed –

How Good is our Care and Support during the COVID-19 pandemic?

This key question has three quality indicators associated with it:-

1. People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic.
2. Infection control practices support a safe environment for both people experiencing care and staff
3. Staffing arrangements are responsive to the changing needs of people experiencing care

A total of 17 inspections were carried out in 13 services during 2020-21

- 15 inspections in 11 care homes
- 2 inspections in other adult services

Where there were performance concerns at an inspection resulting in a number of requirements being imposed, a follow up visit was arranged. A follow up visit can result in further action being taken or grades being amended. This was relevant to 4 care home services during 2020-21.

Inspection visits can also be carried out if complaints are made against a service.

Dundee was placed 28th poorest out of 31 Partnerships for the proportion of care services rated as good or better in Scotland (80%).This figure is below the Scottish average (82%).

Summary of Inspection Gradings

Grade 2020-21	OVERALL	People's health and wellbeing are supported and safeguarded during the COVID-19 pandemic		Infection control practices support a safe environment for people experiencing care and staff		Staffing arrangements are responsive to the changing needs of people experiencing care	
6 excellent	-	-	-	-	-	-	-
5 very good	5%	1	(7.5%)	-	-	1	(7.5%)
4 good	49%	8	(62%)	4	(31%)	7	(54%)
3 adequate	20%	1	(7.5%)	5	(38.5%)	2	(15.5%)
2 weak	23%	3	(23%)	3	(23%)	3	(23%)
1 unsatisfactory	3%	-	-	1	(7.5%)	-	-

Of the services that were inspected, 9 of the 13 received no requirements for improvement. You can read the inspection reports of the 4 services which received requirements on the Care Inspectorate website. https://www.careinspectorate.com/index.php/inspection-reports

These inspections relate to :

Bridge View Care Home inspected on 22 June 2020
Forebank Care Home inspected on 6 August 2020
Pitkerro Care Centre inspected on 24 June 2020
Rose House Care Home inspected on 27 November 2020

No enforcement notices were issued and two care homes received Letters of Serious Concern from The Care Inspectorate.

A complaint is an expression of dissatisfaction about a registered care service's action or lack of action, or about the standard of service provided by or on behalf of a registered care service.
Following investigation, a decision is made by the Care Inspectorate whether the complaint is upheld or not upheld.

During 2020-21 the Care Inspectorate received complaints relating to 2 services in Dundee. Of these, all were upheld or at least one of the following elements were upheld.

Healthcare
- Nutrition
- Medication issues
- Infection Control issues
- Hydration
- Tissue Viability
- Inadequate healthcare or healthcare treatment

Wellbeing
- Behaviour

Record-Keeping
- Personal Plans/agreements

Communication
- Between staff and service users/relatives/carers

Policies and Procedures
- Complaints procedure

Staff
- Recruitment procedure (including disclosure checks)
- Training/qualifications

Healthcare Improvement Scotland

Healthcare Improvement Scotland (HIS) undertook an unannounced inspection of Royal Victoria Hospital during July 2020. 6 requirements were made regarding 2 outcomes:

- People's health and well-being are supported and safeguarded during the COVID-19 pandemic
- Infection control practices support a safe environment for both people experiencing care and staff

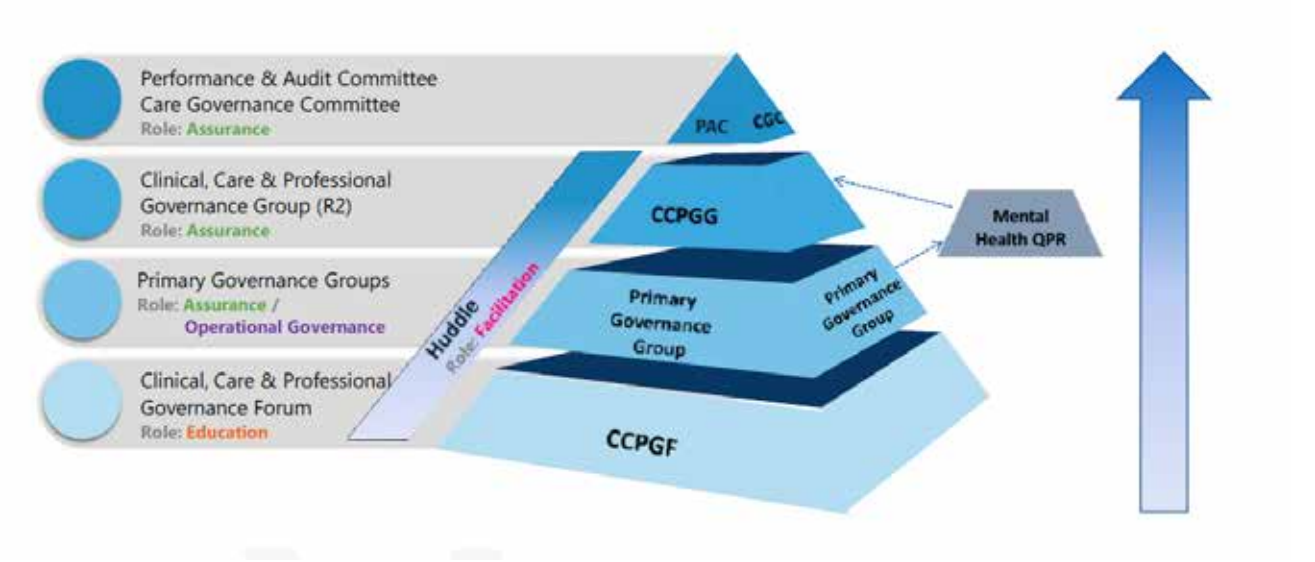
An improvement action plan has been developed regarding these and 3 areas of good practice were also identified.

Clinical Care and Professional Governance

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 Partnership is an active leader and contributor within these.



In addition to this established framework, there has been a requirement for monitoring, reporting and redesigning of services as a result of the COVID-19 Pandemic, to ensure the delivery of safe and effective services.

The continuing impact of the pandemic is being felt by staff across the Partnership as they continue to support service delivery alongside supporting COVID-19 testing and the delivery of vaccinations.

Measures are in place to support staff through the wellbeing framework and the Spiritual Care service has been instrumental in supporting staff and teams through very challenging and traumatic events.

- The contribution of the health and social care workforce, including those employed by independent and third sector providers, has continued to be a critical and invaluable enabler during the COVID-19 pandemic. Recognising and responding to the significant impact the pandemic has had on workforce wellbeing has been a priority during the response period and within the recovery plan. Collaborative working with Dundee City Council, NHS Tayside and staff-side / Union representatives has supported a co-ordinated approach. Dundee City Council Learning and Organisational Development Service is leading the development of a Dundee Health and Social Care Partnership Wellbeing Framework that aligns with the Scottish Government's National Framework for Workforce Wellbeing. The Framework includes a series of targeted interventions and activities which respond to observations of workforce wellbeing and identified risk and protective factors. Further development and implementation of the framework across Partnership services, including the Senior Management and Leadership Team, will be a priority over the next 12 months.

I maybe feel that as the pandemic has went on and our supported people were still not allowed to shops etc but the general public were it was quite restrictive for them. Although I totally understand the risks and the reasons why.

Staff Feedback regarding the Supported Living Team

I have always felt supported and know I can get management support at any time.

Staff Feedback regarding the Supported Living Team

As this has been a new situation to all of us I feel everyone has been very supportive and worked together.

Staff Feedback regarding the Supported Living Team

- Karen Laing from the Community Learning Disability Nursing Team has become a Queens Nursing Institute Scotland `QNIS` Nurse. This is a major achievement in promoting the role of the LD community nurse. This was commended in an article in pages 14 &15, the Dundee Courier on 12/05/21 to mark International Nurses Day.
- The Positive Steps Assertive Outreach Service was shortlisted as part of the Non-Fatal Overdose Response Team for a NHS Tayside Star Award for innovation.

Source: The Courier and Advertiser, 12 May 2021

7 Looking to the Future

CONTINUE
to develop our approach to locality working and enhance the collation, analysis and reporting of performance information at a locality and neighbourhood level.

STRENGTHEN
Clinical, Care and Professional Governance reporting arrangements for hosted services through governance systems and for Primary Governance Groups.

CONTINUE
to work with partners across the Dundee Partnership to streamline and add structure to our engagement with local communities.

CONTINUE
to implement the Primary Care Improvement Plan, including testing new models of community based service delivery and building on and further developing our new initiatives in response to COVID-19.

RESPOND
to the findings from the review processes currently being undertaken by the Tayside Mental Health Inquiry and Dundee Drugs Commission by working closely with partners, including people with lived experience to fully implement existing action plans and consider any emerging challenges.

INCREASE
the pace of improvement in relation to key performance challenges including falls, complex delayed discharges and unscheduled care.

ACTION
the areas for improvement identified by the Best Value self-evaluation for Dundee City Council and respond to any subsequent recommendations in their Best Value Audit report.

LEARN
from national and local research about the short and long term impact of COVID-19 and use this to plan supports and services which address the needs of the population.

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 Care Experience Survey disseminated by the Scottish Government every two years. The latest one was completed in 2019-20.

The methodology was changed by Scottish Government for the 2019-20 survey, on how the responses included in these results are filtered, therefore it is not accurate to compare longitudinally. This is because the question which allow the Scottish Government to ascertain which respondents receive care / support from the Health and Social Care Partnerships was changed and the interpretation of these questions is subjective and varies per respondent.

National Indicator	2015-16 Dundee	2015-16 Scotland	2017-18 Dundee	2017-18 Scotland	2019-20 Dundee	2019-20 Scotland	Comparison with Scotland 2019-20
1. Percentage of adults able to look after their health very well or quite well	93%	94%	93%	93%	92%	93%	
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	88%	84%	84%	81%	79%	81%	
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%	78%	76%	73%	75%	
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	76%	75%	81%	74%	72%	74%	
5. Percentage of adults receiving any care or support who rate it as excellent or good	84%	81%	82%	80%	75%	80%	
6. Percentage of people with positive experience of the care provided by their GP practice	90%	87%	84%	83%	79%	79%	
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%	85%	80%	77%	80%	
8. Percentage of carers who feel supported to continue in their caring role	44%	41%	38%	37%	35%	34%	
9. Percentage of adults supported at home who agree they felt safe	85%	84%	87%	83%	82%	83%	

National Indicator	2015-16 Dundee (Scotland)	2016-17 Dundee (Scotland)	2017-18 Dundee (Scotland)	2018-19 Dundee (Scotland)	2019-20 Dundee (Scotland)	2020 Dundee (Scotland)	Comparison with Scotland 2020
11. Premature mortality rate (per 100,000 people aged under 75)	546 (441)	572 (441)	554 (425)	539 (432)	542* (426)*	604* (457)*	↓
12. Emergency admission rate (per 100,000 people aged 18+)	12,168 (12,281)	12,425 (12,215)	12,815 (12,192)	12,703 (12,195)	12,463 (12,522)	11,823* (11,100)*	↓
13. Emergency bed day rate (per 100,000 people aged 18+)	146,192 (128,630)	141,439 (126,945)	135,284 (115,518)	125,377 (116,485)	114,566* (118,288)*	97,449* (101,852)*	↑
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	122 (98)	127 (101)	127 (103)	129 (103)	128 (105)	146* (114)*	↓
15. Proportion of last 6 months of life spent at home or in a community setting	87% (87%)	87% (87%)	89% (88%)	89% (88%)	89% (88%)	92%* (90%)*	↑
16. Falls rate per 1,000 population aged 65+	25 (22)	26 (22)	29 (23)	31 (22)	31 (23)	31* (22)*	↓
17. Proportion of care services graded'good'(4) or better in Care Inspectorate inspections	88% (83%)	86% (84%)	85% (85%)	86% (82%)	80% (82%)	80%** (83%)**	↓
18. Percentage of adults with intensive care needs receiving care at home	50.0%* (61.2%)*	54.0%* (61.6%)*	54.4%* (60.7%)*	58.7%* (62.1%)*	57.8%* (63.0%)*	59.5%* (62.9%)*	↓
19. Percentage of days people spend in hospital when they are ready to be discharged, per 1,000 population	832 (915)	754 (841)	349 (762)	372 (793)	443 (774)	324* (488)*	↑
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	28% (24%)	27% (24%)	27% (25%)	26% (24%)	23% (24%)	20%* (21%)*	↑

* The primary source of data for these indicators are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2020; this ensures that these indicators are based on the most complete and robust data currently available. Please note that figures presented will not take into account the full impact of COVID-19 during 2020/21.

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

Improved since 2015/16 | Stayed the same since 2015/16 | Worsened since 2015/16

↑ Better than Scotland | ↓ Worse than Scotland | ↔ Same as Scotland

Appendix 3

Glossary of Terms

Acute (Care) Hospital	A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).
Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health and social 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.
Anticipatory Care Planning	Anticipatory Care Planning is about thinking ahead and understanding your health. It's about knowing how to use services better and it helps people make choices about their future care.
Best Value	Best Value is about ensuring that there is good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public. The duty of Best Value applies to all public bodies in Scotland.
Carer	A person of any age who provides, or intends to provide, unpaid care for at least one other person. This could providing support for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse issues. Carers provide care for adults and/or children but the definition used here excludes people who provide care for a child or young person with similar needs to their peers.
Clinical Care and Professional Governance (CCPG)	The system which ensures that health, social work and social care services are person-centred, safe and effective.
Emergency Admission	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 Support	Support services for people with poor physical and/ 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 the Enablement Service is a short term care at home service which is provided for a limited time period.

Health Inequalities	Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. They are avoidable and they do not occur randomly or by chance. They are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.
Health and Wellbeing Indicators	A suite of indicators which draws together data to measure the performance of Health and Social Care Parternships in relation to the Health and Wellbeing Outcomes. 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.
Integration Joint Board (IJB)	Dundee Integration Joint Board (IJB) was set up in October 2015. The IJB is responsible for the planning, oversight and delivery of integrated functions delegated by NHS Tayside and Dundee City Council.
Lived Experience	The term person with lived experience is used to describe a person who has first-hand accounts and impressions of living as a member of a minority or disadvantaged group, this can include carers of that person or other family/friends affected by the persons experience. Person with Lived Experience is a term used in a number of circumstances in health and social care, in particular: • a person using substances, in recovery, or with previous experiences of drug or alcohol use as well as a person with current or previous experience supporting/caring for someone in recovery or being impacted by someone else's substance use. • a person who can identify as currently experiencing mental illness or who has previously been impacted by mental ill health.
Local Community Planning Partnerships (LCPP)	Local Community Planning Partnerships (LCPP) are groups of professionals and citizens who work in partnership to deliver priorities in a geographical area. In Dundee each of the 8 electoral wards have a LCPP group.
Long Term Condition	Long-term conditions are also known as chronic diseases. These are conditions for which there is currently no cure, and which are managed with drugs and other treatment. This includes diabetes, chronic obstructive pulmonary disease, arthritis and hypertension. Some Mental Health Conditions are also seen as long term and enduring.
The Partnership	Throughout this document the Partnership referred to is Dundee Health and Social Care Partnership (DHSCP).

Pharmacotherapy	Pharmacotherapy is therapy using pharmaceutical drugs.
Power of Attorney	A power of attorney is a document can be used to appoint someone to make decisions on your behalf. The appointment can be effective immediately or can become effective only if you are unable to make decisions on your own.
Premature Mortality	This is when individuals die at an earlier age that would normally be expected in a particular population.
Self-Directed Support	The Social Care (Self-directed Support) (Scotland) Act 2013, requires local authorities in Scotland to offer people four choices on how they can get their social care. The choices are: • **Option 1**: direct payment • **Option 2**: the person directs the available support • **Option 3**: the local authority arranges the support • **Option 4**: a mix of the above Option 1 and Option 2 are designed to give the supported person the greatest choice over their care and support.

The Dundee Strategic and Commissioning Plan
and associated documents were produced,
on behalf of the Dundee Integration Joint Board,
in partnership with a wide range of stakeholders
and was overseen by the Integrated Strategic Planning Group.

Get in touch:

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Dundee
Health & Social Care
Partnership