ANNUAL PERFORMANCE REPORT

2017-18

Dundee
Health & Social Care
Partnership

CONTENTS

FOREWORD

Since the establishment of the Dundee Integration Joint Board on 1st April 2016, the Board and the wider Health and Social Care Partnership have worked together with service users and their families, carers and communities to support the citizens of Dundee to live a fulfilled life. The provision of health and social care services is a complex task which is increasingly delivered against challenging financial and resource pressures. We have made significant steps this year in better understanding some of the key challenges we face in relation to issues such as; falls, unscheduled care and delayed discharge, which has increasingly supported us to better target our improvement actions and resource investment.

In our second year of operation we have continued to make progress in both redesigning the way we deliver health and social care services and in enhancing the positive impact these services have on individuals and communities. During the last year we have continued to make progress in reducing the impact of delayed discharge and the length of time people spend in hospital after being admitted in an emergency through continued development of community-based health and social care services. We have also made progress in tackling health inequalities and have reduced the variation in performance between the most and least deprived areas of Dundee in key national performance indicators for emergency bed days, delayed discharges and readmissions within 28 days. The Partnership has continued to demonstrate a strong commitment to working in collaboration with individuals and communities, including many examples of where we have listened to service users and their families and improved our services based on what they have said and suggested to us. The most recent Scottish Health and Care Experience survey results demonstrate that Dundee is performing better than the Scottish average across a number of measures that reflect people's experiences of accessing health and social care services. The Partnership has also secured an additional national investment of £600k for three years to pilot a Health and Work Support Service and £480k to increase the number of community link workers to support reducing inequalities within the city.

The contribution of service users, their families, carers and wider communities has been invaluable to the progress we have made over the last year; we continue to be thankful for their work to design, develop and deliver services that are increasingly personalised and enable people to live independently in their communities for as long as possible. We are particularly proud of the work that has taken place in the last 12 months to implement new carers legislation and to involve people with lived experience of mental health challenges in service redesign. The commitment, dedication and professionalism of the workforce within the Partnership, and within other organisations who we work collaboratively with, has been critical in shaping and driving forward improvements across all health and social care services and in sustaining a high standard of quality across those services which we directly deliver to the citizens of Dundee.

We want to make a difference to the lives of those who need our support and to achieve the best outcomes for families and communities. Whilst the last 12 months have brought significant progress in relation to the personalisation, accessibility, quality and performance of health and social care services in Dundee, as set out in this report, we know that there is always more to do. In particular, we are committed to working over the next 12 months, and beyond, to continue to realign service delivery to our four service delivery areas, improve responses to people at risk of harm, redesign services for mental health and substance misuse to increase accessibility and improve outcomes for people, develop pathways for people with long-term conditions and enhance local supports for carers. We look forward to reporting our progress in these areas, and across the broad range of services planned and delivered by the Partnership In July 2019.

Ken Lynn
Chair, Dundee Integration Joint Board

Doug Cross
Vice Chair, Dundee Integration Joint Board

1.0 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).

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. 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 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 Partnership has focused on 8 Strategic Priorities:

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

Figure 1

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

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

In our second year of operation we did not review our Strategic and Commissioning Plan, however we will undertake a full review of the plan during our third year (2018-19). Our review will incorporate our learning and build on what is working well, it will also have a specific focus on further developing the way in which we plan, commission and deliver health and social care services within our four service delivery areas. As part of the review process we will be undertaking a range of activities to actively seek the views and contributions of all of our stakeholders, including our service users and carers.

1.1 This Report

The Partnership is required to publish an Annual Performance Report which assesses how well it has planned, overseen and delivered the services it is responsible for. This annual performance report reflects on what we have achieved over the last year and the challenges that we have faced, as well as looking towards our priorities for next year (2018-19).

This Annual Performance Report includes

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

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

1.2 What we do

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

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

Additionally Dundee, Angus and Perth and Kinross Health and Social Care Partnerships have 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.

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

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

1.3 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 individual and families, underpins everything that we do.

During 2017-18 the Performance and Audit Committee (PAC) continued to scrutinise the performance of the Partnership in achieving its vision and strategic priorities, including overseeing financial performance and other aspects of governance activities. Throughout the year the PAC has received quarterly 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.
The PAC has requested additional analytical reports in areas where performance has been poor, such as unscheduled hospital care, complex delayed discharges, waiting times and falls, to support an improved understanding of underlying challenges and the development of more detailed improvement plans.

Over the last 12 months we have worked with Angus and Perth and Kinross Health and Social Care Partnerships to develop a core suite of performance indicators that will be reported and benchmarked across Tayside. In addition, individual teams and services have continued to develop their own performance indicators and they undertake a range of self-evaluation activities such as audits, surveys of service users and case reviews. During 2017-18 the Dundee Community Planning Partnership participated in a joint thematic inspection of adult support and protection, including adult protection services provided by the Partnership. There has been significant learning from this inspection and an improvement plan is being developed in response to the areas for improvement identified.

Clinical care and professional governance is an important aspect of our work to improve the wellbeing of people and communities by ensuring the safety and quality of health and social care services. During 2017-18 further work has been undertaken to ensure clinical care and professional governance activities form a central part of our day-to-day work, as well as to monitor these activities to identify patterns of events that require a focused response to improve. An internal audit of clinical, care and professional governance was conducted and found that there is an adequate and effective system of risk management, control and governance in place. The main area for improvement identified by the audit related to clarity regarding the roles of each of the different clinical, care and professional governance groups. This will be a priority during 2018-19. You can read more about our approach to clinical care and professional governance on our website.

We recognise that our commitment to continuous improvements means that further work will be required during 2018-19 to further embed self-evaluation, quality assurance, performance monitoring and clinical care and professional governance. A key priority over the next 12 months will be to ensure that appropriate arrangements are in place at a service delivery area level as we continue the transition to locality and neighbourhood-based models of service delivery.

1.4 How we deliver services in communities

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

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

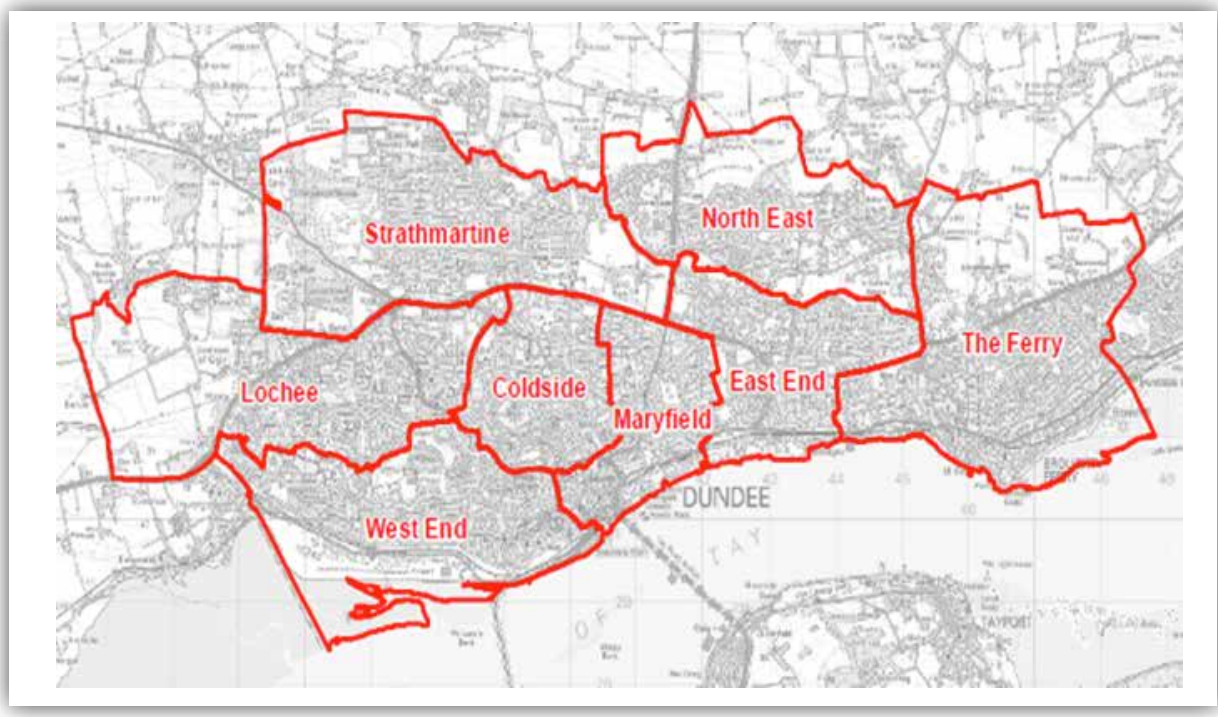


Figure 2 - Map of 8 LCPP areas in Dundee

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

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

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

Over the last 12 months we have enhanced our focus on targeting our resources, service planning and service delivery at LCPP and neighbourhood level. This has resulted in the piloting of service redesign in different service delivery areas.

- Development of a locality approach to carers in Coldside and Strathmartine.
- Roll out of the MacMillan Improving the Cancer Journey in Coldside and Lochee.
- Roll out of the leg ulcer clinic to a second locality.
- The whole system approach to supporting children and families in Lochee.
- An East End Health and Wellbeing Drop In Initiative offering a free drop-in service with a focus on wellbeing information, activities and support.

Further work is progressing to realign statutory services against the four service delivery areas and it is anticipated that during 2018-19 that this will be reflected in further changes to the way health and social care services are delivered in community settings.

A key development for general practice in 2017-18 was the publication of the General Medical Service Contract. The contract marks a significant change in how we will work in the future. It aims to have GPs as "expert medical generalists" at the heart of co-ordinating clinical care for patients. Teams will be developed differently to support patients. In the future you may well be seen by a professional who is not a GP as your first contact for advice and support. This may be a nurse, paramedic, physiotherapist, link worker or psychologist. You may also have some of your care in community based settings rather than just in general practice.

There are a number of key areas of development

- Pharmacotherapy
- Care and treatment services
- Vaccinations and travel advice
- Urgent care
- Support for mental health, musculoskeletal conditions and wider social and wellbeing issues

Aspects of this work are being co-ordinated across Tayside, while other areas are being developed locally to ensure that the services develop to meet the needs of local communities. A Dundee group has been established to develop a primary care improvement plan which outlines how this work will move forward.

Dundee has a number of practices that have faced challenges in recruiting GPs, which has led to increasing pressure on the teams in those practices. Work led by Dundee has supported a range of new roles being developed and tested, including a successful "career start" programme for newly qualified GPs. This has been a popular option and the current round of recruitment to posts may well be oversubscribed.

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

Progress towards our current equality outcomes was presented to the IJB in March 2018 https://www.dundeehscp.com/our-publications/news-matters/publication-equality-mainstreaming-progress-report-2016-2018. The Equality Mainstreaming Progress Report 2016-2018 sets out the progress made in mainstreaming the equality duty and in achieving equality outcomes over the last two years.

We have continued to be active participants in the Dundee City Council Corporate Equality Group and the NHS Tayside Equality and Diversity Steering Group. However, moving forward we recognise the need to establish our own integrated arrangements for promoting equality and human rights across the Partnership at governance, strategic and service delivery levels. During 2017-18 a range of activities have taken place to support the achievement of our equality outcomes. You can find out more about this in section 3 of the Mainstreaming Equality Progress Report.

It has been agreed that a short-life working group will be established in 2018 to give clear recommendations in relation to how equalities issues are supported, governed, monitored and driven forward by the Partnership. This agreement stemmed from the recognition that the IJB is directly subject to the Public Sector Equality Duty and therefore continuing to address equality matters through pre-integration arrangements within Dundee City Council and NHS Tayside is not sufficient to ensure compliance with the Act. It also reflects the strong commitment within the Partnership's Strategic and Commissioning Plan to addressing health inequalities.

A key priority for the short-life working group during 2018-19 will be the review of the Partnership's existing equality outcomes to ensure that they are fit for purpose, reflect the desired outcomes of affected communities and are fully aligned with the revised outcomes published by Dundee City Council and NHS Tayside in 2017. The short-life working group will ensure that revised equality outcomes are co-produced with relevant people, utilising and strengthening existing engagement mechanisms.

From April 2018 the Fairer Scotland Duty, under Part 1 of the Equality Act 2010, came into force across Scotland. The new duty places a legal responsibility on public bodies, including Integration Joint Boards to 'pay due regard' to how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions. The short-life working group will give consideration to how the Partnership's implementation of the Fairer Scotland Duty can be aligned within the existing duty under the 2010 Act and existing commitments within the Strategic and Commissioning Plan to address health inequalities.

1.6 How we engage and communicate with our stakeholders

The Partnership is committed to understanding the needs of the different communities in Dundee. We recognise that meaningful engagement and participation with our stakeholders requires us to take into account their individual and collective characteristics. We support the vision of integration described by "Our Voice" where

"People who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services"

How we listen to and include people as equal partners will be key to achieving our Strategic Priorities, putting people's voices at the heart of decision making will ensure that outcomes improve over time.

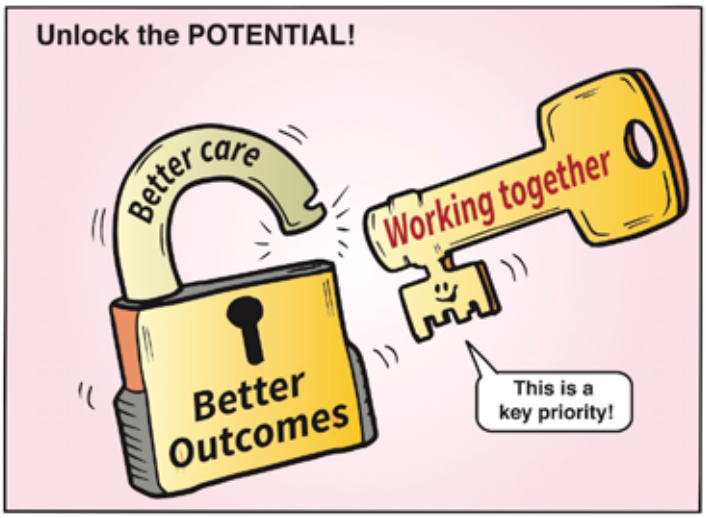
We are working to include stakeholders and communities at all stages of the Strategic commissioning cycle; planning, doing, reviewing and analysing.

During 2017-18 we have continued to implement our Participation and Engagement Strategy. We have reviewed the membership of all of our strategic planning groups to ensure that stakeholders are able to participate as equal partners in the strategic planning and commissioning process.

The Communication and Participation Sub Group of the Integrated Strategic Planning Group has continued to meet and we have reviewed the role, remit and membership of this group in order to better represent the breadth of organisations involved with the Partnership. The group has identified the following priorities for 2018-19:

- Governance and reporting
- Communication with stakeholders
- Creating links and networks
- Resources/online tools

Following the publication of "Equal, Expert and Valued" by the coalition of carers in Scotland the IJB undertook an assessment against the coalition's 'Best Practice Standards for Carer's Engagement' and identified areas for improvement which will be taken forward during 2018-19.



2.1 Where our resources come from

The Partnership's 2017-18 integrated budget for adult health and social care services was confirmed at the IJB's meeting held in June 2017. This budget consists of resources delegated to the Partnership by Dundee City Council and NHS Tayside to support the delivery of adult health and social care services. The Scottish Government set out a number of parameters in relation to establishing the level of delegated budgets in 2017-18 in order to support integration. These included instructing NHS Boards to maintain the value of the delegated budget to at least 2016-17 recurring cash levels and restricting the amount of reduction local authorities could apply to the delegated budget in 2017-18 (£2.440m for Dundee).

In addition, the Scottish Government directed resources through Health Boards to Integration Joint Boards to invest in social care, which included ensuring that all adult social care workers received the Scottish Living Wage, ensuring sleepover payments are paid at least at statutory minimums, funding to prepare for the implementation of the Carers Act in 2018-19 and changes to social care charging.

However despite these interventions at a national level, a number of challenges and risks were identified given the increasing levels of demand for services to vulnerable people in Dundee alongside the financial challenges faced by NHS Tayside and Dundee City Council. These risks include the demographic impact of an increasingly frail population, prevalence levels of people with a disability, mental health and substance misuse problems and the management of the prescribing budget.

This report sets out how the Health and Social Care Partnership performed in relation to these challenges throughout 2017-18.

2.2 How we have used our resources

Dundee Integration Joint Board received regular financial monitoring information throughout 2017-18 which highlighted the range of pressure areas and services which were likely to over or underspend. These overspend areas included the management of the GP Prescribing budget, staff costs associated with hospital based services and the impact of mental health inpatient services hosted by Perth and Kinross Integration Joint Board on behalf of Dundee, for which Dundee is responsible for meeting a proportionate share of costs. A risk sharing arrangement is in place between the IJB, Dundee City Council and NHS Tayside in relation to situations where overspends occur, which in 2017-18 resulted in any overspends being met by the Council or NHS Tayside.

The actual financial position for the delegated budget for 2017-18 was as follows:

- Dundee Integration Joint Board made an overall surplus of £29k in 2017-18 on the total delegated budget of £262.184m. This overall underspend (0.01% of 2017-18 budget), arising within the social care budget has been carried forward into 2018-19 through the Integration Joint Board's reserves, mainly to support the further development of new models of care and other commitments the IJB has made during 2017-18.

- In health budgets an overspend of £2.119m was reported. This consisted of overspends of £2.620m in prescribing and £448k in relation to Dundee's proportionate share of overspends in hosted services across Tayside. There was however an underspend of £949k on health services directly operationally managed by the Dundee Health and Social Care Partnership. This overspend was funded by NHS Tayside under the terms of the risk sharing arrangement for 2017-18.

The actual expenditure profile for integrated health and social care services for 2017-18 is shown in figure 3

Figure 3 – Annual Expenditure Profile 2016-17

Service Type	2017-18 Net Expenditure / (Income) £000	2016-17 Net Expenditure / (Income) £000	Increase/ (Decrease)
Older People's Services	71,201	66,987	4,214
Mental Health	18,996	18,593	403
Learning Disability	31,215	29,427	1,788
Physical Disability	8,923	7,433	1,490
Substance Misuse	3,945	3,666	279
Community Nurse Services/AHP*/Other Adult	12,412	12,009	403
Community Services (Hosted)	10,151	10,184	(33)
Other Dundee Services/Support/ Management	5,799	4,851	948
Prescribing	35,818	35,450	368
General Medical Services (FHS**)	24,163	24,533	(370)
FHS - Cash limited & Non Cash Limited	17,155	20,048	(2,893)
Total of Costs Reported during 2016/17	**239,778**	**233,181**	**6,597**
IJB Operational Costs	267	229	38
Central Support Recharge	4,658	4,352	306
Acute Large Hospital Set Aside	17,452	21,059	(3,607)
Total Cost of Services	**262,155**	**258,821**	**3,334**
Delegated Budget 2016/17	262,184	263,784	(1,600)
Surplus on Provision of Services	**(29)**	**(4,963)**	**(4,934)**

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

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

Figure 4 – Financial Performance Summary

	2017-18 Expenditure £000	2016-17 Expenditure £000
Health Services - Hospital In-Patients	40,474*	44,696*
Other Health Care Services	115,194	116,068
Care Home and Adult Placement Social Care Services	29,474	28,049
Supporting Unpaid Carers	1,270	1,158
Other Social Care Services	75,743	68,736
Total Expenditure	262,155	258,821

* Mainly due to £3.6M reduction in the calculation of Large Hospital Set Aside

You can read more about our financial performance in our Annual Accounts 2017-18.

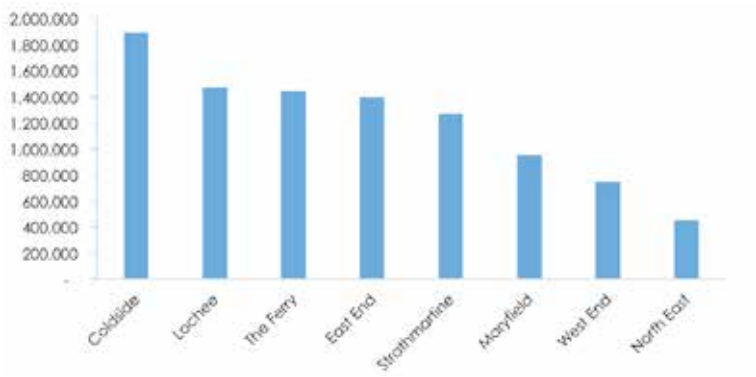
Reserves:
At the end of 2016-17, Dundee Integration Joint Board (IJB) was able to create reserves to enable it to continue to support tests of change and service redesign in addition to meeting unforeseen "in year" financial pressures. The surplus in 2017-18 is significantly less however this will also be added to reserves. The IJB has committed the majority of these reserves over the short term to support its activities including resourcing the scaling up of tests of change.

Shifts in Resources:
Over the last 12 months, the IJB has invested additional resources in social care and community based services across client groups while redesigning services to reduce spend on the hospital bed base in line with its strategic plan. This is reflected in the figures above.

2.3 What we have spent in communities

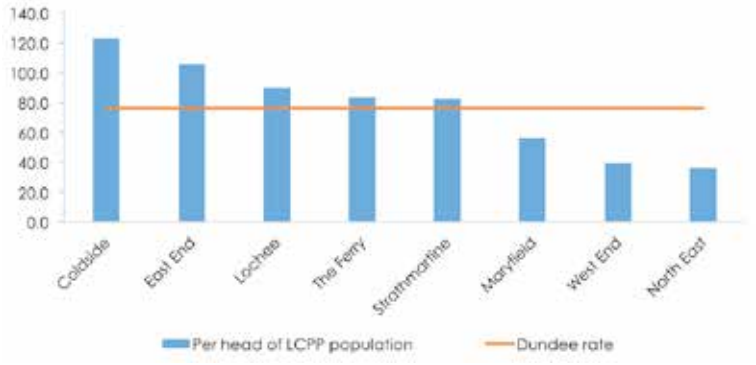
The Partnership's service delivery areas continued to develop throughout 2017-18.
Future performance reports will reflect these new structures and service delivery area expenditure profiles once these arrangements are embedded. During 2017-18, work commenced to identify where resources are spent within locality areas in the city for some services.
This work is helping us to understand how resources are currently distributed across localities and our findings for homecare and social care response services are shown in figures 5 – 8. Each chart illustrates the variation in both total spend and spend per head across localities.
The next step during 2018-19 is for us to expand the use of data to better understand how resources should be allocated, taking into account a number of pertinent factors such as health inequalities, demand on services and demographics projections. This will be reported throughout 2018-19 and summarised in the 2018-19 annual performance report.

Figure 5 – Homecare Spend (£) by LCPP (age 16+)



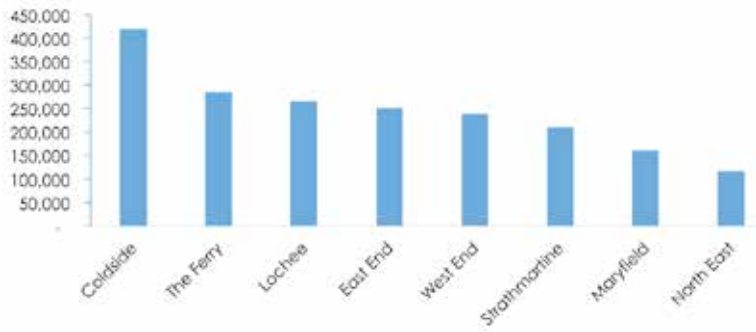
- The most financial resources are spent in Coldside, Lochee, The Ferry and East End.
- The higher spend in Coldside indicates that Coldside population has greater levels of care and support needs.
- The high spend in Lochee and East End is due to the two localities being the most deprived areas in Dundee, therefore areas with increased needs for homecare.
- The relatively high spend in The Ferry is because this area has the highest population of people aged 65 and over, thus increasing the need for home care and support.

Figure 6 – Homecare Spend (£) per head by LCPP population (age 16+)



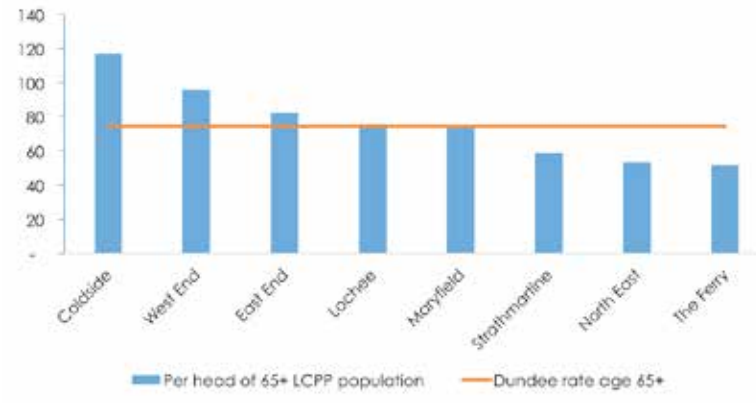
- There is variation in the spend per head of locality population, which reflects the different needs between the LCPP areas.
- Coldside is the LCPP area with the highest spend per head of the locality population, followed by East End and Lochee. The lowest spend per head is in North East.

Figure 7 – Social Care Response Service spend (£) by LCPP (age 65+)



- The highest investment is in Coldside and the lowest is in North East.
- The high spend in Coldside is because of the high number of people age 65+ living here and also the large number of sheltered and very sheltered housing which is supported by the Social Care Response Service when there is not a warden on duty.

Figure 8 – Social Care Response Service spend (£) per head by LCPP population (age 65+)



- Coldside, West End and East End are above Dundee average.
- The absolute investment on social care response services is the second highest in The Ferry (Figure 7), however figure 8 shows that spend on this service per head of The Ferry population age 65 and over is below Dundee average. This is due to the greater proportion of people age 65+ living in The Ferry area.

OUR PERFORMANCE

3.0

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

You can find more detail about how well we are performing against the 23 national Health and Wellbeing Indicators in our 2017-18 quarterly performance reports on our website.

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

National Outcome 1 links to the following Strategic Priorities:

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

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

How well we are performing

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

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

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

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

"How good is your health overall?"

85% of respondents rated their health as very or fairly good, compared to 9% who said it was fair and 6% who said it was very or fairly poor. These results are consistent with the 2016 results.

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 2017-18 for every 1000 people in Dundee who were aged 18 and over, there were 128 emergency admissions. This is higher than the Scottish rate and was the 9th poorest performing Partnership in Scotland, out of all 32 Partnerships. For every 1000 people in Scotland who were aged 18 and over, there were 120 emergency admissions in 2017-18.

Emergency admission rates vary across the city. The highest emergency admission rate was in East End (158 admissions per 1000 people) and the lowest rate was in West End (89 admissions per 1000 people). There is also high variation between the neighbourhoods within each LCPP. An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on our website.

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

Encouraging people to have choice and control over the services and supports they receive is a priority. However figure 9 shows that the number of people who received Self Directed Support options 1 and 2 remains low. The amount spent on delivering services and supports under options 1 and 2 has increased considerably from over £961k in 2015-16 to over £1.7M in 2017-18.

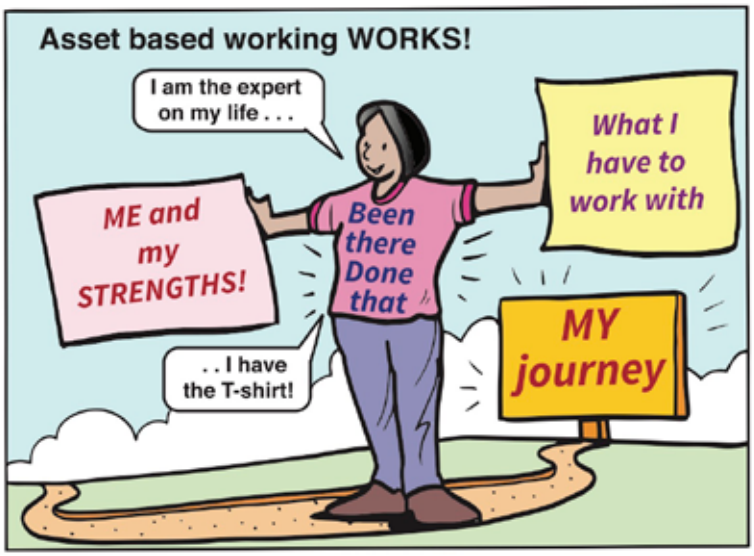
Figure 9 – Self Directed Support – Options 1 and 2

	2014-15		2015-16		2016-17		2017-18	
Option	**No. of people**	**Cost**	**No. of people**	**Cost**	**No. of people**	**Cost**	**No. of people**	**Cost**
Option 1	40	803,313	50	£865,451	52	£1,016,659	65	£1,413,326
Option 2	12	£22,691	22	£96,279	30	£308,726	39	£287,817

Since the implementation of the Social Care - Self-directed support (Scotland) Act 2013 the spend on packages of care for people opting for Options 1 and 2 has increased year on year although Dundee remains low in terms of proportions of people receiving Options 1 and 2, compared to other Partnerships.

Dundee has a high number of people living with dementia. In 2017 there were 2,546 people with a diagnosis of dementia (Alzheimer's Scotland). Health and social care employees work hard to ensure that people with dementia are identified and supported as early as possible and this is measured using a European methodology for estimating prevalence and rates of diagnosis. NHS Tayside measures this against a standard, called the local delivery plan standard, and expects there to be minimum of 50% rate of diagnosis. Dundee is performing well against this standard, with a 64% diagnosis rate at March 2018.

Post-diagnostic support, provided over an extended period, is essential in order to equip people with dementia, their families and their carers with the tools, connections, resources and plans they need to live as well as possible with dementia and prepare for the future. Everyone diagnosed with dementia is entitled to receive at least 12 months of post diagnostic support. 214 people were referred for post diagnostic support, which was 100% of new diagnoses.



What we have achieved to deliver this outcome

- There have been continued efforts to promote an outcomes focused approach which is asset based, focusing on all assets that people can draw upon in their own lives to be healthier and independent for longer in their own community. This may consist of help they can receive from family and friends, peers with similar issues, technology and professional information and advice. The Partnership will provide support in relation to any needs that cannot be met by community based assets. An asset based approach also involves working in partnership to co-design services with the statutory, third and independent sectors and with individuals, families and communities.
- Over the past year, a review has been undertaken by the Personalisation Delivery Group. They wanted to know how far personalised approaches have been embedded into our services. Taking into account the intentions of the Scottish Government in their plan for personalisation and by comparing our performance with other Partnerships, the following recommendations were agreed by the Personalisation Board and are currently being taken forward:
    - Review current eligibility criteria for people accessing services.
    - Focus more on what supports exist in localities.
    - Change the way we contract services to focus on personal outcomes and review how the Partnership allocates resources so that they are more personalised.
    - Develop a quality charter for direct payment employers. This should say what people who self-direct their support, using a direct payment, should expect from their employees as a minimum standard of quality of care and support.
    - Develop and deliver further outcome focused learning opportunities.

PERSON CENTRED CARE AND SUPPORT

Mr G is a young man with high functioning autism who felt he needed support to form friendships and improve his confidence in social situations. Accessing a Self Directed Support budget enabled him to employ personal assistants to support him to participate in opportunities in his local community by helping research what was going on locally and plan his travel and finances to get there and take part.

- In addition, we have employed two specialist social workers with a specific focus on supporting the implementation of the Social Care - Self Directed Support (Scotland) Act 2013 across our services. These social workers will support staff through the application process for options 1 and 2 to ensure that these options are understood and accessible to people using services. We have also commissioned the Dundee Carer's Centre to provide support to people accessing self directed support direct payments in Dundee.

EARLY INTERVENTION AND PREVENTION

Ms Q has complex needs and lives in a care home. She was admitted to hospital as a result of unstable diabetes.

Through the collaborative work of the general nurse and review officer and in conjunction with care home staff, GP and specialist diabetes nurse an appropriate management plan was devised with Ms Q. Care home staff were trained and Ms Q's anticipatory care plan was updated which allowed the care home to better support Ms Q and prevent further hospital admissions.

PERSON CENTRED CARE AND SUPPORT

Mrs K met with her advisor from the Dundee Carer's Centre and decided her personal outcome was to undertake a degree at a local university. She accessed a self directed support direct payment to employ personal assistants to support her to live independently for the first time away from her family and to manage study and travel. She has employed people who are close to her own age who enable her to participate in social activities within the campus and she is now settled into her new accommodation and student life.

- The Healthy Weight Partnership organised an event to kick-start a movement in the city to design healthy weight initiatives. Over 100 people from a wide range of sectors took part. The challenges and opportunities of achieving and maintaining a healthy weight were outlined by inspirational child healthy weight advocate and TV expert Professor Paul Gately, with local experts outlining the picture in Dundee. Scotland's Chief Nursing Officer Professor Fiona McQueen, who has led by example by personally taking positive steps to achieve a healthy weight, contributed to the day along with a diverse range of public, private and voluntary sector organisations who shared ways of doing things differently. On the day participants had first-hand experience of the challenges to eating healthily and being active in the city. More information can be found at: https://www.healthyweightdundee.com/.
- Over the last year we have taken a collaborative approach to the use of technology enabled care. Some important developments include:
    - Organisation of the third Smart Care Convention. This event was an opportunity to inform colleagues about technology which is already available and could be used more widely such as the 'Attend Anywhere' video consulting system and the Kardia monitor for atrial fibrillation. Speakers described the challenges and opportunities brought by developments such as the 'Internet of Things' and the digitisation of the UK's telephone system.
    - Consultation on the draft smart health and care strategy. This included visits to local groups and gathering comments. These were broadly supportive of the draft strategy, however feedback included the need to support people to use technology if required. These comments will inform the implementation of the strategy which was launched in November 2017. https://www.dundeehscp.com/sites/default/files/publications/smart_health_and_care_nov17.pdf

- Preparation for new Dundee and Angus independent living centre website.
- Consultation with local community groups and city wide interest groups to discuss telehealth and telecare. (Florence is a simple text based home mobile health monitoring system and Attend Anywhere is a simple to use video consulting tool. This is useful for people who cannot attend clinics in person and for certain out of hours services where no physical examination is required.

EARLY INTERVENTION AND PREVENTION

Mr C is in his fifties and has Down's Syndrome, associated learning disability and has been diagnosed with Alzheimer's Dementia. He values his independence and is very sociable, enjoying opportunities for participating in many activities, in particular dancing, snooker, football, walking and going into town.

Due to the progression of Alzheimer's disease, Mr C sometimes struggled to find his way home. Risks of wandering and concerns regarding deterioration in his cognition have increased leading to a multi-disciplinary team's decision to introduce a GPS system which would assist in locating Mr C during instances when he went missing.

Further deterioration in Mr C's orientation and memory followed and he had to move to accommodation with additional support. While there, he managed to maintain his independence and freedom of movement with the help of the GPS system. Additional smart technology (alarms) has been fitted to the windows and doors in his accommodation to alert staff quickly if he leaves the building.

With this additional support in place, Mr C can enjoy his independence, however we are aware that he has a progressive condition which is being closely monitored and it's very likely that he will require further aids and support in the future to ensure that he maintains as good quality of life as possible.

- Our enhanced community support and post diagnostic support teams work in localities to identify people at an early stage of their journey and provide comprehensive assessment, early intervention and anticipatory care. When people's health begins to deteriorate, a range of services is provided to allow them to maximise their recovery and independence in their own home, for example the Enhanced Community Support Acute Service.
- A test of change has been implemented and evaluated on the introduction of the lead professional approach by Dundee's Homelessness Partnership. Staff reported that taking a lead professional approach feels very different to what they previously thought represented joint working through multi-disciplinary team meetings. Where there is a lead professional, one person takes responsibility for overseeing; the actions, the supports delivered and reporting the outcomes achieved at review. This approach has meant that staff are much clearer about when actions have been completed and whether or not these have resulted in outcomes being met.
- The community companion project is aimed at adults living in Dundee who are either experiencing or have the potential to experience social isolation. Each service user is

carefully matched up to a community companion based on personality, hobbies and interests. Community companions visit people in their own homes, accompany them to social activities and shopping trips. The Community Companions Project has received positive feedback from service users, their families and also professionals. Professionals have noted that having support to enable people to build real face-to-face relationships with volunteers and peers (within the cafes and events) helps to not only reduce social isolation and loneliness but also helps to lessen the anxiety associated with change. Particularly relevant within the current climate of changes to service provision was most notably the reduction, and in some cases total withdrawal, of on-site warden services from sheltered housing. Referrals can now be made directly by GPs and recent feedback related to how valuable the contact with the volunteer was in terms of positively influencing health outcomes.

BUILDING CAPACITY

Mr O moved to Dundee to be closer to his family after a diagnosis of Multiple Sclerosis (MS). Other than his elderly mother and a niece, he had no support network for socialising.

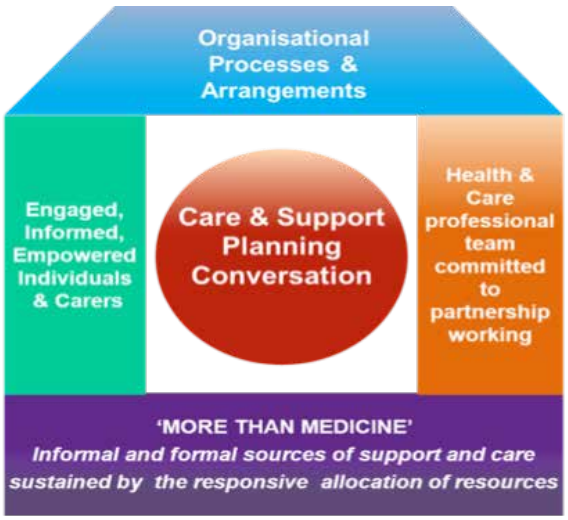
His mother referred him to the Community Companion service and after an assessment he was matched to a volunteer.

The volunteer provided Mr O with a sense of independence and instead of deskilling Mr O, the volunteer looked at ways that Mr O could do the things he wanted to with appropriate support. In the beginning Mr O had little or no confidence so the volunteer worked with him by going on short outings near to where he lives to allow him to build the confidence needed to start going further afield.

Mr O and his volunteer developed a social plan, which highlighted Mr O's goals, one of which was to join the gym.

After a few weeks the project sourced a gym which offered activity programmes to suit Mr O's medical condition. It was aimed at those with varying degrees of disability. Mr O was eager to go but also apprehensive due to his MS so his community companion went to the gym session with him. This allowed Mr O to gain the confidence to attend the session and have the moral support of someone who he saw as a friend. The community companion continued the visits to the gym for a few weeks until Mr O felt confident enough to go alone. From then, Mr O began to see that having a serious health condition did not have to hold him back from doing the things he wanted and his confidence soared, he met new friends and is now attending the gym by himself.

- Over the past three years, general practices and specific specialist services across Tayside have been supported by the Partnership and additional partners to implement Care and Support Planning, using the House of Care framework (CSP/HoC) - a different way of working to support people with one or more long term conditions (LTCs) during routine reviews. Key principles include;



CSP conversations (heart of house) – including, 'What matters to you?' & goal setting/action planning

Support for self management (More than Medicine foundation) - available and accessible

Prepared person (L wall) - usually a 2 step process to collect all useful information prior to the CSP conversation, sharing this with the person and prompting them to think of their question, which offers time to reflect and discuss

Prepared professional(s) (R wall) – appropriately trained and committed to a person centred partnership approach

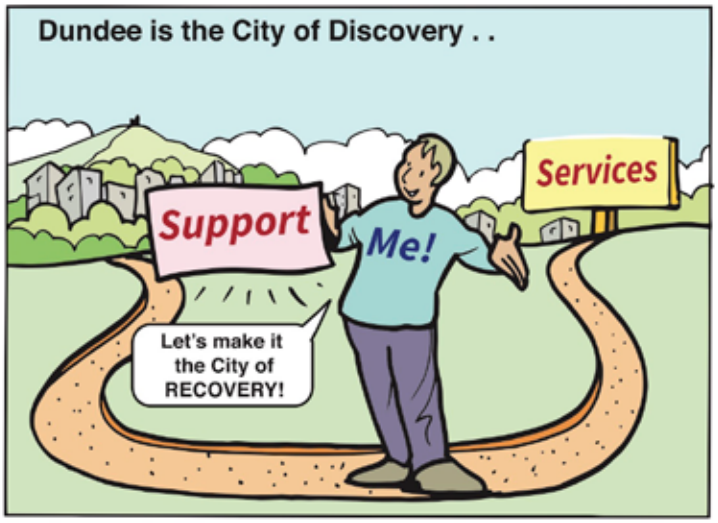
CSP processes (roof) – developed and refined to support CSP conversations

CSP/HoC enables people to be in the driving seat of their care and thus can improve quality of care. Local evaluation has deemed the approach of merit from the perspective of people with LTCs who feel listened to, more involved and value the sharing of information (results) prior to routine reviews, so as to prompt them to think about questions they want clarified and what they might want to do to manage their long term condition better. Once implementation is embedded into the routine way of working, staff feedback is also favourable, as people with LTCs start to become more involved and empowered to manage their LTC via self-management. Furthermore, adopting a multi-morbidity approach, where all LTCs are reviewed in a single (two stage) review can also be efficient and cost effective. Significant resource has been invested to spread the word, provide training and support implementation. To date, seven practices across Tayside have successfully implemented and sustained CSP/HoC for one or more LTCs. This includes two practices in Dundee, with a further two planning their implementation approach post training. Additional practices in Dundee have expressed interest and will continue to be supported.

There is also good alignment of CSP/HoC with other policy drivers, including realistic medicine (shared decision making and personalised care), health literacy action plan and anticipatory care planning. CSP/HoC is viewed by many as a key enabler within the new general medical services contract and will be considered during primary care implementation planning.

- We are working to increase the availability of high intensity psychological interventions to the community mental health teams in a number of ways. We have already increased staffing levels within the multi-disciplinary adult psychotherapy service and are looking to increase the number of clinical psychologists who work directly within our community mental health teams. We are currently funding and supporting three members of community mental health staff to complete diplomas in cognitive behaviour therapy and a commitment has been made to ensure these staff receive protected time to deliver this psychological treatment when their training is complete. We are further increasing the access to psychological therapies by enabling more mental health staff to provide appropriate low intensity psychological intervention and support.

- The adult psychological therapies service accepts around 1,250 new referrals each year. We have put in place a new intervention called "Dundee Life Skills" which is offered to people likely to benefit from this when they are first referred to the service. This means we can offer ten hours of group therapy work based on cognitive-behavioural principles without people having to wait any significant time to be seen. Over the next year, we hope to work with community partners so that this can be more freely available within communities and delivered in partnership with those communities.



- Our Community Justice Service has been building on current partnerships in relation to the assessment and delivery of substance misuse interventions. This includes a commissioned NHS team who are co-located with Community Justice Service staff undertaking the clinical assessment and interventions required for drug treatment pathways. Similarly, Alcohol Treatment Requirements are delivered in partnership with NHS services and with Tayside Council for Alcohol. We work with and commission 3rd sector partners to delivered targeted interventions offering substance misuse support such as an Arrest Referral Service delivered across Tayside by Action for Children.

- A quarterly NHS dental care drop in clinic is hosted in the Community Justice Service hub and there is a community nurse for women's health located in our Community Justice Women's service.

National Outcome 2: Independent Living – People, including those with disabilities, long term conditions or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.

National Outcome 2 links to the following strategic priority:

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

Local people have confirmed that they want support to be independent 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 well we are performing

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

"I was supported to live as independently as possible"

84% of respondents stated that they were supported to live as independently as possible. This is higher than the 81% of respondents across Scottish who felt the same, however a drop from the 88% reported in the 15-16 survey.

Dundee has a high rate of readmissions to hospital, where the patient had been discharged within the last 28 days. In 2017-18 12.3% of people discharged from hospital following an emergency admission, were readmitted within 28 days. This is an increase compared with 2016-17. Dundee has the highest 28 day readmission rate in Scotland.

Despite a high rate of readmissions to hospital, the number of bed days lost to delayed discharges for people aged 75 and over 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 2017-18, for every 100 people aged 75 and over, 34.7 bed days were lost due to a delayed discharge. This is an improvement since 2016-17, when there were 75.5 bed days lost for every 100 people aged 75 and over. In 2017-18 Dundee was the 8th best performing Partnership in 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 the Coldside LCPP contribute to the largest rate of delayed discharge bed days. For every 100 people aged 75 and over living in Coldside there were 34 bed days lost in 2017-18, which is more than double the rate in The Ferry. The lowest delayed discharge bed day rate was in The Ferry where for every 100 people aged 75 and over there were 15 delayed discharge bed days used in 2017-18. A statistical analysis of this data was completed which demonstrated that although there is variation across LCPP areas, the gap between the highest and lowest LCPPs narrowed over 2017-18.

There are a number of preventative and rehabilitative supports available in the community, however the measure most commonly used to measure performance in this area calculates the number of people who received personal care or a Direct Payment for personal care as a % of all people with intensive needs. Using the most recent national data available for 2016-17, 55% of people aged 18 and over with intensive needs received personal care at home or a Direct Payment for personal care. This is slightly lower than the Scottish figure of 61%.

Despite Dundee citizens feeling that they were supported to live as independently as possible and preventative and rehabilitative services and supports being delivered in the community, emergency bed day rates for people aged 18 and over remain high. Dundee has a high rate of emergency occupied bed days, although there has been a substantial reduction between 2016-17 and 2017-18. This is a positive change, meaning that, on average, for every 100 people in Dundee 132 bed days were occupied during 2017-18, compared with 136 bed days occupied in 2016-17. This equates to a reduction of over 10,300 bed days. Despite this improvement, Dundee is still performing more poorly than the Scottish average and was the 6th poorest performing Partnership in Scotland, out of all 32 Partnerships. For every 100 people in Scotland 116 bed days were occupied during 2017-18.

Emergency bed day rates vary across the city. The highest emergency bed day rate was in Lochee (182 bed days occupied per 100 people) and the lowest rate was in West End (89 bed days occupied per 100 people). There is also high variation between neighbourhoods within each of these LCPPs. Although variation is high, a statistical analysis of this data was completed which demonstrated that the gap between the highest and lowest LCPPs narrowed over 2017-18.

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

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

What we have achieved to deliver this outcome

- During the last twelve months the Partnership has increased investment in home based care services, by £1 million, in order to bridge the changes recommended from the review of homecare services.
- Frail people who are acutely unwell may need at times to be in hospital. They are supported there by a highly effective acute frailty team which now operates seven days a week. This includes in reach into a number of other in patient areas. Where people do need to go to hospital this is only for the length of time they need to be in hospital and they can step down as quickly as possible using a range of supports and resources such as an assessment at home service which opened during 2017 and an intermediate care unit. This ensures that assessment is undertaken at home or in a home-like setting rather than an acute hospital and people are supported by a multidisciplinary discharge hub and the enhanced community support team.
- Dundee and Angus Health and Social Care Partnerships have launched a new shared community equipment loan service for people with disabilities. The new venture is based at the independent living and community equipment centre in Dundee and provides, delivers, installs, repairs, maintains and recycles a range of equipment to help people of all ages to live independently. It also provides a technical advice service and carries out risk assessments with medical and care professionals, both in-store and in people's homes. Between April 2017 and March 2018 the feedback received from the majority of service users rated the

service as good (99.46%), OK (0.51%) and bad (0.03%). The service achieved most of the equipment deliveries within 3 days (85.1%) with an overall average of 1.34 days and most of the necessary equipment uplift collections within an average of 1.18 days, achieving 81.65% of all collections within 1-3 days.

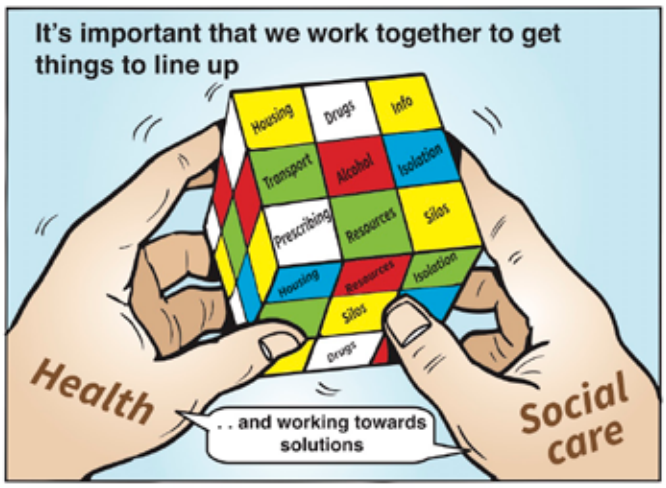
- The youth housing options service is a model of early intervention, conflict resolution and support to assist young adults and their families to repair and rebuild relationships. In 2017-18 there were 245 young adults who presented for housing options advice from a range of sources such as housing, health and social care services and providing conflict resolution where family relationships had broken down. 94 young adults were supported to remain in or return to the family home and 151 young adults were supported to obtain alternative accommodation. 127 young adults were also supported to maintain or secure vocational placements.

PERSON CENTRED CARE AND SUPPORT

Due to a breakdown in family relationships, Miss Q presented as homeless and spent a number of years on the housing list whilst living in homeless accommodation. During this time, she was surrounded by people who were able to take advantage of her vulnerability and was unable to get out and about due to steep pavements being unsuitable for her wheelchair.

Miss Q moved to a new build adapted property provided by a local housing association who had worked with the Partnership. Here, she had a package of care to help her with her personal care but was also able to adjust the kitchen units within her house so she could reach things and be as independent as possible. She was on a bus route that had lowered pavements so she could get to the bus stop and on and off buses. She was then able to get out and about and socialise with her friends. She had a much better standard of living and enjoyed being able to sleep in her own bed.

During 2017-18, the Power of Attorney campaign in partnership with Angus and Perth and Kinross Health and Social Care Partnerships continued. The campaign is supported by additional local awareness raising events in Dundee to help to promote Power of Attorney, reduce the need for guardianship and enable people to be discharged from hospital when they are well. It is planned to promote anticipatory care plans as part of the campaign during 2018-19 to further increase opportunities for early intervention and prevention. Initial data gathering indicated an increase in power of attorneys and this will continue to be monitored over coming years.



EARLY INTERVENTION AND PREVENTION

Mrs T cannot access public transport due to mobility issues. She originally started using the Dundee community transport service to visit a close relative. She formed an excellent relationship with her driver over this period, as they enjoyed football banter over their rival support for Dundee and Dundee United Football Clubs. On her relative's death, Mrs T decided she should no longer use the service, despite being encouraged to do so. Mrs T agreed that the service could keep in touch with her to ensure that she wasn't becoming socially isolated. At the time that the service was scheduled to be in touch with Mrs T, a relative called to ask for support as Mrs T had barely been out of the house since her bereavement. The service contacted Mrs T and persuaded her that her driver was missing her and their football banter and suggested that she might just like a trip out for a cup of tea. Mrs T was very emotional but agreed to this suggestion and asked if it would be okay to be dropped at Dobbies so she could look at plants and go to the café. This became a regular trip for Mrs T every few weeks, and Mrs T has since added other social activities including an exercise class. Mrs T recently requested that a friend who she met through the exercise class could also be picked up by the service so that they can travel together. We believe that this support has been crucial in helping Mrs T with her bereavement, helping her to avoid becoming lonely and to expand her range of social activities and to form a new friendship.

National Outcome 3: Positive Experience and Outcomes – People who use health and social care services have positive experiences of those services and have their dignity respected

Outcome 3 links to all of the Partnership Strategic Priorities.

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

How well we are performing

The national health and care experience survey asked a sample of Dundee citizens aged 18 and over to respond to the following questions or statements

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

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

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

78% of Dundee respondents who were supported at home agreed that they had a say in how their help, care or support was provided. This is slightly higher than the 76% reported for Scotland as a whole.

82% of Dundee respondents who received any care or support rated it as good or excellent. This was slightly higher than the 80% of respondents from Scotland as a whole who reported this.

84% of Dundee respondents reported that they had a positive experience of care provided by their GP practice. This is similar to the 83% reported by Scotland as a whole. There was variation in responses across GP practices in Dundee ranging from 58% to 97%.

Experience of care appears to be positive and this is particularly important when people reach the later stages in their life. Where possible, we try to predice the progress of disease in order to enable a planned approach to palliative and end of life care. However this remains challenging when there are multiple morbidities and altered cancer progression profiles. Integrated palliative care approaches allow the Partnership to support those who are living through their last days and weeks in a way that is responsive to each person's individual circumstances, wishes, hopes and priorities. Of the people who died during 2017-18, 89% of time in the last 6 months of life was spent at home. This is a positive result (similar to the Scottish average and third best in the 'family group') and could not be achieved without a strong partnership between acute and community teams, the third and independent sectors and patients and their loved ones. The Tay PEOLC Managed Care Network is further exploring information related to those who spent greater than 10% of their last six months in hospital, to understand the role of hospital care at this time and how best to ensure acute admissions are purposeful, positive and person-centred.

In 2017-18 a total of 46 complaints were received regarding social work and social care services provided by the Partnership. Just over half of the complaints (54%) were resolved at the first stage of the complaint process, frontline resolution. For 65% 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 in figure 10.

Figure 10 - Complaints regarding Social Work and Social Care services

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

For 39% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

In 2017-18 a total of 114 complaints were received about health services. 43% of complaints were resolved at the first stage of the complain process, frontline resolution. Most complaints (55%) were responded to and resolved within the target timescales.

Figure 11 - Complaints regarding Health Services

Top 5 Complaint Reason
Staff attitude
Disagreement with treatment/ care plan
Problem with medication
Unacceptable time to wait for appointment
Lack of support

For 39% 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 and carers.

This compliment was received about the blue badge service

"Thank you for your quick response the service has been great"

This compliment was received about a Care Management Team for Older People

"I wanted to let you know that the work and empathy of my mum's Care Manager was second to none. Although he was only involved for a short time prior to her passing, he showed the care and commitment that made those last weeks for her as comfortable and the best they could be by way of ensuring that her care was met by those she knew and trusted. So often we only hear the negatives but I wanted you to know that on behalf of her family and friends that her care was superb"

These compliments were received about the Equipment Store at the Dundee and Angus Independent Living Centre:

"Thank you. I am delighted at the speed of the refurbishment for the shower chair so I just wanted to pass on my thanks to all involved for this."

"Would you please convey my appreciation and thanks you to each and every one of you who are making my life so much easier. It is absolutely fantastic to be able to get equipment in before I've even turned around, the patients really like the telephone calls beforehand and my patient... is absolutely tickled pink at now being able to go home instead of long term care."

This compliment was received about Ward 4, Victoria Hospital:

"Please note I must take time to compliment all nursing staff & doctors at ward 4 for all the attention and care I received during my stay which was second to none... "

This compliment was received about staff at a Partnership care home:

"My mother-in-law was a resident for eight months until she died. Staff at the care home welcomed her into the home and respected her and valued her uniqueness. The staff provided excellent care and support for her from day 1, they encouraged us as a family to make it as homely as possible so that she would feel more comfortable. They had shown her and the family compassion - dignity and were always respectfully present without being intrusive during her last days, they made a very difficult situation so much easier not only for my mother-in-law but for all her family."

- The Care Inspectorate is the regulator of care services in Scotland and as part of their inspection they award grades. In 2017-18 Dundee had the ninth lowest proportion of care services rated as good or better in Scotland (88%). Of the 12 services directly provided by the Health and Social Care Partnership that were subject to inspection by the Care Inspectorate over the last year 75% received grades of 'very good' or 'excellent'.

What we have achieved to deliver this Outcome

Throughout 2017-18, information gathered from people who use services and their carers were used to make continuous improvements. Some of these are described below:

- The Multi-disciplinary Adult Psychotherapy Service (MAPS) consistently achieves high levels of patient satisfaction, evidenced in the last two years patient satisfaction surveys. It has engaged in a range of initiatives to seek to reduce demand and capacity issues. In the short to medium term this has included recruiting additional staff to meet demand. In the medium to longer term, the service is now undertaking a broader review of the service and through co-production with stakeholders, which includes service users. This work will commence during summer 2018. Some examples of patient feedback is below:

"My therapist has come across as experienced, professional, respectful and friendly. She has shown tremendous expertise and has helped me improve my quality of life "

"I feel an absolute benefit to my mental health since starting treatment with my therapist. I feel more positive in my thinking and trust in her to help me move forward in all other areas 100%. Others in my life also see a significant change in me in a positive way also "

"My experience with the service has been nothing but positive – it has saved my life on numerous occasions and I am now in a place that I didn't think was possible to reach mentally – solely down to the excellent care and huge amounts of trust in the team "

"I feel understood and listened to by my therapist. Her help and her skills have been invaluable towards my own recovery. The rapport we have built is strong to the point I feel I can open up and trust about the issues I need support with. Very professional and friendly"

"This service has been absolutely invaluable to me. It has been a long road to recovery but I have made it. I have learned so much about myself, and understand and know about what has been wrong… has been fantastic and all she has helped me through has given me my tools to manage myself and situations that previously would have seen me self destruct etc. 100% fantastic service! "

- The Psychological Therapies Service conducts regularly surveys to determine whether people are satisfied with the service they receive. 96% of people considered that their clinician treated their concerns seriously and 96% had confidence in their clinician. Overall, 90% of people believed they received the help that mattered to them:

"My service has been first class. I've been helped so much when I was lost and in a dark place "

"My experience of psychology has been nothing but positive. I am made (to feel) at ease as soon as I go in the room and nothing I say is silly or too much bother "

"I would not trust anyone more than I do (my psychologist) ... my psychologist is fantastic and I have built up so much trust "

"(My psychologist) is highly experienced and is excellent at her job ... and I am so grateful for all the help and support she has provided me with and the difference she has made in my life. The positive impact of our sessions will be lifelong "

" (The psychologist) is above and beyond supportive. My son is very comfortable with her. Very approachable and wonderful manner."

" (My psychologist) allows my family members to sit in on appointments which is a great help."

- Veterans First Point Tayside (V1P) was developed in 2015, it has demonstrated the Partnership's commitment to the Armed Forces Covenant, ensuring that veterans – and particularly those with the most enduring health and welfare difficulties are able to access priority care and treatment from mainstream and specialist services.

  Although a small service, V1P has delivered care and treatment to over 230 veterans and their family members living across Dundee, Perth and Angus. The service has been independently evaluated and demonstrates clinically significant outcomes. The credibility, accessibility and coordination of care has resulted in high levels of service user satisfaction through a cost effective service structure.

  A satisfaction survey completed by veterans who used the service, which was undertaken between April and May 2018 found that:

  - 82% felt their worker listens and take concerns seriously
  - 86% felt the service has helped them to understand their difficulties
  - 92% felt involved in making choices about care and treatment
  - 94% felt they get the help that matters to them
  - 94% have confidence in their therapist

- The responses to a patients and relatives questionnaire at Kingsway Care Centre highlighted concerns about information given to patients. We have now revised the information given to patients admitted to the in-patient areas. This has resulted in a change to format and language which we hope will make the information more user friendly and less clinical in nature. A similar process was carried out for users of the dementia post-diagnostic support service (PDS) which has resulted in a revised customer feedback questionnaire.
  A major project to produce a Tayside wide older people functional standards for use within the community services has now been produced, approved and is now undergoing implementation within our service. Customer feedback was sought during the production of these standards to ensure that the standards are person focused as well as clinically appropriate.

- Oakland Day Centre sought feedback from people who use the centre and their carers regarding quality of support given and asked them to suggest improvements. Examples of improvements made include:
  - The outside area was improved by the addition of raised beds in the garden areas to enable all service users to participate in gardening activities. A sensory garden is also in development which includes a variety of colours & smells.
  - The range of activities has been widened to include; yoga stretch, bread making, stamp collecting and outings to the Secret Bunker and Miniature Kelpies.
  - A new white board system was put in place to notify service users of what activities are happening and where – this includes pictures for people with cognitive impairment.
  - A wishing tree was put up over the last year and a variety of service user wishes carried out due to this, some examples of wishes granted are; 'I wish I could have fish 'n' chips at Arbroath Harbour, like I used to with my mum when I was young'. ' I wish I could go on a scenic bus tour, with a picnic'.

- Craigie House sought feedback from residents. Examples of improvements made include
  - A focus group, involving residents and carers was set up to review the food menus. The menus were changed including an increased range of options. The focus group is ongoing to make changes as requested by residents. The management team is engaging with the Rep Theatre on a project called 'a Guid Yarn' which is a cross generational project based around residents stories, reminiscence and the arts.

- The MacKinnon Centre sought feedback via a suggestion tree and also questionnaire. Examples of improvements made include
  - Creation of a singing appreciation group.
  - Shower baskets being introduced in the bathroom en-suite.
  - Brochures in service users bedrooms with information about things to do around Broughty Ferry
  - Hot water equipment purchased for self serve tea, coffee and hot chocolate station in patio area and in respite lounge for all to use independently.
  - Service users wished to purchase a Juke Box, and raised over £800 for various charities.
  - Wi-Fi now accessible to all in Mackinnon Centre.
  - Book and DVD library created.
  - Art work of service users displayed in the hall for all to appreciate.

- There have been a range of improvements in the Sexual and Reproductive Health service, including
  - The HIV nursing service was established and lead on a service user forum. Patients requested more updates on service changes and support and so a patient newsletter is now being developed.
  - Patients fedback that they were unable to get through to reception on occasion when calling the service - netcall installed as a telephone management and redirection system.
  - Patients suggested making the waiting area space less clinical. The information displayed was reduced and the space was made more "homely".
  - Young people who use The Corner fed back that they would like to be able to access more services at The Corner - full STI testing in now offered at The Corner.

- Dundee Community Living (Learning Disabilities) invited all stakeholders, including supported individuals, their families, professionals and agencies involved with the service to feedback via a questionnaire. The responses were very positive, with an overall high level of satisfaction

  Some examples of the feedback are:

"I like my new flat"

"My mum can stay over at my flat now".

"I have chosen all the decorations and furniture here".

"I am always happy here."

"The staff are really good".

"The team handles complex issues really well".

"There is a high quality of care".

"This is a well- run service".

"They are good communicators".

Examples of improvements made include:

- Improvements in the transition process were made to support people making their final move into supported accommodation. This involved multi-disciplinary planning and a person centred and flexible approach to the process of change.
- One of the gardens was re-developed, with new plants and seating in memory of a supported person who passed away early in 2017. This was requested and led by the other tenants in the accommodation.
- Extended senior cover system was introduced to provide staff with support for emergency and non- routine issues, while ensuring that off duty senior staff obtain an uninterrupted break on their days off. This was achieved by co-ordinating rotas of different parts of the service.
- Flexible working arrangements were implemented as part of a proactive approach to staff support and retention. This has proven successful and is due to be reviewed later this year.

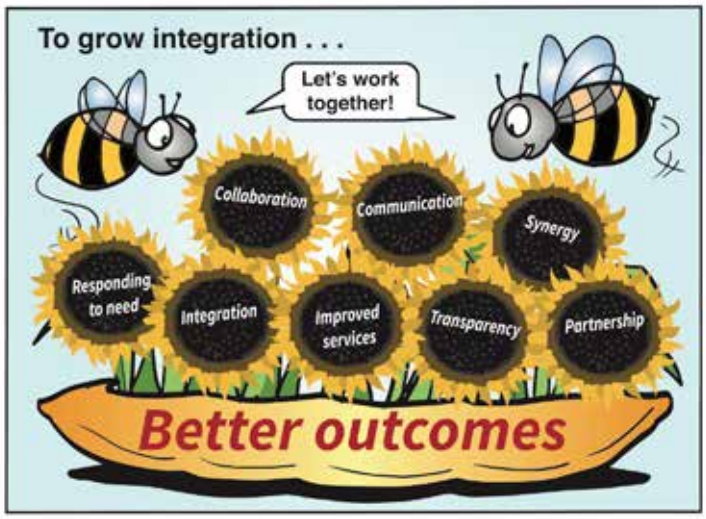
POSITIVE EXPERIENCES AND OUTCOMES

After her stroke, Mrs C required rehabilitation which helped her to learn how to manage the symptoms of her stroke and allowed her time to adjust to her disability.

However, Mrs C's health deteriorated resulting in the need for an operation. After a short stay in a care home, Mrs C continued her rehabilitation on a new care pathway which enables people recovering from strokes and acquired brain injury to move from acute medical care, through the Centre for Brain Injury Rehabilitation to the Mackinnon Centre which has temporary accommodation and support available for people who have a brain injury.

As well as classes in gardening, cookery and art, the Mackinnon Centre provides daily support for physiotherapy and people are able to develop their independent living skills and practise with the aids and adaptations they may need in preparation for going back home or moving to a new home if their previous home is no longer suitable.

A wheelchair adapted home was found for Mrs C. Her husband, who is her main carer at home, has been able to learn from staff at the centre about how best to help and support his wife.



- The supported living team invited all stakeholders, including supported individuals, their families, professionals and agencies involved with our service to feedback via a survey.

  Some examples of the feedback are below:

  "I like going to football matches"

  "I tell staff where I like to go".

  "They take me shopping and paint my nails for me".

  "found staff member effective, supportive, caring & interested in the progress of client".

  "team are client focused, holistic & mindful in their support".

  "excellent communication with staff".

  "we are happy with level of support from staff".

  Examples of improvements made include:

  - 2 bathrooms were upgraded to meet the needs of the tenants in one of the houses. This has encouraged the tenants to gain more independence and has also improved the hygiene within the house.
  - Tenants were involved in choosing new décor for their houses and being supported to choose and buy soft furnishings etc, ensuring their homes are individual to them.

EARLY INTERVENTION AND PREVENTION

Weavers Burn is a housing support and care at home service, which currently provides support for 10 adults with a learning disability who have complex needs. The service opened in November 2014 and was specifically commissioned to support people who have behaviours which may be perceived as challenging.

Since Weavers Burn opened, we have worked closely with the Behavioural Support and Intervention (BSI) team, which comprises of psychology, occupational therapy, speech and language therapy and specialist nursing staff. They have provided fortnightly clinics within Weavers Burn to provide support, training and guidance to staff.

Using a positive behavioural support (PBS) model, as a team we have focussed on reducing the number of incidents occurring as a result of violent or aggressive behaviour. The PBS model focusses on early intervention and prevention. Each individual at Weavers Burn has a PBS plan created by the BSI team, with contribution from the Weavers Burn staff team. Staff use distraction and diversion techniques to prevent escalation of behaviour and use behavioural monitoring forms to record behavioural challenges. These forms are analysed by the staff and the BSI team, to identify potential triggers to behaviour. Working on the premise that all behaviour indicates a need, staff work to address the needs of the individual in a different way, so that the individual does not need to exhibit the behaviour to have their needs met.

(continued...)

Through applying this approach consistently, we have gradually seen a reduction in the incidents which have occurred as a result of aggressive or violent behaviour. As a quality control all incidents of this nature are reported to our health and safety officer, who analyses the information and produces quarterly reports. Data shows a steady reduction in the incidents occurring, and in particular there was a reduction during 2017-18, compared with 2016-17.

Due to the consistent approach of staff leading to a reduction in incidents, the BSI team have, over the last year, gradually discharged nearly all tenants from their service. They have changed their clinic from fortnightly to monthly, as they feel that the staff have a good understanding of the positive behavioural support approach and apply it in a consistent manner, following the PBS guidelines. At a recent meeting the clinical psychologist acknowledged the hard work of the Weavers Burn team in achieving these results.

This has been a really positive outcome for Weavers Burn. When less challenging incidents occur, individuals are more able to access ordinary community facilities and benefit from a more meaningful, improved quality of life. The staff team can see the positive results and this encourages them to maintain their consistent approach and improves their job satisfaction. The relatives of the people we support are happy to see the positive improvements. At a recent carer's meeting some very positive feedback was received and the carers have requested to meet with the Care Inspectorate as a group when they next visit, so that they may share that feedback with them.

- Following feedback from patients attending the leg ulcer clinic in Westgate. One suggestion has been acted upon to have "a facility near to my address." We have done so and have opened a second clinic in the east locality of the town to support the patients in that area.
- The Alcohol & Drug Partnership (ADP) and the Integration Joint Board (IJB) held a stakeholder engagement event focusing on the new strategic and commissioning plan for substance misuse in Dundee.
- This draft plan sets out the strategic priorities and guides to the delivery of a transformational improvement programme across the city. Key features within the plan include these proposals taken from comments on the day from stakeholders.
    - Strengthening the governance arrangements for alcohol & drug responses.
    - Improvements to service delivery - including greater integration of services delivered from community settings.
    - Improving co-production processes and two-way communications with individuals, families and communities.
    - Increasing the focus on prevention and early intervention.
- Developing Recovery is a project which views recovery through the lens of those living it. 40 film cameras were given to 40 people to take black and white film images of recovery regarding their own or someone else's recovery. The project also engaged with families, relatives and carers recovering from the effects of a loved ones' substance misuse. Once the film was developed and printed, the participants were then asked to write a short narrative saying what the image meant to them. Dundee Photographic Society provided professional and technical support to the participants.

This project is an example of supporting people to tell their own story in a visual and creative way.

The images and narratives were displayed in an exhibition in The Steeple Church. This ran until April 2018.

Castles

"I made this clay tower in a pottery class while I was in prison. I designed the whole thing myself. I got the inspiration from the Scottish history class I went to. Working on this was very therapeutic. I felt proud of my achievement when I finally completed it. Working on this was probably the first step on my road to recovery."

- Local surveys which asked questions about perceptions of substance misuse revealed that:
    - Women are more likely to worry about going out at night due to a perception of people misusing substances in their communities:
    - Older people are more likely to think that crime and social problems within their communities are worse due to substance misuse.
    - Individuals living within Lochee, East End, Maryfield and Coldside were more likely to agree with the statement that drugs and alcohol contribute to crime and social problems in their communities. In contrast, respondents from The Ferry had very low levels of agreement to this statement.

Information from both surveys has been used to inform the strategic and commissioning plan. The information helped shape the key priorities and the actions that will be introduced to achieve these priorities.

More specifically, following the surveys, one of the four key priorities in the plan is that of resilient communities – and actions will focus on working with and supporting communities to respond and prevent the impact of substance misuse.

- Positive feedback has been received from a number of families about improved transition arrangements for young people with additional support needs. Consideration is being given to how feedback can be collected and collated systematically to support future performance reporting. Single referral meetings for young people with additional support needs across respective adult teams has helped to promote more smooth transition processes. Guidance for the workforce has been developed and was introduced during early 2018 "Transition Guidance for Young People with Additional Support Needs leaving School".
- The Making Recovery Real (MRR) partnership continues to work together listening to people with lived experience (PWLE) of mental health challenges. The partnership now have a dedicated worker based at Dundee Voluntary Action whose main role is to support the development of recovery locally. 12 story sharing facilitators have been trained and 35 stories have been gathered

to date in various formats. An event to identify emerging themes took place and findings were shared with the mental health strategic planning group. MRR has just released its 2nd film, MRR in Dundee 'One City, Many Recoveries'. This short film is now to be used in a training pack being developed for front line staff and for other PWLE. The film shares the unique experience of participants and their journey to recovery. The aim is to promote recovery and support the recovery of others. In addition, a further 6 week Peer2Peer training was aimed at anyone with their own lived experience of mental health difficulties who wish to use their experience to help and support others.

- A co-designed event was held to explore where and how more peer recovery opportunities in mental health could be created within communities, voluntary and statutory organisations. A number of staff from various services and supports attended including the community mental health teams and the mental health officer team and Addaction. They have committed to developing volunteer peer recovery opportunities in their own services and supports.
- The Mental Health Service Users' Network (SUN) held the second of two events to extend the network into localities. There are now three volunteers working with the network and the aim is to ensure the voice of mental health service users is firmly on the agenda.
- We have continued to work closely with our Cancer Voices Panel, made up of people who have experience of living with or caring for people with cancer, to develop and improve the service. As a result of their input and feedback, we have:
    - Changed the job title of our front-line workers to make their role clearer and avoid confusion with other link workers operating in the city.
    - Ensured that the successful candidates for the Macmillan Support Facilitators positions, had a high degree of empathy and emotional intelligence, rich experience of working with vulnerable people and the ability to deal with people in distress.
    - Improved the tone, language and content of our materials, so that they are reassuring, friendly and focussed on the benefits for the individual and give strong messages around wellbeing and our person-centred approach.
    - Have made our holistic needs assessment form (the tool used to identify concerns and priorities for individuals) available for completion in hard copy as well as electronically. We will also consider sending it to people in advance so that they have time to consider what's important to them.
    - Commenced the development of an evaluation framework, which is focused on improving outcomes for individuals.
    - Commenced planning a series of six to eight health and wellbeing events for later in 2018.
- It is recognised that to help achieve a fulfilled life there needs to be attention and focus given to how life draws to a close for each individual. A planned approach to end of life care involves ensuring what matters to each person is known and impacts on the support they receive. The Partnership has developed an approach through the Palliative Care Bundle that allows for services to respond to changing needs as illness impacts on individual's lives and at the point where they are at the end of their life. This approach is being linked to acute hospital discharges and adopted across Tayside. Dundee is delivering a Health Improvement Scotland quality improvement project focused on identifying palliative and end of life care needs and co-ordinating the right support for those living with dementia. Education programs provided in partnership with the specialist palliative care service, Tayside Palliative and End of Life Care MCN , Macmillan, care homes and home care teams underpin this approach and have further developed community capacity to deliver palliative care.

- The council advice services GP Co-location Initiative continues to tackle health inequalities and mitigates the impact of Welfare Reform. Welfare rights officers are co-located in GP practices and have consensual access to individual medical records. This helps to limit the impact of socio-economic issues on people's health and wellbeing and frees up time for GPs and health professionals to concentrate on clinical care issues. Welfare rights officers are now co-located in six GP practices in Dundee; Taybank, Lochee, Family Medical Group (Wallacetown), Erskine, Mill and Maryfield as well as two satellite offices in Douglas and Fintry. Our voluntary sector partners in Brooksbank Centre and services also cover The Crescent Practice in Whitfield. Overall 48,905 Dundee patients have access to the service. As a result of having contact with welfare rights officers and access to advice, clients of the service have experienced improved health and wellbeing, felt less stigmatised due to the familiarity of seeing advisers within the GP environment and report increased feelings of self-worth, self-motivation and confidence, resulting in increased ability to use other services. An improvement service social return on investment report suggested that

  for every £1 invested, this service generates up to £50 in social and health and wellbeing benefits for patients and stakeholders of the service.

The service was also a case study within Voluntary Health Scotland's Gold Star Exemplars Report (April 2017).

In 2017-18 the service made 921 appointments and saw 734 patients across the 7 GP practices and 2 satellite practices. This has resulted in £1,564,432.65 extra household income for patients through benefits and tax credit claims. The service was also the winner of a special gold award (Chairperson's Award) at the COSLA Excellence Awards 2017. A video showing the work of the project is available at http://awards.cosla.gov.uk/project/local-matters-dundee-city-council-co-location-of-welfare-rights-advisers-in-gp-surgeries/

POSITIVE EXPERIENCES AND OUTCOMES

North East Sensory Services (NESS) is contracted to provide a social work, equipment and rehabilitation service on behalf of the Partnership to people who are affected by significant sensory impairment.

Mr M was diagnosed with Usher syndrome, a condition causing both deafness and visual impairment. He had been deaf since childhood but his vision recently deteriorated and he has been registered as partially sighted. The NESS social work assessment focused on being able to

- work
- get out independently (he had relinquished his driving licence)
- communicate (vision was central to his ability to lip read and make sense of the world)
- manage tasks such as choosing clothes, making food and drinks, personal care
- In addition he recognised he needed help to emotionally cope with his diagnosis and his wife wanted to know how to support him.

Mr M was supported to apply to 'Access to Work' to allow him to continue in employment, through transport to work, equipment and sensory awareness training for his colleagues. The NESS social worker supported Mr M's application for benefits and his wife with a claim for Carers' Allowance.

(continued...)

Mr M received advice and training on how to get around safely.

He was introduced to various types of equipment to make the most of his vision. NESS equipment service provided a TV loop system, equipment advice and helped link Mr M to community resources including lip reading classes and specialist counselling. An NHS hearing therapist looked at hearing aid support.

The occupational therapy service supported Mr M regarding showering and NESS helped with a range of independent living skills (including shaving). Scottish Fire and Rescue Service gave a home fire safety visit and advice about a vibrating smoke alarm.

Throughout this work, Mr and Mrs M were supported and knew who to contact with worries or questions. Mrs M was signposted to support for carers.

- The Charter for Involvement was developed with people who use services through the National Involvement Network (NIN). Local members of the NIN have supported a local Charter for Involvement group which meets on a regular basis in Dundee throughout the year. People with a learning disability and/or autism in Dundee and their service providers continue to promote and support the charter for involvement and meet regularly to share experiences, support each other to speak up and learn from each other. The Scottish Government and Big Lottery have funded a dedicated worker to progress the work of this group in Dundee.

National Outcome 4: Quality of Life – Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of services no matter where they live.

Outcome 4 links to all of the Partnership Strategic Priorities.

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

How well we are performing

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

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

85% of Dundee respondents supported at home agreed that their services and support had an impact on improving or maintaining their quality of life. This is higher than the 80% reported by Scotland as a whole.

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

Dundee had a high rate of hospital admissions as a result of falls, with a rate of 28 admissions for every 1,000 of the 65 and over population. In 2017-18 Dundee was the second poorest performing Partnership in Scotland which had a falls rate of 22 admissions for every 1,000 population aged 65 and over.

West End had the highest rate of falls in Dundee with 38 per 1,000 of the 65 and over population. Strathmartine had the lowest rate of falls in Dundee with 20 per 1,000 of the 65 and over population.

An analysis of falls rates by neighbourhoods within localities has been completed and can be found on our website.

What we have achieved to deliver this outcome

- We have analysed and reported on indepth information regarding falls related hospital admissions. This included analysis at LCPP level and reported falls which occurred in the home and away from the home or place of work. Additionally, this analysis gave insight into care packages received, diagnosed long term conditions, average cost per admission and dispensed prescribed items.
- There are currently six falls prevention classes held each week in three locations – Mackinnon Centre, Kings Cross Hospital and Royal Victoria Hospital and these classes accept both self, carer and professional referrals. These classes are organised and run by the community rehabilitation and falls team. These classes are supported by physiotherapists and support workers and are aimed at people

who have fallen or who have a fear of falling. The classes improve strength, balance, confidence and function. Education is also provided to participants on reducing the risk of falls in the future. The evidence base behind providing classes to prevent falling states that balance and strength must be challenged in order for improvements to be seen. For this reason there are three levels which are aimed at different levels of ability and frailty. There is also an Otago based maintenance class within the community, to prevent re-referrals and recurrent falls. The current waiting list is approximately 15 weeks from referral, however following an initial assessment people are offered advice and basic exercises to prevent falls while they await their place at the class.

- Education and falls prevention roadshows are being rolled out to established groups in the community in collaboration with other services within the Partnership. In addition to this, training has been provided to physiotherapy community staff, ambulance crews, social care response workers, medical students and care home workers.
- GP referrals into medicine for the elderly services are now screened by the falls service instead of by medical teams. Patients are then signposted to the most appropriate clinic (physiotherapy, occupational therapy, nurse or medical). This has reduced the time patients wait to be seen by the most appropriate person. Previously there was a waiting time of up to 16 weeks to access the medical clinic and then referred to the multidisciplinary team. This has been reduced to 4-6 weeks for the medical clinic and 1-2 weeks for the multi-disciplinary team.
- The Community Rehabilitation Team provides support to care home employees, particularly regarding the Otago falls programme. All care homes in Dundee that expressed interest in receiving support have been provided with training to employees.
- On a daily basis (Monday to Friday) physiotherapy services identify from referred patients aged 65+ who have either fallen twice in the last 12 months or who are at risk of a fall. They undertake balance, gait and strength assessments to reduce the risk of future falls. Patients are provided with strength and balance exercises, a falls booklet and referred to either the Community Rehabilitation Team or the Falls Service.
- Services worked together to develop a pathway for use by the Scottish Ambulance Service and this has recently been implemented to help avoid the conveyance of service users who have fallen, but are uninjured, to hospital. This involves referring directly to the Falls Service and the First Contact, Out of Hours and Social Care Response Teams. Work is currently being undertaken to further develop cross-sector working and promote the importance of all these services, recognising potential falls risk to the service user and referring for assessment as appropriate. An educational falls pack has been developed for service users. The Social Care Response Team is accessing IT systems to identify patients who have increased frequency of falling and refer to the Falls Service. Scottish Ambulance Service, the Social Care Response Team and patients can now refer directly to the Falls Service. This has improved the identification of people at risk of a fall.
- On a daily basis the Falls Team receives a list of people who attended the Emergency Department following a fall. The team contacts each person by telephone and then signposts to information and refers to services which can support underlying issues such as balance, substance misuse, polypharmacy and sensory impairment.
- A shift is being made from the more traditional 'medical model' and service led approach, to a more integrated and holistic approach to improving quality of life and outcomes. For example, in relation to the provision of mental health, over the last year we have begun the process of undertaking significant re-design of community based treatment and support services to enhance our focus on recovery and an asset-based and outcome focused approach. 15 people with lived experience

of mental health difficulties have just completed the 'Peer2Peer' training and will use that training to facilitate other people's recovery journey. A further 15 are about to start the same training and the ambition is to create a 'pool' of peer support volunteers who will be able to support mental health services locally.

PERSON CENTRED CARE AND SUPPORT

DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM

Mrs E is in her 90's and was referred to the Dundee Enhanced Community Support Acute (DECS-A) Team with a history of multiple long term conditions. She lives alone with care workers attending three times a week in the morning. She has a supportive family but her sons had noticed that she had become increasingly anxious over a month ago when she had a fall and had since been visiting her on a daily basis.

Her GP referred her to DECS-A with a 3 week history of increasing shortness of breath plus other concerns.

Following assessment by the DECS-A team the clinical diagnosis was of heart failure.

In order to support Mrs E to continue to live independently, a number of supports and interventions were put in place. These included; a polypharmacy review, numerous scans which were organised at day hospital and the enhanced community support district nurses were involved in supporting the team with regular bloods and daily weights. In addition, Red Cross provided additional support with care needs to ensure Mrs E was safe to stay at home.

Despite developing a chest infection, which was treated accordingly, Mrs E's health improved and she was thankful to the team that she was able to stay at home. She was referred to the heart failure nurses following discharge for ongoing support in the community.

Mrs E was under the care of DECS-A for a total of 18 days and had this service not been available along with the support of her sons and Red Cross care workers input she would have been admitted to hospital.

DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM

Mr A is over 70 years old with a history of multiple long tern conditions including dementia. He was referred by the acute frailty team bleep holder with functional decline over the past month with further decline over 1 week associated with 2 falls but no head injury or loss of consciousness. He also had frequency of urine, hallucinations and reduced appetite. The GP had treated Mr A with antibiotics to cover a urinary tract infection and was requesting admission to hospital as was unsure why he had deteriorated so rapidly over the course of the week.

Following an initial assessment he was found to be unable to leave his bed but able to stand using a handrail beside the bed and required assistance of 2 people to mobilise. He had symptoms suggestive of a lower respiratory tract infection and from previous records it was noted he had a poor swallow and was at risk of aspiration.

The main carer was his wife and their grandson was providing assistance with bathing and showering. Power of Attorney was already in place and the family had agreed for a DNACPR with the GP just prior to referral to the service.

Mr A was looked after by the DECS-A team. He was treated with antibiotics for aspiration pneumonia. The team was able to expedite his physiotherapy referral and brought him into day hospital for follow up and perform x-rays of his hips as he was complaining of hip pain which confirmed severe osteoarthritis (OA) of the right hip and moderate OA in the left.

He significantly improved however it was felt his conditions were progressing and the DECS-A team liaised with the parkinsons disease palliative care nurse and his geriatric consultant who agreed to no further increment in medication. We felt he would benefit from follow up from the specialist nurse to educate the family, as per their wishes, on the progression of his condition and how they could prepare for the future as they were aware that he was on the whole deteriorating.

Mr A was medically discharged from DECS-A after 14 days, however he remained on the caseload as his family requested ongoing input from the team. A referral to the speech and language therapist was also put in place regarding Mr A's potentially deteriorating swallow.

DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM

Lessons learned

1. If DECS-A had not been available, both patients would have required long in patient stays and require step down to some form of rehabilitation.
2. They would have been exposed to hospital acquired infections and other sequelae.
3. The Red Cross and community rehabilitation team were integral to prevent admission to hospital. Had these patients been admitted to hospital they may not have been able to return to their homes and may have required step down to a nursing home following rehabilitation.
4. Both families were grateful that Mrs E and Mr A were supported to stay at home and felt involved in their management.

Summary

Prevention of admission ultimately allowed better use of resources and avoided a long inpatient stay with the high probability of step down to 24 hour care. This reduced admission sequelae, allowed health and social care professionals to work collaboratively and allowed for a patient centric approach keeping the patient at the heart of all conversations.

- Enablement and support is a short term (up to six weeks) service which works intensively with people aged 16 and over to achieve the best outcomes with people. The ethos is to keep people motivated, engaged and to be as independent as possible.
- The Strategic Housing Investment Plan (SHIP) sets out our plans to invest in housing developments for adults with particular health and / or social care needs. It supports our ambition to deliver flexible models of support that enable people to live within their own homes where at all possible and receive the right support at the right time. Significant investment has been made in this area in recent years and this has led to fewer people living in institutional settings or in placements out with the city which are often very costly.
  In partnership with Dundee City Council Neighbourhood Services we have commitments identified within the SHIP as far as 2021, with numbers for a further two years currently being confirmed. There continues to be a commitment to ensure that all new build housing provision has assistive / smart technology capabilities and this is reflected within our commissioning processes.
- A collaborative group was established in order to
  - Look at ways service providers and the Partnership could work together to consider more efficient ways of delivering support, sharing resources and improving the lives of people we all support.
  - Explore a different way of commissioning new developments and services, taking account of capacity, strengths, local knowledge and added value.

- Work together to ensure social care support is in line with anticipated completion dates of planned housing developments.
- Undertake this work as a test of change to ensure a more collaborative approach to procuring social care whilst ensuring best use of available resources and increasing third sector influence in commissioning processes.

- Following an audit being undertaken in conjunction with advocacy organisations some changes are being (or have already been) progressed to increase the availability of advocacy support for young people and adults. The developments involve Dundee Independent Advocacy Support (DIAS), Advocating Together and Partners in Advocacy. A more collaborative approach is also evolving between organisations and this is proving beneficial, not least in terms of best use of overall available resources.
- Through service user consultation and working with other services the White Top Centre continues to contribute to improving the quality of life for service users. This has been achieved in a number of different ways over the last year.
    - We continue to joint work with Promoting a More Inclusive Society (PAMIS) and received an opportunity to be involved through PAMIS for involvement in Dundee Woman's Festival. A performance was held at White Top where four young women participated in the play "Dare to Dream "-(A vote for Learning for People with profound and Multiple Learning Disabilities). The performance told a story of the dreams and aspirations for lifelong learning for everyone with profound and multiple learning disabilities.
    - Through PAMIS our service users accessed 'Pony Axe S' for equine experience which was accessible for people with profound and multiple learning disabilities. This enabled our service users to be included in the local community and experience new opportunities.
    - We have worked with PAMIS and Tayberry Enterprise for storytelling with tactile and audio experiences and this continues to be successful. Tayside Enterprise contributed with a regular drumming session.
- The AwareSense forum met to follow up on responses to a 'See Hear' consultation. People with hearing and sight impairment identified that they experienced problems of accessibility in all areas of their lives. The AwareSense group was set up to get people with sensory impairment, businesses, charities and groups involved with leisure and culture to tackle the problems from a local perspective.

  The aims of the forum are to raise awareness, discover challenges, report issues, celebrate achievements and share good practice. An example of the work the group is the development of a presentation to raise awareness of contacting emergency services for BSL users. This was developed by members of the AwareSense forum and members of the deaf community and is available on the AwareSense facebook page.

  The AwareSense forum has also joined a project with University of Abertay, North East Sensory Services and BSL users in Dundee looking at whether 3D image interpreting might improve on 2D image interpreting. The forum is also awaiting a report from scientists from Dundee Science Centre as to whether it might be possible to interpret digitally from english to BSL.
- The Health and Work Support Service will provide integration and alignment of core health and work services and will provide a single point of contact for people accessing the service. These services include working health services, healthy working lives and new services for those on longer term sickness absence or the short term unemployed. This will follow a case management led approach with access to interventions for physical and mental health conditions, signposting to appropriate services and guidance regarding return to work. Referral pathways into the service are being concluded with partners such as Jobcentre Plus and Remploy who are the Fair Start Scotland contract providers as well as other affiliated services. A marketing campaign will take place with employers and GP's in the city to advise them of the support available to their employee's and patients. This pilot will run in Dundee and

Fife for two years with a national roll-out across Scotland planned if it is successful.

The aims and outcomes of Health and Work Support

- To make it easier for those who need support to get help when they need it.
- Support people to move into and remain in sustainable employment.
- Reduce health related absenteeism, job loss and improve levels of productivity.
- Support people to manage their health condition.

- There has been a remodelling of sheltered housing provided by housing associations in Dundee. As support tasks will no longer be undertaken by HOPE (Helping Older People Engage) staff, they can now work alongside tenants, signposting them to appropriate organisations. This floating support service was established 3 years ago and has proven to be a successful model of intervention.

PERSON CENTRED CARE AND SUPPORT

Mrs R is over 90 years old, visually impaired, hard of hearing and lives alone in her semi-detached house. Mrs R met a community engagemement worker from the HOPE project at a promotional event. The event being a group setting was not suitable for Mrs R's needs, so a home visit was offered.

The community engagement worker was concerned to learn that that Mrs R descends her stairs backwards. This is the only way she could manage the stairs and she didn't want to move from her home. A referral was made to the occupational therapy service for assessment for a stair lift. The occupational therapist (OT) attended very quickly and a stair lift was installed. Mrs R is delighted that she is able to go up and down the stairs safely and she no longer lives in fear.

Although carer workers visit each day and her brother is supportive, Mrs R often felt isolated and bored and was keen to get to grips with her tablet and smart phone. Through Caledonia's Volunteer project, a volunteer was arranged to visit Mrs R at home to give her some tuition. Mrs R learned quickly and she now enjoys receiving family photos and updates on Facebook and can text and make phone calls on her mobile.

Enquiries were made about talking books and arrangements were made to take Mrs R down to the Blind Society lunch club. Mrs R bumped in to a neighbour, with whom she now goes along to the club.

To encourage appetite, Mrs R was referred to Meal Makers for a weekly befriender to visit with a homemade cooked meal. As Mrs R could only really travel with a companion, arrangements were made for the 'Plus1' to be added to her bus pass, enabling a companion to travel for free.

Thanks to Mrs R and her spreading the good word, the community engagement worker was invited along to other community groups and received other referrals.

The Partnership hosts the Tayside Specialist Palliative Care Service on behalf of Tayside and has continued to develop this service to provide direct care for those with more complex needs (at home, hospice and in hospital) and in bringing the service together has allowed for shared learning and approaches to improve this care. The specialist service also provides enabling advice for others to deliver care 24/7 and education to improve knowledge, skills and confidence throughout the partnership.

National Outcome 5: Reduce Health Inequality – Health and social care services contribute to reducing health inequalities

National Outcome 5 links to the following Partnership strategic priorities:

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

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

How well we are performing

Dundee had the 2nd highest premature mortality rate in Scotland in 2016, with 572 unexpected deaths per 100,000 population aged 75 and under. Historically, Dundee has always had a higher premature mortality rate than the Scottish rate and although the Dundee rate decreased between 2010 and 2014 it began to increase thereafter.

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

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

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

The Dundee citizen's survey, which was last reported in 2017 established the public's views on general and specific aspects of life in Dundee, including; the home, neighbourhood, health, education, employment, community safety, financial issues, public services and satisfaction with the local authority. The analysis is separated into Community Regeneration Areas (CRA) (areas experiencing significant levels of deprivation) and non-Community Regeneration Areas (non-CRAs).

The survey asked respondents to rate their general health on a 5 point scale from very good to very poor. 49% of respondents from CRAs reported that their general health was very good, compared with 67% in non CRAs. Participants who lived in Fintry, Whitfield and Mill O Mains were the most likely to rate their health as 'very good' (67%) while participants who lived in Ardler, St Mary's and Kirkton were least likely (44%).

What we have achieved to deliver this outcome

- Due to the specific challenges facing some population groups in achieving good health, and the adverse social circumstances that surround this, dedicated health inequalities activity in the city underwent a redesign process in 2017. This involved restructuring Dundee Healthy Living Initiative, Equally Well Service, Sources of Support Social Prescribing Scheme, Keep Well service and the Health and Homeless Outreach Team into one integrated service that focuses on enhanced targeting, closer working relationships, and improved referral pathways between specific teams and other services. Key elements of the redesign include
    - Rebranding components of the service working developmentally at a local level (previously Dundee Healthy Living Initiative and Equally Well) as the Community Health Team.
    - Re-designing development worker posts as Community Health Inequalities Workers.
    - Community health activities that are open access and targeted.
    - Health checks targeted at vulnerable groups and open access in locality settings.
    - Evolving the shape, structure and skill mix of the service on an ongoing basis.
- Three locality health inequalities teams have been formed with representatives from all parts of the service to raise awareness of roles and responsibilities, build relationships, explore links and avoid duplication. Next steps for the locality teams are to provide links with other local structures, develop collective pieces of work, undertake joint community engagement activity and create effective links with other locality health and social care staff.
- The Keep Well service uses anticipatory care health checks to engage with populations who are at higher risk of health inequalities. These include people aged 40 – 64 years who live within the 20% most deprived postcodes in the city, and those who fall within identified vulnerable groups such as carers, people who have committed offences, the ethnic minority population, people who are homeless and those with a substance misuse issue. The Keep Well community team also continues to support participating GP practices to offer health checks. A part-time senior Keep Well nurse is jointly funded by the Community Justice Service. The nurse is co-located with our Community Payback Teams and engages with individuals as they attend for supervision or other contacts including unpaid work, offering health checks and advice they may be more receptive.

Mrs A is approximately 60 years old and attended the DD4 Network in Mid Craigie. Through engaging with an associate practitioner, Mrs A agreed to a health check with the Keep Well nurse, which was carried out at Brooksbank Centre. Past medical history was discussed and Mrs A shared that she possibly had angina and high cholesterol; however she had not taken any prescribed medication for a couple of years and had not had further cholesterol checks. Time was spent discussing this with her, and the Keep Well nurse advised that Mrs A see her GP for clarity about diagnosis and medication, which she agreed to do. Bloods were taken to check for cholesterol and blood sugar levels during the health check appointment. Positive reinforcement was given for several lifestyle changes Mrs A had already made. She expressed interest in doing more exercise and an Active for Life referral was discussed once Mrs A had seen her GP. The appointment ended with agreement that the Keep Well nurse would phone Mrs A the following day to discuss blood results and whether these needed to be discussed with her GP.

- Mrs A's cholesterol was above recommended limits and her Cardiovascular Risk Score was significantly raised. The Keep Well nurse advised that this be discussed with her GP.
- A follow up appointment was made with the Keep Well nurse to discuss the outcome from the GP appointment and complete an exercise referral form.

(continued...)

- At the follow up appointment, Mrs A informed the Keep Well nurse that she had commenced medication for high cholesterol and now had better understanding of her angina diagnosis.

The benefit of Mrs A having an opportunistic health check in a local setting is that she is now receiving appropriate treatment and will be reviewed on a regular basis. She is exercising regularly, meaning that her physical health will improve, reducing the risk of cardiovascular disease.

Due to the redesign of health inequalities activity in the city, the Keep Well community team has extended its role from an appointment/ clinic based service to also offering opportunistic health checks in a range of local settings such as community cafes and hubs. This has enabled the nurses to engage with at-risk people who may not be engaging with services in other ways. In 2017-18 the Keep Well community team delivered a total of 740 comprehensive health checks and follow-up appointments, including to 319 people affected by substance misuse, 121 people in the criminal justice system, 119 carers, and to 72 people opportunistically. Individuals are supported with a wide range of health, lifestyle and social issues after the initial health check and evolving associate practitioner posts provide support for clients to access services and local activities that can help improve their health and wellbeing. Evaluation demonstrates that the range of medical interventions, ongoing support and lifestyle changes delivered through Keep Well are having a positive impact on individuals and may be contributing to a number of national health and social care outcomes.

- Since May 2017, the Health and Homelessness Outreach Team has been located within the Health Inequalities Service and has been heavily involved in service reviews and development activity to integrate its work fully into the new model. The small team comprises general and mental health nurses who support people living in homeless hostels and temporary accommodation to address their clinical, mental and social health needs. The work of the team is reflected in a range of strategic plans, which aim to modernise the approach to homelessness in the city with an increased focus on prevention and tenancy sustainment.
- The Community Health Team works with groups and individuals in deprived areas of the city to identify issues impacting on their health and wellbeing and supports the development and implementation of interventions to address these. New additions to the programme in line with the redesign include cooking and budgeting courses, cooking courses for people in recovery, and a mental health short course for particularly vulnerable people, which is currently under construction. In 2017-18, 857 local people attended health related short courses, 1370 were given health advice from nurses at local information points, 130 gained accreditation in REHIS (Royal Environmental Health Institute of Scotland) courses and 857 individuals took part in indoor and outdoor physical activity sessions such as volunteer-led short health walks and Tai Chi.

Walking Group at Baxter Park

Feedback from people who were supported by the Community Health Team:

"I have learnt how to keep on top of my debts"

"The only time I leave the house is to come to the course"

"learning how easy it is to make meals healthy and cheap"

"I know where my money goes now and I have closed my online bingo account"

- Social prescribing 'Sources of Support' (SOS) is one means of supporting self-management. Link workers, working within designated GP practices take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017-18, 256 patients were referred to three link workers and 220 engaged. An external evaluation demonstrated that the service had positive impacts on both clients and GPs themselves. Over 70% of referred patients engaged with the scheme in some way with a fairly even split between males and females, 76% were aged between 20 and 59 years, and over half were single. 92% of clients had a mental health issue and 25% had a physical health issue. The majority were unemployed and/or unfit to work and in receipt of welfare benefits. 61% of clients lived in the most deprived areas and 59% required assisted visits to access services. Evidence shows that 65% of patient goals were met and 84% had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem. Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. This year saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme. Seven new link workers and a team leader came into post early in 2018 increasing the team to 11 and extending the service from four GP practices to 16.

Miss D is a young woman with a history of trauma and homelessness, which continues to impact on her mental health. She suffers from depression, anxiety and post-traumatic stress disorder exacerbated by ongoing financial difficulties and significant anti-social behaviour in her neighbourhood including threat of violence and drug-dealing. Miss D is the mother of a young baby and is keen to overcome her struggles to be the best mum possible. She hopes to be able to deal with her anxiety so that she can take her child to a local mums and toddlers group.

Miss D received the following support from her Sources of Support link worker

- Help to undertake all aspects of gaining a new tenancy including liaison with housing staff and supported visits to appointments .
- Assistance with a community care grant for new flooring, liaison with local furniture project for household goods and referral to Dundee Energy Efficiency Advice Project for transfer of credit to meter in new house.
- Provision of home safety equipment from Brooksbank Centre.
- Referral to money advice service for benefits check and support to submit an application for personal independence payment .
- Referral to Penumbra and accompanied to first appointment.
- Support to submit a crisis grant and referral to the foodbank when universal credit was not paid correctly .
- Linked with SOS volunteer to accompany Miss D to local mums and toddler groups.
- With the link worker's help and support, Miss D has moved into her new home and is managing to deal independently with issues that she previously found difficult. Consistent communication from the link worker through consultations, texts, phone calls and emails supported Miss D to navigate complex systems that were causing distress and anxiety and to engage with services that could help. She remains in touch with Penumbra which is providing support after discharge from the link worker service. Miss D has social contact with other young mums and is feeling much more positive about her life.

- We developed a collaborative approach to no recourse to public funds with partners across Dundee City Council, the third sector and NHS Tayside to provide fair and consistent advice and assistance to those facing destitution. During 2017-18 this approach was formalised by way of multi-agency procedures. In implementing the new approach, significant learning has taken place on how to support people facing destitution. It is planned to review progress with implementation during 2018-19, based on learning throughout implementation. This review will inform further development of our approach to destitution within Dundee.

- The Integrated Neighbourhood Service is a multi-agency approach that supports those who are furthest from work. The aim of this project is to explore how a more community – based model improves the journey to employment for local people. An employability services review found that people wanted employability services and supports to be available and accessible in their local area. The service is now delivered in a different way following on from the end of year evaluation. The network still currently runs in Brooksbank as before but has now ceased in The Crescent building but still has outreach services in that area covering the some of the community cafes'. There has also been an expansion of services to both Finmill centre and the Lochee community hub. These are all recognised areas of multiple deprivation. A 12 month evaluation report was completed. In the first 12 months, 212 people registered for support through the DD4 pilot. The majority of people attended for

employability reasons and received employability related outcomes. However within the evaluation there is also evidence of a range of other needs and outcomes for people. One of the many benefits highlighted from the multi-agency co-location of services was that inter-agency referrals even out with the days the pilot was operating and training opportunities amongst services were shared. A number of case studies have been used in the evaluation which describes the person's journey. These case studies reveal the service was perceived as friendly, helpful and provided a safe space to discuss sensitive issues. The impression was that this is a seamless service.

- The Race Equality Health and Social Care Pilot Project was initiated to help facilitate and develop sustainable engagement between the Partnership, third sector stakeholders and ethnic minority (EM) groups / communities and in the process, to help build the capacity of both EM groups and the Partnership in developing a sustainable engagement model. The Council for Ethnic Minority Voluntary Sector Organisations (CEMVO) Scotland was commissioned by the Scottish Government to manage and support this pilot. Three key areas for improvement and development were identified as a result of the pilot project; male isolation, women's health and wellbeing and self directed support. The Partnership will continue to foster relations with the community groups who were involved in the pilot work and to work with and support them to address identified issues. Findings from the pilot will also inform the work that will be undertaken next year to review the Partnerships equality outcomes.

- The Learning Disability Acute Liaison Nurse was introduced in response to recommendations made in Fatal Accident Inquiries which highlighted the risks that individuals with a learning disability, who have been admitted for unscheduled hospital care, can face if acute staff are unfamiliar with the specific needs of the learning disability population. The service provides support and advice to medical and nursing staff to provide appropriate care and treatment, making the reasonable adjustments neccessary, to ensure that the individual with a learning disability has the best care experience possible. An evaluation of the service identified the need for a service at the weekend and an additional nurse post is currently being recruited to.

- Since July 2016, we have been working in partnership with Macmillan Cancer Support, Dundee City Council, Leisure and Culture Dundee, NHS Tayside and voluntary sector organisations to develop the Dundee Macmillan Improving the Cancer Journey (ICJ) Service which was launched to the public on 9 November 2017. The service offers tailored practical, personal and emotional support to local people affected by cancer, based on a holistic needs assessment and what matters to them. As well as a successful public launch event, hosted by the Lord Provost, other key achievements across the year have included:

    - Recruiting and building the ICJ team.
    - Developing a partnership with NHS Scotland so that everyone who is diagnosed with cancer in Dundee receives an invitation letter to use the service.
    - Running a joint health and wellbeing event for people living with lung cancer with the transforming care after treatment project.

Launch of the Dundee Macmillan Improving the Cancer Journey Service

Ms S survived breast cancer ten years ago and has many close family members to cancer. She now has stomach cancer, which necessitated a gastrectomy. She is coeliac and has had a life long problem with her mobility. She uses a walker around the home. Ms S also suffers with social anxiety and clinical depression, which severely disturbs her sleep. She mentioned that she didn't know why she should keep going anymore.

Actions:

- Referred to Tayside Cancer Support for a befriender to visit Ms S at home
- Referred to psychologist regarding issues around death, any situational factors in depression, fear around eating and medication issues
- Arranged for a dietician to call with advice and make a further appointment
- Provided Ms S with some research on dealing with the gastrectomy whilst coeliac
- Arranged appointment with GP to discuss medication changes

Outcomes:

Ms S is regularly attending appointments at Maggie's to manage her multiple emotional concerns including her social anxiety, powerlessness, and to help her to see that there is life after cancer.

Ms S is now eating a balanced diet after a phone call and follow up appointment with the dietician, which means she can now take her medication. This means she is now sleeping and her depression is at a manageable level. Ms S is doing the gentle movement 'Move More' DVD which has helped her mobility.

Ms S is now going to a cafe with friends twice a week, as she can now manage this both physically and emotionally. She has also joined a number of groups at Maggie's, which has widened her support network.

69 people (41 females and 28 males) have accessed the service between its launch. 69% of these are from the two most deprived SIMD quintiles. Over half of our service users are from the 55-64 and 75 plus age groups. We have seen people with a range of cancer types with the most common being breast, lung and prostate.

Service users have raised a total of 597 concerns between them, which is an average of around nine concerns each. These include tiredness or exhaustion or fatigue, money or finance, appetite, transport, memory loss, mobility, anxiety, weight loss and loss of interest in activities.

The team has taken 725 actions to respond to the concerns raised by service users. The majority of the actions have been discussion and advice and provision of self-management information, which reflects the person-centred and enabling approach of the service. Our most frequent onward referrals are to; the local authority based Macmillan Welfare Benefits Team, Maggie's, Macmillan Cancer Support and Tayside Cancer Support.

National Outcome 6: Carers are Supported – People who provide unpaid care are supported to look after their own health and wellbeing, and to reduce any negative impact on their caring role on their own health and wellbeing.

Outcome 6 links to the following Partnership strategic priority:

- Quality of Life (Strategic Priority 4)

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

How well we have performed

According to the 2011 Census there were 13,072 unpaid carers in Dundee providing on average an estimated 360,000 hours of care each week. If such unpaid care had not been available those requiring support at home may have needed to seek more formal social care support, which they may have had to fund themselves. The cost of Dundee's home care service is approximately £20 per hour. Of the total number of carers in Dundee at the time of the 2011 Census, there were 3,909 who were providing more than 50 hours of care each week. Those who were receiving this level of care from family or friends may otherwise have been unable to continue to live in their own homes and may have had to move to housing with care or to residential or nursing care, depending on the nature and level of their individual care and support needs. The costs of such provision is high and can require a significant financial contribution from the individual involved. With the rising number of older people, it is anticipated that the number of unpaid carers in Dundee will grow and we know that there will be a need to 'scale up' the level of carer support accordingly.

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

"I feel supported to continue caring".

38% of Dundee respondents who provided unpaid care felt supported to continue in their caring role. This is similar to the 37% of carers from Scotland as a whole who felt supported to continue in their caring role. There is variation in responses across GP practices ranging from 28% to 60%.

What we have achieved to deliver this outcome

- An event was held on 24th November, which was also Carers Rights Day. At this event 'Caring Dundee', 'What's Best for Dundee Carers' and a local 'Charter for Carers were launched. Caring Dundee is a three year strategic plan which recognises the significant and vital contribution that carers make in supporting people they care for. Throughout the life of the plan the Partnership aims to focus on identifying, listening to, supporting and empowering unpaid carers, of all ages. The plan was developed through listening to the views and experiences of carers in order that our future direction reflects carers' priorities and provides all carers with an opportunity to shape and influence how they are supported. It describes how we will implement the Carers (Scotland) Act 2016. As part of the plan

the Charter for Carers was produced by local carers and carers organisations in consultation with local agencies and establishments and a variety of local agencies have signed up to the pledges in the charter. For more information see https://www.dundeehscp.com/our-publications/news-matters/caring-dundee.

Megan Clark from Dundee Carer's Centre, Councillor Ken Lynn, Joe FitzPatrick MSP and Alexis Chappell, Locality Manager from Dundee Health and Social Care Partnership

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

  The pilot project took an innovative and co-productive approach to the development, design and delivery of the service and enhanced understanding of how fundamental user involvement is in the process to achieve the right services and supports for people.

  Partners learned about each other's roles and service, the co-production and co-design process and how to use the approach to redesign services. It helped identify key attributes to success and what could work better and has already made an impact on how the Partnership is delivering short breaks for people with mental health challenges and their families. The experience and learning gained will be used to influence other areas in the future, to enhance outcomes for service users and their carers.

  The pilot project became mainstream in February 2018 and since then the referral rate and the number of short breaks provided to carers increased significantly. The variety of ways in which carers request their breaks also continues to widen, with conventional city/caravan breaks to headphones for gaming and sewing machines. The majority of referrals are received through ther Carer's Centre, however other routes are also starting to occur, such as through Social Prescribing. The feedback from those who received a break continues to be positive.

CARERS

"I didn't consider myself as a carer until I was referred to Sources of Support by my G.P. The woman there was really helpful and when I explained my situation and spoke about my wife's mental health difficulties she helped me realise I was a carer and referred me to Penumbra's Carers Support Service.

I find that dealing with my wife's mood swings can be very challenging. My wife can put me down a lot which affects my confidence. This makes me feel angry towards her then I feel guilty for having these thoughts. The support gives me a chance to talk about these feelings in a confidential setting as talking to family can cause more arguments. Due to both of us having mental health difficulties it can be difficult and put a strain on the relationship.

It is nice when my wife appreciates what I do for her and she has been helpful lately as I have been suffering with my physical health. I like the times when we are away from our everyday routine and family dramas. Being supported to access short breaks has been a great help to me as it gives me and my wife something to look forward to and helps both our mental health by relaxing and spending quality time together.

The support has also helped me keep informed of other sources of help such as CONNECT and the welfare rights service to help me with my benefits. I have information about pain management courses I can access and was supported to contact the council and arrange an assessment from occupational therapy. This resulted in several adaptions to my home which has helped my physical health.

I was given crisis numbers and supported to complete a safe plan due to having suicidal thoughts. I have looked back at my safe plan when things are getting tough. My mental health has improved as I feel safer knowing I have support and a plan in place when I am struggling".

The Dundee Carers Centre Short Break Service continues to provide carers with a short break through the brokerage process that meets their identified outcomes.

Demand for the service continues to increase with 350 carers and 466 supported people benefitting from a short break during 2017-18.

CARERS

Mrs P referred herself to the short breaks service, she cares for her 19-year-old son who has learning difficulties, global development delay, hearing loss and a recent diagnosis of autism.

Mrs P attends to all his care needs as he is a vulnerable adult. He needs support and assistance with most daily tasks. Mrs P takes him to all his appointments, to clubs and to college and is on hand for personal care, as he needs assistance when using the bathroom.

Mrs P also looks after her elderly mum and dad, they live close by and she likes to be on hand for them too.

Mrs P has very limited opportunities to enjoy time for herself and feels a tremendous sense of guilt at not spending quality time with her husband and daughter.

Mrs P was suffering from a lot of stress due to her caring role.

The support broker arranged to meet with Mrs P to have a chat about having a short break from her caring role.

(continued...)

- The main concern for Mrs P was the stress and the feeling of guilt that she was
- experiencing, although she appreciates that her husband and daughter are also carers she felt that they didn't spend enough time together as a family.
- It was recognised that Mrs P had opportunities to have some time to herself but would always feel that she had to be on hand for her son and parents, she used to read a lot and found this very relaxing but has long since given this up.

The brokerage process helped the carer to recognise the importance of having regular breaks and keeping herself healthy.

The short break included

- Signposting to the National Autistic Society for some peer support
- A health and wellbeing check with the healthy living initiative nurse
- Restaurant and theatre vouchers to enable some quality time with her husband
- Cinema tickets to enable some quality time with her daughter
- Book voucher to take up reading again and enable some quality "me time"
- Afternoon tea vouchers to enable some quality time with her parents

The breaks will provide an opportunity for Mrs P to take regular time away from her caring role and provide her with some long term sustainable solutions.

- In preparation for the enactment of the Carers (Scotland) Act in 2018, the Scottish Government allocated funding to Dundee Carers Partnership for a pilot project between May and October 2017. The aim of the project was to explore how the Act could best be implemented to support carers in Dundee.
  The project was undertaken in a co-productive way through a project group including carers, colleagues from local carers organisations, Dundee City Council, NHS Tayside and the Partnership.
  The group used the national standards for community engagement as a reference.
  http://www.scdc.org.uk/what/training/voice-online-tool-community-engagement/
  During its first meeting, the group identified some principles to guide the project and generate open and honest dialogue about the Act.

"We must include carers and workers on an equal footing. Everybody has something valuable to offer – we need to encourage and support people to share their ideas with us, and give them time to do so. We can share learning from other areas e.g. localities. As carers and practitioners, we should work together to plan and run events, as this will help us give and get information more effectively. We need to show 'what's in it for me' – why should carers and practitioners take part in our work? We need to be as inclusive as possible, e.g. thinking about communications needs and equalities. We'll make efforts to reach carers of people with different conditions."

The group designed the project using a mixed method approach. This used different channels and tools for different purposes, as part of a coherent overall plan. A survey was sent to over 2,500 people and elicited 261 responses. Six community focus groups were arranged for 29 carers and supported people on short break service statements (SBSS) and the duty to provide support to carers. Two focus groups (totalling 15 carers) were held with specific black and minority ethnic carers where the survey questions were discussed

and replies and discussions recorded. 11 Partnership assessment and care management practitioners were interviewed and thirty 1:1 questionnaires were completed. 47 people also volunteered to help review anticipatory care and support plan documentation. The project gave an opportunity to further develop a co-productive approach, which gave a different experience by using a "you said-we listened" or "we suggest this-you tell us what you think" approach. This process gave an opportunity for all involved to be there at the start of the process.

"All views were looked at with the same respect".

"An environment to share ideas, develop them and strengthen them".

"Felt open and equal with great facilitation (that was vital)".

"There was an equal chance for both sides to contribute (practitioners and carers)".

- To enable health and wellbeing checks to be promoted and embedded for carers over the age of 18 years, time was dedicated over the last 12 months to raise awareness of carers' health checks and the services offered by the Keep Well Team. The Keep Well Team have also attended events to engage with carers directly and ensured that information about carers' health checks is available on local intranet and internet websites. In particular, partnership working between Keep Well and Dundee Carers Centre has been enhanced. Workers at the centre are encouraging unpaid carers to attend for a health check appointment and dedicated health check sessions are available at the centre. Community based venues and appointments at alternative times are also now available. Many carers have been supported beyond the initial health check by the Keep Well associate practitioner. The associate practitioner has supported engagement with other services including community based activities aimed at having a positive influence on their physical health and/or mental wellbeing. Carer feedback is very positive of the added value of this support. Working in an integrated way with carers and agencies supporting them over the last year is beginning to have a positive impact on the number of referrals received; there were 32 carers referred in the first three months of 2017-18 in comparison with 47 carers referred during the whole of 2016-17.
- The Carers Partnership has been preparing in advance of the Carers (Scotland) Act 2016 which received Royal Assent in March 2016 and came into effect on 1 April 2018.
- Some key activities undertaken during 2017-18 were
    - The provision of learning and development activities and briefing sessions for our workforce and partners to enhance their understanding of carers' and the Act.
    - Further developing the locality models for supporting carers within the service delivery area in which they live with the Carers Centre. Carers have embraced this development and early results suggest that carers are accessing support more efficiently and timeously than before.
    - Introducing a carers interest network to involve practitioners across health, social care, third and independent sector in developing coordinated approaches to supporting carers.
    - Launching a range of carers factsheets on the Partnership website and the online 'Mylife' portal to provide information to carers which will assist with their caring role.
    - Planning and development of a 'Carers of Dundee' website which will be launched in 2018. This will provide a range of information and advice to carers.
    - Development of procedures and multi-agency guidance which will be launched in 2018 – 2019.

The Carers Partnership has continued to support developments for the Carer Positive Employer Award. During 2017-18, members of the Partnership worked with the Human Resources sections of Dundee City Council and NHS Tayside to further develop structures which will support achievement of the next stage of the award. The award incorporates 3 levels or stages, from 'engaged' to 'established' through to 'exemplary'. Work has progressed throughout 2017-2018 which allowed NHS Tayside to be accepted for the "established" stage of the award and which will support an application for "established" status for Dundee City Council in the near future. Other agencies within the Carers Partnership have also been recognised with Carers Positive Awards including Dundee Carers Centre and Penumbra.

- Dundee Carers Partnership won an Outstanding Service and Commitment Award from Dundee City Council. The Carers Partnership demonstrated the work led by the multi-agency strategic planning group over the past few years. The Carers Partnership was awarded the Chief Executive OSCA 2018 from David Martin, Chief Executive of Dundee City Council.

The Carers Partnership was recognised as

"Ensuring that carers are identified, respected and involved; have a positive caring experience; and can live a fulfilled and healthy life balanced with their caring role".

National Outcome 7: People are Safe –
People who use health and social care services are safe from harm

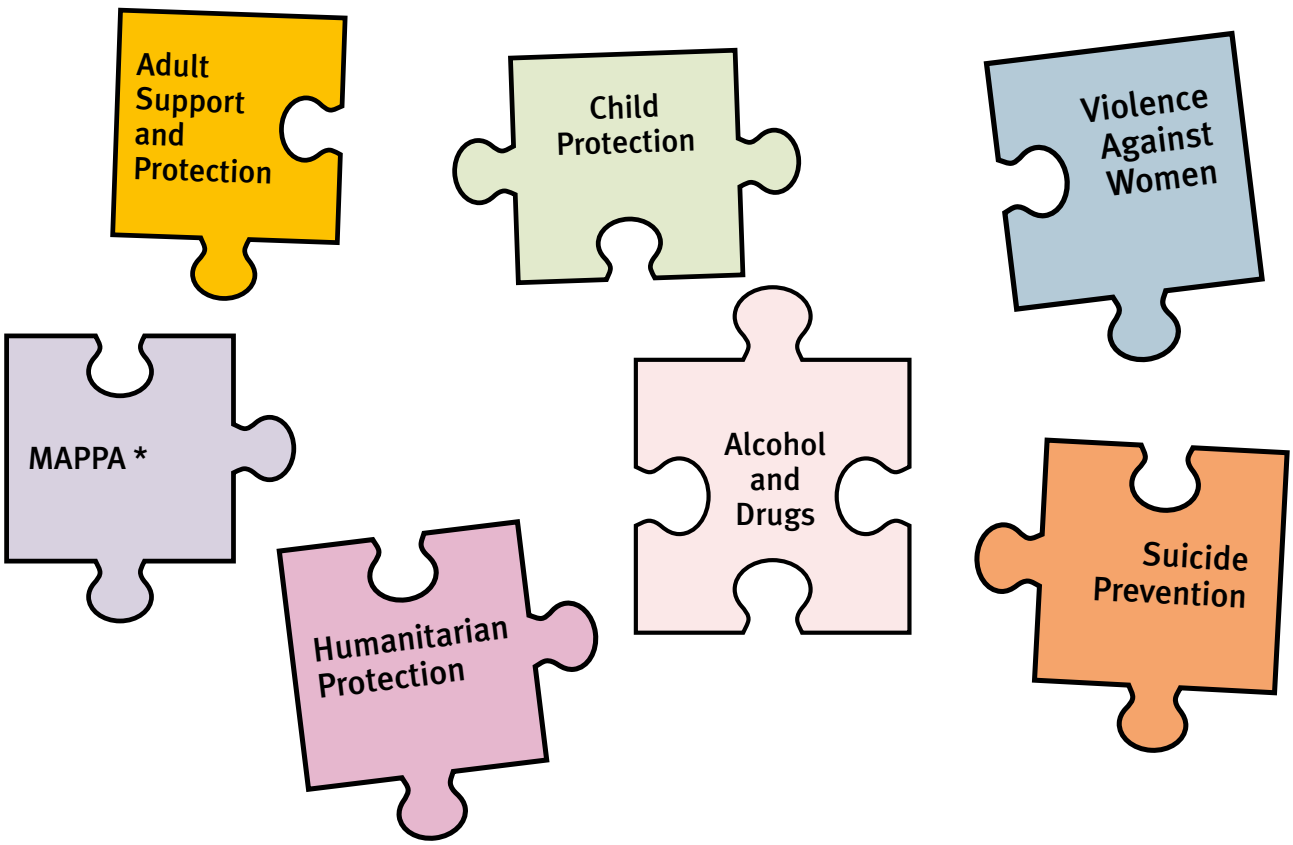
Outcome 7 links to all of the Partnership Strategic Priorities.

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

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

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

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



*** Multi-Agency Public Protection Arrangements for high risk offenders who present a risk of harm to the public**

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

How well are we performing

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

"I felt safe".

87% of Dundee respondents who are supported at home reported that they felt safe. This is higher than the 83% of respondents across Scotland as a whole.

In 2017-18 the Partnership continued to contribute to a variety of multi-agency actions to protect vulnerable people from harm and reduce risk. The Partnership has a lead role within the statutory response to the protection of adults at risk of harm, co-ordinating and contributing to the assessment of risk, planning and implementation of actions to reduce harm and, where necessary, taking the required legal measures to protect adults who are unable to protect themselves.

In 2017-18 the total number of referrals to the Partnership for adults at risk was 937 (a slight increase from the previous year's total of 914). Police Scotland continue to be the primary source of referrals, 887, but the introduction of the Risk and Concern Hub within Police Scotland Division D, has led to a more holistic assessment of wellbeing concerns, through the use of accurate and proportionate research leading to better decision-making by trained staff and swifter sharing of relevant information to the Partnership. Consequently, although over 3000 Adult Concern Reports were generated from police responses across the city last year only a third of these required further assessment by the Partnership.

These changes demonstrate the impact of focused work with referring agencies to enhance the quality of early identification, assessment of adults at risk and the commitment to a proportionate response at the right time.

Adults at Risk Referrals

	Number of Referrals
2017 - 2018	937
2016 - 2017	914
2015 - 2016	1246

Referrals from Police Scotland

	Number of Referrals
2017 - 2018	887
2016 - 2017	741
2015 - 2016	1074

The Partnership has continued to coordinate an Early Screening Group (ESG) to provide a multi-agency forum in which concerns about adults who are vulnerable and potentially at risk can be considered. In 2017-18 480 people were considered by the ESG (a slight decrease on the previous year) providing opportunities for early intervention and prevention and contributing to the overall decrease in the number of adult support and protection referrals received. Following evaluation activity undertaken the previous year in partnership with Police Scotland and the Fire and Rescue Service, there has been an increased focus on responding to other forms of harm such as fire safety and scams and the development of and building links with substance misuse, mental health and neighbourhood services.

Analysis of data has identified that a significant number of people are referred through the ESG who do not meet the criteria for formal intervention through Adult Support and Protection, Adults with Incapacity (Scotland) Act 2000 or Mental Health (Care and Treatment) (Scotland) Act 2003.

This has contributed to the development and implementation of a "lead professional" model for adults which will be further implemented during 2018-19.

The Partnership contributed to the multi-agency risk assessment conference (MARAC) process for high risk victims of domestic abuse. This process assists agencies to share information about the risk people experiencing domestic abuse face and to develop joint safety plans to help to reduce this risk and keep victims, and their wider family and friends, safe from harm.

During 2017-18 there were 138 cases discussed at the Dundee MARAC.

Also during 2017-18 the review of the MARAC process was completed and a report was presented to the Dundee Violence Against Women Partnership and to the Chief Officers' Group. A number of key recommendations were highlighted and improvement actions developed for implementation during 2018-19.

What we have achieved to deliver this outcome

- Members of the Adult Support and Protection Stakeholder Group, chaired by Advocating Together have held meetings regularly, where the main focus of the work of the group was their three priority areas:

  1 Self-directed Support
  2 Hate Crime
  3 Financial Harm

  In the last year the group undertook a survey on the progress that Dundee has made since their 2011 'Hidden in Plain Sight' report on the harassment of disabled people. They reported their findings to the Adult Support and Protection Committee. As a result of the recommendations made, the group has decided to increase their involvement with a focus on advocacy and awareness raising throughout 2018.

- The Protecting People Communications and Engagement Group co-ordinate a number of public facing events throughout the year to promote awareness of protecting people issues. To coincide with World Elder Abuse Awareness Day in June, partners from the Celebrate Age Network and Dundee Pensioner's Forum hosted a stall at the Dundee farmers market in addition to a "pop up" event at Royal Victoria Hospital.

Stand at the World Elder Abuse Awareness Day

Engagement Event " Transitions - Protecting People of All Ages"

- In January 2018 the Chief Officers Group for Public Protection hosted an engagement event "Transitions – Protecting People of all Ages". The event was attended by 60 stakeholders representing a cross section of statutory and voluntary organisations concerned with protecting the citizens of Dundee. This included Children and Families Service, Neighbourhood Services, Health and Social Care Partnership, NHS Tayside, Police Scotland, Community Justice Service, Scottish Prison Service and a variety of Third Sector Providers. Participants at the event heard from Chris Kilkenny, who described his experiences of growing up as a Looked After Child in Edinburgh. They also heard about examples of how the Health and Social Care Partnership has been working with Dundee City Council Children and Families Service to improve transitions for Looked After Children and children with disabilities, as well as work to better support life transitions for people experiencing homelessness. Building on these examples of joint working participants considered what further action can be taken to support vulnerable people through age and life transitions. The Protecting People Committees will be considering the information from the event and agreeing actions in response during 2018-19.

- Contracts for all externally commissioned services outline the Partnership's expectation in terms of adult support and protection and child protection and are explicit in terms of health and safety and moving and handling requirements. Information on health and safety matters is shared with providers as a matter of course including medical advice alerts which are issued from the Health and Safety Officer. Clear processes are in place for reporting any issues around individual safety and there are agreed procedures in place for identifying required improvement actions.
- A domestic domestic abuse resource worker has been appointed to work with perpetrators of domestic abuse in a preventative / non-mandatory approach. The focus is on perpetrators who have not yet been through the court system but would benefit from behaviour-change intervention, to prevent the escalation of their abusive behaviour. The resource worker also provides advice and support to other staff working with families affected by domestic abuse. We are currently applying for additional Scottish Government funding to develop the Caledonian Programme for working with perpetrators of domestic abuse. If successful, this will ensure an evidence-based approach to working with perpetrators who have been convicted for their domestic abuse will be implemented in Dundee.
- During 2017-18 the Dundee Violence Against Women Partnership (VAWP) continued to work on establishing a co-ordinated response to commercial sexual exploitation and prostitution with a focus on a routes out of prostitution approach and tackling the demand for prostitution. A working group of the VAWP has been set up to lead on this process. Together with Dundee University the VAWP is conducting dedicated research which focuses on the experiences and needs of the women who are involved in prostitution and looking to identify what responses would be most effective to support the women to exit prostitution. Services will be restructured in line with the outcomes of the research project. During 2017-18 the research project with Dundee University commenced and a preliminary study of women engaging with homeless services and involved in prostitution took place.
- The VAWP is focusing on raising awareness around the prevention of female genital mutilation (FGM). This multi-agency work is being led by the Dundee International Women's Centre and focuses on the delivery of awareness sessions to relevant front-line staff. During 2017-18 we continued to deliver training on FGM and other forms of harmful practices, mainly to NHS and Partnership staff.

PERSON CENTRED CARE AND SUPPORT

Mrs B is a 70 year old lady living in a care home who made a disclosure of historical sexual abuse. The care home was struggling to manage this ladies behaviour due to her cognitive impairment and was considering to serve notice to terminate her placement.

During the adult support and protection process the review officer and mental health nurse liaised closely with the police in looking at the most appropriate way for Mrs B to be interviewed. Further co-ordinated support was provided by the review officer and mental health nurse in looking at distraction techniques and additional social activities with one to one support.

As a result of the above Mrs B is happier, more settled in her placement, with the care home now more able to meet her outcomes.

- The adult psychological therapies service is currently using funding from the Scottish Government's Mental Health Innovation Fund to run a specialist "Survive and Thrive" project. Survive and Thrive is a psycho-educational intervention for people who have experienced trauma like sexual, physical and psychological abuse in childhood as well as domestic violence, physical or sexual assualt in adulthood. Trained facilitators present information on the normal range of reactions to trauma, as well as fostering the development of more adaptive coping strategies. It aims to stabilise symptoms, promote safety and improve coping, using cognitive behavioural therapy principles. During 2017-18 we have run 24 cohorts of Survive and Thrive, with 174 people commencing this treatment.
- As part of the three year Mental Health Officer Service Action Plan, the mental health officer (MHO) team members approached Making Recovery Real with a view to exploring how they could link in with the initiative to help them share their discussions on possible improvements with people who have experience of using the service, about areas for improvement and how best improvements can be achieved. An event was held where people with lived experience of mental health challenges and of using the MHO services and mental health officer team members identified key areas for improvement and how they would work together to develop and test new ways of working. It was agreed this should not be a one-off discussion but a dialogue where people with lived experience can be engaged in on-going discussions about areas for improvement and how best improvements can be achieved. This is continuing to happen and the MHO team are also considering roles for peer recovery volunteers to support the people who come into contact with their service. This will provide a further enhancement to the MHO service.
- Addressing the impact of drug and alcohol use on individuals, families and communities is an important area of work for the Partnership and the wider Community Planning Partnership. In 2015 the Dundee Alcohol and Drug Partnership (ADP) established a network of Mutual Aid SMART Recovery groups across the city. The aim of establishing this network was to provide individuals and families affected by substance misuse the opportunity to participate and be supported by self-help groups based within communities. The groups are peer-led and recovery 'champions' have been specifically trained to organise and run the groups. This network offers the support individuals need in order to sustain their recovery from substance misuse, prevent relapse and receive support from their peers and communities.
- In 2017 Dundee obtained an area-wide license to run SMART Recovery groups. This means that groups can be set up across the city and these groups include some individuals who attend regularly and others who attend as and when they require support. Some groups focus on family members and carers and others provide peer support to individuals affected by their own substance use. In line with the SMART principle of anonymity, attendance at meetings is not recorded or monitored.
- The three locality-based hubs set up in 2014 (including the Albert Street Hub, the Cairn Centre Hub and the Lochee Community Hub) continued to function during 2017-18, ensuring that local people affected by substance misuse and their families can have easier access to the services they need.
- The Dundee Alcohol and Drug Partnership is currently extending the take-home naloxon programme to increase the safety of individuals at risk of overdosing through their drug use. This programme includes providing training to friends, families and staff to administer naloxon in the event of an overdose and by doing so save a person's life.
- During 2017-18 a new strategic and commissioning plan for substance misuse was developed. As part of the implementation of this plan, we will develop a four-tier approach to the provision of services and support in Dundee. Services at each tier will be delivered from locality settings and using a multi-disciplinary approach so that citizens experience a coordinated, effective and streamlined service provision.

- In 2018 an independent commission on drug misuse was appointed to investigate the current situation in Dundee and hear evidence from communities and individuals with lived experience. The commission will take 12 months to investigate and provide a report on its findings.
- Suicide prevention is another area of focused work. Over the past year another 30 individuals have been trained in Applied Suicide Intervention Skills (ASIST). During Suicide Prevention Week 2017 the Partnership worked with key partners to raise awareness of the Tayside Suicide? Help! App. Worthwhile pop up style events took place in various locations of the City alongside – Police Scotland, Scotland's Fire & Rescue Service, Dundee Voluntary Action, NHS Tayside and Samaritans which directly engaged with 250 people. The Scottish Government has been reviewing their accredited training packages as well as holding engagement and consultation events across Scotland in order to produce a new suicide prevention national strategy and action plan. In the interim the Dundee Suicide Prevention Strategic Partnership is working together with individuals with lived experience to co-produce a strategic plan. As well as this, key work and actions are being taken forward focussing on three outcomes
    - Citizens in distress and their families are identified early, feel listened to, respected and understood.
    - Citizens in distress can easily access information, advice and support they need to prevent suicide and live a fulfilled life.
    - People bereaved or affected by suicide are supported.
- Over the last year procedures relating to Adults with Incapacity and Mental Health Acts have been revised to support consistency of practice relating to these areas across the Partnership. Procedures relating to Adults with Incapacity (Scotland) Act and Mental Health (Care and Treatment) Act 2003 were developed and implemented during 2017 – 2018. These aim to provide clear guidance and support to workforce across health and social care. It is planned to review progress with implementation during 2018 – 2019 based on learning. This review will inform further development of our approach to supporting Adults with Incapacity within Dundee.
- In the Mental Health Strategy for Scotland 2017-2027, the Scottish Government reported that by by 2021 they will evaluate the distress brief intervention currently being piloted in 4 Scottish areas with the intention of rolling this out nationwide. In the interim the Dundee Mental Health Strategic Planning and Commissioning Group is looking at how they can respond now to people who have mental health challenges who are in distress. Plans have been developed to improve how we support people experiencing distress. The availability of 24/7 community mental health support, the strengthening of the pathways between AHE, primary and community mental health supports, the provision of a safe place including accommodation, a 24/7 phone line offering mental health support and drop-in facilities are all included in the plan.
- The Partnership has led a strategic and operational multi-agency partnership approach to developing and implementing the vulnerable persons relocation scheme in Dundee. The outcomes have been positive to date with families stating that they feel more confident, empowered and less isolated. All families are accessing healthcare appropriate to their needs and are learning English so that they can access employment and further education. The approach developed in Dundee has been based on listening to families involved in the scheme.
- Through the Partnership's Integrated Care Fund the Safe Zone Bus has continued to operate successfully during the last year. This is a partnership initiative which aims to create a place of safety that meets the needs of any person whose wellbeing is threatened by their inability to get home safely due to alcohol misuse, emotional distress or any other risk of vulnerability. The Safe Zone Bus is active every Friday and Saturday night in the city centre staffed by support workers and volunteers

from Tayside Council on Alcohol (TCA) and Police Scotland. Over the last 12 months the number of visitors rose to over 1000 for the first time. Since April 2017, the Safe Zone Bus has provided support at the Dundee Dance Event, a concert at Slessor Gardens and Fresher's Week at Dundee University Student Union (DUSA). The Safe Zone Bus was also in attendance for Halloween, Christmas Parties and St Patricks Day at Dundee University Students Association. Not only has this contributed to the ongoing growth of the project, it has also enabled us to promote the project to new audiences who may not previously have been aware of the support that is available. In addition, the purchase of a minibus to use as a sweeper service has made a noteworthy impact on the service. The sweeper service was launched during September 2017 and the vehicle has assisted in treating 106 of the visitors to the project since that date. The sweeper service is staffed by volunteers from TCA and staff from Police Scotland. This has widened the scope of the project to the whole of the city centre and has contributed to year on year growth. The sweeper bus has since been rebranded to match the livery of the Safe Zone Bus, thanks to contributions in funding from Police Scotland and the Dundee Council Community Safety Partnership. The Safe Zone Bus Project has previously been nominated for awards by the UK Bus Awards, by Police Scotland as policing partner of the year and the Safe Zone team have been nominated for Volunteer Team of the Year at the forthcoming Volunteer Awards hosted by Volunteer Dundee.

- Keep Safe works in partnership with Dundee Safe Place Initiative, Police Scotland and a network of local businesses to create 'Keep Safe' places for disabled, vulnerable, and elderly people when out and about in the community. Advocating Together provide 'Keep Safe' training to organisations and businesses who are interested in becoming 'Keep Safe' places and visit local groups to hand out Keep Safe cards and explain Keep Safe to a wide variety of vulnerable people.

Currently in Dundee there are 18 Keep Safe places, these are:

- The Overgate Shopping Centre
- The City Centre Management office, City Square
- The Dundee Carers Centre, Seagate
- Dundee Sheriff Court, West Bell Street
- All 14 Dundee Libraries

- The Partnership's Clinical, Care and Professional Governance Forum provides opportunities for services to share and learn from each other. For example, during the last year the decline in young people accessing chlamydia testing has been highlighted. Some work is being undertaken to determine why there is a decline. NHS Tayside is the first pilot site for this audit of the change in testing profiles. Following patient feedback highlighting the lack of compassionate care, services undertook training to highlight the patient experience and ensure all care delivered is compassionate. Learning from adverse events continues across the Partnership with local adverse event reviews all being discussed at the forum. Following reviews, changes have been made to our transport systems between sites, in relation to transporting medical notes and there was a review of the process for contacting the Scottish Ambulance Service from non acute sites ensuring a safe and timely response to any emergency call. In addition the Forum has supported services in preparing for the revised complaints process as directed by the Scottish Public Services Ombudsmen and the new Duty of Candour processes, both of which were implemented during 2017-18.

- We developed a collaborative approach to the implementation of the scottish manual handling passport scheme with partners across Dundee City Council, the third sector and NHS Tayside to ensure that our workforce and people who use our services experience safe provision of manual handling. During the period 2017-18, we developed and implemented manual handling procedures

and joint documentation with NHS Tayside. In addition, we provided training to unpaid carers through a partnership with Dundee Carers Centre. During 2018-19, it is planned to audit our progress in implementing the Scottish Manual Handling Passport Scheme and use the results of this audit to inform continuous improvement of manual handling provision across Dundee.

- Longhaugh Community Team, over a five day period, delivered safety messages in relation to online security and internet safety following a number of fraud type incidents. Short video blogs were designed to provide key safety messages to members of the community of all ages.
- At the end of 2017 the Care Inspectorate, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary for Scotland undertook their first thematic inspection of adult support and protection arrangements in Scotland. Dundee Community Planning Partnership participated, alongside 5 other Partnerships from across Scotland, and was scrutinised in three key areas:
    - Outcomes for adults at risk of harm and their unpaid carers;
    - Key adult support and protection processes; and,
    - Leadership for adult support and protection.
- The Health and Social Care Partnership worked with other community planning partners to support the inspection process, including participating in case file auditing and professional discussions with inspectors. The report recognises that multi-agency partners work well together to deliver positive outcomes for adults at risk of harm and their carers. It acknowledges that the Community Planning Partnership responds timeously to adult protection referrals and adults at risk of harm; works hard to support all vulnerable people, carries out effective work on financial harm and supports involvement and inclusion of adults at risk of harm and unpaid carers. The involvement of the full range of community planning partners, including the third sector, Fire and Rescue and banking sector in adult protection activity was recognised as an area of good practice by the inspection team. The inspection team were also supportive of programmes of improvement led by the Health and Social Care Partnership in areas such as the 'lead professional' model, development of the Early Screening Group and Initial Referral Discussion (IRD)/Case Conference practice. Whilst the report confirms that adults at risk in Dundee are safer, have enhanced wellbeing and an improved quality of life as a result of adult support and protection processes the inspection team found a number of key processes that require significant improvement, particularly in relation to;
    - Clearly defined pathways for adult support and protection responses, particularly at IRD and case conference stages,
    - Completion and quality of chronologies, risk assessments and risk management / protection plans and
    - Full implementation of the Mosaic IT system (the client database used within the Partnership for social work services).

Over the next three months the Partnership will be working closely with other community planning partners, supported by the Care Inspectorate, to develop a two year transformation programme to address these areas for improvement. Progress will be reported in our next annual report.

National Outcome 8: Engaged Workforce – People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

Outcome 8 links to the following Partnership strategic priorities

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

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

How well are we performing

- We continue to work closely with NHS Tayside to implement the 'imatter' continuous improvement model. imatter seeks to understand individual staff experience within their teams, allowing discussion about what is good (and to be celebrated) and what is not as good and needs improvement. All staff employed by NHS Tayside and those staff employed by Dundee City Council who work in Partnership teams have been offered the opportunity to participate in imatter.
- Our last imatter results showed an overall employee engagement index score for the Partnership of 77% with over 1500 staff members participating. This score was slightly higher than the score for NHS Tayside Board as a whole (75%) and our response rate (75%) was considerably higher than NHS Tayside Board (60%). During 2017-18 teams have developed and implemented their own action plans to address areas for improvement. The next round of data gathering for imatter will start in June with reports due to be issued in October 2018.

What we have achieved to deliver this outcome

- Our communications and engagement group continues to oversee corporate communications with our workforce. We have used a number of methods of engagement, including "News Matters" (our widely distributed staff newsletter), direct communication via e-mail, town hall events, NHS Tayside and Dundee City Council communication routes, social media and our local press. A subgroup of the communications and engagement group has been established to review our use of "News Matters" and to explore how we can make better use of social media to facilitate a 2 way dialogue with staff.
- Our locality managers, who are responsible for managing the delivery of health and social care services across our four service delivery areas, have used a number of different methods to bring together the teams that they are responsible for supporting. This has included team briefings and breakfast meetings. These approaches have enabled locality managers to engage in a two-way dialogue with employees to support the establishment of new ways of working and to identify areas of improvement for the future. A communications framework to support this is in development.

- We are creating more opportunities for our workforce to be engaged with the communities in which they work. Our health and wellbeing networks bring together our workforce within the local community planning areas they are aligned to. Our networks have been central to the development of the local community plans and we are exploring how they can link with other locality networks. The Partnership continues to be represented at each LCPP meeting, providing local community representatives with the opportunity to receive current information about the work of the Partnership, to raise any areas of concern and to work together to co-produce solutions. We are working with our community planning colleagues to develop a framework for locality engagement which can support the development of locality plans which are in line with the local community plans.
- Our workforce has had access to a wide range of learning and development opportunities during the last year. Some examples include
    - Three learning networks which draw engagement from staff and volunteers from across the whole Partnership. These include a care home learning network, a care at home learning network and an employability learning network.
    - Facilitation training to support staff and volunteers from across the Partnership to actively support and engage with their wider stakeholders (including the public) by better planning events according to the principles of adult learning.
    - Guiding principles workshops have been developed (a key component of the Workforce and Organisational Development Strategy). During 2017-18 there were workshops delivered regarding creativity, people's voice and visible leadership.
    - Workforce development plans and principles for drugs and alcohol service staff and employability staff were created and are in the process of being implemented.
    - A large scale staff and community engagement event was organised and facilitated for the Employability Partnership.
    - Business coaching for senior managers to support their personal development and also to help shape the development of locality teams and shape strategic work.
    - Delivery of a shared model of integrated induction for the Partnership workforce across the city - an innovating and unique development bringing together the workforce from all areas of the city.
    - Adaptive leadership programme and the advanced leadership programme for senior managers that supports the development of leadership skills in times of complex change.
    - Action learning facilitation programme to build capacity regarding the use of action learning across the Partnership.
    - Ongoing professional support regarding mental health officer, adult support and protection and other professional roles.
    - Development events for multi disciplinary teams to look at change and developments.
    - Development and engagement events for community nursing, as they move into a locality model of working.
    - Support to build capacity of Affina Team Coaches.
    - Design and delivery of a Partnership 'Expo Event' showcasing exemplars of practice across the city.
    - Development of leadership portal with the Open University to support skills and knowledge.
- The IJB held budget development sessions during the year to provide members with a greater understanding of the factors and cost pressures likely to impact on the financial resources available to the Partnership and the range of interventions which may be required to bring the budget into balance in 2018-19. This ensured IJB members were fully aware of the risks associated with the developing budget and supported them in making informed decisions in setting the IJB's budget.

- A development session for IJB members was held to increase the understanding of primary care based services and discuss the challenges being faced by primary care, particularly general practice. A number of papers have been discussed with the IJB on specific aspects of this, including the new GMS contract and the requirements to develop services which support new models of working going forward. The IJB recognised the critical nature of primary care services to so much of the care that people receive.
- We invest time and resources in our clinical staff to ensure that they provide safe and effective care. The psychological therapies service require all staff - in keeping with professional guidelines - to engage in clinical supervision. Through auditing this, we know that all parts of our service are providing staff with an excellent level of supervision.

MANAGING OUR RESOURCES EFFECTIVELY

The Wellgate Day Support Service undertook the staff experience continuous improvement model i-Matter during the spring of 2017. The aim of this staff engagement initiative was to support our ongoing commitment to developing a healthy organisational culture.

This process began with a questionnaire that allowed staff members to share their views anonymously of their experience at work which then generated a team report. All staff within the team completed the questionnaire, giving a 100% response rate.

The findings reported an overall employee engagement index of 85%. The team arranged to meet over pizza one evening to discuss the report findings and to identify agreed areas of improvement that they could concentrate on during the next few months. Everyone agreed that the report was very positive. Each member of the team has a set of skills individually which when put together makes a committed, enthusiastic and efficient team.

The team agreed to look at one area for improvement. This area was in relation to the question "I am given the time and resources to support my learning growth". On reflection the team identified that they received regular supervision, training and were in receipt of annual personal development reviews, however people felt that it was difficult at times to undertake e-learning training within the workplace due to distractions and interruptions.

The team also highlighted that they felt that they don't always have time to plan for the activities that they provide to service users. Some members of the team highlighted that they can struggle to keep activities interesting and engaging for service users. This was particularly evident with new members of the staff team.

As a result of undertaking the i-matter action plan we have arranged sessions to allow dedicated time to staff to undertake e-learning. The feedback following these sessions has been mixed as whilst some of the team feel they have benefitted from this time others felt that the disruption of leaving the work place and travel to the e-lab was quite disrupting and not necessary.

Activity planners have also been developed by the team during a team day. These planners provide in-depth information to staff regarding each activity that the service run. An ideas section is also included to promote innovation and creativity to the groups that we run.

- The Chief Officers' (Public Protection) Group (COG) delivers a programme of events throughout the year with the intention of upskilling those working in Dundee about different protecting people issues and to provide an opportunity to explore, discuss and consider solutions for such issues. Throughout the second half of the year consultation took place with practitioners attending the Child Protection Practitioners Forum, Adult Support and Protection Practitioners Forum and Adult Support and Protection Stakeholder Group regarding the purpose and format of COG events. A revised programme of engagement activities has now been initiated comprising of a focus on transitions and breakfast sessions between operational staff and chief officers.

- The Community Health Team has an important role to play in building the capacity of a wide range of frontline staff to incorporate a health inequalities perspective in their role. A suite of sessions is delivered regularly, including poverty sensitive practice, mind yer heid and substance misuse, recovery and stigma training. In 2017-18, twenty sessions were delivered by the Community Health Team to 237 participants across these training courses.

  In addition to this, the equally well co-ordinator developed a new health inequalities and prevention training session that helps implement the recommendations from the Dundee Partnership Prevention Framework Report, and which includes a useful tool to support staff to use social prescribing approaches as a route to improving service user outcomes. In the past year, 78 sessions were delivered to 1041 frontline staff, almost half of whom were sited in Dundee Health and Social Care Partnership. Evaluation and follow-up surveys show that upwards of 80% of participants now recognise vulnerable and at-risk individuals, can have a positive exploratory conversation to identify the factors affecting them, and can signpost them to supportive services and activities that can help.

- The Tayside Palliative and End of Life Care (PEOLC), Managed Clinical Network was established in 2017 with support from Dundee, Angus and Perth and Kinross Partnerships. TayPEOLC has partnered with others across communities, health and social care, universities and nationally to improve information supporting palliative care, pharmacy and medicines, education, end of life care and research. This approach will further collaborate across settings and with the wide range of stakeholders identified in the Scottish Government's advice note (http://www.gov.scot/Publications/2018/05/4658) when attending to the full continuum palliative and end of life care needs. The model in the Partnership, to have a lead officer for PEOLC, has been noted as a good example within this advisory note.

National Outcome 9: Resources are used efficiently and effectively – Best Value is delivered and scarce resources are used effectively and efficiently in the provision of health and social care services

Outcome 9 links to the following Partnership strategic priorities:

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

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

How well we have performed

Emergency hospital care, including readmissions to hospital where the patient had previously been discharged within the last 28 days, is one of the biggest demands on the Partnership budget. Many hospital admissions are avoidable and often people either remain in hospital after they are assessed as fit to return home or they are readmitted to hospital shortly after they were discharged. You can read more about our performance in relation to emergency admissions and readmissions under outcome two in this report. In 2017-18 27% of Dundee's health and care budget was spent on hospital stays which was the third highest in Scotland. Dundee spent approximately £40M on hospital inpatient stays and approximately £262M in total on health and social care.

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

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

81% of Dundee respondents who are supported at home agreed that their health and care services seemed to be well co-ordinated. This is higher than the 74% of respondents across Scotland as a whole who agreed with this statement.

What we have achieved to deliver this outcome

- We have analysed and reported on indepth information regarding falls and unscheduled hospital care in order to better understand demand and resource use and to inform service improvements regarding outcomes and efficiencies. This included analysis at LCPP level , by age group and hospital specialty.
- Throughout the last year the Partnership has undertaken work to redesign a number of services, including mental health and learning disability services and substance misuse services, in order to deliver better outcomes for individuals and communities, enhance the quality and safety of services and ensure best value.
- The mental health and learning disability redesign consultation has concluded and proposals have been agreed by NHS Tayside and the IJB regarding the future service model for inpatient services across Tayside for adults with mental illness and learning disability and / or autism. From a local perspective, key priorities are being progressed to ensure a range of community supports are in place. These priorities include the further development of available support for people experiencing distress, a strengthening of pathways between primary care and community mental

health services, an increase in the availability of low intensity psychological therapy supports, increased availability of peer support, the introduction of 24/7 community mental health services. For people with learning disabilities, further work to reduce health inequalities remains a key priority. Some examples of how this has been achieved:

- Extension of the acute liaison service beyond office hours .
- Increased capacity for teaching and awareness raising with colleagues working in the acute sector.
- The strengthening of pathways between primary care and specialist learning disability services.
- The strengthening of collaborative working with childrens services colleagues for example within the New Beginnings Service.
- Progress is being made to reduce inequalities.

- There have been improvements in pathways and transitions between community, primary care and acute mental health services. This includes a daily huddle via tele-conferencing, involving all mental health inpatient wards and community teams across Tayside to support better transitions between acute and community settings. Progress is being evaluated and will be reported as this becomes available. Early experience is that communication across the sector in this regard has improved. Plans are underway to pilot an enhanced model of care involving primary care and mental health services. The expected impact of this is faster access to assessment and potentially quicker identification of the right kind of support. A project plan is now in development and will be considered as part of the Primary Care Improvement Plan.

MODELS OF SUPPORT, PATHWAYS OF CARE

Miss Y is a young person who was referred to the supported accommodation service. She initially presented as very insecure, with low self-esteem and prone to aggressive behaviour towards her family and the environment. Miss Y had a mild learning disability and ADHD and spent the last few years in a specialist hospital due to a deterioration in her mental health and wellbeing. She was offered a flat in a supported accommodation complex and the transition process followed. During that time staff from the supported accommodation team focused on building a relationship of trust with Miss Y, her family and hospital team, as well as supporting her to increase her confidence, self-worth and to reduce her dependence on the routines and structures of the hospital life. The team was supported by specialist health professionals. When Miss Y was eventually able to move to her own flat, an intensive support programme was put in place to allow her to adjust to her new life and to cope with stressors and challenges associated with the new situation, as well as learning the practical skills required to live independently. This has been a success and the team around Miss Y, as well as her family, are now able to see more of her true personality, which is warm, caring and full of humour. They are now supporting Miss Y to plan a holiday. Her story can be an inspiration to other people in long term hospital care and also hospital professionals, showing that; a carefully planned transition, involving joint working of all parties, can result in a long term positive outcome.

- Upon transfer of responsibilities for substance misuse services transferring to the Integrated Joint Board in January 2017, an evaluation of the service risks, performance and model using learning from Local Adverse Events Reviews, Significant Case Reviews, Tayside Clinical Care and Professional Governance, National Standards and Guidance, legal requirements, current performance and workforce capacity was undertaken. This led to a change in how drug waiting times were recorded by the medical and nursing part of the service. This was so that greater transparency and understanding could be gained regarding the actual wait for drug treatment to inform an improvement and redesign programme.
- A range of stakeholders across NHS Tayside and the three Partnerships are involved in a Delphi process which will give a better understanding of pathways. This involves a survey which is completed by health and social care professionals to gather information regarding critical processes in a pathway. This will be used to improve outcomes for people and system efficiencies.
- The COPD team continues to work closely with the population of Dundee and those that provide support to manage this condition across the spectrum of self management, primary and secondary care. A variety of initiatives support this including the COPD discharge service which provides support to patients following necessary hospital admission to prevent readmission. This is being further supported by the Managed Care Network which will also contribute to pathway development.
- A key factor in the effective and efficient delivery of health and social care is ensuring support is provided when it is needed and capitalises on opportunities when those who can be harder to engage are engaged with other partner services. For example
    - As part of community based orders, individuals will be meeting regularly with staff and exploring what steps can be taken to achieve a reduction in reoffending through improving positive life choices. To build on a period of reflection, health staff are co-located within the Community Justice Service (CJS) centre and can be called upon to support health interventions, as and when needed. The Scottish Government's National Strategy for Community Justice' states that

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

    - Ensuring that workers from different disciplines (including CJS and Health) communicate effectively and work together closely can help improve the health and wellbeing of service users , at critical moments and it can also save lives.
    - To strengthen the links between CJS and mental health support the community justice nurse has been connected with the Community Mental Health Team. This will enable her to undertake initial assessments and interventions, make direct referrals and work more closely with colleagues supporting people experiencing mental health challenges.
    - The CJS remains highly aware of the impact of substance misuse and CJS staff contribute to the operational reviews of Tayside drug related deaths, as well as this a large number of CJS staff submitted comments to the Dundee Drug Misuse Commission's initial call for evidence.
    - A range of developing new models of care and service re-design initiatives is captured within the Transformation Programme. This includes investment of funding designed to support the integration of health and social care services, specific Scottish Government funding to resource national policy initiatives (eg payment of the living wage for adult social care staff) and initiatives in response to financial challenges and efficiency saving requirements. During 2017-18, the IJB established a Transformation Delivery Group. The role of this group is to develop, monitor and support the various strands of the Transformation Programme, ensuring consistency with the priorities set out within the IJB's Strategic and Commissioning Plan.

An example of the Transformation Programme in action is through the reshaping of non acute care for older people where new community models of care were tested, provided good outcomes for patients and services thereby providing the confidence to professionals to support the expansion of the models. This provided the opportunity to shift from more traditional forms of care, reducing the number of beds within the hospital setting, releasing resources for reinvestment and efficiency savings.

The Transformation Programme is key to the IJB meeting its objectives over the coming years.

MODELS OF SUPPORT / PATHWAYS OF CARE

It was recommended by the hospital that Mrs G required a care home placement. However, this was not what she wanted, would incur a delay and would take up a scarce resource. So an integrated approach was taken and an assessment bed in Menzieshill House Care Home was used and Mrs G continued to work with allied health professionals which increased her mobility with the use of gutter frame. Mrs G was discharged to her home, and received support from the Red Cross Assessment at Home Service. Mrs G is now living independently with a package of care and continues to make gains.

Within the Partnership there are a range of Strategic Planning Groups who are responsible for overseeing the planning and commissioning of services for specific populations and areas of service, such as mental health, learning disabilities, carers and substance misuse.
During 2017-18 the following strategic commissioning statements were produced

- Carers Strategy
- Housing Options and Homelessness Strategic Plan
- Smart Health and Care Strategy
- Joint Sensory Services Strategy & Commissioning Plan
- Substance Misuse Strategic and Commissioning Plan

These can be viewed on our website.

THE QUALITY OF OUR SERVICES

4.0

In 2017-18 there were 149 services for adults registered with the Care Inspectorate in Dundee. This includes services directly provided by the Partnership, services commissioned by the Partnership from third sector and independent providers and services operating independently of the Partnership. Of these services, 81 were inspected during the year, of which 21 were combined inspections, where both the Housing Support and Support Services were inspected together.

29 care homes were inspected and of these inspections 5 services received requirement(s) and 14 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

52 housing support and support services were inspected and during these inspections 14 services received requirement(s) and 7 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

Nurse agencies and the the adult placement service were not inspected during 2017-18.

This means that of the 81 services that were inspected during the last 12 months 77% received no requirements for improvement. The level of complaints upheld or partially upheld is similar to that of other Partnerships within our 'family group'.

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

Of the 12 services directly provided by the Partnership that were subject to inspection by the Care Inspectorate over the last year 9 (75%) received grades which were all 'very good' or 'excellent'. Further information about these inspections is available in Appendix 3. Whilst over the last year the quality of services directly delivered by the Partnership has in the vast majority of cases been very good we recognise the need to continuously maintain and further improve the quality of the services we deliver and to address any aspects of quality that fall below this standard.

Other key functions or services provided or commissioned by the Partnership are also regulated by Audit Scotland, Healthcare Inspection Scotland and Mental Welfare Commission. These organisations did not inspect any Partnership services during 2017-18.

5.0 LOOKING TO THE FUTURE

Looking forward to 2018-19 we will continue to work towards the delivery of our strategic priorities, with a particular focus on:

- Better articulating our future locality planning through the review of our Strategic and Commissioning Plan.
- Realigning statutory services to the four service delivery areas in order to ensure services are located where they are needed most.
- Continuing the large scale mental health services redesign in order to improve timely access to services which are integrated and focussed on recovery.
- Improving responses to people at risk of harm, including those who do not meet the statutory definition of an adults at risk of harm, as defined in The Adult Support and Protection (Scotland) Act 2007.
- Increasing the level and range of services delivered in localities, in line with the Primary Care Improvement Plan and supporting the implementation of this plan and the role of GPs as 'expert medical generalists'.
- Redesigning services for adults with substance misuse problems to improve access to recovery orientated treatment services and supports and improve outcomes for people and their families.
- Further develop collaborative working with Children and Families and Community Justice, including in areas such as public protection, transitions and the possible development of the Women's Community Custody Unit.
- Embedding approaches across services which identifies and responds to health inequality.
- Reducing the length of time people are delayed in hospital due to complex reasons regarding; accommodation, specialist individualised support or legal reasons.
- Developing pathways for adults who experience long term conditions, including regular users of specialist acute services.
- Increasing the proportion of carers who feel supported to continue caring by implementing the Carer's Act and further developing the range of supports for carers.
- Reviewing existing equality outcomes to ensure they are fit for purpose, reflect the desired outcomes of affected communities.

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

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

APPENDIX 1

National Health and Wellbeing Outcomes

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

APPENDIX 2

Performance against National Health and Wellbeing Indicators

Indicators 1-9 are measured using the National Health and Care Experience Survey disseminated by the Scottish Government every two years. The latest one was completed in 2017-18 and is due to be repeated in 2019-20.

National Indicator	2015-16 Dundee	2015-16 Scotland	2017-18 Dundee	2017-18 Scotland	Comparison with Scotland
1. Percentage of adults able to look after their health very well or quite well	93%	94%	93%	93%	↔
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	88%	84%	84%	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%	↑
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%	↑
5. Percentage of adults receiving any care or support who rate it as excellent or good	84%	81%	82%	80%	↑
6. Percentage of people with positive experience of the care provided by their GP practice	90%	87%	84%	83%	↑
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%	↑
8. Percentage of carers who feel supported to continue in their caring role	44%	41%	38%	37%	↑
9. Percentage of adults supported at home who agree they felt safe	85%	84%	87%	83%	↑

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

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

National Indicator	2015-16 Dundee	2015-16 Scotland	2016-17 Dundee	2016-17 Scotland	2017-18 Dundee	2017-18 Scotland	Comparison with Scotland 2017-18
10. Percentage of staff who say they would recommend their workplace as a good place to work	75%	Not available	75%	Not available	Not available	Not available	
11. Premature mortality rate (per 100,000 people aged under 75)	546	441	572	440	Not available	Not available	
12. Emergency admission rate (per 100,000 people aged 18+)	12,154	12,138	12, 411	12, 037	12, 790	11, 959	↓
13. Emergency bed day rate (per 100,000 people aged 18+)	142,407	122,713	136,059	119,649	131, 673	115, 518	↓
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	121	96	125	95	123	97	↓
15. Proportion of last 6 months of life spent at home or in a community setting	87%	87%	87%	87%	89%	88%	↑
16. Falls rate per 1,000 population aged 65+	25	21	26	21	28	22	↓
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	88%	83%	86%	84%	85%	85%	↔
18. Percentage of adults with intensive care needs receiving care at home	54%	62%	55%	61%	Not available	Not available	
19. Percentage of days people spend in hospital when they are ready to be discharged, per 1,000 population	832	915	755	842	347	772	↑
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	27%	23%	26%	23%	27%	23%	↓
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Not available	Not available	Not available	Not available	Not available	Not available	Not available
22. Percentage of people who are discharged from hospital within 72 hours of being ready	Not available	Not available	Not available	Not available	Not available	Not available	Not available
23. Expenditure on end of life care	Not available	Not available	Not available	Not available	Not available	Not available	Not available

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

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

APPENDIX 3

Statutory Inspections during 2017-18

CARE INSPECTORATE GRADINGS TO SERVICES DELIVERED DIRECTLY BY THE PARTNERSHIP

Name of Service	Service Type	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
Craigie House	Care Home	22/11/2017	(5) ↑	(4)	(5)	(4)
Janet Brougham	Care Home	05/10/2017	5	(6)	(5)	4 ↓
Menzieshill House	Care Home	13/10/2017	5	(5)	(5)	5
Turrif House	Care Home	07/03/2018	5	(5)	(5)	5
MacKinnon Centre	Care Home (Respite)	12/01/2018	6	(6)	6	(6)
White Top Centre	Care Home (Respite)	22/11/2017	6	(6)	5 ↓	(6)
Homecare Social Care Response Team	Care at Home/ Housing Support	08/09/2017	5	N/A	5	(5)
Care at Home City Wide	Care at Home/ Housing Support	21/03/2018	5	N/A	5	5
Homecare Enablement and Support & Community MH Older People Team	Care at Home/ Housing Support	03/11/2017	5	N/A	(5)	5

Name of Service	Service Type	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
Dundee Community Living	Care at Home/ Housing Support	13/10/2017	6	N/A	6	(6)
Supported Living Team	Care at Home/ Housing Support	12/12/2017	6	N/A	6	(6)
Weavers Burn	Care at Home/ Housing Support	11/07/2017	4 ↑	5	3	4 ↑

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

EXTERNALLY CONTRACTED SERVICES
CARE INSPECTORATE INSPECTIONS WHERE THERE WERE REQUIREMENTS 2017-2018

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
25/10/2017 09/02/2018	Ballumbie Court	Care Home	3	4	4 ↑	3

Requirements

1. The service provider must ensure medication is managed in a manner that protects the health, welfare and safety of service users. In order to achieve this the provider must ensure;
- administration of medication or reason for omission must be recorded on the MAR sheet at the time of administration
- they maintain accurate, detailed records on how much and where to apply particular topical creams/ointments.

2. The provider must make proper provision for the health, welfare and safety of service users. In order to achieve this the provider must ensure;
(i) fluid charts are completed for those service users who require them
(ii) review and record findings and update each care plan as so required to ensure that each service user who needs assistance to drink has a care plan that describes specific interventions for that individual. This must include the individual's daily intake target.

3. The provider must make proper provision for the health, welfare and safety of service users. In order to achieve this the provider must ensure;
(i) weight monitoring is carried out as prescribed in the care plan
(ii) review and record findings and update each care plan as so required to ensure that each service user who needs assistance to monitor their weight and nutritional status has a care plan that describes specific interventions for that individual.

4. The provider must ensure all activities support plans are meaningful and person centred and are used to inform and guide staff practice. This means the service should undertake a quality review of all support plans to ensure the planned support delivered by staff meets the assessed need.

5. The provider must ensure all staff who complete records used to evaluate service users health can do so accurately. This means the service should ensure all staff revisit essential training in how to complete:

- Malnutrition Universal Screening Tool (MUST)
- food and fluid charts
- activity records
- appropriate and meaningful evaluations

6. All staff competency in completing records should be assessed on a regular basis.

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
16/02/18 09/08/17	Bridge View House Nursing Home	Care Home	3	4	3	3

Requirements

1. The provider must ensure the health and wellbeing of service users. To achieve this, the provider must:

- review medication storage and administration procedures to ensure that the administration of medication follows best practice guidance and medication is administered within the prescribed timescale.

- refresher training should be provided, which includes evidence of competency.

2. The provider must make proper provision for the health, welfare and safety of service users. In order to achieve this the provider must ensure;

Staff carry out all dressing changes within timescales set in treatment plans and ensure all wound assessments are kept up to date.

3. The provider must make proper provision for the health, welfare and safety of service users. In order to achieve this the provider must ensure;

Staff complete all relevant weight monitoring/recording tools in the service users' care files as directed by the provider's policy and procedure documentation. This will enable effective monitoring and evaluation of care.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of	Quality of Staff	Quality of Leadership and
25/05/2017 07/11/2017 12/03/2018	Helenslea	Care Home	2	2	2	2

Requirements

1. The provider must, having regard to the size and nature of the care service, the numbers and needs of service users, ensure that at all times suitably qualified and competent persons are working in the service in numbers as are appropriate for the health, safety and welfare of service users.

2. The provider must demonstrate that there are suitable and sufficient meaningful activities for service users to engage in based on their personal choices and abilities. Activities should promote and maintain health and wellbeing of service users. There must be access to outdoor space and events.

3. The provider must ensure that medication is managed and administered safely and to the standard of best practice guidance, including 'Handling Medicines in Social Care' 2007 and the Care Inspectorate's Health Guidance 'Maintenance of Medication Records'.

4. The provider must ensure that risks of under nutrition are recognised and acted upon by providing an appropriate fortified diet according to service users' needs and preferences. The provider must also offer nutritionally balanced choices.

In order to do this you must:
- Ensure that staff are aware of dietary needs (fortified or texture modified) and preferences of individual service users and meet these.
- Ensure that there is evidence of these needs and preferences being met by the use of food charts and observation of meals and snack times
- Inspection report for Helenslea

5. Ensure that staff have the necessary skills to identify people at risk of malnutrition, dehydration and weight loss.

6. The provider must ensure that there is an appropriate system in place for carrying out and monitoring safety of the environment, maintenance and repairs procedures.

This must include (but is not limited to):

- Developing environmental risk assessments and taking steps to minimise risks identified.
- Carrying out regular and planned environmental audits.
- Ensuring that any deficits identified are addressed promptly
- Ensure that any minor repairs are carried out timeously and records kept of this.

7. The provider must ensure that the home is kept clean, hygienic and that appropriate infection control systems are in place and being routinely monitored to control the spread of infection. Infection control procedures must be improved within the home with specific reference to laundry procedures including storage systems, cleaning procedures and schedules and use of personal protective equipment.

8. The provider must demonstrate that it has followed good practice in relation to safe recruitment practices and must not employ any person in the provision of a care service unless that person is fit to be so employed.

9. The provider must ensure that the Care Inspectorate are notified within 24 hours of any unforeseen event including outbreaks of infection.

10. The provider must ensure that risk of under nutrition are recognised and acted upon by providing an appropriate fortified diet according to service users' needs and preferences. The provider must also offer nutritionally balanced choices.
In order to do this you must:
- Develop and implement clear care plans to avoid unplanned weight loss, under nourishment or dehydration.
- Develop and implement clear care plans when people are identified as underweight, malnourished or at risk of dehydration.
- Ensure that staff are aware of dietary needs (fortified or texture modified) and preferences of individual service users.
- Ensure that there is evidence of these needs and preferences being met by the use of food charts and observation of meals and snack times.
- Ensure that staff have the necessary skills to identify people at risk of malnutrition, dehydration and weight loss.
- Ensure that there is robust monitoring and audit of prevention and care plans.

11. The provider must ensure that medication is managed and administered safely and to the standard of best practice guidance, including 'Handling Medicines in Social Care' 2007 and the Care Inspectorate's Health Guidance 'Maintenance of Medication Records'

12. The provider must demonstrate that there are suitable and sufficient meaningful activities for service users to engage in based on their personal choices and abilities. Activities should promote and maintain health and wellbeing of service users. There must be access to outdoor space and events.

13. The provider must devise, implement and fully embed robust quality assurance arrangements that evidence improving outcomes for service users.

14. The provider must demonstrate that it has followed good practice guidance in relation to safe recruitment practices and must not employ any person in the provision of a care service unless that person is fit to be so employed.

15. The provider must ensure that people who use the service are fully supported to meet personal care needs as and when required and requested.

16. The provider must ensure that all complaints are managed in accordance with the Complaints Procedure. The provider must, within 20 working days after the date on which the complaint is made, or such shorter a period as may be reasonable in the circumstances, inform the complainant of the action (if any) that is to be taken.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
13/02/2018	Pitkerro Care Home	Care Home - Private	3 ↓	(4)	3 ↓	(4)

Requirements

1. The provider must ensure that all residents' personal plans document how needs are identified, met and reviewed and reflect current management of care needs. In order to achieve this the provider must:
   - demonstrate that written information about care arrangements for residents is accurate and up-to-date
   - demonstrate that staff follow best practice in recording keeping and documentation
   - ensure that all care related documentation is regularly reviewed and audited.

The provider must ensure that all residents nutrition and hydration needs are adequately met. In order to achieve this the provider must:
   - provide meals which are presented suitably
   - ensure that, when help is needed, it is carried out in a dignified way
   - demonstrate that mealtimes are conducted in as relaxed an atmosphere as possible
   - provide access to fresh water at all times
   - ensure that, when the monitoring of fluid intake is required, this is recorded accurately and reviewed regularly.

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

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Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
18/04/17 21/11/17	The Bughties	Care Home	2	3 ↓	3 ↓	2

Requirements

1. The provider must ensure that personal plans are reviewed at least once in every six month period.

2. The provider must ensure all trained staff who administer medication are aware of their responsibility and accountability to administer prescribed medication and can demonstrate their understanding through practice. The service should introduce strategies which monitor and evaluate trained staff competency of the task on a regular basis. There should be evidence of a managerial oversight of all medication records.

3. The service must make proper provision for the health, welfare and safety of service users. The service should meet the condition of registration to carry out improvements as agreed with the Care Inspectorate. The service must ensure that regular health and safety checks are carried out and recorded. Any remedial actionidentified should be taken to rectify repairs to the building and to equipment used by residents as soon as possible.

4. The service must review recruitment recording systems to evidence that all necessary checks have beencompleted as part of the recruitment process. Evidence of these checks must be kept with other recruitment records for that employee.

5. The provider must ensure all staff are aware of infection prevention and the control measures in place to prevent cross infection and contamination and when these should be introduced to practice. In order to achieve this the service should:

(I) plan and confirm infection control training dates

(2) provide evidence of how they will evaluate staff understanding of the learning and be able to demonstrate through their practice.

6. The service provider must ensure all information is shared and recorded in a consistent manner. In order to achieve this the service should ensure all staff are aware of the lines of communication within the service and can demonstrate their understanding through practice. This must include the use of appropriate documentation when recording, for example accident and incident reports.

7. The service must ensure that regular health and safety checks are carried out and recorded. Any remedial action identified should be taken to rectify repairs to the building and to equipment used by residents as soon as possible.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
19/01/2018	Dundee Survival Group	Housing Support	4	N/A	(4)	4

Requirements

1. The provider must ensure that when it recruits staff, it follows the guidance in "Safer Recruitment Through Better Recruitment" (Scottish Government 2016). This will help to ensure that all staff who are employed in this service are fit to work with vulnerable people.

2. The provider must ensure that all notifiable incidents are reported to the Care Inspectorate as per the guidance 'Records all services (except CM's) must keep and notification reporting guidance'.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
13/12/17	Positive Steps (East)	Housing Support	5 ↓	N/A	(6)	3 ↓

Requirements

1. The provider must ensure that when it recruits staff, it follows the guidance in "Safer Recruitment Through Better Recruitment" (Scottish Government 2016). This will help to ensure that all staff who are employed in the service are fit to work with vulnerable people.

2. The provider must notify the Care Inspectorate of all accidents and incidents resulting in harm or potential risk of harm to a person who is using the service.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
19/01/18	Jean Drummond Centre	Support services - not care at home	4 ↓	4 ↓	(5)	4 ↓

Requirement

1. The provider needs to review what it does, what it can do given its resources and re-visit and re-formulate its aims and objectives to reflect that so that there is a clear direction for the service.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
07/04/17	Allied Healthcare Group Limited	Support Services - care at home	4	N/A	(5)	4

Requirement

1. The provider must ensure that all notifiable incidents are reported to the Care Inspectorate as per the guidance 'Records all services (excl CM's) must keep and notification reporting guidance'.

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

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Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
22/06/2017	Avenue Care Services Ltd	Support service - care at home	3	N/A	2	2

Requirements

1. The service must ensure that all staff are employed following appropriate checks and that where necessary risk assessments are carried out to reduce any risk to people who use the service.
2. The provider should ensure that the service has robust quality assurance processes and that audits and checks are completed within stated timescales and clearly evidence how any issues identified are to be addressed by whom and by when. These should be signed by an appropriate person to evidence that they have been completed and issues are addressed.

A follow up inspection was held on 8 December 2017 to see what the service had done to meet the above and any previous requirements not already met.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
22/06/2017 30/03/2018	Avenue Care Services Ltd	Support service - care at home	2	N/A	3 ↑	2

Requirements

1. The provider must ensure that risk assessments are in place with control measures to reduce the risks to people using the service. This is to include: using information from assessments, families and staff to identify risks to people using the service;
   - agreeing and recording the measures that staff should take to reduce these risks;
   - providing information on who to contact if there are any difficulties in following the measures agreed from the risk assessment;
   - reviewing risk assessments to ensure the measures are still appropriate and necessary.
2. The service must ensure that all services have a care plan which sets out how their needs will be met. In order to achieve this, the service must:
   - ensure the plan is developed in full consultation with the service user and/or their relative/ representative;
   - review and update the care plan in line with changes in the service user's needs.
3. The provider must demonstrate they have an effective communication system in place to inform them if care at home workers do not attend service users' visits as planned. In order to do this, the provider must:
   - ensure they have a communication system developed and implemented to notify senior staff when care at home workers do not attend a visit to a service user at the schedule time;
   - ensure the communication system is not reliant on service users or their representatives making the provider aware of any non-visits.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
30/06/2017	Blackwood Homes and Care - Tayside	Support services - care at home	3	N/A	3	3

Requirements

1. The service should ensure that where a person has a scheduled visit there are systems in place to ensure that this takes place and that if a visit is missed the service knows about it quickly and can take steps to ensure that person is safe and supported.

2. The service should ensure that all customers receive a schedule outlining what staff are coming to support them and at what time this is planned to take place. The schedule should be given to people in advance of the time so they can plan their lives around this.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
06/07/17	British Red Cross	Housing support service - care at home	4	N/A	(4)	3 ↓

Requirements

1. The provider must ensure that they have a robust quality assurance system in place that is effective in identifying areas for improvement. This includes ensuring that personal plans and associated documents are accurate and amended promptly when a change is required

2. The provider must ensure that their recruitment procedures and practice demonstrate best practice. This includes establishing who is responsible for assessing the information received through recruitment checks such as reference and PVG results. Appropriate action should be taken to address any concerns highlighted and a record of the outcome held on file to help prevent any potential risk to people.

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

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Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
05/06/17	Oran Home Care Ltd	Housing support service - care at home	4	N/A	(4)	4

Requirements

1. The service provider must ensure medication is managed in a manner that protects the health and wellbeing of service users. In order to achieve this the service provider must ensure that:

(a) There is a comprehensive assessment to ensure the correct level of support is being carried out;

(b) There is a regular review of medication support carried out and recorded within the required six monthly care review or sooner if required;

(c) Care plans are updated to reflect the medication support required;

(d) Staff must be aware of the support required and record their actions on the medication log or Medication Administration Record depending on the type of medication support required.

2. The provider must ensure that it is always suitably competent persons who carry out safe and effective moving and assisting techniques in order to protect service users and staff. All staff must receive appropriate training, updates and observed competencies in line with good practice guidance in order to carry out safe and effective moving and handling practices. In order to achieve this the service provider must:

(a) Provide comprehensive moving and handling training at induction for new employees;

(b) Provide the opportunity for all staff to attend a moving and handling training session;

(c) Carry out a minimum of annual observed competency assessment of all staff in moving and handling practice;

(d) Ensure there is a record of all moving and handling training and observed competency based moving and handling assessments for staff.

3. The provider must ensure that residents care plans provide robust detail that has been fully assessed and provide staff with guidance on how to support residents. In order to achieve this, the provider must:

(a) Undertake a full assessment of the resident's specific healthcare needs and carry out a risk assessment and instructions in the event of a potential emergency situation arising;

(b) Ensure that the written plan is clear and concise;

(c) Ensure that where end of life care is provided, there is a clear written plan of care to be provided and that all staff are aware of the information within the care plan;

(d) Ensure that the written plan is being effectively monitored and audited.

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

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Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
30/01/2018	Carr Gomm - Support Services 2	Care at Home/ Housing Support	5	N/A	5 ↑	(4)

Requirement

1. The provider must ensure that medication is administered safely and recorded properly. They must:
   - Ensure that the correct medication is given at the correct time
   - Ensure that the medication is taken
   - Ensure that this is recorded and signed

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
03/05/2017	Dudhope Villa & Sister Properties	Care at Home/ Housing Support	3	N/A	3	3

Requirements

1. The provider must ensure that support plans and risk assessments reflect current need and safety strategies. In order to achieve this the provider must:
   (a) Ensure support plans and risk assessments are reviewed no less than six monthly;
   (b) Ensure support plans and risk assessments are updated immediately following any change to the service user's needs.

2. The provider must ensure that its quality assurance methods are robust and effective.

3. To ensure the service is delivered in a way which promotes choice, autonomy and enablement the provider should develop a systematic approach to service improvement including drawing up an action plan with timescales.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
19/04/2017	Gowrie Care (Homeless Service)	Care at Home/ Housing Support	4	N/A	(5)	4

Requirements

1. The provider must make sure that personal support plans are reviewed with each resident and their carers or representative if appropriate, at least once in each six month period to ensure that the care and support described continues to meet the needs of each individual. The provider should keep a record of these meetings and or discussions and a minute taken. Minutes should contain a summary of the discussion held, the decisions made as a result of the discussion and when this will be reviewed again.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
13/12/2017	Scottish Autism - Tayside Housing Support & Outreach Service	Support Services - Care at Home	5	N/A	(6)	5

Requirement

1. The service provider must ensure that the recording of medication is clear and follows best practice guidance. This is to ensure that medication records are clear and easily understood. This is in order to protect the health and wellbeing of service users. In order to achieve this the service provider must:

- Ensure that administration of medication or reason for omission must be recorded on the MAR sheet at the time of administration. Administration codes must be used consistently by all members of staff to ensure that there is a shared understanding when a medication has not been administered or to explain other administration issues.
- Where handwritten instructions have been added to the MAR sheet these must be signed by the authorising GP or two members of staff who transcribe the doctors' instructions.
- As required medication must be recorded clearly, evidencing the effects of medication given.

Inspection Date	Name of Org/Service	Service Type	Quality of Care and Support	Quality of Environment	Quality of Staff	Quality of Leadership and Management
24/05/2017	Transform Community Development	Housing Support Service	3	N/A	3 ↓	3

Requirements

1. To ensure the health and wellbeing of service users the provider must ensure that appropriate financial safeguards are in place. In order to achieve this the provider must:

   a) Carry out a full review of all financial policies, procedures and processes;

   b) Ensure that, where appropriate, financial risk assessments are in place for service users;

   c) Ensure that steps are taken to obtain the appropriate financial safeguards for each service user;

   d) Ensure regular audits are carried out on the funds held for service users.

2. The provider must ensure that the support service users require from staff is clear. In order to achieve this the provider must ensure:

   a) Assessments of risk and the strategies to reduce risk are agreed and in place;

   b) Plans of support are agreed and in place and accurately reflect the current needs of service users;

   c) These assessments and plans are reviewed no less than six monthly and updated when necessary.

3. The provider must ensure that quality assurance methods are robust and effective.

4. To ensure the service is delivered in a way which promotes participation, good practice and improvement the provider should develop a systematic approach to service development including drawing up a clear plan with timescales.

A follow up inspection was held on 1 February 2018. Requirements 1 and 4 were met within timescale. Requirement 2 was not met and will continue in reports. Requirement 3 was met outwith timescales.

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

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MENTAL WELFARE COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2017-2018

No inspections

HEALTHCARE IMPROVEMENT SCOTLAND REQUIREMENTS AND RECOMMENDATIONS 2017-18

No inspections

AUDIT SCOTLAND AND ACCOUNTS COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2017-18

No inspections

APPENDIX 4

Glossary of Terms

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

Ethnic Minority (EM) Group — The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race.

GP Clusters — The collaboration of a group of General Practitioners for the purpose of service improvement.

Health 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 draw together measures relation to health and social care integration. These were developed in partnership with NHS Scotland, COSLA and the third and independent sectors.

Health and Wellbeing Outcomes — The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

Home Care — Help provided directly in the service user's own home. Home carers are people employed to provide direct personal physical, emotional, social or health care and support to service users.

IJB — An Integration Joint Board was established in Dundee to oversee the integrated arrangements and onward service delivery. The Integration Joint Board exercises control over a significant number of functions and a significant amount of resource.

LCPP — Local Community Partnerships a groups of professionals and citizens work in partnership to deliver priorities regarding a geographical area.

Long Term Condition — Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

Natural Neighbourhoods .... 54 small geographical areas where communities live which are aligned to the 8 Local Community Planning Partnership Areas in Dundee

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

Partnership ..... Dundee Health and Social Care Partnership

Post Diagnostic Support ..... The support a person receives following a diagnosis of dementia. In 2010's 'Scotland's National Dementia Strategy', the Scottish Government made a commitment to improving post-diagnostic support for those receiving a diagnosis of dementia. The Scottish Government endorsed a 12 month post-diagnostic support model that used The Five Pillars methodology developed by Alzheimer Scotland, and concluded with a person-centred support plan. The Scottish Government published their third national dementia strategy in 2017 which continues to support the post-diagnostic support entitlement.

Power of Attorney ..... A power of attorney is a document you can use 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 ..... Premature mortality is a measure of unfulfilled life expectancy.

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

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

Self Directed Support ..... Self-directed support (SDS) allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the individual budget spent on their support. In order to achieve this the Scottish Government introduced The Social Care (Self-directed Support) (Scotland) Act 2013. The Act came into force on 01 April 2014 and places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their social care and support.
Self-directed Support includes a range of options to ensure everyone can exercise choice and control:

- a Direct Payment (a cash payment);
- funding allocated to a provider of your choice (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent);
- the council can arrange a service for you; or
- you can choose a mix of these options for different types of support.

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

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

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

Technology Enabled Care ..... Technology Enabled Care (TEC) is the application of technology to support people to self-manage their own health and stay happy, safe and independent in their own homes. It refers to the use of telehealth, telecare and telemedicine in providing care for patients with frailty and / or long term conditions that is convenient, accessible and cost-effective.

Dundee
Health & Social Care
Partnership

If you require this document in alternative formats please email dundeedhscp@dundeecity.gov.uk or telephone 01382 434000.

GET IN TOUCH:

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