Dundee Health and Social Care Partnership

Annual Performance Report

2019 - 2020

Dundee Health & Social Care Partnership

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Foreword

Our Vision

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

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

During 2019-20 we have continued to work with our statutory partners, service users and their families, carers and communities to deliver our ambitious vision and to make real improvements to the lives of people in Dundee. Over the last year we have redesigned our physiotherapy and occupational therapy teams to improve quality, patient outcomes and service accessibility. Our work with the British Red Cross to provide enhanced support at the point of discharge from hospital has helped us to further reduce care home admissions and increase the proportion of people able to continue to live independently in their own homes. We have also increased the capacity of our care and treatment services to support; enhanced management of leg ulcers, wound care, phlebotomy and injections in the community. We have continued to maintain good performance in reducing the number of days Dundee citizens spend in hospital as a result of an emergency (a 13% reduction between 2015-16 and 2019-20), in the Care Inspectorate's grading of services directly provided by the Partnership and in relation to the number of bed days lost to delayed discharge for people aged 75 years and over. Through a significant focus on personalisation of services we have more than doubled the spend on Self-Directed Support Options 1 and 2, with a £5.5 million spend in 2019-20. Whilst this is encouraging progress we recognise that there is still much work to do to further improve our performance in this area. We have also achieved significant reductions in expenditure through improved prescribing practice.

A major focus for the Partnership during 2019-20 has been to listen to the findings of the Dundee Drug Commission and Tayside Mental Health Inquiry. This has included work with Community Planning Partners to reflect on our performance and to identify effective improvement actions, including the development and agreement of the Substance Use Action Plan for Change. We look forward to reporting on our progress in implementing these plans in our annual report for 2020-21.

At the time of publication of this annual report the Partnership, alongside other public, third and private sector organisations, is responding to the unprecedented challenges of the COVID-19 pandemic. Partnership services have been rapidly re-designed to support the health and social care response to people who have been directly impacted by COVID-19, as well as to maintain essential services to individuals and wider communities. Significant work has also been undertaken to support our workforce and unpaid carers and to protect their mental health and wellbeing. Our response to the pandemic will be reported in our next annual performance report.

Trudy McLeay, Chair
Dundee Integration Joint Board

Councillor Ken Lynn, Vice Chair
Dundee Integration Joint Board

1.1 Who We Are

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

In accordance with the **Public Bodies (Joint Working) (Scotland) Act 2014** ('Public Bodies Act'), an Integrated Strategic Planning Group ('ISPG') established by the IJB, developed the Health and Social Care Strategic and Commissioning Plan ('Plan'), which was effective from 1 April 2019.

Our Plan describes our strategic priorities for the next three years and the key actions required to deliver on our ambitious vision for the city. The Plan represents the knowledge we have gained through our ongoing engagement with communities, people who use Health and Social Care services, their families and with carers.

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

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

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

Additionally Dundee, Angus and Perth and Kinross Health and Social Care Partnerships have mutual hosting responsibilities. Hosting arrangements were agreed for highly specialist or area wide services. On behalf of the three Tayside Health and Social Care Partnerships, Dundee hosts and leads the planning and delivery of a number of services such as sexual and reproductive health, specialist palliative care, the Centre for Brain Injury Rehabilitation, medical advisory services and nutrition and dietetic services.

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

The vision of the Partnership is:

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

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

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

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

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

1

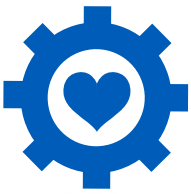
Health Inequalities

2

Early Intervention Prevention

3

Localities and Engaging with Communities



4

Models of Support/ Pathways of Care

Novel Coronavirus (COVID-19)

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

During the latter part of the 2019-20 financial year, the pattern of service delivery changed and emergency and crisis responses were implemented.

The safety and wellbeing of local citizens and our workforce guided all decision making. This was supported by the emergency legislation, including the Coronavirus (Scotland) Act 2020, and by local Resilience and Mobilisation Plans which allowed us to continue to support people who use our services and their carers. Arrangements were put in place to allow the introduction of services without an assessment and colleagues worked innovatively to provide care and support in dynamic and responsive ways.

At the time of drafting this report, the pandemic is still present and an immunisation plan is not imminent. This means that service delivery is not how we intended it to be when agreeing our Strategic and Commissioning Plan. Our responses are focused on remobilisation and we foresee that there will be an increased rehabilitative requirement placed on our workforce for the foreseeable future.

It is impossible to fully predict the trajectory of the pandemic and any subsequent waves of prevalence, however we are using all national and local statistical modelling to assist us to plan services and supports. We are seeking and developing ways to engage with stakeholders including service users and carers that will support co-production which has been significantly hampered latterly.

The content of this report focusses on services provided up until the emergency response was implemented.

Whilst we always look to the future, identify areas for improvement and priority areas for the following year this is currently evolving and developing as we respond tactically and receptively to the current situation.

1.1 How We Measure Our Performance

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

During 2019-20 the Performance and Audit Committee (PAC) of the Integration Joint Board (IJB) continued to scrutinise the performance of the Partnership in achieving it's 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. https://www.dundeehscp.com/publications.

The PAC has requested additional analytical reports in areas where performance has been poor, such as readmissions, complex delayed discharges and falls, to support an improved understanding of underlying challenges and the development of more detailed improvement plans. The PAC has also received an in-depth report analysing variations in performance across the eight Local Community Planning Partnerships (LCPPs) in Dundee; this report is the first stage in a longer process to help the Partnership better understand variations in performance by locality.

The PAC also received a Performance Report from Dundee Carers Partnership.

Over the last 12 months 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.

Clinical Care and Professional Governance (CCPG) is an important aspect of our work to improve the wellbeing of people and communities by ensuring the safety and quality of Health and Social Care services. The Framework for CCPG within integrated services is set out in the agreed framework – Getting It Right for Everyone: Clinical, Care and Professional Governance Framework. CCPG relies on all of these elements being brought together through robust reporting and escalation processes using a risk management approach to ensure person-centred, safe and effective patient care.

We recognise that our commitment to continuous improvements means that further work will be required during 2020-21 to build on and strengthen the self-evaluation, quality assurance, performance monitoring and clinical care and professional governance arrangements that are already in place. A key priority over the next 12 months will be to ensure enhanced collation, analysis and reporting of information at a locality and neighbourhood level.

The Partnership has been part of and has contributed to the statutory Best Value Self Evaluation which was conducted during 2019. The Accounts Commission is the public spending watchdog for Local Authorities and is responsible for assessing Best Value.

The self-evaluation has been compiled by assessing the Council against the criteria contained in the eight Best Value themes:

- Vision and Leadership
- Governance and Accountability
- Use of Resources
- Partnerships and Collaborative Working
- Community Responsiveness
- Sustainability
- Fairness and Equality
- Performance, Improvement and Outcomes

In order to continually assess performance against these themes, they have been cross referenced throughout the 'Our Performance' section of this report.

1.2 How We Deliver Services In Communities

The 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 it's communities and the people it supports. There are eight Local Community Planning Partnership (LCPP) areas with established communication and development plans and regular meetings between community representatives and statutory services. The Partnership is an active partner in Local Community Planning Partnerships.

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

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

The eight LCPPs are made up of 54 natural neighbourhoods. Unlike rural areas, where a sense of community can be linked to a whole village or small town, the nature of Dundee's communities can mean that the natural neighbourhoods that sit within the LCPP areas often have differing demographic, health and socio-economic profiles. This has been highlighted throughout this report as part of the 'How We Performed' 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.

1.3 How We Promote Equalities and Human Rights

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

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

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

The Partnership's existing equality outcomes were reviewed to reflect the desired outcomes of people with Protected Characteristics and those affected by poverty. The outcomes were aligned with the revised outcomes published by Dundee City Council and NHS Tayside in 2017. This resulted in the publication of our Equality Outcomes and Mainstreaming Framework 2019-2022. (**https://www.dundeehscp.com/sites/default/files/publications/mainsteam_report_and_equality_outcomes-_2019-**).

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

1.4 How We Engage and Communicate with Our Stakeholders

We continue to work in partnership across the city and nationally. We maintain our commitment to understanding the needs of individuals, families and carers in different geographic communities and communities of interest in Dundee. We recognise that meaningful engagement and participation requires us to take account of 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".**

In December 2019 the IJB approved our new Participation and Engagement Strategy.

Our new Strategy recognises that engagement is better done in partnership, taking advantage of expertise, resources and relationships which exist across our communities to best listen to those who need and make use of our services and supports.

Our Strategy was reviewed and adapted by the Communication and Engagement subgroup – a group made up of representatives from across the Partnership, NHS Tayside, Dundee City Council and the Third Sector Interface.

The reviewed Strategy is not intended to be a comprehensive action plan for all of our engagement work. Rather it sets the broad principles by which we will engage with patients, service users, their families and carers and our staff. The Strategy has been designed in an accessible way to ensure it can be understood and be relevant to all those with whom we wish to engage. As a result of the new Strategy we have begun work to develop an online resource for our workforce to support them in engagement work. This will provide a base for new information of how best to support co-production within infection control restrictions.

Our services continue to engage directly with individuals and their carers to improve service delivery. We use a range of engagement methods including surveys, customer questionnaires, education/information sessions, face-to-face feedback and interviews.

We continue with actions identified though our self-assessment against The Coalition of Carers in Scotland Best Practice Standards for Community Engagement and completed a second round of self-assessment. We have applied our learning from this exercise to support other stakeholder representatives who are part of our decision making processes. We have continued active involvement of carer and patient representatives on the IJB.

Our Strategic Planning Groups (SPG) continue to maintain and improve their engagement with a wide range of stakeholders and are committed to putting people at the heart of decision making. For example, the Strategic Planning Group for people with a Learning Disability and Autism supports Advocating Together which employs adults with a Learning Disability and/or Autism. Work has progressed in relation to the Charter for Involvement in Dundee.

(**https://arcscotland.org.uk/involvement/charter-for-involvement/**).

Colleagues from the charity ARC support the Dundee Involvement Network and the Learning Disability Providers Forum. The Network gives people who get support in Dundee a chance to share ideas and experiences and consider how they can influence their supports and services; the Forum includes local providers, third sector and direct provision from HSCP and is a vehicle for providers to keep up to date, share good practice and raise matters through the Learning Disability SPG.

On 22 October 2019 a 'Your Keys To Life in Dundee' event was hosted by the Partnership with the aim of informing and consulting with people with a learning disability and/or autism and their carers and family members. The event was attended by about 230 people in total, around 100 of whom were identified as having a learning disability or autism. There were 30 stallholders with a range of information about keeping healthy and also information about services and supports.

This event was seen as part of an ongoing dialogue with people and stakeholders which has shaped direction and progress. Those who attended were given a chance to learn about supports and services they use or might use; and to share their views about what they thought was important for their future.

Feedback at the end of the Keys to Life in Dundee Event October 2019:

A four week 'Carers of Dundee' marketing campaign began in late May 2019 leading up to an open-air event in Slessor Gardens on 15th June. The event and other work raised awareness about carers in Dundee and promoted collaboration in supporting carers. During the campaign all traffic increased through the Carers of Dundee website and Carers of Dundee social media with a 59% increase in direct traffic to the website and a 17% increase in followers across Carers of Dundee social media platforms. 14 agencies/organisations exhibited at the event and approximately 600 people visited the marquee.

Our Mental Health Strategic Planning and Commissioning Group continues to keep people with lived experience at the centre of decision making as we co-produce plans and redesign services and supports to better meet community and individual needs. Strong relationships with a range of local groups and networks including Dundee Healthy Minds Network, Making Recovery Real Network, Faith in Communities, and community based health issue groups ensure that channels are open for both ongoing and project specific dialogue.

A recommendation from the Dundee Drug Commission's report was that there needs to be meaningful involvement of people who experience problems with drugs, their families and advocates. In response to this the Alcohol and Drug Partnership sought to find out how people with lived experience would like to be involved in decision making and improving services and what would be meaningful to them. There was an event held during October 2019 to explore how the community and services can work

together in a real way to make change and break down barriers people face. The ADP did not seek to prescribe how they were going to involve people with lived experience within the ADP, but to be as co-productive as possible. This resulted in a report that was used to make initial recommendations regarding meaningful involvement of individuals with lived experience for the Dundee Partnership Action Plan for Change.
Two of the actions approved within the Dundee Action Plan for Change in relation to engaging and communicating are;

- Establish a Lived Experience Quality Group to ensure that involvement of people with lived experience is embedded effectively and meaningfully across the ADP structure and the wider delivery of support.
- Support the delivery of two development sessions, each year to bring together people who use supports, families and service providers to share information and test out progress.

We continue to work closely with our Community Planning colleagues as part of the Community Learning and Development (CLD) Strategy Group and have further developed and agreed the Framework for Community Engagement in order to:

- Ensure a consistency of approach across the Partnership.
- Improve the quality of Engagement activity across the Partnership
- Provide an assurance mechanism for the Partnership about the quality of engagement taking place.

The CLD Strategy Group is developing an on-line resource to allow all members of the Partnership to record and share engagement activity. This will help the Partnership to listen better to individuals and communities, will help avoid duplication and "consultation fatigue" and will assist with audit and performance management of our engagement activity. We will continue to work with partners to develop this approach further during 2019-20.

As part of our commitment to our equality outcome that 'We will give people information about our supports, services and plans in a way that they can access it and understand it.' We have completed, published and disseminated a summary version of our Strategic and Commissioning Plan.

https://www.dundeehscp.com/sites/default/files/publications/dhscp_strategic_plan_2019_summary.pdf

Following the annual review of the Short Breaks Services Statement the Dundee Carers Partnership made plans in early 2020 to progress further carer involvement to seek views on how this information could be presented in accessible ways.

https://www.dundeehscp.com/sites/default/files/publications/short_breaks_services_statement_dundee.pdf.

The MyLife Portal for Dundee was discontinued and the information held about services and supports was transferred to ALISS https://www.aliss.org/. We have been contributing to discussions about Scotland's National Directory which is currently focussing on NHS services and will work in conjunction with ALISS. We will be further informed by pilot work being carried out in other NHS Board and HSCP areas.

2 OUR RESOURCES

2.1 Where Our Resources Come From

The Partnership's 2019-20 integrated budget for adult Health and Social Care services was confirmed at the IJB's meeting held in June 2019. 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 budget settlement from Dundee City Council for 2019-20 included an uplift for inflation of £1,958k and additional funding from the Scottish Government of £4,387k for the implementation of new legislative and other national policy requirements and financial commitments, including further implementation of the Carers Act, the introduction of free personal care for under 65s, further payment of the living wage, and increases in free personal and nursing care payments. The Scottish Government subsequently provided local authorities with the flexibility to reduce allocations to integration authorities by up to 2.2% of their allocation in setting their 2019-20 budgets. Dundee City Council applied this flexibility and reduced the funding provided by £2,971k resulting in a net increase in the Integration Joint Boards budget of £3,374k.

The NHS budget settlement included an uplift passed on directly from the Scottish Government of 2.6% to fund general increases in expenditure. However, a number of legacy funding issues within the budget such as prescribing and Dundee's share of the In-Patient Mental Health Service hosted by Perth and Kinross needed to be addressed within the budget process.

In addition to the budget settlements from Dundee City Council and NHS Tayside, additional Scottish Government ring fenced funding was provided during the year to support national initiatives for Primary Care Improvement, Mental Health Action 15 and Alcohol and Drug Partnerships.

Set within this financial context are services which face increasing levels of demand to support vulnerable people in Dundee. This includes the demographic impact of an increasingly frail population, prevalence levels of people with a disability, mental health and substance misuse problems and levels of demand for GP prescribing. The culmination of these factors resulted in a projected budget shortfall of £5.936m

in resources in the Health and Social Care Partnership's 2019-20 budget at the budget setting stage. The IJB considered and agreed to a range of savings and interventions which would be applied throughout the year in order to balance the budget, however entered the financial year with unidentified savings of £546k.

This section of the report sets out how the Health and Social Care Partnership performed in relation to these challenges throughout 2019-20.

2.2 How We Have Used Our Resources

This section links to

National Health and Wellbeing Outcome 9: Resources are used effectively and efficiently in the provision of Health and Social Care services.

and

Dundee City Council Best Value Theme - Use of Resources

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

With the backdrop of a significantly challenging overall financial settlement as noted in section 2.2, Dundee IJB received regular financial monitoring information throughout 2019-20 which continued to highlight the range of pressure areas and services which were likely to over or underspend throughout the financial year. These overspend areas included the continued challenges of meeting the demographic demands of an increasingly frail population, reducing delayed hospital stays resulting in further investment in community based Health and Social Care services and the impact of pressures in the mental health inpatient service. GP and other prescribing expenditure performance improved significantly during 2019-20 to move from being one of the Partnership's main expenditure pressure areas to an underspend position due to a range of prescribing efficiency measures.

The overall financial performance consisted of an underlying overspend of £6,037k in Social Care budgets (overspend of £3,360k in 2018-19) and an underlying underspend of £266k in NHS budgets (underspend of £1,836k in 2018-19) resulting in a net deficit of £5,771k before the application of the risk share agreement of £3,063k and ring-fence funding of £434k. 2019-20 saw the first year of a change to the financial risk sharing arrangement set out within the Dundee Health and Social Care Integration Scheme whereby in the event of an overspend within the delegated budget, after the application of a financial recovery plan and use of IJB reserves, the overspend will be allocated based on each Parties' proportionate contribution to the IJB's budget for that financial year on a like for like basis. Under this arrangement, NHS Tayside became liable to make a further contribution of £2,042k and Dundee City Council liable to make a further contribution of £1,021k giving a total additional funding of £3,063k. This resulted in a net £2,274k overspend for the IJB or 0.8% variance against available funding.

The actual expenditure profile for integrated Health and Social Care services for 2019-20 is shown in the table below:

Service Type	2019-20 Net Expenditure/ (Income) £000	2018-19 Net Expenditure/ (Income) £000	Increase/ (Decrease) £000
Older People's Services	78,086	71,019	7,067
Mental Health	21,062	18,447	2,615
Learning Disability	35,448	33,186	2,262
Physical Disability	8,672	9,680	(1,008)
Substance Misuse	5,256	4,330	926
Community Nurse Services/ AHP*/Other Adult	15,128	13,089	2,039
Community Services (Hosted)	10,776	11,463	(687)
Other Dundee Services/Support/ Management	4,875	7,314	(2,439)
Prescribing	32,406	33,620	(1,214)
General Medical Services (FHS**)	26,687	25,110	1,577
FHS - Cash limited & Non Cash limited	19,216	18,083	1,133
Total of Costs Reported during 2019-20	**257,611**	**245,341**	**12,270**
IJB Operational Costs	294	287	7
Acute Large Hospital Set Aside	18,172	17,449	723
Total Cost of Services	**276,077**	**263,077**	**13,000**
Delegated Budget*	(273,803)	(261,283)	(12,520)
Deficit on Provision of Services	**2,274**	**1,794**	**480**

*Adjusted for additional risk sharing contributions from Dundee City Council and NHS Tayside to the value of £3,063k

All above figures subject to change following completion of the audit of the accounts. Final audited accounts will be available at the end of November 2020.

The summary of this financial performance is shown below:

Financial Performance Summary

	2016-17	2017-18	2018-19	2019-20
Total Spend	£254.5M	£257.5M	£263.1M	£276,10M
Health Service - Hospital In-patient	£44.7M	£40.4M	£42.1M	£43.6M
Other Social Care Services	£64.4M	£71.1M	£72.6M	£76.4M
Other Health Care Services	£116.2M	£115.2M	£117.5M	£123.2M
Care Home and Adult Placement Social Care Services	£28.0M	£29.5M	£29.5M	£31.5M
Supporting Unpaid Carers	£1.2M	£1.3M	£1.4M	£1.4M

You can read more about our financial performance in our Unaudited Annual Accounts 2019-20 with the Audited Accounts available at the end of November 2020.

Reserves:

The IJB utilised some of its reserves in supporting service redesign during 2019-20 in addition to requiring to contribute uncommitted reserves to the underlying overspend position under the terms of the risk sharing agreement with NHS Tayside and Dundee City Council. This resulted in a shift in the reserves position from £2,766k at the start of the year to £492k at the end of the year. This balance all relates to ring fenced funding which will be invested in the purposes for which they were intended during 2020-21 (i.e. Primary Care Improvement Plan, Mental Health Action Plan and Alcohol and Drug Partnership Funding).

Shifts in Resources:

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

3 OUR PERFORMANCE

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

The National Health & Wellbeing Indicators 1-9 are reported from The Health & Care Experience Survey administered by the Scottish Government. A sample of Dundee citizens aged 18 and over were asked nine questions relating to their health and the care and support they receive. The last survey was held 2017-18.

Rolling data from April 2019 to March 2020 is used to measure performance against targets set in Measuring Performance Under Integration (MPUI) for four high level service delivery areas – emergency admissions, emergency bed days, accident and emergency and delayed discharges.

A sample of Dundee citizens aged 16 and over participated in the Dundee City Council's 2019 Citizens' Survey to establish 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. Full results from the 2019 survey can be found on the Dundee City Council website.

You can find more detail about how well we are performing against the 23 national Health and Wellbeing Indicators in our 2019-20 quarterly performance reports on our website.

Working in Localities – People are able to access the care, support or treatment that they need within their local community.

Working in Localities links to:

- All four of the Partnership Strategic Priorities
- All seven of the Dundee City Council Best Value Themes

Work is progressing to realign the delivery of statutory services against the four service delivery areas. Aspects of this work are being co-ordinated across Tayside, while other areas are being developed locally to ensure that services develop to meet the needs of local communities.

What we have achieved to deliver this outcome

- Dundee Carers Centre Caring Places has progressed a locality approach to supporting carers. The successful development of the locality approach for support for carers in Coldside and Strathmartine has been mirrored in all 8 LCPP areas. Carers of all ages and their families have embraced this model of support, and local organisations working in these communities also report a greater confidence in identifying and supporting carers who access their facilities and services. This has led to increasing the number of carers of all ages identified and supported within the local communities across Dundee. Dundee Carers Centre continues to have a town centre base where carers can drop in, meet and attend activities. Each local team has bases where they can meet carers informally in the local community and has a good knowledge of the informal community supports available in their area. The teams are establishing strong networks with colleagues from other specialisms , carers , volunteers and other agencies operating in their area. It is anticipated that this will bring an increase in expertise and understanding and facilitate co-production of local responses to local concerns.
- The Crescent shows how services to tackle social and health inequalities in one of Scotland's most deprived housing estates were integrated, in a way which also supports the physical regeneration of the estate and engages with local people. Aims include improved social and health outcomes and an increase in public and private sector house building to continue the regeneration of the area. Within the Crescent there is a Medical Practice, out-patient clinics as well as a library and community services.
- We are progressing with options for same-day prescribing from substance misuse services; moving to deliver services form different localities within Dundee and to increase the prescribing capacity.
- During 2019-20, there continued to be a focus on establishing a sustainable Independent Living Service which enables citizens of Dundee to live a healthy and independent fulfilled life. To achieve this operational leadership has been strengthened by establishing integrated leadership roles to enable effective leadership of change and redesign. Alongside this, Physiotherapy and Occupational Therapy Services have been realigned to create a locality focus. The services provide assessment, diagnosis and rehabilitation across in-patient, out-patient and community settings and work across a wide range of pathways supporting person centered care.
- We have made significant progress with the implementation of all 7 aspects of the Primary Care Improvement Plan, despite a number of ongoing challenges. The tests of change which were started in 19-20 have been scaled up across most of the services being developed. These will continue to develop in 20-21 as we recruit and identify suitable space, refining the models as this happens.

- The Primary Care Improvement Plan has led to the development of a First Contact Physiotherapy Service with Physiotherapists seeing patients in place of a GP for musculoskeletal conditions.
- Significant improvements were achieved during the redesign and development of Physiotherapy and Occupational Therapy Teams in order to improve quality, patient outcomes, person centered care and access to services. This service has been a front runner in the use of technology to improve access to services.
- Increased the capacity of care and treatment services to support the care of all individuals with leg ulcers whose care can be managed in a community setting, with the benefits this brings of improved healing rates. Workforce roles have been expanded to provide patients with wound care phlebotomy and injections from this team.
- The newly developed pharmacotherapy service delivery was successfully rolled out across all medical practices, and additional components are being developed as capacity in the locality pharmacy team allows.
- The redevelopment of Lochee Health Centre was completed to create an integrated space for both the practice and a wide range of teams who work to care for those in the local community. The new building includes a community kitchen which can be used by groups to support cooking skills and healthy eating.

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

Outcome 1 links to:

All four of the Partnership Strategic Priorities

Dundee City Council Best Value Themes - Fairness and Equality, Sustainability, Community Responsiveness, Partnership and Collaborative Working

Local data provides strong evidence of the high levels of deprivation in Dundee. **55,840 (37.5%)** people in Dundee City live in a datazone within the 20% most deprived in Scotland (Scottish Index of Multiple Deprivation 2020). Evidence across a range of issues such as attainment, health, mental health and substance misuse highlights a strong correlation between poverty and poorer life outcomes. A 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. Looking after their own health may be more difficult for people with long term conditions including mental illness and disabilities. The combined effects of these are evidenced by the increased demand and usage of Health and Social Care services.

How We Performed

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

Health & Social Care Experience Survey 2017/18

93% very/quite well — **Dundee**

93% very/quite well — **Scotland**

"How good is your health overall?"

Dundee Citizens Survey 2019

77% very/fairly good

The Dundee City Council's Citizens Survey is completed annually. There was a drop in the % of people who reported that their overall health is very or fairly good from 83% in 2018 to 77% in 2019.

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

Despite Dundee citizens giving a positive response to how good their health is and being able to look after their own health, emergency admission rates are high. This means that per head of the population a large number of people aged 18 and over are being admitted to an acute hospital in Dundee as an emergency. In 2019 for every 1000 people in Dundee who were aged 18 and over, there were 125 emergency admissions. (Source Public Health Scotland) This is slightly lower than the Scottish rate and was the 16th poorest performing Partnership in Scotland, out of all 32 Partnerships.

Emergency admission rates vary across the city. The highest emergency admission rate was in East End (173 admissions per 1000 people) and the lowest rate was in West End (84 admissions per 1000 people). There is also high variation between the neighbourhoods within each LCPP. (Source: NHS Tayside)
An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on our website.

During 2019 emergency admission performance was slightly better in Dundee than across Scotland and Dundee was the 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. The table below shows that the number of people who received Self Directed Support options 1 and 2 has increased in 2019-20. The amount spent on delivering services and supports under options 1 and 2 increased considerably from just over £1M in 2015-16 to £5.5M in 2019-20.

Self Directed Support – Options 1 and 2

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

Since the implementation of the Social Care - Self-Directed Support (Scotland) Act 2013 the number of packages of care for people opting for Options 1 and 2 has increased year on year. Over the last year there has been an increase in spend of 3% for Option 1 and 236% for Option 2.

Dundee has a high number of people with dementia. During 2018, dementia was the cause of death for 834 males (4.8% of all deaths) and 887 females (8.8% of all male deaths and was the leading cause of death for women in Dundee (15.4% of all female deaths). Health and Social Care employees work hard to ensure that people with dementia are identified and supported as early as possible. Post-diagnostic support, provided over an extended period is essential for equipping people with dementia, their families and their carers, with the tools, connections, resources and plans they need to live as well as possible and prepare for the future. Everyone diagnosed with dementia is entitled to receive at least 12 months of post diagnostic support. 324 people were referred for post diagnostic support during 2019-20, which was 100% of new diagnoses.

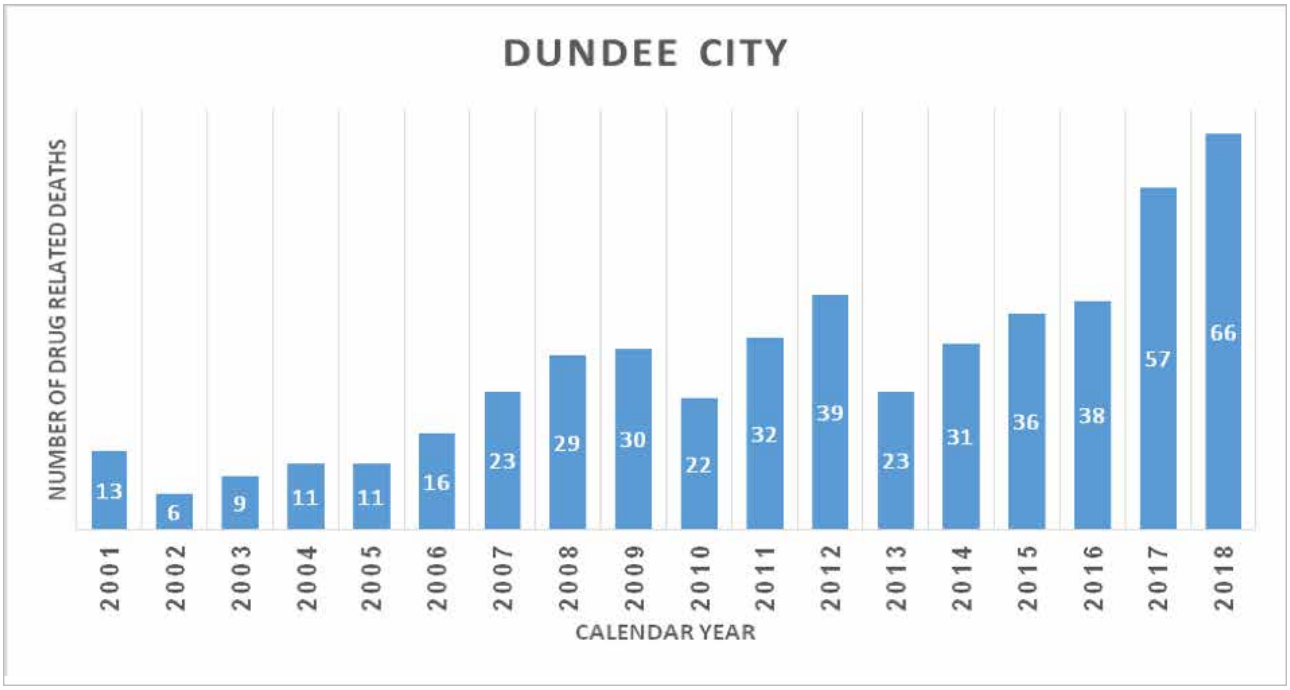
Alcohol-specific death rates are disproportionately higher in areas of socioeconomic deprivation. In Dundee, individuals living in areas of deprivation are 2.4 times more likely to die with an alcohol-specific diagnosis compared to their less deprived counterparts. Overall rates of alcohol-related deaths are still much higher than those seen in the early 1980s, and the Scottish rates are much higher than those seen in England and Wales.

Scotland has the highest rates of drug-related deaths per million of population in Europe. Significant efforts have been made in Scotland to understand these deaths, including the development of local processes to investigate the nature, health and social circumstances of all individuals who have died due to their drug misuse.

Over the period 2014 – 18, for Scotland as a whole, the average of 862 drug related deaths per year represented a death rate of 0.16 per 1,000 of population. In Dundee, the number of drug deaths have been rising almost every year since 2001 to an average of 46 deaths per year for the period of 2014-18. This represents a death rate of 0.31 per 1,000 of population – the highest rate of all Local Authorities in Scotland.

A drug death is a death that has occurred from the presumed non-intentional overdose of illicit (or illicitly obtained) controlled substances in Tayside. In 2018 there were 66 drug deaths in Dundee. The highest number of deaths was in the 35-44 age group.

Number of Drug Deaths in Dundee 2001 – 2018



What we have achieved to deliver this outcome

- During 2019 there was further development of the Post Diagnostic Support (PDS) service which included; further integrated working, achieving national targets and introduction of Cognitive Stimulation. Therapy Group work was introduced as a way of meeting increased demand for PDS. An additional social work post was created to further develop integrated working and team profile, knowledge and skills. More senior staff have been trained as Dementia Specialist Improvement Leads.

It is recognised that people value a range of service delivery options and the service continues with an open referral system where service users and their carers can approach the service directly. In addition. Information leaflets for service users and carers are regularly reviewed to ensure they are accessible to everyone.

I feel that I can express myself again. I feel that my opinions are still valued and are relevant. I really enjoyed myself.

feedback regarding the PDS Cognitive Stimulation Therapy group

The PDS team was invited by 'Focus on Dementia' to share their learning and experience of running the Cognitive Stimulation Therapy group at a national event in February 2020.

- The Psychiatry of Old Age Care Home Team is made up of general nurses, including advanced nurse practitioners (ANP), mental health nurses and social work review officers. Their role is to enhance the quality of care provided to people in care homes and to support the care home residents, families and staff. One of the roles of the team is to advance discussions regarding Anticipatory Care Planning to ensure people receive the correct and chosen care at the end of their life. Over the last year there has been an increase in the preparation of Anticipatory Care Plans in care homes.

During routine visits to a care home it was identified that one resident was deteriorating and had no Anticipatory Care Plan (ACP) in place. The ANP asked the care home to discuss this with the family and a meeting was arranged. The meeting did not involve the resident due to capacity issues but the family held Power of Attorney and felt they could express past and present wishes. At the meeting the ANP provided information regarding the person's health and likely progressions in a sensitive manner. An Anticipatory Care Plan was implemented with the aim that the person remained in the care home setting where they had lived for a number of years. The resident was able to end their life in a pain free, dignified way in their home without having to be moved to an acute hospital setting. The family and care home staff were grateful for this support.

This team has also developed their service to further support people in need of urgent care. Nurses within the team now respond to urgent care visits in Care Homes on behalf of GPs. This model of working has been deemed a success and will be rolled out further in the coming year.

We felt we were delivering good end of life care, but having the Care Home Team support when a resident is deteriorating actually helps us realise we are doing all we can to keep the resident comfortable

The Psychiatry of Old Age Care Home Team was a finalist in the 'Silo Busting' category at the SSSC Awards 2019.

- Dundee's Enhanced Community Support Acute unit (DESCA) was set up in 2018 to provide acute support to people who experience a downturn in their health. With prompt and appropriate personalised care support some older people can avoid hospital admission and be successfully treated at home by intense and specialist services from medicine for the elderly senior consultants and medical colleagues. There are many advantages of people remaining at home including shorter recovery times and reduction of risk of hospital acquired infections. The service also provides valuable support to people on their discharge from hospital, reducing their length of stay and enhancing their recovery.
- During 2019 there have been significant developments to support those who are acutely unwell and cannot attend their Medical Practice and alternative models to GP home visits are being developed.

  For those residents in a care home who are acutely unwell, an advanced nurse practitioner may now visit them. They can complete a holistic assessment and put a management plan in place. The nurses are part of the wider integrated care home team and so they have a close relationship with both the workforce and patients in the care homes they are working with. The initial test of change has been with 2 practices and the 8 care homes associated with those practices. Once additional practitioners are recruited this will roll out to other practices and homes.
- The Community Listening Service (CLS) provides spiritual care within GP surgeries and can be accessed by all patients in Dundee. 17 of the 23 GP surgeries have an assigned Listener who provides appointments within the surgery itself; others have access to Listeners in neighbouring surgeries or to ad hoc appointments with CLS staff as an interim until a Listener is assigned. In 2019, there were around 1,800 available appointments across Dundee. Over 1,300 of these appointments were taken, with DNAs and cancellations at around 35%. In total, around 800 Listening Service appointments were attended. These appointments were conducted by 17 volunteer Listeners, and managed by one staff co-ordinator.

I was glad I went to chat with [listener]. She listened to me and made me understand and choose how to deal with problems I am having. I am able to move forward and try to deal with things head on.

Quote from person who used the CL service

A Patient Reported Outcome Measure (PROM) capturing the elements of spiritual care was developed in Scotland and has been used to evaluate CLS in recent years. When asked whether they felt they were listened to, were able to talk about what was on their mind, were understood, and if their faith/beliefs were valued, 91% of respondents indicated that they felt this was the case 'All of the time' (Tayside PROM study, 2019 (unpublished)). The free text responses revealed common themes of relief, perspective, hope and gratitude.

Telephone listening appointments have been made available during the COVID 19 pandemic and have helped people who were considered housebound due to poor physical or mental health, people dealing with long-term physical conditions including chronic pain, people returning home from hospital stays and also care home residents.

- An inaugural conference designed to raise awareness and educate adults with a learning disability and their carers about available health screening services and the importance of getting screened to help people take good care of themselves took place in April 2019.

The event was planned and co-ordinated by a multi-agency team including Public Health, local advocacy services and practitioners from the Partnership Learning Disability Service. The event was designed to be fun and interactive, with delegates enjoying performances by Inform Theatre, a drama group for adults with a learning disability and being encouraged to explore resources and ask questions of health care professionals involved in delivering Breast Screening, Cervical Screening and Bowel Screening. The event attracted a large number of delegates who provided positive feedback on the day and it is hoped that this will be repeated bi-annually.

- The Dundee Alcohol & Drugs Partnership, as well as front-line services and individuals with lived experience across the city provided evidence and supported the work of the Independent Drug Commission that was set up in April 2018. The Dundee Drug Commission Report "Responding to Drug Use with Kindness, Compassion and Hope" was published in August 2019. The report provided 16 recommendations for changes that focused on issues relating to leadership, stigma, treatment and support, drug related deaths, the protection of children and young people and mental health. The recommendations were presented under three headings, including:
    - Culture and systems
    - A holistic system model – including integrated Primary Care Provision
    - Causes and effects of drug use

The agency Dundee Action Plan for Change was approved by the IJB in December 2019. Some key achievements of the Action Plan to date include;

- A governance review of the ADP was carried out and now there is a revised governance structure of the ADP. The ADP has taken a leading role in developing, progressing and monitoring the actions for change. An ADP Implementation Group has been set up to replace the current Alcohol and Drug Strategic Planning Group. Five work-streams have been established and are now leading on specific elements of the development and progress of the plan for change. The work-streams include Substance Harm Immediate Reponses, Whole System of Care, Children and Families, Prevention and the Resilient Communities.
- A test of change was carried out for the development of the Non-Fatal Overdose Pathway. This was a success and is now business as usual with a multi-agency team offering person-centered support within 72 hours to those who have experienced a non-fatal drug overdose.
- There has been an increase in assertive outreach – including a test of change through the Integrated Substance Misuse Service to follow up with people who disengage.
- Same-day prescribing and direct access clinics have been implemented by Integrated Substance Misuse Services. ISMS have started moving towards delivering services from different localities within Dundee to increase the prescribing capacity.
- Dundee has volunteered to be an early adopter of the Scottish Government pilot to develop a joint mental health and substance misuse approach.

- Three new non-medical prescribing (NMP) trainee nurses have been placed within Children & Families Teams.
- Dundee has been working towards implementing trauma informed approaches, targeting those at increased risk of substance use / and death. A trauma informed leadership test of change was launched in Dundee. Training was delivered to the Chief Officers Group which included utilising Trauma Lived-Experience of the workforce. More dates are to follow in 2020. A front-line workforce mapping was also carried out and a Trauma Training Framework is under development.
- To ensure Gendered Approaches are considered in all activities and accommodated in design and delivery of services this has been embedded into the Dundee Action Plan for change.

There will be ongoing challenges to deliver on the Dundee Action Plan for Change, especially with the outbreak of the Covid 19 pandemic. However, the ADP remain committed to progressing this work as much as possible given the current climate. You can find the Dundee Drug Commission report and the Dundee Action Plan for Change on the Dundee City Council website or click **here**.

- The Community Health Team delivered it's training programme consisting of Mind Yer Heid+, Poverty Sensitive Practice and Substance Use, Stigma and Supporting Recovery, with 116 participants across 13 sessions. Options are being explored for online delivery to include new material on the impact of Covid-19 on health inequalities.
  The Recovery Friendly Dundee initiative led by the Community Health Team is now part of the Alcohol and Drug Partnership's Resilient Communities workgroup to align actions with the Dundee Partnership Action Plan for Change. With support from Figure 8 Consultancy, Recovery Friendly Dundee has undertaken two public surveys to identify priority actions and guide its work going forward. The first survey received 219 responses and the second is still open. Further engagement will explore the findings from both surveys and develop actions within local communities that will help remove stigma and support recovery for the benefit of everyone in Dundee.

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.

Outcome 2 links to:

the Partnership Strategic Priorities: Health Inequalities (Strategic Priority 1), Early Intervention / Prevention (Strategic Priority 2), Locality Working and Engaging with Communities (Strategic Priority 3), Models of Support / Pathways of Care (Strategic Priority 4)

Dundee City Council Best Value Themes - Fairness and Equality, Sustainability, Community Responsiveness, Partnership and Collaborative Working

Local people tell us 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 We Performed

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

Health & Social Care Experience Survey 2017/18

Dundee has a high rate of readmissions to hospital, where the patient had been discharged within the last 28 days. In 2019 12.7% of people discharged from hospital following an emergency admission, were readmitted within 28 days. Dundee has the highest 28 day readmission rate in Scotland. (Source: Public Health 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 2019-20, for every 100 people aged 75 and over, 44.3 bed days were lost due to a delayed discharge. This is a deterioration on the 2018-19 figure, when there were 37.2 bed days lost for every 100 people aged 75 and over. In 2019-20 Dundee was the 9th best performing Partnership in Scotland. (Source: Public Health Scotland)

There is variation between the number of bed days lost to a delayed discharge across LCPPs. People aged 75 and over who live in West End LCPP contribute to the largest rate of delayed discharge bed days for all reasons. For every 100 people aged 75 and over living in West End there were 67 bed days lost in 2019-20, which is more than double the rate in North East. The lowest delayed discharge bed day rate was in North East where for every 100 people aged 75 and over there were 21 delayed discharge bed days used in 2019-20. (Source: NHS Tayside)

There are a number of preventative and rehabilitative supports available in the community, one measure is the extent to which the partnership is maintaining people with long term care needs in the community. Care at Home is one of the most important services available to Partnerships to support people with community care needs to remain at home. This indicator measures the number of adults who are 65+ receiving care at home as a percentage of total number adults needing long term care. Using the most recent national data available for 2018, 58.6% of people in Dundee aged 65 and over with long term care needs were receiving personal care at home. This is slightly lower than the Scottish figure of 62.1%.

Despite many Dundee citizens feeling that they were supported to live as independently as possible and preventative and rehabilitative services and supports being delivered in the community, emergency bed day rates for people aged 18 and over remain higher than most other Partnerships. Dundee has a high rate of emergency occupied bed days for all hospital specialties – acute and mental health, although there has been a substantial reduction (7.7%) between 2018-19 and 2019-20. (Source: NHS Tayside Provisional Data) This is a positive change, meaning that, on average, for every 100 people in Dundee 116 bed days were occupied during 2019-20, compared with 125 bed days occupied in 2018-19. Despite this improvement, during calendar year 2019, Dundee performed more poorly than the Scottish average and was the 11th poorest performing Partnership in Scotland, out of all 32 Partnerships. Whilst performance in Dundee is poorer than the Scottish average, when assessment is made alongside the other 'family group' Partnerships performance is more positive. five Partnerships performed more poorly than Dundee and 3 Partnerships performed better than Dundee.

Emergency bed day rates vary across the city. The highest emergency bed day rate was in Lochee (154 bed days occupied per 100 people) and the lowest rate was in West End (78 bed days occupied per 100 people). There is also high variation between neighbourhoods within each of these LCPPs. An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on our website.

What we have achieved to deliver this outcome

- A Contract Tendering Exercise was undertaken with the specific aim of increasing the range of provision options for older people with support needs, both in terms of the providers delivering these supports and the types of service they provide. This led to the development of a multi-provider framework approach to meeting a range of care and support needs, namely personal care/social care, housing support and respite/short breaks. The number of providers was increased from 10 on the previous framework to 24, with the new framework commencing on 3 June 2019. The previous framework was for the delivery of care at home only so the new framework enables a single provider to deliver a range of services that will all contribute to meeting the supported person's identified outcomes.
- The range of intermediate care options has been extended and there are now 6 step down flats across 3 different providers, as well as a test of change which has introduced a capacity for 3 people to move to step down accommodation in the substance misuse discharge pathway in partnership with Dundee Survival Group. This 'step down' option enables people to be discharged from hospital to a supported environment when they are assessed as being medically fit to do so. Individuals can then continue their rehabilitation and ongoing assessment with support from an on-site care team. The flat can also be used to enable 'step up', where there has been a deterioration in an individual's health which means they require a period of intensive support/assessment and it is not possible for the person to remain in their own home during this period.
- A review of Care at Home Services concluded in 2019. There are currently two strands to the Service: Enablement & Support and Mainstream Social Care. These services work in collaboration with internal Health & Social Care Teams and external stakeholders. They have an established partnership with health colleagues and have a fast access to Pharmacist Technicians and Allied Professionals. The services aim is to work with service users, carers and families to reach and maintain the individual's

full potential. The service focuses on the individuals care and support needs whilst improving their outcomes, along with boosting their confidence and abilities in what they are able to do for themselves. There is continual focus on promoting independence, maintaining individual skills and confidence. The service provides individual tailored packages of care along with a focus on wellbeing and health and safety for everyone wishing to remain in their own home.

- Practical Support and Shopping services enhance service users' quality of life whilst offering support and advice and signposting to other community services. The service has a range of provision including Meals Service delivery which during 2019 provided just over 100,000 meals in the community.

Mrs V attended a day centre once a week and had all support carried out from staff. Mrs V had severe anxiety when leaving home; she did not feel safe or secure away from her home/ surroundings and would become very vocal and anxious when out of her comfort zone. Mrs V wanted to work on gaining independence, enjoy social outings and home skills and she started receiving a care at home and housing support service. 2 years on Mrs V now enjoys social outings, she has attended many shows/musicals she has travelled to Aberdeen, Glasgow and Edinburgh by train to go shopping. She really enjoys going to restaurants for meals and drinks with her friend and new weekly activities for Mrs V are Boccia, shopping and various tasks at home. Mrs V wanted to decorate so she was supported to shops to pick decor and furniture and also supported with quotes from companies to carry out the work. Mrs V always liked to clean so the role she took on was cleaning the kitchen and two years on she will prep and cook her food. She says she likes helping staff which is a great outcome as she no longer sees staff as helping her.

- The Partnership has continued to develop an Assessment at Home model in partnership with British Red Cross as a means of enabling people to step down from a hospital setting and continue the assessment of their care needs in their own homes.

  During 2019-20, the Assessment at Home service supported 95 people to return home from hospital as an alternative to care home admission. Of these 95 people, 72% were enabled to continue to live independently in their own homes following the assessment period. The remaining 28% of people who moved into 24 hour care were afforded the opportunity to return home first, rather than move straight to a care home from hospital, which is usually a more positive route for a Care Home admission.

  The Discharge Hub successfully bid for specific winter money in 2019 to enhance mainstream social care provision over the winter period (Oct 2019-Mar 2020). This meant that people were discharged home with support from the Assessment Team pending being transferred to long-term care providers via the Resource Allocation Meeting . This model helped to reduce the number of people who were delayed discharges across Ninewells, Royal Victoria Hospital and Bluebell Intermediate Care Unit and increase capacity in the hospital during the winter period. Figures show that 222 people were supported to return home with support from Red Cross pending a long-term package of care being sourced. This service significantly reduces the length of stay for some patients who otherwise would be delayed in hospital awaiting a long-term service.

Mrs C was referred for 24-hour assessment after she had a fall at home. This fall had resulted in a left eye injury and Mrs C had been assessed as high risk of falls.

Upon receiving the initial assessment prior to discharge it was clear Mrs C would require encouragement using her tri-wheel to avoid further falls. Mrs C also required support with all aspects of personal care and concerns had been raised about nutrition and weight loss due to her poor eyesight. Mrc C had a diagnosis of COPD and could become very breathless, meaning she required a break in between tasks.

Within the hospital setting Mrs C was observed to be out of bed around 2-3 times throughout the night and there were concerns as to how she would manage at home with no support in place overnight.

Mrs C was discharged home at which point her 24 hour assessment began.

Care Workers would fully assist Mrs C to get out of her day clothes and support getting nightwear on. The care worker would then administer medication throughout visits and provide support with meal preparation.

After a few days of intense support, care workers began to take a step back and encouraged Mrs C to carry out her own personal care and, after a few days, she managed to independently dress with no support. Overnight support was no longer required as she was not requiring assistance during the night and there was no evidence of risk when she was using the toilet. Mrs C continued to be supported and was soon able to cook her own meals and make homemade soup on the hob with no support.

As a result of ongoing assessment, Mrs C's 24 hour package was then reduced to four daily visits and the British Red Cross (BRC) team kept in regular contact via telephone to provide updates on how Mrs C was managing at home.

Although she was independent with medication prior to hospital admission, Mrs C now had difficulty opening the Venalink medication system. BRC contacted the pharmacist who provided a home visit to show Mrs C different aids to help with this task and discussed which would be easiest to use. An appropriate aid was sourced which allowed Mrs C to manage her medication independently thereafter.

BRC also contacted the Food Train to place a shopping referral which was accepted.

Also, with support of volunteers, Mrs C was able to get to her hairdresser appointments.

Two months following assessment, a review meeting was arranged where Mrs C asserted she wanted to close the package as she was managing well, and she wanted to thank the staff involved.

Mrs C has now become fully independent with no support in place.

- The Medicine for the Elderly (MfE) service currently supports the provision of an Acute Frailty Team (AFT) in the Acute Medical Unit (AMU) and a short stay Acute MfE Ward in Ninewells Hospital. A 'front door' approach means that the support is provided as early as possible on contact with the unit or the ward. In addition to this there is support for relevant orthopedic patients or in the Emergency Department.

  The Tayside MfE vision is that older people admitted to AMU undergo an assessment for frailty and, when identified as appropriate, MfE multidisciplinary review is undertaken within 24hrs of admission. A comprehensive geriatric assessment will be initiated and the most appropriate setting will be

identified for this to be continued. The assessment will be as close to home as possible and delivered in the least acute setting based on patient need, wishes and availability to increase chance of functional recovery for the person.

The AFT service is provided Monday to Friday 8am to 8pm with targeted provision at the weekend. There is a full range of professionals within the service to ensure the right professionals are available at the right time. The Multi-Disciplinary Team includes Medical, Pharmacy, Nursing and Allied Health Professional as well as a Discharge coordinator.

The options available for the individual are explored at an early stage leading to a variety of options including returning home with:

- An intensive assessment at home service (for those seen as vulnerable to 24 hour care admission).
- An increased care package.
- Third sector support.
- Enhanced Community Support Service.

Or admission to:

- Acute Medical Unit.
- Medicine for the elderly unit.
- Royal Victoria Hospital rehabilitation and assessment ward.

- The Community Mental Health Older People (CMHOP) Teams worked to further improve and integrate their service over the last year. This included the redesign of management structures with joint team leads and senior practitioner roles and the increase in support work colleagues to enable people to remain living in their communities.

The CMHOP teams worked with a service user who had long standing mental health issues. In their younger years they were admitted to hospital for mental health care and treatment on several occasions. The servicer user was transferred to the Mental Health team for older people for care and support. Through assessment it was apparent that the person required the support of both mental health and social work practitioners. The main goal of the person was to remain out of hospital or a care home and live in the community. Although there were risks identified the joint approach to risk assessment and planning within the team assisted this goal. The mental health nurse and social worker worked jointly with the individual to support and protect while also ensuring they had choice and were able to make decisions. The individual remained in a community setting until the end of their life.

This team also developed and implemented a joint risk assessment procedure and the provision of further support to the Intermediate Care Unit. Joint risk assessment provides an opportunity for the person and everyone working with them to share information and experience regarding any risks for that person. This ensures the person is fully involved and prevents the person having to tell their story multiple times and allows practitioners to identify the most appropriate method/person to provide support for the individual.

Mr C, a 75+ year old man was admitted to Kingsway Care Centre with low mood and cognitive difficulties. He lives with his daughter who is his main carer, but who was struggling to help her father.

Mr C improved physically and mentally during admission; however he and his daughter were unsure about how they would manage on his discharge. This required additional rehabilitation and he was therefore transferred to the Intermediate Care Unit. The rehabilitation is undertaken by the team who will follow him back home into the community, thus providing continuity of care

Once Mr C and his daughter were more confident they would manage at home, he was discharged with the full support of the community mental health team for older people.

- The Dundee & Angus Independent Living Centre is a successful partnership between the Dundee and Angus Partnerships. Independent Living Dundee & Angus website **https://www.ilda.scot/** has been produced to support the work of the centre and professionals who work within it. The site features information and demonstrations of specially adapted kitchen tools, level access showers, adjustable beds, a stair lift and other equipment to help people live independently.

  The equipment in the Independent Living Centre makes a real practical difference to people's lives. The website opens up the exhibition area at the centre to many more people and helps disabled people, carers and professionals know what might be available prior to visiting the centre, or without making a visit to the centre. It is especially helpful for those with difficulties travelling or attending the centre.

  The website was produced in partnership with Dundee Voluntary Action. There are links to many other local and national websites carrying useful advice and information. For example, there is a link to the Community Occupational Therapy Services Attend Anywhere online waiting room. The 'Get Assessed' page includes a form which people can fill in online to request advice.

- The Midlin Help at Home service was commissioned in late 2018 as part of the strategy to build the number of organisations providing low level interventions by volunteers. Help at Home is a flexible support service run by a team of staff and volunteers. It aims to help people to live independently within their own homes by providing support to help people gain or maintain skills and confidence. The types of support provided by the service can include: practical assistance with household tasks; light housework; laundry; carrying out errands or supporting the individual to carry out errands; picking up prescriptions; shopping for essential items; helping people attend activities; and, offering advice/information/signposting to other organisations and services. The service works closely with the Partnership teams, positively playing their role in people's lives.

Mr W was referred to Mid-Lin Help at Home by HOPE project. Mr W was isolated at home and at times forgetting to eat which was affecting his health. Mr W had lost confidence in going out of the house.

During initial visits it was identified that Mr W would like to be involved in activities in the community. He wanted to see more people socially and feel part of activities again. He felt isolated at home, although he liked his home environment.

The service planned to improve quality of life for Mr W and support to feel less isolated by increasing interactions through participation in social and community activities including being supported to attend; Boomerang Centre, Mid Lin Day Centre. He was also supported to use the Out and About bus and Community Cars.

This support had a positive effect and Mr W reported that his appetite had improved as he was now enjoying meals with others, he no longer felt isolated, his confidence improved and by getting out of the house his activity levels increased.

Here are a few quotes from people connected with the service:

Over the moon with the service provided. Able to relax while away and enjoy the holiday knowing that someone was assisting family member. Benefitted greatly as main carer.

- Family Member

My anxiety has gone right down, even my GP has commented and been able to reduce my medication.

- Service User

You've been such a good help for me, you helped me organise my health appointments, and I cannot say how much I appreciate your support and my family think the same. Thank you very much.

- Service User

Mrs A was referred to Mid-Lin Help at Home by HOPE project. Mrs A had suffered health problems which resulted in the provision of an electric wheelchair but she lacked the confidence to use it and felt that she had lost independence as a result. The service aimed to improve Mrs A's confidence and support her to be able to access her community by; supporting Mrs A and a family member to go for short walk, supporting Mrs A to gain confidence using the controls on the electric wheelchair, supporting Mrs A on short walks without a family member, supporting Mrs A to visit another family member using her electric wheelchair.

Following this support Mrs A and her family member reported that Mrs A had felt less anxious about going out using the wheelchair and had felt more confident using it.

- Turning Point Scotland promotes the ethos of citizenship and it encourages, supports and enables people to be actively involved in their own communities and also the business of the organisation. 3 supported people are on a service user forum which involves attending meetings at head office every 2 months and being involved in internal developments. One person has undertaken talking mats training with a view to working with staff to gain the views of supported people who don't have verbal communication. Another person has participated in training to become an internal quality assessor and he will visit other services to gain feedback from people about their support and service.

Mr D received support from Turning Point Scotland

Mr D has shown a keen interest in learning to drive for many years; it began with a strong interest in go-karting which he participates in on a weekly basis and has developed good relationships with staff at the venue.

Mr D expressed to staff that he wanted to become more independent and learn to drive rather than relying on staff cars or public transport.

Mr D did not have a full understanding on the process of learning to drive; staff supported him by explaining what was required to achieve this outcome and make him aware of a realistic timeframe.

Staff discussed the process with Mr D:

- Applying for provisional license
- Theory test
- Being able to read the written word and understand road signs
- Learning to read and write (sourcing a literacy class)
- Being introduced to a new person (driving instructor)
- Communicating effectively with the driving instructor
- How he would communicate to the driving instructor if he required staff support
- How long it would take

Staff supported Mr D to liaise with his care manger and welfare guardian and learning to drive was discussed at his annual review.

Staff supported Mr D to source a local literacy course to begin the process of learning to read and write to aid him with the theory section of learning to drive and longer term aim of understanding road signs. Mr D attends the class on a weekly basis and at first had 1:1 sessions but has since progressed to joining in the group sessions.

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 four of the Partnership Strategic Priorities

All seven of the Dundee City Council Best Value Themes

Improving Health and Social Care outcomes for people who use services and their carers is the priority of the Partnership. 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 We Performed

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

Dundee

Scotland

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

Dundee

Scotland

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

Dundee

Scotland

This information suggests that experience of care appears to be positive. The Partnership is focused on ensuring that when people are reaching the end of their life their experience of care and support is as good as it can be. 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 calendar year 2019, 90% of time in the last 6 months of life was spent at home. This is a positive result (similar to the Scottish average) and sits around the 'family group' median. This 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 Palliative and End of Life Care Managed Care Network is further exploring information related to those who spent greater than10% 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 2019-20 a total of 48 complaints were received regarding social work and social care services provided by the Partnership. Over half of the complaints (61%) were resolved at the first stage of the complaint process, frontline resolution. For 58% of the total complaints received, the Partnership was able to respond within target dates set out in our own procedures or agreed directly with the complainant. Complaints related to a number of different aspects of social work and social care service provision and these are categorised below.

Figure 10 - Complaints regarding Social Work and Social Care services

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

For 31% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

In 2019-20 a total of 182 complaints were received about health services. 24% of complaints were resolved at the first stage of the complain process, frontline resolution. Most complaints (56%) were responded to and resolved within the target timescales which is the same as in 2018-19.

Figure 11 - Complaints regarding Health Services

Top 5 Complaint Reasons
Staff attitude
Disagreement with treatment/ care plan
Problem with medication
Unacceptable time to wait for appointment
Clinical treatment

For 56% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

Compliments

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

This compliment was received about Ward 7 at Royal Victoria Hospital:

> **Fortunate to have such dedicated staff on the ward. I very much appreciated their help and would like to thank them for their assistance during my stay**

This compliment was received about one of our Physio Staff and the team:

> **Excellent receptionist who was welcoming and to Cat herself for providing me with some relief**

This compliment was received about the Discharge Hub:

> **Never had someone who went more than the extra mile for me like you have. You managed to do more for me in 5 days than anyone else in 15 years, everywhere should have a Tracey.**

The Care Inspectorate is the regulator of care services in Scotland and as part of their inspection they award grades. In 2019-20 Dundee was placed 24th out of 31 partnerships for the proportion of care services rated as good or better in Scotland (80%).This figure now sits slightly below the Scottish average (81.8%).

What we have achieved to deliver this outcome

Throughout 2019-20, information gathered from people who use services and their carers were used to make continuous improvements. Some examples of this are described below:

- Meeting the increasing demand for Rheumatology Occupational Therapy and providing an equity of service for patients with fatigue has been a problem across Tayside and in particular Dundee. The development of the Fatigue Management Group in Dundee for patients with long term conditions, particularly Inflammatory Arthritis and Fibromyalgia, has been developed to meet this. There is also the option of telephone intervention in fatigue management for patients and 'Near Me' technology is being developed.
- The Social Care Response service is an inter-agency emergency service, delivered in the community. It is responsive, reactive and provides a 24 hours a day, 365 days a year response. The service works in partnership with Scottish Ambulance Service, Police, Fire Service, Community Nursing and Out of Hours Services. More staff were employed in 2019 to strive and meet demographic challenges along with the rising needs and demands within the community. The service provides Assistive Technology equipment and demand for this has grown over the years. Technology Assistants are now available 7 days a week and provide a service after 5pm.

Feedback regarding the Social Care Response Service:

They help me a lot and it means my family don't have to worry about me as they are too far away, I like all my carers they are all really nice and friendly, please don't change them.

They are there when I need them. I don't mind if I get male or female carers they always respect my privacy and make me feel safe. A good bunch! 10 out of 10!

This is a very good service I am treated with dignity and respect.

The service I have received has been second to none, all the carers are excellent with a friendly and helpful attitude, I could not wish for better.

- The Care Inspectorate commended the Social Care Response service in having the most up to date lifting equipment for service users along with the latest pieces of technology.
- Paramedic homecare service user survey results 2019:
    - 98% rated the service as excellent or very good and 2% rated the service as good.
    - 88% said they thought staff were respectful when working within their home.
    - 88% said they thought that staff treated them with respect and dignity.
    - 88% said they thought that staff respected their preferences and choices.
    - 90% said that they found staff to be caring, polite, pleasant and professional.
    - 90% said that they found staff supportive and informative when providing a service.
    - 94% said that they thought the service was reliable.
    - 86% said that they thought that all staff showed their identification badge when visiting their home.
    - 90% said that they thought that all staff wore appropriate corporate clothing.
    - 96% said they thought that staff explained clearly what assistance they could /could not provide.
    - 97% said they were reassured by the response of staff when they called through to community alarm.
    - 96% said that all calls were answered in a prompt and professional manner.
    - 84% said that they were provided with a service agreement.
    - 84% said they were provided with a Right to be Heard leaflet.
- Westland Supported Accommodation aims to promote the independence, inclusion, and well-being of tenants in their home environment. The service has been credited with using resources in flexible, efficient, and creative ways to ensure positive outcomes are achieved. The photos on page 42 show tenants on their first holiday away in August 19 since living in Magdalen House. This was manageable due to the changes in registered service type to care at home service and housing support. All the tenants loved their holiday away and enjoyed making plans to visit different places and see different things and felt empowered that they had been able to plan the holiday with the support of staff and are planning their next holiday to Blackpool when "the virus is gone".
- The Patient Assessment, Liaison and Management Service (PALMS) places mental health specialists directly within GP practices and encourages people concerned about their mental health and wellbeing to book appointments directly without having to see a GP first. Within the first six months pilot project, around 50% of people were seen within five days. 52% of people were given direct advice about managing their well-being.

  98% of people seen within PALMS indicated "yes, definitely" to the question "Did the mental health specialist listen and treat your concerns seriously?" and only 2% answered "no" to the question "Overall, are you happy with the service you received?" The success of the pilot has allowed us to begin to adopt the model across all GP practices in the City.
- Within Community Mental Health Services, we have established processes for co-producing new developments with people with lived experience. Dundee Healthy Minds Network members have influenced the approaches that will be delivered to people who have difficulties regulating their emotions and how care will be delivered to people experiencing a significant mental health crisis. The approach brings the Clinical Leaders of our services directly together with those who use our services.

- The Revive and Restore Café (or R & R for short) is a volunteer led café located in Coldside Church in Dundee for those who want to engage or stay engaged in recovery from dependency problems. CrossReach supports the volunteers who work in the café, and staff also help in the cafe.

R & R Cafe
Revive & Restore

The R & R café is home to the best bacon and egg roll. As good as they are, with the egg cooked to perfection and ready to burst on the unsuspecting novice to such delicacies, the roll is perhaps only surpassed by the company. Today, when I, like everyone present, needed a welcome, a blether or just a good cup of tea and a chance to catch a breath, I found all this at the R & R. Thanks to my companions at the craft table, the wee ones, the big ones, the helpers, the ones that needed a bit more help. You welcomed me, you blethered with me, you allowed me time to breathe, to reset before I went back outside once more. You are humanity."

What the R&R Recovery Cafe means to me:

I feel I am helping the community and they help me

The R+R group is my start in my painful and slow recovery

It helps me speak to new and regular customers

It makes me feel respected, appreciated and worthwhile

I and we need the café for so many reasons

It gets me out for the day (usually due to anxiety issues)

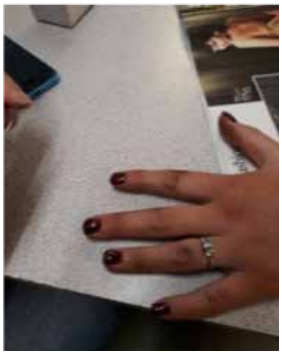
It makes me feel part of a great team

- The Peer Recovery Network has now been in service since April 2019 and has successfully recruited 3 Peer Workers with lived experience who have been in post since June 2019. Training programmes have been developed for the Peer Workers as well as the volunteers. The Peer Workers have undertaken core training which consisted of: Roles and Responsibilities, Safeguarding, Drugs and Alcohol Awareness, Mental Health Awareness and Group Skills and Facilitation skills. On completion of training, they were allocated their placements with Tayside Council on Alcohol (TCA), Addaction and Hillcrest Future where they spend 3 days a week learning valuable skills round the substance use field and spend 2 days with the Peer Recovery Network for development. We now successfully use the Outcome Star for support and supervision for both the Peer Workers and volunteers and find this to be a positive tool in engaging in conversation on recovery and highlighting any issues that may arise ranging from housing, family, emotional or physical health. The Peer Workers are undergoing their Smart Recovery Training and are shadowing groups to learn about facilitating a group in the next few months. The Peer Workers have been actively involved in developing the Recovery Drop-In in the East End of Dundee, working in partnership with the volunteers, Dundee City Council and NHS, and supporting them at the drop in as well as engaging with new participants coming along. They have also been working with the volunteers to research and design an awareness raising training programme around stigma and recovery to deliver in the community. The Peer Workers have been supporting the volunteers to deliver the Recovery Friendly pledge and supporting them to become Recovery Friendly Ambassadors.

  The Peer Recovery Network is also now engaging with Perth Prison to deliver Peer Support training to individuals to support their peers. It is hoped that on release to Dundee they will continue to access support with services and be signposted to addiction services in their own area and continue to attend a recovery drop in to maintain their own recovery and reduce isolation and the risk of overdose and future offending.

  The confidence of the Peer Workers has grown and this was evident in the press release of the Hope Festival when two of the Peer Workers suggested they would like to promote the festival through the Evening Telegraph. This would not have happened a few weeks prior. They stated that the opportunity to work and not be judged came about through being supported, valued and given the chance to lead ordinary lives. They have felt supported at every stage whether this be with their line manager, mentor on placement or through the whole organisation. The Peer Workers will be taking over the training of volunteers in the next few weeks as they now feel confident in doing so.

  The drop – in at Whitfield is attended each week and the numbers are growing. The volunteers have successfully totalled up 134 hours of volunteering at the drop in, with 19 hours engaging with the community for the Recovery Friendly Pledge and 65 hours of training and development. We introduced a volunteer of the month and this has been well received with the volunteers feeling valued and their contribution greatly appreciated. The volunteers come up with lots of different ideas that will aid recovery ranging from a Halloween party, motivational speaker coming in to design a fitness programme that they can undertake which does not cost them any money. They are also exploring a family Christmas Party and looking to form a Christmas Choir for the Christmas fete.




- We know there are a number of reasons why women find it difficult to access services. Safe spaces within local hostels and the Cairn Centre allow women the opportunity to meet with Community Recovery Service staff, develop a rapport and build trust with a view to empowering women to access other support and services in the community.

  The sessions involve women taking part in activities and discussion around self care. Women can also access emotional and practical support around any of the issues they are experiencing.

  Some of the issues women have been supported around include:

  - Harm Reduction advice and support / Blood Borne Virus testing / Naloxone training
  - Relapse Prevention
  - Sexual Health support
  - Personal Safety information for women involved in commercial sexual exploitation
  - Managing thoughts, feelings and emotions

  Women who have been regularly accessing support from the Women's Only Space at the Cairn Centre have spoken with staff about feeling unable to access community facilities, believing they would not be made to feel welcome.

  Staff applied for Gift Aid funding and this was used to support women to come together and access community facilities. Trips to date have included a visit to the V&A museum, Verdant Works and Discovery Point. As well as a visit to the Roseangle Café to see the Exhibition of Hope which showcased art work that some of the women had created and a Sound Bath session held in the Cairn Centre.

Just talking about normal things help me, that's all I want normality for a few hours

She even helps with little things I couldn't afford due to my habit

You can talk to Kelly about anything, she doesn't judge she just wants me to make sure I'm taking all the safety tips and measures I can when out working

Two hours away from chaos is what I need and I love group

It helps me forget what I'm away to do at night but I need to do it

Working in partnership with Just Bee productions, group participants have been drawing and painting as well as working on creative writing and poetry. Conversations have focused on recovery and moving forward.

Group participants have been working on putting together scrap books which contain words and pictures that best describe their recovery journey.

Writing pieces and artwork produced by group participants were on display in Roseangle Kitchen Community Café in an "Exhibition of Hope – a celebration of art, words and people, sharing a vision of hope".

The exhibition was held to reach out to community members in the hope of breaking down the stigma of addiction and showcasing that recovery is happening around us.

Group participants shared with staff how proud they were that their pieces were being exhibited.

Inspirational people

A really chilled place to come and draw and chat

Nobody judges me

The chat and banter- a calm place where we can be creative

Working in partnership with Dundee Futures Project, we provide 'Soup & Something'. Group participants prepare soup and dessert, using fresh ingredients and cooking from scratch.

During food preparation, information is given around cooking on a budget, healthier food options and how to avoid food waste.

Once prepared, group participants sit down and eat together, as well as having the opportunity to take food home for later.




I never realized what cooking skills I already had

I've not cooked for years and it's amazing how much I'm enjoying this

Cooking helps me forget the chaos for a few hours





- The development of peer support and peer recovery continues to be consolidated throughout our communities. At present there are peer support workers embedded in partner agencies, developing relationships and utilising ongoing training and mentoring opportunities along with their invaluable, lived experience to support the people they work with. During the Covid-19 Pandemic the Safe Zone Community Outreach project benefited from the support of peers, who have utilised their communication skills to engage directly with members of the public seeking assistance, support or simply a safe conversation.
- Dundee Community Living is a Care at Home/Housing Support service which supports adults with a Learning Disability and/or Autism to live in their own tenancies and be part of their local community. The service is based in 5 different community settings and supports 18 individuals, providing 24 hour care.

  In 2019 stakeholders (supported people, their families, relevant professionals and agencies) continued to be consulted. The responses were very positive, with an overall high level of satisfaction, reflected in achieving top grades (grade "6") from the Care Inspectorate for the fifth year running.

  The following quotes were received from people supported by the service:

I am very happy with the community living team. It takes me a long time to trust people but I trust the staff here. They are always available if I need them and support me in many different ways

They look after my health, I need a textured diet in my food. I am in a Makaton choir. Staff administer my medication. I get support with shopping, healthy eating and staying fit

The following quotes were received from families of people supported by the service:

The service are good communicators; and we work very well together in the interests of better supporting my daughter. I think she has developed her skills since moving to the community living team. She is more independent and her behaviour is much more settled

They have gained his trust which is a big one for him as he does not trust easily. There is a lot of compassion and humour and when we visit they make us feel welcome

- The Wellgate Day Support Service provides meaningful day opportunities for adults with learning disabilities. The service gathers feedback in a variety of ways including supported people reviews, questionnaires and changes are made following listening and responding to supported people, carers and stakeholders. Examples include:
    - Easy read questionnaires, information leaflets and a User Involvement Strategy compiled in partnership with supported people and Advocating Together
    - Holding quarterly meetings with carers
    - The purchase of high back chairs with sides to contribute towards a comfortable, homely but safe environment and changes made to lunch choices which encourage independence

Wellgate Day Support Service was given the Lord Provost Award at the Dundee City Council Outstanding Service and Commitment Awards in June 2019. This was given in recognition of the work undertaken in partnership with the Community Learning Disability Nurses, Occupational Therapy and Central Library in provide resources to improve the understanding of ageing and memory loss for supported people who have a learning disability

- Rose Lodge provides a combined Care at Home and Housing Support Service to up to 16 adults who require additional support because of a learning disability or mental health issues. A recent survey found that 100% of service users agreed or strongly agreed that :
    - they were treated well and got the support that they wanted
    - staff understood what they want from life
    - they got to be independent and make their own choices
    - they got time to speak with staff
    - were supported to lead a healthy life
    - got the chance to make changes to their care/support
    - could help with planning the service and day to day things

National Outcome 4: Quality of Life – Health and Social Care services are centered 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:

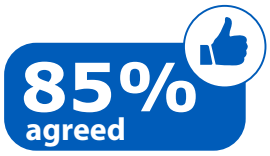
All four of the Partnership Strategic Priorities

Dundee City Council Best Value Themes - Fairness and Equality, Partnership and Collaborative Working, Sustainability, Effective Use of Resources, Community Responsiveness.

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 We Performed

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



Dundee

Scotland

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 31 admissions for every 1,000 of the 65 and over population. In 2019 Dundee was the poorest performing Partnership in Scotland. (Source: Public Health Scotland)

Coldside had the highest rate of falls in Dundee with 39 per 1,000 of the 65 and over population, followed by Lochee with a rate of 31. North East had the lowest rate of falls in Dundee with 25 per 1,000 of the 65 and over population. (Source: NHS Tayside)

What we have achieved to deliver this outcome

The Physiotherapy and Occupational Therapy Teams have redesigned and developed their services to improve service quality, patient outcomes and access to services.

- The Rheumatology Occupational Therapy team has experienced a significant increase in referrals for fatigue management and osteoarthritis over the last year. In order to meet demand the teams have developed groups. The Fatigue Management Groups are for patients with long term conditions. The Osteoarthritis Educational Group educates numerous people instead of individual sessions, regarding joint protection.

Patients now have access to see a Physiotherapist in a Medical Practice rather than see a GP for musculoskeletal problems.

The First Contact Physiotherapy service was nominated for a STAR award in 2019.

- The Outpatient Hand Therapy Team developed a Carpal Tunnel Syndrome Pathway for use throughout NHS Tayside which has streamlined and improved the care of patients. Of 78 patients referred with Carpal Tunnel Syndrome, 72 % were managed by an Allied Health Professional specialist without surgical input.

Just a big 'Thank You' for all your help with my hand. You restored my faith in the healing power of the body and enabled me to skip amongst the trees again

In partnership with the Tayside Urology Team and Maggie's Centre Dundee the Pelvic and Obstetric Physiotherapy Team delivers a two hour session every six weeks to a group of men about to undergo treatment for prostate cancer. This session covers topics about immediate aftercare including catheter care and removal and initial management of urinary incontinence. It covers education and advice on management of constipation, healthy drinking and pelvic floor exercises. Longer term issues are also discussed such as erectile dysfunction and treatment options. The men are invited to ask questions and chat in an informal setting. The Maggie's centre is a great place to host these sessions as the atmosphere is very comfortable and non-clinical. It also introduces the men and their family to other support networks provided by Maggies. It also introduces them to staff they may meet on their journey and who to contact if they need further help and support.

- The Physiotherapy and Occupational Therapy Teams have developed their use of technology to improve access to their services.
  - The Rheumatology and Occupational Therapy teams offers the option of telephone intervention and review with patients who due to geographical/time constraints are unable to attend face to face appointments. An example of this is in fatigue management and the team is currently in the process of setting up the use of Near Me. This team has also participated in a randomised clinical trial: LIFT (Lessening the impact of fatigue in inflammatory rheumatic diseases).
  - The Tayside Pain Management Programme continued to use the text messaging service, Florence, to provide additional support to patients attending the weekly Pain Management Programme. Patients were seen on a weekly basis in a group by the multi disciplinary team. Text messages were then sent to the patients between sessions to supplement their treatment, providing motivational messages and reminders to complete self management tasks. This service was well received by the patients, who felt it helped them to keep up the momentum of the programme between sessions. It also helped the clinicians to gather some information about how the patients were getting on with tasks such as pacing activity, in order to spend the time on the group sessions more effectively, with sessions targeted at areas the patients were struggling most with.
  - The Pelvic and Obstetric Physio Team has worked with primary and secondary care colleagues and Transforming Outpatients to help develop the Urogynaecology pathway and develop proposed new guidelines for referrers. This is to promote and encourage self management, initially for urinary incontinence. In order to reach as many people as possible patients attending their GP surgery can access self help information (paper or website with videos) that they can adopt without having to attend specialist clinics. Leaflets are available in multiple languages and there is a DVD available containing British Sign Language.

  The Pelvic and Obstetric Physiotherapy Team requested feedback from some of the people who used their service.

From the first meeting she connected and treated me like a person and not just a case. She seemed as though she had all the time in the world to take a history at the first visit I felt she got to know me. She was very accepting and open minded to what I said

The physiotherapy lecture for prolapse and incontinence was great. Really helpful

- The musculoskeletal physiotherapy team took part in a test of change using 'Vision Anywhere' software – this was led by eHealth and provided a federated appointment system (Vision 360) so that any patient from any GP practice can be seen by a physio. The physio would have access to the patients medical record and ability to update it following the patient consultation.

Mrs P attended one of the First Contact Physiotherapy (FCP) clinics having seen the service advertised in her own GP practice – as an infographic on the TV screen within the practice.

Mrs P identified from the information provided that seeing the FCP was appropriate for her condition. She contacted her GP practice and was given an appointment to attend one of the hub sites that day to see a member of the FCP team.

Mrs P was assessed and the results of the consultation inputted directly into the Primary Care Record and Mrs P was advised on self management.

Mrs P did require onward referral to the MSK Out Patient Physiotherapy service. This was done by the FCP at the time of the consultation and Mrs P is now on the waiting list for MSK Physiotherapy. Mrs P also now has information and exercises to commence in the time period pending her appointment. Mrs P expressed that 'this is a fantastic service' and should the need arise that she would definitely use it again. Mrs P recognised that the GP was not the person she needed to see but that Physiotherapy in the form of FCP was and she was able to access the service allowing Mrs P to see the right person at the right time for her; at a time and place that was most convenient for Mrs P.

- The Outpatient Hand Therapy Team Initiation of the Attend Anywhere Clinic for virtual hand trauma patients allowed appropriate patients with minor hand injuries who live out with Dundee to be treated via face to face with linked computer/phone communication.
- Falls prevention is an ongoing challenge which can only be met by robust interagency working and development of community resources. A fall is the outcome of a complex interaction of risk factors, many of which are modifiable. The introduction of the Dundee Joint Falls Pathway aims to identify people at high risk of falling and intervene to reduce that risk. The pathway will deliver benefits to the population by improving quality of life, reducing morbidity and mortality and enabling more people to be independent for longer. 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.

  The pathway for patients presenting at the Emergency Department has been reviewed and now provides a more streamlined process for people requiring a falls screening assessment. This has also released capacity for the falls service to focus more on patient assessment and intervention.

  The falls group has focused on building capacity for citizens to access a wide range of physical activities to improve health and wellbeing, including the Green Health Partnership, which will support the release of senior clinical staff to focus on the more complex presentations.

The early identification of 'at risk' patients using a stage 1 screening tool has been established across Health and Social Care ensuring appropriate intervention can begin at the earliest opportunity.

A review of those who suffer multiple falls was undertaken to identify if appropriate services were involved. Some 95% of multiple fallers were receiving care from older people's services and/or Allied Health Professions Services demonstrating that patients are identified and supported.

- Continued implementation of a 7 day service provided by the Integrated Discharge Hub. Working in conjunction with the Acute Frailty Team and Home Care, this ensures that people receive a service at the right time in the right place from the right person, and that their discharge arrangements are coordinated across 7 days. The next phase of the implementation is testing the 7 day working pattern of support workers to support co-ordinators.

- Dundee is one of a number of sites working with Healthcare Improvement Scotland's ihub to support the implementation of The Scottish Government's Strategic Framework for Action on Palliative and End of Life Care which states that everyone who needs palliative care will have access to it by 2021. The learning from this project has already informed work for the wider Care Home and Hospital Pathway Improvement Group.

  The focus is on improving the earlier identification of and coordination of care for those who have palliative care needs as well as testing and evaluating Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model and identifying ways to make improvements in palliative and end of life care for people with dementia.

  To gain deeper understanding of the complexity of the system and the experience of people receiving care, a number of person pathways were undertaken to strengthen knowledge. Individual experiences of care were mapped and showed evidence of positive outcomes in care where reviews, conversations and decision-making was evident at the earliest point in the journey which reflected the experience of the person receiving planned symptom management and comfort care as they moved towards end of life. It is clear that planning for transitions, expertise and knowledge to interpret changes in presentation are key in achieving the wishes for end of life that matter to the individual. In addition to this, capturing the experience of families and carers also supported the need for improving care. The stories highlighted areas of good practice and also where delivery of care could be improved for the individual and their family.

- The Dundee Macmillan Improving the Cancer Journey (ICJ) service launched in November 2017. Our partnership with Macmillan Cancer Support ensures everyone in Dundee affected by cancer can access a high quality, integrated and co-ordinated health and social care system that meets their needs.

  Public Health Scotland sends a letter of invitation to all eligible individuals in our local authority area. Based on identification of holistic needs and a personalised conversation about what matters to them, the service offers tailored physical, psychological, social, financial and practical support.

  There has been good uptake of the service from across the city, with a greater number of referrals in the highly-deprived areas. ICJ reaches and supports the people who need it the most, with 62% of people using the service from those with the greatest need (Scottish Index of Multiple Deprivation Quintiles 1 and 2). Sources of referral include a wide range of statutory and third sector agencies, health professionals and self-referral.

  During 2019-20, 311 people affected by cancer were supported. Demand for the service continues to grow – since inception 566 local people have been supported with 923 care plans coproduced. 57% of people were over 65 years old, with the younger age group increasing to 43%. 55% were female, 45% male. 25% were receiving treatment and 18% at the end of treatment.

Thanks to you and your wider team for all your help and support in carrying out the HNA and managing all our patients concerns post treatment. Honestly the feedback from patients is just amazing. It's so reassuring for us knowing that when our patients have finished and are having ongoing concerns that they are being picked up by you. Thanks so much!

- Feedback from Clinical Nurse Specialist, Oncology, Ninewells Hospital

- 8713 concerns have been identified by people affected by cancer to date – with tired, exhausted or fatigued, money and housing, and moving around consistently the most common concerns. The most significant concerns were around caring for others, being cared for and family.
- The ICJ team has taken 10101 actions, working with over 40 different community teams and organisations to support local people and improve outcomes. The most frequent referrals are to the Macmillan Welfare Rights team, Maggie's and Occupational Therapy. Nearly £850,000 in financial gains has been secured for people affected by cancer in Dundee since April 2018.

These people showed me I was not alone. I thought that I could handle everything but that was because I was not facing the facts. I was stuck in a space and unable to progress. They helped me to look at my life from the outside and gently encouraged me to ask for the help I desperately needed. They made me believe I had personal resources and strength, then they gave me the best chance to capitalise on my resources. I was lifted out of the present moment and can now see a future for myself.

- Person affected by cancer, Dundee

- The Chronic Obstructive Pulmonary Disease (COPD) Team supports people from diagnosis stage throughout their journey with this life limiting illness. Team members provide support in clinic settings and at home in a person-centred way with the overarching aim of improving the quality of life for each person they work with.

  In addition to accepting referrals from outpatient clinics and Medical Practices, the team provide a Hospital Discharge Service for people for the first 14 days at home recovering from an exacerbation of COPD. Team members visit to monitor the person's symptoms, check how they are managing at home and find out more about the home circumstances. They take appropriate action if there are changes in the person's condition including arranging further support and services and changing medication if the person has an ongoing exacerbation. The service provided by the team helps to maintain the person in their own home and reduces the need for hospital admission.

National Outcome 5: Reduce Health Inequality – Health and Social Care services contribute to reducing health inequalities

Outcome 5 links to:

The Partnership Strategic Priorities: Health Inequalities (Strategic Priority 1), Locality Working and Engaging with Communities (Strategic Priority 3)

Dundee City Council Best Value Themes - Fairness and Equality, Sustainability, Community Responsiveness

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 We Performed

Dundee had the 3rd highest premature mortality rate in Scotland during calendar year 2019, with 542 unexpected deaths per 100,000 population aged 75 and under. (Source: Public Health Scotland)

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

A higher percentage of people in Dundee live 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.

In Dundee life expectancy is 74.0 years for males and 79.2 for females, whereas it is 77 years in Scotland as a whole for males and 81.1 for females. Dundee has the second lowest life expectancy in Scotland for males and third lowest for females. Life expectancy varies substantially by deprivation level and the occurrence of health conditions and disability. Healthy life expectancy is used to understand how many years in 'good health' a person will live. In Scotland as a whole, men are expected to life 61.9 years in good health and in Dundee men are expected to live 56.5 years in good health. In Scotland as a whole, women are expected to life 62.2 years in good health and in Dundee women are expected to live 59.8 years in good health.

What we have achieved to deliver this outcome

- In Summer 2019, a liaison service was provided by the Integrated Discharge Hub (The Hub) to include support for Substance Misuse and Psychiatry of Old Age. These Liaison Services had previously been part of their respective community services, however it was decided that their inclusion within the Hub delivers a more holistic and seamless approach and ensures individuals who come into hospital leave with the support they require to thrive following discharge, thus preventing a "revolving door" scenario. An admission to hospital following difficulties in the community can often be the first indication that an individual requires further intervention, therefore Liaison staff act as the link to community teams to ensure appropriate follow-up is in place to support them following discharge.

As part of the Transforming Tayside Programme, the Hub has been working to reduce the pressures on clinical staff by developing a "single point of referral" model which will formalise the referral system for Health and Social Care input prior to discharge. Referrals for individuals experiencing issues such as substance misuse and homelessness can also now be driven by all members of the Hub team through their attendance at multidisciplinary ward meetings.

Staff within the Hub are responsible for assessing and allocating appropriate patients to step down and manage their transfer. Individuals who are discharged to step down are assigned a support worker from the Hub who will continue to provide support throughout the individual's stay at step down, ensuring that all appropriate Health and Social Care provisions are in place to empower and promote independence when they return home.

As part of the range of improvement measures implemented over time to support better outcomes for individuals and to ensure discharge takes place on the Planned Date of Discharge (PDD), the Hub is undertaking a test of change in conjunction with Dundee Survival Group (DSG) to provide a step down housing and support facility. The test of change began in July 2019 and was funded from the Homelessness Strategy to support patients who have a substance misuse issue and/or are at risk of homelessness upon discharge from hospital.

This service is for individuals who are in hospital and assessed as being medically fit but cannot be discharged because the accommodation they lived in prior to their admission is no longer appropriate. Typically, this may mean significant adaptations are required to their home or they are waiting for suitable alternative permanent accommodation to become available.

Rather than remain in hospital, the step down service enables the individual to move from a hospital setting into temporary accommodation with DSG meeting the individual's housing and support needs for the duration of their stay.

Service users are supported to develop the skills they require to live independently in the community and to establish links with community substance misuse support services to ensure their opportunity to continue in their recovery is maximised. DSG works with the resident with their consent to complete "Outcome Stars" which are used to assess qualitative outcomes.

- In 2019-20 a mapping exercise identified some overlap in terms of roles, remit and responsibilities across the three nursing teams; Keep Well, Health and Homelessness Outreach Team and the Community Health Team. This necessitated a review of the nursing roles and remit with clarification of the generic elements and what is more distinct to post and team, taking into account different qualifications, registration, banding, skills and experience.

  All nurses have been involved in regular meetings and development sessions to explore professional issues, how and where to establish more integrated ways of working, and how best to utilise and maximise the nursing input.

The Nursing Teams

Briefly, the role of each nursing team is as follows:

Dundee Keep Well Community Team

- Outreach in a range of community settings; short health consultations, comprehensive health checks, follow up, referral onwards, support to access services
- Targeting of vulnerable groups eg those affected by substance use, the homeless, carers - through partnership working with other teams and services
- 590 health checks were completed during 19-20. The largest clients groups benefiting from these were:
- 237 people involved in drug and alcohol use
- 128 carers
- 113 people involved in the criminal justice system
- 39 homeless people.

Health and Homelessness Outreach Team

- Working with people in temporary accommodation, hostels or those at risk of homelessness and in partnership with a wide range of other agencies
- Contacts come from direct referrals, opportunistic contacts, targeted outreach
- Support for harm reduction, regular crisis care plus earlier intervention/ prevention, liaison with appropriate services

Community Health Team

- Community engagement and health consultations in a range of local settings
- Health talks to local groups
- Development of group work

Progress

As a result of development sessions, key areas were agreed where systems and processes could be integrated as well as clarification of the unique role and area of expertise for different nursing posts. Some successes this year were a move towards:

- Better co-ordination and integration of Nurse Consultations/Comprehensive Health Assessment
- Equity of the community development programme and agreement of the public health nursing role
- Improved articulation and recognition of the role of the mental health nurses and how this links to other roles and services
- Better promotion and articulation of what the nurses can provide
- Improved links with the wider policy context and strategic/operational planning processes
- Clearer referral pathways and integrated clinical recording systems
- Updated outcome measures and targets to better reflect new ways of working
- Improved and appropriate professional, management, clinical support and supervision

These developments have not been without their challenges. Different teams, management structures and reporting requirements make for a complicated and unique operational landscape; developments are impacted by what is happening in other parts of the service and system; partner services; exploring and agreeing what could/ should be more integrated, whilst identifying what is core to all and what is specialist.

Mr P was attending Murray Royal Hospital on a one week alcohol detox programme. Upon discharge from hospital, the Keep Well Nurse had arranged to see Mr P as he felt that he would require support on discharge from hospital and he expressed feeling alone and vulnerable. Mr P was encouraged to attend his local community cafe where he discussed ongoing support with the wider Keep Well team and a plan was made to support Mr P.

He continues to attend his local community cafe on a weekly basis as well as other community cafes. Mr P reported that he receives wonderful support from the Keep Well Nurse as well as peer support from people attending the cafe. He continues to be alcohol free and has attended a cooking course which a community health worker runs. Prior to working with the team, Mr P admitted that he was reclusive and only ventured outdoors once a week for shopping. He suffered anxiety and social isolation however now he ventures outdoors several times weekly and suffers very few anxiety attacks. He feels his life is now more positive and that his mental and physical health has improved significantly. This holistic team approach has proved invaluable in Mr P's progressive journey.

- The City's determination to tackle poverty and inequality led to the formation of the Dundee Fairness Commission. Dundee Fighting for Fairness launched a revised Action Plan in 2019, focusing on 3 key themes: People & Money; Mental Health and Stigma. The key to success is the collaborative process and truly understanding what it feels like to be fighting inequality and poverty every day. The Community Commissioners are able to influence change through their experience and ideas. The third Commission has followed the format of the second one, with a new set of commissioners, and started to meet in May 2019. Its recommendations are due to be published in late 2020.

  Within the bounds of the approaches taken by each of the commissions, the views of the wider community were / are being sought to help inform discussions and the resulting conclusions.

- The Adult Psychological Therapies Service has expanded to include a new Patient Assessment, Management and Liaison Service (PALMS). The aim is to enable 'without barriers' access to a within-GP practice Mental Health Specialist (MHS) with the hypothesised outcome being that assessments carried out by MHSs should allow patients to access to the most appropriate mental health support through referral/more tailored signposting, whilst also helping to reduce GP workload. This is currently established in all but one GP practices in 'cluster 4'. This service puts a specialist psychologist at the heart of the primary care team. People registered with the GP practice can book an appointment directly and most people are seen within a few days. Anyone needing specialist mental healthcare are referred directly to the most appropriate team. Over the next two years it is hoped that every GP practice in the City will have a PALMS specialist available to them.

  Patient feedback indicates that the Mental Health Specialist (MHS) role was viewed as a valuable addition and patients thought they received the advice that mattered to them. GP feedback was also highly positive and indicated that consultancy with the MHS was valued. There has been a significant reduction in re-presentations for mental health consultations, four months after a PALMS assessment.

  97% of the people who received this service were satisfied with the help received.

I am leaving the surgery feeling a lot lighter than when I arrived. I feel like I have been listened to and that my thoughts about my illness are valid and accurate. I have been given information about various services which will assist me with current issues I'm facing. Thank you kindly

Valuable input and advice from appointment. Non-judgemental and reassuring sign posting to easily accessible self-help. Very worthwhile appointment with very professional and empathic health professional

The mental health specialist is great. I feel like she really listens and takes my concerns seriously. She also remembers what I've said before and about my life which is really comforting – feel like a real person and not just another patient. I also like that this is held here at the GP, it's less intimidating

- Within Community Mental Health Services, a new Clinical Pathway for people who have difficulties regulating their emotions, has been agreed. Sometimes called Emotionally Unstable Personality Disorder or Borderline Personality Disorder, the Clinical Pathway will help deliver the treatments most likely to help people with these challenges. The Dundee Service User Network helped initiate meaningful discussions about this Clinical Pathway with a group of people who know just how hard it is to live with this type of problem. It is already known from research that the STEPPS Group treatment (System Training for Emotional Predictability and Problem Solving) helps people feel less distressed and reduces the number of crisis contacts people have with services. Over 2019-20, STEPPS will be embedded within the wider Clinical Pathway.

- Sources of Support (SOS) is a social prescribing link worker service operating in GP Practices in Dundee and sited within the Health Inequalities Service. It is part of the Scottish Government Community Link worker Programme, the Primary Care Improvement Plan, the Dundee Health and Social Care Strategic Plan, and the Mental Health and Wellbeing Strategic and Commissioning Plan (Action 15). The remit is to work with patients whose mental health and wellbeing is impacted by social and economic issues. Link workers form part of the practice teams liaising with a wide range of partners to achieve the best outcomes for the patient. Link workers often help the patients to meet their core needs such as food, clothes, warmth, housing, income and wellbeing. Once these needs are met, factors such as structure and routine, sense of purpose and belonging can be addressed.

  The service was asked to extend coverage to an additional 10 practices within existing resources to meet the requirements of the GP contract. This posed significant challenges and a small number of tests of change were explored to progress new ways of working that would allow all GP practices to benefit from the service without a reduction in service quality.

  893 people were referred to Sources of Support during 2019-20.

  To take the service change forward, internal resources were used to recruit a support worker to provide lower level but important aspects of patient care such as confidence building and desensitisation.

  In addition, the service has helped to build capacity of other staff in specified practices to signpost and refer patients to a range of activities and agencies where more intensive link worker support is not required.

  Lastly, the service took part in a test of change with PALMS (Patient Assessment and Liaison Mental Health Service) in Hawkhill Medical Centre where link worker referrals were made by the Psychologist undertaking assessments rather than GPs. This approach allowed the service to expand into the practice in June 2019.

Mr H had recently lost his job and home, and was feeling anxious and depressed. This affected his mental health, he was 'sofa surfing' and had just received his first payment of Universal Credit.

Mr H admitted he was struggling with life, had suicidal ideations and subsequently took an overdose.

The first step was to create a suicide safety plan and work with his GP to ensure appropriate medical interventions were in place.

"I was only getting £50 in benefits for a while so I attempted suicide twice. My weight was down to 62kg. I had a problem with alcohol also... so I seen (link worker) and that lassie deserves a medal… cause she can get things done… I am proof this system does work. If it wasn't for (link worker's) dedication and commitment I wouldn't be here today. "

Referrals

- Organised discussion on side effects of medication and the extent of suicidal thoughts and intent with GP
- Appointment at Housing Options service to make a homeless presentation
- Referral to colleague within Health and Homeless Outreach Team for additional mental health support
- Referral to Positive Steps for ongoing tenancy support
- Referral to Active 4 Life to improve mental and physical wellbeing
- Chaired a multi-disciplinary team meeting with Care Manager and Positive Steps to ensure a smooth handover upon discharge

Communication

- Supporting letter provided to Housing Options in support of Mr H's homeless application, which helped him get a 'homeless priority'
- Welfare check requested through Police Scotland on two occasions due to concerns for Mr H's safety due to suicidal thoughts
- Liaised with PiP assessor to ensure Mr H successfully claimed Personal Independence Payment without having to undergo a medical assessment
- Liaised with Mr H's Work Coach to ensure he was awarded the Limited Capability for Work or Work Related Activity elements of Universal Credit

Outcome

Mr H was successfully re-housed in his own tenancy. He received help with getting this decorated and furnished, and was assisted by Positive Steps throughout the transition. Mr H is financially stable having been awarded the correct benefit premiums for his ill health, and is looking forward to returning to work when he feels able.

"I know that I developed mental health problems which I never thought I would get... (link worker) helped me receive PIP and high rate universal credit and a bus pass. Now I am not fully better but getting there…I have a new house which is all done up now looking really good. I've worked all my life and that's my end goal plus I can earn more money working which is what I want when I'm ready "

- The Scottish Government established the Homelessness and Rough Sleeping Action Group (HARSAG) in October 2017 to produce short and long term solutions to end homelessness and rough sleeping. The group produced key recommendations for ending homelessness and rough sleeping. They are entirely consistent with our recently adopted 'Not Just a Roof' Housing Options and Homelessness Strategy.

  The cornerstone of the recommendations is a transition to a Rapid Rehousing approach along with Housing First. Rapid Rehousing is about taking a housing led approach for rehousing people who have experienced homelessness ensuring that they reach a settled housing option as quickly as possible rather than staying too long in temporary accommodation.

  The Vision for Rapid Rehousing and Housing First is set out in the recently approved Rapid Rehousing Transition Plan (RRTP) **https://www.dundeecity.gov.uk/reports/reports/9-2019.pdf.**

  Dundee City Council and it's Common Housing Register (CHR), Registered Social Landlords (RSLS) have approved and implemented in 2019-20 a 10% increase to its Homeless lets up to 55%, non CHR, RSL partners have also agreed a 10% increase in Section 5 Referrals up to 35% to its Homeless lets. These changes will help homeless people in Dundee into permanent accommodation quicker and will reduce the time spent in temporary accommodation.

  The ongoing review of temporary accommodation has a vision to reduce the need of temporary direct access beds by 157 units over 5 years and increase permanent supported accommodation by 51 places as well as creating 100 Housing First tenancies.

  Housing First is about providing secure tenancies for homeless individuals with more complex support needs along with a package of assertive intensive housing support, Dundee is one of the 5 pathfinder local authorities. A Local Consortium has been created to deliver intensive housing support for the programme of 100 tenancies over 3 years. At the end of 19-20 there were 44 Housing First tenancies created and 89% sustained.

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 Partnership Strategic Priorities: Health Inequalities (Strategic Priority 1), Early Intervention / Prevention (Strategic Priority 2), Localities and Engaging with Communities (Strategic Priority 3)

Dundee City Council Best Value Themes - Fairness and Equality, Partnership and Collaborative Working, Sustainability, Community Responsiveness

Across Dundee unpaid carers provide a significant level of care and support for family and friends who have health conditions, a disability, a mental health condition or substance misuse issues, are frail due to older age or have other health and social care needs. For most people this support is the preferred way of receiving support and meets many social and emotional needs as well as providing practical help. The provision of such unpaid care can avoid the need for more formal interventions for some and for others unpaid care is delivered as part of packages of care and support, alongside services provided by the Partnership. This is particularly the case for those with very high level care and support needs who are being supported in their own homes or other community settings. As well as the contribution carers make to individuals and to the life of communities, carers make an immeasurable contribution to the economy and we recognise that there would be huge financial costs if we were to attempt to replicate the care and support they give.

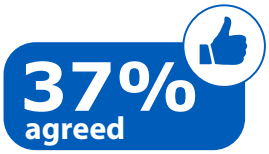
How We Performed

Of the total number of carers in Dundee at the time of the 2011 Census, there were 3,909 who were providing more than 50 hours of care each week. Carers sustain, maintain and contribute to the quality of life and health and wellbeing of the people they support. Depending on the nature and level of their individual care and support needs some of those who receive a significant level of care from family or friends may otherwise be unable to continue to live in their own homes and may have had to move to housing with care or to residential or nursing care, or would have experienced a detrimental impact on their health and wellbeing. With the rising number of older people and increased complexity of needs of people with disabilities remaining at home, it is anticipated that the number of unpaid carers in Dundee will grow and we know that there will be a need to 'scale up' the level of carer support accordingly.

Health & Social Care Experience Survey 2017/18

"I feel supported to continue caring".

Dundee



Scotland

There was variation in responses across Medical Practices ranging from 28% to 60%.

What we have achieved to deliver this outcome

- The Health and Social Care Strategic and Commissioning Plan 2019-22 highlights the 'immeasurable positive contribution carers provide' and reinforces the continuing 'commitment to ensuring that the role of carers remains integral to all that we do'. A Caring Dundee (A Strategic Plan for supporting carers in Dundee) has supported action through the Dundee Carers Partnership.
- During 2019-20 the Dundee Carers Partnership took initial steps to develop the next local strategy. The development of this Strategy, in partnership with carers and key stakeholders, will enable the Partnership to capture further areas of focus ensuring that we continue to support the significant contribution that carers make in our communities across the City.
- A Caring Dundee was reviewed in 2020 and the IJB agreed that in light of current circumstances a revised strategy will be not be available in 2021. The Carers Partnership has developed responses during the pandemic and will take action to continue to provide support for carers and respond to new needs.
- The Dundee Carers Partnership leads on innovation and improvement through Strategic Planning, development and provision of services and supports for carers of all ages. The Partnership group considers barriers to achieving these and any strategic matters arising which affect carers personal outcomes. The performance and progress against the actions in the plan are reviewed at each meeting.

Dundee Carers Partnership vision is to have:

"A Caring Dundee in which all Carers feel listened to, valued and supported so that they feel well and are able to live a life alongside caring"

- The Carers Interest Network (CIN) is a networking group bringing together professionals from across organisations providing generic and targeted support to unpaid carers across Dundee. The network acts as a forum to share information about services and supports available locally and to enhance knowledge exchange amongst professionals. The aim of the Carers Interest Network is to enhance carer identification and foster joint working and collaborations with other organisations, services and networks to better meet the needs of carers in Dundee. The network is co-ordinated by Dundee Carers Centre. 5 Carers Interest Network sessions were held during 2019-20, with 92 attendances. The CIN inputted and contributed to the following key pieces of work on behalf of the Carers Partnership, including:

    - Carers Act Multi Agency Guidance Information Toolkit
    - Input into the development of the local Short Breaks Services Statement
    - Carer and Workforce Training Update
    - Developing local supports & information resources for carers and professionals – Carers of Dundee website and Local Carers Charter
    - Input into the development of the Local Carers Strategy

- A Caring Dundee set out four Strategic Outcomes and progress during 2019-20 is organised under each Outcome

Strategic Outcome 1: Carers will say that they are identified, respected and involved

1. A 'Carers of Dundee' marketing campaign ran for 4 weeks from late May 2019. The aim was to generate awareness and collaboration in supporting carers in Dundee. During the campaign all traffic increased through the Carers of Dundee website and Carers of Dundee social media with a 59% increase in direct traffic to the Carers of Dundee website and we recorded a 17% increase in followers across social media platforms.
2. In National Carers Week in June 2019 the communications team at Dundee Carers Centre distributed the first issues of a 'Carers of Dundee' quarterly newsletter and e-newsletter for 2019. This has continued to strengthen the brand and increased the reach of information relevant to carers. The information promotes Carers Partnership activities as well as information about agencies offering carers support in the city and their events and activities.
3. The carers involvement groups facilitated by Dundee Carers Centre has continued to develop in an inclusive way. Carers Voice, Young Carers Voice and the Lifeline Group have increased carer involvement opportunities in service design. Plans have been made to create a second distinct Lifeline Group as greater demand for this peer support has been identified.
4. Young Carers often support adults who have a wide range of health and care needs. Dundee Carers Centre have been working in partnership with young people and Dundee City Council Children and Families Service to increase awareness of young carers rights and the supports available. In order to ensure that young carers have the best experience of, and benefit from, completing a Young Carers Statement, a small group of young carers were involved in a test of the process ending in May 2019. Young carers identify a shared ownership of the process of Young Carers Statements.

"By taking part in the Young Carer Statement test it made me feel listened to and valued as a carer. I no longer feel anxious about being a carer or feel nervous about being asked why I am late to school again, it has made my life so much easier at school which now makes it a happier place to be. By having my Young Carer Statement in place it makes me feel settled and content within Education. The most challenging part of my Statement was having to detail any barriers I was experiencing in Education but now looking back this was the most meaningful part.. because of including this in my statement I now have methods in place to support me." (Young Carer who took part in Young Carer Statement Test)

T is a young carer for their single parent who has cancer. T's parent now lives with long term side effects of surgery which also limits their ability to leave the house. When the Carers Centre worker first met T, T was constantly worried about their parent. In addition they carried out tasks such as shopping, preparing food, organising medication, helping their parent dress, housework and looking after the family pet. T's young extended family member is a frequent visitor and T often looks after them. T's parent sought support for T after the school let them know this was available.

The initial focus of 1:1 support was to establish a positive, trusting relationship with T as they found it challenging to identify themselves as a carer. T identified that their school attendance was poor, the school were unaware of the extent of the caring role, T did not have quality time to themself and did not attend any social activities or groups.

T identified goals they wished to work towards through 1:1 support:

T applied for Short Breaks funding through the Carers Centre for a games console so they could pursue their gaming hobby, have time for themselves, but also knowing they could do this at home should their parent need them.
T went home at lunchtime every day to check on their parent and through 1:1 reduced this to 3 times per week enabling them to interact with peers at lunchtime
T also spoke to their Guidance Teacher, so the school could understand the extent of their caring role and support their attendance, T feels well understood and their Guidance Teacher now regularly checks in with T regarding their caring role.
T accessed day trips through the Carers Centre summer programme, and through these activities made friends, and developed confidence in group settings, taking on a leadership role in some groups.
T then went on residential with the Carers Centre which was a big milestone in feeling able to leave their parent overnight.

Now T no longer accesses 1:1 support as they feel able to manage their caring role and maintain a healthy mindset.
T now feels able to ask for help from family, school or the Carers Centre and doesn't feel they have to manage everything on their own.
T accesses group support in school, and is a Young Carer Ambassador in school, taking a leadership role in raising awareness of and supporting young carers in their school as well as feeding into decision making processes for young carers
T also accessed a mentoring programme run through the school focusing on future learning and employment in the arts industry.
T makes newly identified young carers in their school feel at ease in the group and also contributes to supporting citywide events for young carers - they feel proud to undertake this role and make a difference.

Strategic Outcome 2: Carers will say that they have had a positive caring experience

5. The Dundee Carers Charter sets out what carers can expect from services, the type of support they can access and the opportunities for involvement in decisions affecting the people they care for. The Carers Charter was refreshed in 2019 to reflect the Carers of Dundee brand.
6. The Adult Carer Support Plan recording template was redesigned on the Mosaic Record System and introduced in February 2020. The updated format supports Health and Social Care Partnership practitioners to complete assessments and support plans for adult carers who require a formal plan and additional support to achieve their personal outcomes in their caring role.
7. Across the city and through a range of agencies, one-to-one support and a variety of Carer Support Groups have continued to expand peer support activities so that carers can learn from each other's experiences and skills as well as offering support and advice to each other.

I feel like I need someone to speak to and who understands how difficult things can be. I've been going to the Carers Group on a Thursday and it's really helped because people there understand, and we can have fun but also talk about things that are difficult…When my mum referred me, the group wasn't there and I felt like I needed 1:1 support (I had it before) but because I have the people at the group now and I know that you will be there if I do need to talk, I don't really feel like I need it as much

- Young Carer – illustrating the benefit of peer/group support reducing need for formal 1:1 support

I learn so much from coming to this group, it is great to know what other services and supports are out there for carers. If I didn't come to this group I wouldn't know about them. Thank you!

- Adult Carer talking about the Carers Centre group

Strategic Outcome 3: Carers will say that they have opportunities to lead a fulfilled and healthy life

The Penumbra's Carer Wellbeing Point pilot project has been designed to run from January 2019 until May 2020. Support Workers from Penumbra have been available in a range of community venues across Dundee providing drop in sessions that carers can access directly. The pilot aims to provide an easily accessible point of information so carers can be aware of what's available to support them in their caring role. This includes information on services and supports in Dundee, alongside resources that promote positive wellbeing. So far this has proven to be an effective approach to supporting people in their local area and increasing identification of carers as it is generating conversation about caring and what being a carer means.

Through the Wellbeing Points Support Workers have provided a range of personalised responses and follow up support where required. This has included information and sign-posting in relation to areas such as: mental health and wellbeing; carers health checks; crisis contact numbers and safe planning for those experiencing distress and suicidal thoughts; finances and welfare reform; drug and alcohol dependence; counselling services; informal community-based group; short breaks and volunteering opportunities. Some bereavement support has also been provided including supporting those bereaved by suicide.

At present, Penumbra has increased presence in areas where people have been affected by recent completed suicides to offer people in these local communities greater opportunities to be supported and increase awareness of what is available to them in these circumstances.

It was really useful getting to know about all this stuff…I didn't know half of these supports were available in Dundee

- Wellbeing Point Carer

Strategic Outcome 4: Carers will say that they have a good balance between caring and other things in their life and have choices about caring

The Carers Partnership commissions Dundee Carers Centre to provide a Short Breaks Brokerage Service for Carers in Dundee. The Brokerage Team supports carers to consider what a short break means to them and what kind of break would best meet their outcomes. Following this the team help source funding or breaks as appropriate. Demand for the service continues with 336 carers awarded and benefitting from a short break during 2019-20.

I'm so completely overwhelmed by such a generous gift of all these vouchers. Didn't expect anything like that. It was the most wonderful surprise at a time I really needed the boost. There were tears involved when I opened the envelope (for the first time this year happy ones!) (name)……. and I will most definitely enjoy the dinner vouchers as such a welcome break, out on our own together (not done that since last year) I thank you for taking the time to care at this vulnerable time in our lives just now.

- Carer Positive is a Scottish Government initiative which has been developed by Carers Scotland to support carers in the workplace. The award incorporates 3 levels or stages, from 'engaged' to 'established' through to 'exemplary'. A number of Dundee employers have now received an award including: Carr Gomm, Joe Fitzpatrick MSP, PAMIS, Dundee Carers Centre, Police Scotland/SPA, Scottish Fire and Rescue Service, Scottish Social Services Council, SCVO, Sense Scotland, Skills Development Scotland, HMRC (Local Compliance) Scotland, Dundee City Council, NHS Tayside, Open University, Scottish Courts & Tribunals Service, and Royal Bank of Scotland

  Carers in Dundee who are part of these workforces are supported by their employers, their peers and local carer support services and each of the agencies maintain and continue to improve their approach to carers in their workforce.

National Outcome 7: People are Safe – People who use Health and Social Care services are safe from harm

Outcome 7 links to:

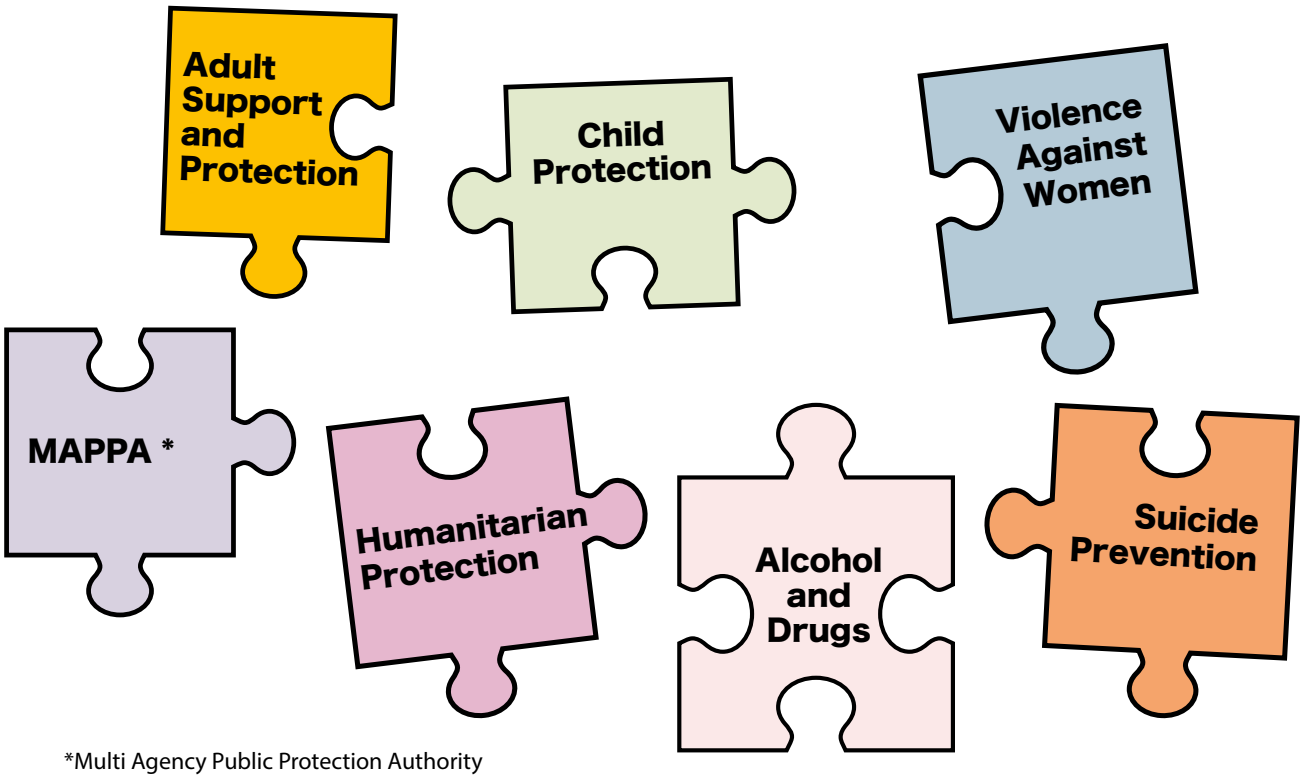
All four of the Partnership Strategic Priorities

Dundee City Council Best Value Themes - Fairness and Equality, Partnership and Collaborative Working, Sustainability

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.

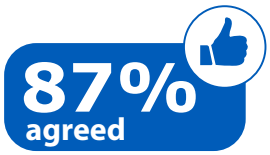


*Multi Agency Public Protection Authority

How We Performed

Health & Social Care Experience Survey 2017/18

"I felt safe".



Dundee

Scotland

2019-20 has seen a continued focus on Adult Support and Protection activity as outlined in the recommendations contained in the Independent Convenor's Biennial Report for 2018-19:
http://www.dundeeprotectsadults.co.uk/Adult%20Support%20Protection%20Report%20final.pdf

Recommendation 7
We will evaluate the impact of the Adult at Risk lead professional model on individuals who do not meet the three point test and ensure that learning from this contributes to the development and delivery of practice across the city.

Recommendation 8
We will evaluate early Screening Activity across the Partnership to be assured that the recognition of and response to adults at risk is consistent and proportionate.

In 2019-20 the total number of referrals for adults at risk was 2146 representing a significant increase of 601 (39%). Police Scotland continues to be the primary source of referrals, 1819, representing an increase of 494 (37%). This is in keeping with the above recommendations and increased awareness of collective responsibility for Adults at Risk across the partnership. In keeping with previous years, the increase in referrals is not reflected in those progressing to statutory proceedings with no significant increase in either Initial Referral Discussions or Case Conferences. In Dundee we have a single pathway for vulnerable adults. As there is an increase in police involvement in non-crime related referrals, e.g. mental health and substance misuse, it follows that there will be an increase in concern reports.

Further work was undertaken during 2019-20 to explore options for supporting vulnerable adults who do not meet the statutory three-point test for statutory adult support and protection intervention. A multi-agency group has considered approaches to assessing and managing risk where vulnerable adults, often with complex needs, require support. Work has also begun as part of the ongoing Transforming Public Protection Programme to review existing arrangements for multi-agency screening of adult and child concerns, with further work to take place during 2021 to develop an options appraisal of potential options for future delivery of screening arrangements.

Adults at Risk Referrals

	Number of Referrals
2019 - 2020	2146
2018 - 2019	1548
2017 - 2018	937
2016 - 2017	914
2015 - 2016	1246

Referrals from Police Scotland

	Number of Referrals
2019 - 2020	1819
2018 - 2019	1325
2017 - 2018	887
2016 - 2017	741
2015 - 2016	1074

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 2019-20 there were 158 cases discussed at the Dundee MARAC.

What we have achieved to deliver this outcome

Over the past year Dundee Adult Support and Protection Committee has committed to reviewing and improving its activity in relation to keeping people safe.
An analysis was undertaken identifying key issues, strengths and areas for improvement from the following sources;

- Former Balanced Scorecard and associated Adult Protection datasets
- Preventative work undertaken across the Partnership including those not generally considered to be Adult Support and Protection.
- Case file audit outcomes and action plans
- Learning and workforce development activity
- Work carried out by the Improvement Service
- Areas of development identified from the Thematic Inspection.
- The findings of SCRs and ICRs
- Protecting People Transformation Programme.

The plan compliments improvement work being undertaken elsewhere across the Partnership.

Five priority areas have been identified, namely;

1. What key outcomes has Dundee Adult Support and Protection Committee achieved?
2. How well does Dundee Adult Support and Protection Committee meet the needs of our stakeholders?
3. How good is Dundee Adult Support and Protection Committee's delivery of services for adults, carers and their families?
4. How good is Dundee Adult Support and Protection Committee's operational management?
5. How good is Dundee Adult Support and Protection Committee's leadership?

Each section considers a priority area, considering the extent which Dundee ASPC can demonstrate key outcomes, what evidence may be used and proposed actions to support the plan before detailing objectives, actions, leads, timescales success criteria and measures/indicators.

A key achievement this year has been the publication of the Tayside Multi-Agency Adult Support and Protection Protocol which can be accessed here.

https://www.dundeecity.gov.uk/sites/default/files/publications/multiagency_protocol.pdf

Effective partnerships between the Health and Social Care Partnership, Police Scotland, Trading Standards, Community Safety, local banks and businesses across Tayside mean we have been able to take decisive, co-ordinated action to respond to people who have required support and protection.

The Multi-Agency Protocol represents the commitment of agencies within Tayside to:

- unite in the prevention of and protection from harm, mistreatment and neglect of adults at risk aged 16 years and over;
- ensure situations of actual or suspected harm, exploitation, mistreatment and neglect are identified, recorded and investigated; and
- provide services and support for adults at risk who are experiencing harm.

- The multi-agency Humanitarian Protection Partnership (HPP) has been established to deliver the Vulnerable Persons Resettlement Scheme (VPRS) and Vulnerable Children's Resettlement Scheme (VCRS) within Dundee. The Partnership is a critical component of this and contributes to processes including initial planning and acceptance of a refugee family and preparing a personalised integration plan for each individual family member to ensure their needs are met.

  Support for resettled families is delivered in an ethos of joint-working, which is enhanced by multi-agency development, learning events and consultation with resettled families.

  It is approximately five years since Dundee City Council welcomed the first 5 refugee families to the city and to date we have resettled a number of refugees from Syria, Iraq, Ethiopia and Somalia. Over these five years Dundee has built up a strong partnership to ensure those 'New Dundonians' can fulfil their full potential, live safely and integrate into Dundee society.

  Continual feedback and reporting from the various teams within the partnership, combines with the results of annual surveys, consultations, staff development events and evaluations to give an overview of the scheme that evolves throughout the year.

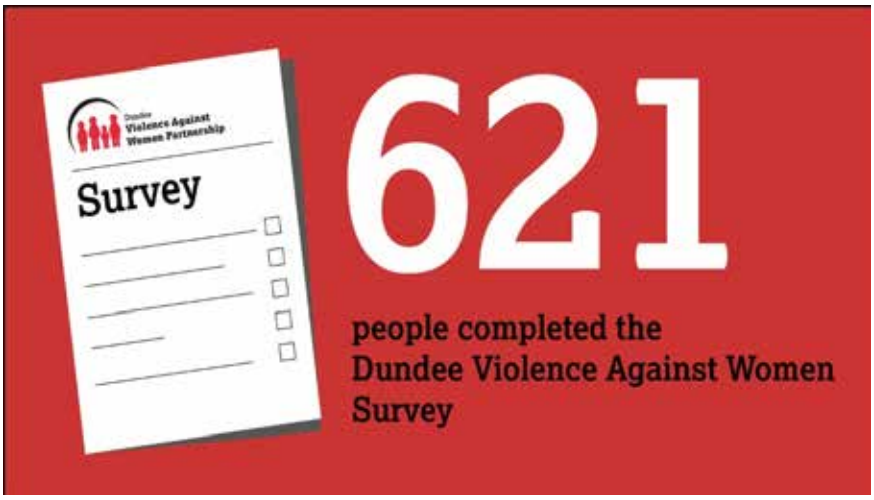
The work carried out by the partnership has been recognised by a number of awards: a COSLA Gold award for the Get Ready for Work Programme, a COSLA Bronze award, Dundee City Council's Outstanding Service and Commitment Award (OSCA) for the multi-disciplinary partnership model; and the Scottish Social Services Council (SSSC) award, 'Silo Buster', recognising "joined up thinking, working and delivering".

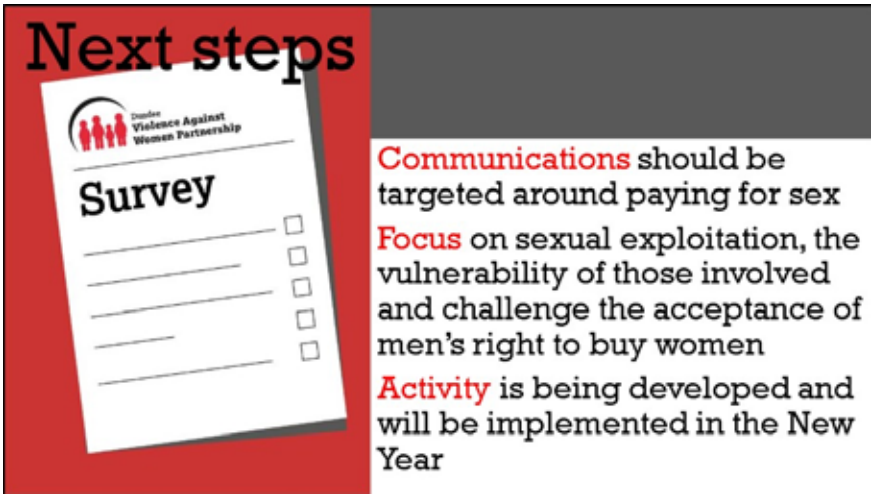
Mohamad left Syria in 2013 due to the war and was resettled in Dundee with his wife and 2 children in March 2017 as part of the Vulnerable Persons Resettlement Scheme. Mohamad was motivated to learn English and find employment as soon as he could. He enrolled on the community English for Speakers of Other Languages (ESOL) class at Mitchell Street Centre and attended 16 hours of English classes a week. In order to quickly improve his English language skills he also used a number of online English learning resources out with his classes. He completed the first 'Get Ready for Work Course', a partnership between Dundee City Council's Employability and ESOL services where he increased his confidence in applying for employment in the UK. Mohamad had worked as an accountant in Syria but also had bus driving experience whilst displaced in Lebanon. He was able to use his international driving license for a year in the UK however he was keen to pass his UK driving test to increase his employment prospects so began lessons and passed his theory and practical test first time. After a year studying English at Mitchell Street Centre, Mohamad moved to a more advanced ESOL class at Dundee and Angus College. He continued to be supported by the Employability Team and independently studied for his PCP (bus driving theory test). In 2019 Mohamad was offered the opportunity to apply for a post of a bus driver with Travel Dundee with support from the staff who ran the Get Ready for Work course. He was enthusiastic about the possibility of employment as a bus driver, passed his medical and then sat his bus driver test, which he passed first time. He is now employed as a bus driver and has said he loves this job and is optimistic about his future in Dundee. He plans to establish his own accounting business as he studies and improves his English even further.

- On April 1, 2019 causing psychological and physical harm using coercive and controlling behaviour was made an offence by the Scottish Government. Against that background the Dundee Violence Against Women Partnership wanted to capture social attitudes towards gender-based violence in the city to help effectively target communications aimed at changing those attitudes where necessary. The survey was posted on line and was available for five weeks in October and November this year. Participation was encouraged via mainstream and social media, as well as word of mouth and a feature on Dundee City Council's website.

  42 questions sought to discover respondents' views on five broad areas of interaction between the sexes - the roles of men and women in society, the roles of men and women in the workplace, sexual violence, abuse within relationships and paying for sexual gratification.

  In order to gauge their views respondents were given an opportunity to select a point on a scale between one and five indicating strong agreement through to complete disagreement. An option of neither agree/nor disagree was offered in each question. The questions and answer options were framed in a way that minimised the tendency of a respondent to agree with a statement when in doubt.





- This year we established a short life working group (including Perth and Kinross and Angus) and developed an improvement plan for MARAC's across Tayside. A new MARAC co-ordinator was appointed and this role has been developed to include leading an operational development group, reviewing processes and procedures for MARAC and creating guidance for all agencies involved in the MARAC process. Two representatives from Dundee are now trained to deliver Safelives MARAC reps training and a MARAC development session was held during the 16 days of action including all stakeholders involved in MARAC. A Tayside wide steering group has now been established to take forward actions from the development session, ensure that the MARAC operates in line with legal

responsibilities and changes to best practice guidance, address any operational issues, including taking an overview of complaints, monitor attendance of MARAC representatives at meetings, take responsibility for the evaluation of the overall effectiveness of the MARAC process; including monitoring of all data sets, annual performance review and monitoring against the 10 core principles of MARAC, ensure that the principles of the MARAC Operating Protocol and the MARAC Information Sharing Protocol are upheld and hold partner agencies to account, ensure that effective partnerships are maintained with other public protection bodies and other MARAC areas, oversee efforts to raise awareness with local practitioners about MARAC and address the impact of the MARAC process on the needs of all victims.

Dundee introduced Safe and Together in 2016. The Safe and Together Model is based on the assumption that a wide-range of professionals and frontline staff must be **'Domestic Abuse Informed'** in order to adequately respond to their responsibility of child safety and wellbeing.

There was renewed focus on implementing S&T in Dundee over 2019-20 and the following actions have been taken:

- Dundee's Safe and Together Action plan refreshed and updated
- Short life working group set up to develop resources/guidance for Dundee (Domestic abuse and Child Protection guidance in progress). Social Work staff from Children and Families and Criminal Justice are involved in this. A short guide to S&T/Risk Assessment tool for domestic abuse has been developed.
- To develop skills and confidence in the delivery of the briefing sessions. 20 practitioners who undertook the original 4 day Core Training have now had training to deliver the briefings and a standardised briefing presentation and materials have been developed.
- The following practitioner forums included discussion topics led by local experts –
  - August - Understanding of perpetrator behaviour led by Vicky Orme, Forensic Psychologist
  - October - Joint forum with Angus focusing on intersections between domestic abuse, mental health and substance use
  - November – Understanding women's trauma and issues of traumatic attachment led by a clinical psychologist
- Online KHub group established – for sharing resources, ideas and challenges
- A standardised briefing and guidance have been developed.
- Programme of cascading briefing sessions is underway and uptake is positive. Sample feedback from briefing sessions delivered so far:

Very informative, gave lots of food for thought and will impact positively on my responses when working with children and families experiencing domestic abuse

Staff are asked to give examples of how they will implement S&T in their practice:

To try and stop placing responsibility for child's safety on the non-abusive parent

What language you use when speaking to parents/how to change your mindset when dealing with these situations

More aware of what language I'll use and focus on the perpetrator

- Full day training for Children and Families Social Work team managers has taken place.

- The 16 days of activism against gender based violence is a global campaign set up in 1991 calling for the elimination of all forms of violence against women. The campaign takes place annually between 25th November-10th December.

  Every year, the Dundee Violence Against Women Partnership (DVAWP) works closely together to deliver a number of awareness raising events as part of this campaign. Events included; street art, spotlight on Shakti Women's Aid for BME women and children, presentation on substance misuse, trauma and violence against women, lunch club, presentation about domestic abuse and children, professional training on honour based violence, forced marriage and female genital mutilation, human traffic awareness and 'Reclaim the Night' march.

Street Art to end Violence Against Women and Girls (Led by Amina MWRC with input from participants from other women's organisations)

One member of staff from Amina said:

"As a trainer on VAWG issues, I'm sometimes disheartened that it can feel I only speak to people who already 'get' the need for VAWG work. What this art project did was allow us to get the message out far wider. We distributed dozens of 16 days programmes and over a hundred 'Any Woman Anywhere' postcards which will hopefully be sent to MSPs.

We also had the opportunity to discuss things with people who challenged the purpose of the activity. We were able to explain, with evidence such as crime statistics, why this work is important. We were also able to promote activities such as our forthcoming film night.

I was glad our organisation's work was promoted by STV and Tay FM as a result of the art project. This could mean more women getting in touch for support via our helpline, and could also lead to more volunteers joining us."

The annual march to raise awareness of violence against women started from outside The Overgate and finished at City Square with entertainment and refreshments in Marryat Hall.

On the run up to the march local artists from Duncan of Jordanstone College of Art and Design led a workshop to make banners and placards for the Reclaim the Night Procession.

- A Commercial Sexual Exploitation Working Group was re-established as a sub group of the Violence Against Women Partnership. This has brought together key agencies supporting women involved in exploitation and a number of key actions have developed out of it. One excellent example is the establishment of a project in Stobswell which aims to support women involved in on-street prostitution. The team is a multi agency partnership and is made up of staff from We are With You (formerly Addaction), Vice Versa, Police Scotland, a Keep Well nurse and link closely with the lead officer for VAW in the protecting people team. An evening drop in session was delivered once a month in the Stobswell area as it was recognised that there was an increase in on street prostitution in the area. The team developed this response with no additional resource. This is an exceptional example of partnership working to meet the needs of some of the most vulnerable women in Dundee. The Police from the local area go out in plain clothes to speak to the women on the street and encourage them to access the drop in. Here they have access to advice and information, signposting, health checks, dried blood spot (DBS) testing, naloxone, condoms, sanitary products, food, clothes, general chat, access to mobile phones, personal alarms, follow-up supports and the UGLY MUG Database. There is early evidence that the drop in is having a positive impact on the women.

Miss B presented to the drop-in during September 2019. She reported that she had been working on the streets for a number of years (on and off). She had previously been on prescribed treatment (Methadone) and had successfully reduced and remained drug free for a period of time. Due to a traumatic event in her daughter's life she struggled to cope and relapsed back to heroin use. She had reported feeling too scared to access support but was now ready to access the supports and services she required. Contact details were provided to Miss B and text messages were sent encouraging her to access the Integrated Substance Misuse Service (ISMS) direct access clinic to discuss her current substance use. Miss B was supported to ISMS and subsequent appointments where she was started on Opioid Replacement Therapy. Miss B was also requiring support with housing as her current tenancy was damp and making her unwell. Support was provided to speak with housing workers and a referral was urgently submitted to Positive Steps. Miss B was offered a tenancy for herself and her daughter within 4-6 weeks which she accepted. Ongoing texts have been sent to let her know if she requires any other supports she can make contact with the team. There have been no further sightings of her working back on the streets since supports were provided.

- For many years Domestic Abuse projects concentrated on supporting the victim, with limited scope to address perpetrator behaviour. In 2018-19 only 9 men in Dundee were made subject to a Community Payback Order with a requirement to undertake Domestic Abuse Programme work. However on 1st April 2019 Dundee, along with Perth and Kinross, joined the Caledonian Programme and the situation greatly improved. During 2019-20 in Dundee the courts have issued 23 Caledonian Programme Requirements and 18 Requirements for the related Respect programme, the total of 41 being over 300% greater than the previous year. Whilst delivering an evaluated and accredited programme to address perpetrator behaviour, the Caledonian Programme does not neglect support to victims nor support to any children impacted by domestic abuse and two voluntary agencies, Action For Children and Perthshire Women's Aid deliver work with women and children as part of an integrated partnership approach. The Caledonian Programme has also enhanced how information is gathered for Court reports with all Community Justice staff receiving training in the Spousal Abuse Risk Assessment (SARA 3) which incorporates victim information and evidence of patterns of behaviour over time, as opposed to reporting on an incident in isolation.

  Alongside the adoption of the Caledonian Programme, Dundee City Council also employs a Domestic Abuse Resource Worker who offers voluntary programme work with men who have not been convicted but agree they want to address their own behaviour. The referrals come from Children's Services and taps into the fact that some men begin to understand that their behaviour is problematic when its negative impact on their children is highlighted.

  Statutory and voluntary agencies within Dundee continue to work together to address domestic abuse and the implementation of the Caledonian Programme has added an integrated approach and a strengthened focus on addressing perpetrator behaviour.

- As one of the immediate responses to the Dundee Drug Death Commission a multiagency group to address Non-fatal Overdoses (NFOD) was established in October 2019. A 5 day a week multiagency conference call was established to share information about individuals reported by Police or ambulance service to have had a non-fatal overdose the day before. Through the information sharing the group was able to identify the agency best placed to follow up the non-fatal overdose and encourage the individual to accept support to address their substance use. The Community Justice Service has participated in the call from its inception, providing information about justice involvement, any relevant links to children who may be impacted and being one of the agencies tasked to make the follow up contact within 72 hours of the incident. The NFOD group has increased all agencies knowledge of each other's work and co-ordinated the multiagency response, as well as ensuring that a timeous offer of support takes place.

- As part of community based orders, individuals meet regularly with staff to explore what steps can be taken to achieve a reduction in reoffending through improving positive life choices. To build on a period of reflection, Partnership staff are co-located within the Community Justice Service (CJS) center 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 closely together can help improve the health and wellbeing of service users at critical moments and it can also save lives (e.g. naloxone administration).

  To strengthen the links between CJS and mental health support there is a Community Justice Nurse connected to the Community Mental Health Team. This enables initial assessments and interventions to be undertaken and allows for direct referrals to be made and close working with colleagues supporting people experiencing mental health challenges.

  The CJS remains highly aware of the impact of substance misuse and having co-located substance misuse nursing staff allows both clinical and offending risk to be managed in one location. The substance misuse nurses provide support to those on CJS statutory orders, working to National Outcomes and Standards. While most of the substance misuse work tends to be around drug treatment there is also a proportion related to alcohol misuse.

  Towards completion of an order both CJS Substance Misuse Nurses and Social Workers will, in identified cases, continue to provide treatment and support to those who have completed their orders. This continues until an identified and available key worker is available at the Integrated Substance Misuse Service and their treatment and recovery can continue in mainstream community delivery.

  For those leaving prison on a parole, non-parole or extended sentence, engagement with mainstream community services remains the best option for the majority of people to become settled in the community. The Substance Misuse Nurses are available for delivery of drug treatment for those leaving prison after a long sentence where these cases are determined by risk and need.

  CJS also has a Keep Well Nurse co-located who offers support regarding physical health and wellbeing issues. This includes the Keep Well Nurse making regular offers of support to individuals attending CJS to undertake unpaid work. The Friarfield co-located base for CJS has also hosted quarterly dental drop-ins that encourage people who may have barriers to attendance at dental practices, to obtain the help they need.

- During 2019-20 the Clinical, Care and Professional Governance (CCPG) Group has met every 2 months to consider:
  - Reports/updates from specific service areas
  - Outcomes of inspection reports
  - Risk registers
  - Reviews carried out under Local Adverse Event Review, Significant Case Review and Significant Case Adverse Event Review procedures
  - Exception reports relevant to Clinical, Care and Professional Governance
  - Introduction of new Clinical, Care and Professional Governance policies and procedures

  Over the past year the CCPG Group has sought to support the sharing of information across a range of services and to ensure the work of the CCPG Group reflects the broad range of services delegated to the Integration Joint Board.

This year has seen the development of primary governance groups under the remit of each Operational Manager who report exceptions in line with the 6 domains of the Getting it Right Framework into the CCPG Group. Exception reports are provided at each CCPG Group.

Each service has now provided a comprehensive report detailing their governance structure, and key areas of work, over the past year and work is ongoing to develop a system whereby more regular, comprehensive reporting will be undertaken by all teams throughout each calendar year, making best use of the available time and targeting the analysis at core and service specific data.

Throughout the year, members of the CCPG Group, along with the Chief Social Work Officer, have been invited to attend the Clinical Quality Forum (NHS Tayside) to further develop a sharing of information and scrutiny at a Tayside wide level. Reporting into the Clinical Quality Forum from the Health and Social Care Partnerships has provoked much debate and work continues between the Partnerships and NHS Tayside in reaching agreement for the most suitable and appropriate datasets and report content. A review of the Getting it Right Framework has commenced to support this process.

You can read the full annual report of the CCPG for 2019-20 on our website (**https://www.dundeecity.gov.uk/reports/agendas/h&sc250619.pdf**).

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:

All four of the Partnership Strategic Priorities

Dundee City Council Best Value Themes - Vision and Leadership, Governance and Accountability, Fairness and Equality, Partnership and Collaborative Working, Sustainability

Workforce engagement helps create an environment where the workforce feels involved in decisions, feels valued and is 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.

What we have achieved to deliver this outcome

- We have progressed our plan to introduce a workforce area on the Partnership website in 2020. It is hoped that this will optimise communication for Health and Social Care colleagues across all sectors in the city. This workforce area will host learning materials and other important communication for our workforce. This area will be accessible to the public which will enhance transparency and allow service users, patients and carers to research any information they might wish to access.
- From 2018 -2020 Roxburghe House Trainers and a Care at Home Trainer have provided joint training for over 200 staff for Palliative Care. Staff have provided excellent feedback regarding this training based within Roxburghe House.
- 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.
- We developed The Participation and Engagement Strategy 2019-22 and within this strategy we recognise that engaging with our workforce helps create a workplace where all colleagues are involved in decisions, feel valued and are treated with dignity and respect. It also allows our workforce to share ideas and have good open communication with everyone around us. We recognise that many people within our workforce will also have experience of Health and Social Care matters as patients, service users and carers.
- Our Locality Managers have used a number of different methods to bring together the teams that they are responsible for leading and 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.

Throughout 2019-2020, NHS Tayside continued to roll-out the approach known as 'Value Management' empowering teams to drive quality improvement in their areas to ensure value for the patient, staff and organisation. This method covers 3 components:

- Weekly collection and analysis of quality and finance data
- Visual management displaying data over time
- Multidisciplinary weekly huddles to discuss learning from data and continuous improvement

Value Management is now embedded within the Integrated Discharge Hub, enabling and empowering the team to own and measure their performance and identify relevant improvement actions. Dundee Physiotherapy Community Rehabilitation team commenced this approach in June 2019 exploring opportunities to reduce the time patients wait for an appointment.

The Pelvic and Obstetric Physiotherapy team in Dundee and Angus started Value Management in November 2019.

- 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.
- Our workforce has had access to a wide range of learning and development opportunities during the last year. We have:
  - Continued to collaborate across NHS Tayside to ensure that core training and learning and development opportunities are planned and delivered on a Partnership basis, with colleagues from NHS Tayside, Dundee City Council and the Third Sector.
  - Created opportunities for different parts of our Health and Social Care workforce to come together for shared learning and reflection through workshops, multi-agency training events, and reflective practice sessions.
  - Continued to hold Dundee Health and Social Care Partnership Joint Induction and Information Sessions for new and existing employees, to support their understanding of what it means to be part of the Health and Social Care workforce in Dundee.
  - Designed and delivered events and development activity aimed at meeting key actions to improve multi agency working across substance use services.
  - Delivered Business Coaching to leaders across the Partnership.
  - Continued to provide qualification attainment (SVQH/NC/other core academic and accredited learning) for relevant parts of the HSC workforce, to meet the requirements of registration, regulation, and to drive up standards of care across the city.
  - Ensured Learning and Organisational Development continues to be a key feature in any relevant strategies and policy development.
- In March 2020, a comprehensive **Induction Resource** and a suite of **COVID-19 learning resources** was developed to ensure that the Health and Social Care workforce in the city, including those who were deployed on a temporary basis to support community based Social Care services, were given the right knowledge and information to practice in a safe and informed way as a response to the COVID-19 pandemic.
- Healthy Working Lives is about promoting self-care and encouraging individuals to take responsibility for their own health and wellbeing. In 2019-20 the aim was for the Partnership to achieve the Healthy Working Lives Gold Award by March 2020, however this was delayed for 6 months due to the COVID-19 pandemic. The review is now scheduled for later in the year. In the interim, Healthy Working Lives continues to actively promote health and wellbeing for Health and Social Care staff and has taken a pro-active approach in supporting the development of the Health and Social Care

Partnership COVID-19 Wellbeing Support Service. In addition to what is already available to staff, additional resources have been sourced and developed to offer support during these unprecedented times.

Personal challenges, caring responsibilities, fear, anxiety, loss, bereavement are anticipated on a daily basis during the pandemic without access to the usual support networks which many will have previously had available to them. Normal approaches to stress and resilience may not be sufficient to manage or reduce the impact of these experiences for some. It is anticipated many more employees will be exposed to on-going stressors on a daily basis repeatedly over a long period of time. Given these and other factors there will be an increased need for health, wellbeing, psychosocial and psychological support.

At the same time Healthy Working Lives continues to offer a range of information, activities and opportunities encouraging staff to be mindful of looking after themselves as well as others.

- In order to deliver good quality services to all our citizens the Partnership has a commitment to ensure that our workforce is aware of the most effective communication supports. We have contributed to the British Sign Language (BSL) plans of our partners in Dundee City Council and NHS Tayside and we will continue our work to ensure we meet the needs of BSL Users in the best possible way.

  Dundee City Council published its **British Sign Language Plan (BSL)** 2018-2024 following intensive engagement in partnership with Angus and Perth and Kinross Councils and BLS users from across Tayside. The Deaf Community has been engaged with by the Council's Equality & Diversity Coordinator in the development of the Plan. The Dundee BSL Forum was established to maintain regular dialogue with the BSL user community in the City. The forum provides an opportunity to share progress in meeting the aims of the Dundee City Council BSL Plan as a source of expertise, advice and guidance. The Disability and Age Action Group (DAAG) undertake quarterly consultations on all aspects of Dundee City Council policy and practice relevant to people with a disability and the older non-disabled population. The DAAG has over the past 10 years or so provided invaluable advice and guidance to Dundee City Council on reducing the barriers faced by many people with disabilities or age related impairments.
- The Carer Interest Network is a practitioners' forum which was developed to enhance learning and development in providing support to carers in Dundee. The Network involves practitioners across Health, Social Care, Third and Independent Sectors in developing co-ordinated approaches to supporting carers in Dundee.
- The Carer Interest Network has provided opportunities to share information and learning to develop supports and resources for carers and professionals (Carers of Dundee brand/website and local Carers Act Multi-Agency Guidance), as well as agency input presentations to raise awareness of the variety of universal services and commissioned supports available to all carers in Dundee.
- As part of the Transforming Public Protection Programme we have started work focused on designing approaches that provide an integrated response to risk across all ages (including multiple risks experienced by members of the same household/family group) and minimises the number of protection processes that any individual or family is subject to. There are two workstreams within this element of the programme:
- Exploring options to more closely align approaches across children and adults in terms of screening and addressing immediate responses to concerns; and,
- Review co-ordination of key protection processes to more clearly align and integrate functions such as chairing of case conferences.

In October 2019 an initial scoping exercise was undertaken to obtain an up-to-date picture of current pathways and processes and of workforce perceptions of perceived strengths, challenges and gaps, drawing on the knowledge and expertise of 39 key staff from across multiple agencies. The scoping exercise also included researching information about best practice approaches elsewhere in Scotland and the rest of the UK to screening and multi-agency meetings. This scoping exercise was the first step in a wider programme of work that will be required to gather and analyse information, data and evidence to enable robust options appraisal of potential future models of service delivery. Practitioner involvement in this work will be a key feature of future activities, building on the contribution of the workforce in the initial scoping exercise.

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:

All four of the Partnership Strategic Priorities

Dundee City Council Best Value Themes - Use of Resources, Sustainability, Partnership and Collaborative Working, Community Responsiveness

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 We 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 2019 23% of Dundee's health and care budget was spent on emergency hospital admissions which was the 13th highest in Scotland. Dundee spent approximately £86M on emergency admissions.

Health & Social Care Experience Survey 2017/18

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

What we have achieved to deliver this outcome

- A range of work has been undertaken across teams and settings to ensure appropriate and realistic prescribing. Prescribing reviews, along with a number of projects in general practice and Locality Pharmacy Teams, has had a positive impact on both safe medicines and prescribing budgets.
- We continue to support the General Medical Services Contract for GP's by delivering a number of services which would traditionally have been delivered by GP's.

  There are 7 key services being developed to operate in a different way. They are:
  - The Vaccination Transformation Programme (VTP)
  - Pharmacotherapy Services
  - Community Treatment and Care Services
  - Urgent Care
  - First Contact Physiotherapy, (musculoskeletal focused physiotherapy services)

- Mental health
- Community Link Workers (referred to as social prescribers)

This means that for many people the GP may no longer the first point of contact when they are unwell, with another professional doing that initial assessment and diagnosis.

- The Scottish Government's Six Essential Actions to Improve Unscheduled Care has given the framework to support the shift in the balance of care away from institutional settings. Our unscheduled pathways and processes in Dundee have supported the aim of working towards caring for people in their homes or a homely setting and reinvest resources in community services. British Red Cross provides Assessment at Home and evidence demonstrates that 62% of people supported have been able to continue living independently at home. The impact of this service demonstrates evidence that community based services could support a higher level of dependence and frailty than the provision within the Intermediate Care Unit, where there was increasing challenges of delivering the necessary rehabilitation provision. This gap in service contributes to delays for people within the acute hospital setting. Additionally, admissions to care home have declined significantly during the operational period of British Red Cross. Initial scoping exercises with NHS Tayside and Dundee Health and Social Care Partnership have highlighted the need for a framework to support the ambitious vision of a co-ordinated response to modelling existing services. During 2020-21 an Inpatient and Community Modelling Group, reporting to the Unscheduled Care Programme Board, will progress a whole systems approach to further shifting the balance of care with a focus on community, transitions/front-door services and inpatient aspects and embedding a consistent understanding and implementation of the Home First Model of Care.
- Transforming services is key to the Dundee City Integration Joint Board continuing to improve outcomes for service users and performance and service redesign opportunities connect to the overarching strategic priorities. During 2019-20, the Partership:
  - Re-designed the internal home care service with the aim of delivering a service which is more responsive to the needs of service users, providing services when they need it and delivering a more sustainable and effective service delivery model.
  - Expanded community supports for older people with mental health needs under the Reshaping Care for Older People Programme, demand for inpatient beds continues to reduce with a resultant reduction in the bed base at the Kingsway Care Centre.
  - Made progress in relation to more efficient and effective prescribing which has seen GP prescribing expenditure for Dundee reduce to below the Scottish average per weighted patient.

  Through delivery of the Dundee City Integration Joint Boards Strategic and Commissioning Plan, Dundee Health and Social Care Partnership continues to reduce the number of hospital beds it directly manages and continues to reduce the number of emergency bed days used by the Dundee population through the acute hospital sector. The bed base is part of the overall description within the legislation around health and social care integration known as the large hospital set aside, with the Dundee City Integration Joint Board being responsible for the planning of acute services that are delegated with NHS Tayside responsible for the operational oversight and management of these services. The sustained progress made by the Partnership in reducing the number of emergency bed days has resulted in NHS Tayside committing to the release of £1m of financial resources to the Partnership on a recurring basis from 2020-21.
- The Partnership was one of a range of different stakeholders who contributed to the self-assessment element of Audit Scotland's Best Value Assurance of Dundee City Council. The period of self-evaluation, including information gathering and interviews took place in the later stages of 2019-20 and early 2020-21. In their published report the Accounts Commission highlighted positive progress made by the Council and partners in establishing a clear and ambitious vision for Dundee, including

understanding the importance of addressing poverty and inequality. However, the report also challenged the Council and partners to work faster to tackle poverty, inequality and substance use. Local partners are currently considering the findings within the report and progress in response to these will be reported in next year's annual report.

In February 2020 the IJB commenced work to assess its own governance arrangements and activities against the Best Value framework developed by the Scottish Government. The exercise aimed to demonstrate to what extent the IJB and each of its partners is delivering Best Value and is securing economy, efficiency, effectiveness and equality in service provision. Evidence was gathered in relation to vision and leadership, effective partnerships, governance and accountability, effective use of resources, performance management, sustainability and equality. The exercise concluded that there is sufficient evidence that Best Value is being achieved through the IJB's governance arrangements. You can find out more about the governance arrangements and actions that supported the Partnership to deliver Best Value and efficiently utilise resources in the Annual Accounts for 2019-20 on our website.

4 The Quality of our Services

Services for adults registered with the Care Inspectorate in Dundee include services directly provided by the Partnership, services commissioned by the Partnership from the Third Sector and independent providers and services operating independently of the Partnership. Of these contracted services, 75 were inspected during the year, of which 22 were combined inspections, where both the Housing Support and Support Services were inspected together. In 2019-20 Dundee was placed 24th out of 31 Partnerships for the proportion of care services rated as good or better in Scotland (80%).This figure is below the Scottish average (81.8%).

28 care homes were inspected and of these inspections 9 services received requirement(s) and 3 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

Complaints received centred around:

- Wellbeing – other
- Choice – activities
- Communication – language difficulties
- Protection of People – Adults
- Staff – Levels
- Record keeping – personal plans/agreements
- Environment – inadequate facilities

Of the 47 Housing Support and Support Services inspected, 7 services received requirement(s) and 7 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services. Complaints received centred around:

- Choice
- Communication - between staff/relatives/carers
- Staff – levels
- Healthcare – Tissue viability
- Record keeping – personal plans/agreements
- Wellbeing - other
- Protection of People – Adults
- Healthcare – Continence Care

The Partnership has no nurse agencies or adult placement services to be inspected.

This means that of the 75 services that were inspected during the last 12 months 79% received no requirements for improvement. This figure shows a deterioration on the 83% figure for 2018-19.

Information about the inspections and requirements 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.

Looking to the Future

At the time of publication of this Annual Performance Report the Partnership, alongside other public, third and private sector organisations, is responding to the unprecedented challenge of the COVID-19 pandemic. Partnership services have been rapidly re-designed to support the Health and Social Care response to people who have been directly impacted by COVID-19, as well as to maintain essential services to individuals and wider communities. Significant work has also been undertaken to support our workforce and unpaid carers and to protect their mental health and wellbeing. Our response to the COVID-19 pandemic will be reported on in our next Annual Performance Report. Our Remobilisation Plan sets the context within which we will undertake wider improvement activities during 2020-21 and will have a significant impact on the capacity and resources available to address improvement priorities.

At this time, we have identified a small number of improvement priorities from 2019-20 that will continue to be implemented over the next 12 months, as well as a small number of new areas that will be prioritised alongside COVID-19 recovery work.

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

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

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

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

RESPOND to the recommendations from the Tayside Mental Health Inquiry and Dundee Drug Commission by working closely with partners, including people with lived experience to fully implement agreed actions.

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

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

REFRESH our arrangements for responding to adults at risk, including our operational guidance and arrangements for assessing and responding to concerns about vulnerable adults who do not meet the adult protection three-point test.

REVIEW our learning from the COVID19 pandemic and continue to adapt our delivery models, based on our learning, to address the impact of Covid -19 on our population and to manage the transition back to community service delivery.

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.

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 was due to be repeated in 2019-20, however this was been delayed due to the Covid-19 Pandemic.

National published data for financial year 2019-20 is not available for indicators 11, 12, 13, 14, 15, 16, 18, 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%	↑
10. Percentage of staff who say they would recommend their workplace as a good place to work	75% (N/A)	75% (N/A)	(N/A)	(N/A)	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

National Indicator Source: Core Suite of Integration Indicators	2015-16 Dundee (Scotland)	2016-17 Dundee (Scotland)	2017-18 Dundee (Scotland)	2018-19 Dundee (Scotland)	2019 Dundee (Scotland)	Comparison with Scotland 2019
11. Premature mortality rate (per 100,000 people aged under 75)	546 (441)	572 (441)	554 (425)	539 (432)	542 (426)	↓
12. Emergency admission rate (per 100,000 people aged 18+)	12,168 (12,281)	12,425 (12,215)	12,815 (12,192)	12,703 (12,195)	12,520 (12,616)	↑
13. Emergency bed day rate (per 100,000 people aged 18+)	146,192 (128,630)	141,439 (126,945)	135,284 (115,518)	125,377 (116,485)	119,246 (118,127)	↑
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	122 (98)	127 (101)	127 (103)	129 (103)	127 (105)	↓
15. Proportion of last 6 months of life spent at home or in a community setting	87% (87%)	87% (87%)	89% (88%)	89% (88%)	90% (89%)	↑
16. Falls rate per 1,000 population aged 65+	25 (22)	26 (22)	29 (23)	31 (22)	31 (23)	↓
17. Proportion of care services graded'good'(4) or better in Care Inspectorate inspections	88% (83%)	86% (84%)	85% (85%)	86% (82%)	80%* (82%)*	↓
19. Percentage of days people spend in hospital when they are ready to be discharged, per 1,000 population	832 (915)	754 (841)	349 (762)	372 (793)	443* (774)*	↑
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	28% (24%)	27% (24%)	27% (25%)	26% (24%)	23% (23%)	↑

*2019-20 data

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

Improved since 2015/16

Worsened since 2015/16

Statutory Inspections during 2019-20

CARE INSPECTORATE PERFORMANCE GRADINGS 2019-20
DUNDEE REGISTERED CARE SERVICES FOR ADULTS (EXCLUDING CARE HOMES)

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
TENANCY SUPPORT											
Dundee Survival Group		Housing Support	Vol	Last inspected 19.01.18							
Dundee Women's Aid		Housing Support	Vol	Last inspected 20.01.19							
Hillcrest Homes Tenancy Support		Housing Support	Vol	Last inspected 13.01.17							
Positive Steps (East)		Housing Support	Vol	Last inspected 13.12.17							
Salvation Army	Burnside Mill	Housing Support	Vol	Last inspected 24.04.18							
Salvation Army	Strathmore Lodge	Housing Support	Vol	Last inspected 26.04.18							
RESPITE											
Sense Scotland	Dundee Respite (Fleuchar Street)	Care Home - People with Learning Disabilities	Vol	Last inspected 06.08.18							
SUPPORT SERVICES - NOT CARE AT HOME											
Alzheimer Scotland	Alzheimer Scotland – Action on Dementia	Support services – not care at home	Vol	Last inspected 17.03.16							
Capability Scotland	Capability Scotland Dundee	Support services – not care at home	Vol	Last inspected 08.10.15							

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
Dundee City Council	Wellgate Day Support Service	Support services – not care at home	DHSCP	Last inspected 25.02.16							
Hillcrest Futures Ltd	Student Support Service	Support services – not care at home	Vol	Last inspected 12.11.15							
Jean Drummond Centre	Jean Dummond Day Centre	Support services – not care at home	Vol	Service ended 23.01.20							
Mid-Lin Day Care Ltd	Mid-Lin Day Care	Support services – not care at home	Vol	Last inspected 19.09.17							
Penumbra	Dundee Nova Service	Support services – not care at home	Vol	Last inspected 19.05.16							
Scottish Autism	Autism Outreach Service (Dundee)	Support services – not care at home	Vol	Last inspected 29.12.17							
Sense Scotland	Hillview Resource Centre	Support services – not care at home	Vol	Last inspected 25.04.17							
SUPPORT SERVICES - WITH CARE AT HOME											
Acasa Care Ltd		Support services – care at home	Private	30.10.19	**5**	**n/a**	**(5)**	**4** ↓	No	No	No
Allied Health-Services Ltd	Allied Health-Services Dundee	Support services – care at home	Private	24.10.19	**4**	**n/a**	**3**	**3**	No	Yes	No
Avenue Care Services Ltd	Avenue Care Services - Perth/Dundee	Support services – care at home	Private	11.12.19	**4**	**n/a**	**4**	**4**	No	No	No

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
Blackwood Homes and Care	Blackwood North East Care and Support Services	Support services – care at home	Vol	20.05.19	5	n/a	(5)	5	No	Yes	No
British Red Cross	British Red Cross Support at Home	Housing support service – care at home	Vol	21.09.19	4	n/a	(4)	3	No	Yes	No
Call-in Homecare Ltd	Call-In Homecare Care at Home	Care at Home/ Housing Support Service	Private	03.03.20	(5)	n/a	(5)	3 ↓	No	Yes Regraded	No
				10.09.19	5	n/a	5	(5)	No	No	No
Crossroads Caring Scotland	Crossroads Caring Scotland - Dundee	Support services – care at home	Vol	19.12.19	4 ↓	n/a	4	3 ↓	No	Yes	No
Dundee City Council	Homecare Social Care Response Service	Care at Home and Housing Support	DHSCP	18.02.20	5	n/a	(5)	5	No	Yes	No
Dundee City Council	Care at Home City Wide	Care at Home and Housing Support	DHSCP	30.01.20	5	n/a	(5)	5	No	No	No
Elite Care (Scotland) Ltd	Dundee and Angus	Housing Support	Private	30.01.20	New registration on 06.11.18 – not yet inspected				No	No	No
Family Friends		Support Service	Private	Last inspected 14.11.18							
Hillcrest Futures Ltd	Hillcrest Futures Homecare Dundee	Support service – care at home	Vol	10.10.19	4	n/a	(4)	3 ↓	Yes	No	No

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
The Inclusion Group (Dundee)	The Inclusion Group	Support services – care at home	Vol	13.01.20	(4)	n/a	3	2 ↓	Yes	No	No
				13.06.19	4 ↑	n/a	3 ↑	3 ↑	Yes	No	No
Mochridhe Limited	Mochridhe Dundee and Angus	Care at home/ housing support	Private	26.08.19	5 ↑	n/a	(4)	4	No	No	No
My Homecare (Dundee) Ltd		Support service	Private	03.05.19	4	n/a	4 ↑	4 ↑	No	No	No
Scottish Association for Mental Health	Dundee Specialist Mental Health Outreach	Care at home/ housing support	Vol	08.07.19	4 ↓	n/a	3 ↓	4 ↓	Yes	No	No
TayCare at Home Limited		Support Services – care at home	Private	18.12.19	5	n/a	(5)	5	No	No	No
TLA Neighbourhood Service Limited	TLA Neighbourhood Services	Housing Support Service	Private	28.01.20	4	n/a	(4)	4	No	No	No

HOUSING WITH CARE SERVICES (SUPPORT SERVICES WITH CARE AT HOME)											
Bield Housing & Care	Dundee Housing with Care/ Housing Support Dundee	Support services – care at home	Vol	17.12.19	5	n/a	(5)	5	No	No	No
Hillcrest Futures Ltd	Hillcrest Futures Dundee Housing with Care Service	Support services – care at home	Vol	New Registration - 14.02.20							

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
CARE AT HOME / HOUSING SUPPORT (COMBINED) - 24 HOUR SERVICES											
Balfield Properties t/a Westlands	Westlands	Care at Home/ Housing Support	Private	10.05.19	6	n/a	(5)	6	No	No	No
Caalcare Limited	Rose Lodge	Care at Home/ Housing Support	Private	23.04.19	6	n/a	(6)	6	No	No	No
Capability Scotland	Dundee Housing Support Service	Housing Support Service	Vol	New Registration - 14.02.20							
Carr Gomm	Support Services 2	Care at Home/ Housing Support	Vol	31.07.19	4	n/a	5 ↑	5 ↑	No	No	No
Cornerstone	Dundee and Angus Services	Care at Home/ Housing Support	Vol	12.12.19	4	n/a	4	4 ↑	No	No	No
Dudhope Villa	Dundee and Angus Services	Dundee and Angus Services	Private	28.08.19	4	n/a	4	3 ↑	Yes	No	No
				23.05.19	(4)	n/a	(4)	2 ↓	No	Yes Regraded	No
Dundee City Council	Dundee Community Living	Care at Home/ Housing Support	DHSCP	13.09.19	6	n/a	6	(6)	No	No	No
Dundee City Council	Supported Living Team	Care at Home/ Housing Support	DHSCP	01.10.19	6 ↑	n/a	6	(5)	No	No	No
Dundee City Council	Weavers Burn	Care at Home/ Housing Support	DHSCP	23.07.19	5	n/a	(5)	5	No	No	No

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
Hillcrest Futures Ltd	Hillbank/ Alexander Street	Care at Home/ Housing Support	Vol	08.11.19	6 ↑	n/a	5	(6)	No	No	No
Hillcrest Futures Ltd	Birkdale/Pitkerro	Care at Home/ Housing Support	Vol	07.06.19	6	n/a	5 ↓	(5)	No	No	No
Hillcrest Futures Ltd	Canning Place/ Millview/Milton St	Care at Home/ Housing Support	Vol	28.08.19	5	n/a	5 ↓	(5)	No	No	No
Hillcrest Futures Ltd	David StMartingale/ Tullideph	Care at Home/ Housing Support	Vol	16.04.19	4 ↓	n/a	(5)	4	No	No	No
Hillcrest Futures Ltd	North Grimsby / Priority Court	Care at Home/ Housing Support	Vol	25.04.19	4 ↓	n/a	4 ↓	3 ↓	Yes	No	No
Hillcrest Futures Ltd	Doocot Park/ Lousen Park/ River Street/ Riverview	Care at Home/ Housing Support	Vol	09.10.19	5	n/a	(5)	(5)	No	No	No
The Inclusion Group (Dundee)	The Inclusion Group	Housing Support Service	Vol	13.01.20	3	n/a	3	2	Yes	No	No
Priority Care Limited	Magdalen House	Care at Home/ Housing Support	Private	24.10.19	4 ↑	n/a	4 ↑	4	No	No	No
The Richmond Fellowship Scotland Ltd	Dundee Services	Care at Home/ Housing Support	Vol	23.08.19	6	n/a	(5)	5	No	No	No
Sense Scotland	Supported Living: Dundee 1 & surrounding areas	Care at Home/ Housing Support	Vol	Last Inspected – 06.09.18							

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership	Requirements	Complaints	Enforcements
Sense Scotland	Supported Living Dundee 2 & surrounding areas	Care at Home/ Housing Support	Vol	11.07.19	4 ↓	n/a	4 ↓	3 ↓	No	No	No
Sense Scotland	Supported Living Dundee 3 & surrounding areas	Care at Home/ Housing Support	Vol	18.06.19	5	n/a	5 ↑	5	No	No	No
Scottish Autism	Tayside Housing Support & Outreach Service	Support Services – Care at Home	Vol	23.01.20	5	n/a	(5)	5	No	No	No
Transform Community Development		Housing Support Service	Vol	04.06.19	2 ↓	n/a	(4)	2 ↓	Yes	No	No
Turning Point Scotland	Dundee	Support Services – Care at Home	Vol	05.11.19	5	n/a	5	(6)	No	No	No

NEW FORMAT INSPECTIONS UNDERTAKEN DURING 2019-2020

Organisation	Name of Service	Service Type	Category DHSCP/ Private/Vol	Inspection Date	People's Wellbeing	Leadership	Staff Team	Setting	Care and Support Planning	Requirements	Complaints	Enforcement
RESPITE												
Dundee City Council	Mackinnon Centre	Respite Unit for People with a Physical Disability	DHSCP	06.12.19	5	n/a	n/a	n/a	4 ↓	No	No	No
Dundee City Council	White Top Centre	Respite for People with a Learning Disability	DHSCP	31.07.19	6	n/a	n/a	n/a	5	No	No	No
SUPPORT SERVICE – NOT CARE AT HOME												
Dundee City Council	Mackinnon Skills Centre	Support service - not care at home	DHSCP	22.07.19	5	n/a	n/a	n/a	4	No	No	No
Dundee City Council	White Top Centre	Support service - not care at home	DHSCP	31.07.19	6	n/a	n/a	n/a	5	No	No	No
SUPPORT SERVICE – WITH CARE AT HOME												
Dundee City Council	Home Care Enablement and Support & Community MH Older People Team	Care at Home and Housing Support	DHSCP	31.01.20	5	5	n/a	n/a	n/a	No	No	No
My Care Tayside	White Top Centre	Housing support service care at home	Private	13.12.19	5	5	n/a	n/a	n/a	No	No	No

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

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SUMMARY OF CARE INSPECTORATE GRADINGS FOR CARE HOMES IN DUNDEE – 1 April 2019 to 31 March 2020

	Category LA/ Private/Vol	Inspection Date	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning	Requirements	Complaints
Balcarres HC-One Oval Limited	P	11.11.19	5 ↓	n/a	n/a	n/a	5	No	No
Balhousie Clement Park Balhousie Care Limited	P	27.08.19	3 ↓	n/a	n/a	n/a	3 ↓	Yes	No
Balhousie St Ronan's Balhousie Care Limited	P	19.07.19	5 ↑	n/a	n/a	n/a	4	No	No
Ballumbie Court HC-One Limited	P	31.05.19	3 ↑	4 ↑	4 ↑	4	4 ↑	Yes	Yes
Benvie Duncare Ltd	P	13.01.20	5	n/a	n/a	n/a	4	No	No
Bridge View House Sanctuary Care	P	30.04.19	3 ↓	3 ↓	3 ↓	3 ↓	4	Yes	No
Carmichael House Kennedy Care Group	P	11.12.19	4	n/a	n/a	n/a	4	No	No
Craigie House Dundee City Council	LA	12.12.19	5	n/a	n/a	n/a	5	No	No
Elder Lea Manor Enhance Healthcare Ltd	P	17.04.19	4	4	4 ↓	4	4	No	No
Ellen Mhor Cygnet Healthcare	P	21.06.19	3 ↓	4	4	4	4	Yes	No
Forebank Forebank Ltd	P	28.01.19	2 ↓	n/a	n/a	n/a	4	Yes	No
Harestane Priority Care Group Ltd	P	16.04.19	5	n/a	n/a	n/a	5	No	No
Janet Brougham House Dundee City Council	LA	08.11.19	5	n/a	n/a	n/a	4	No	No

	Category LA/ Private/Vol	Inspection Date	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning	Requirements	Complaints
Linlathen Neurodisability Centre Living Ambitions Ltd	P	Closed 14.12.19							
Lochleven Care Home Thistle Healthcare Limited	P	13.06.19	5	5	5	5	5	No	No
Menzieshill House Dundee City Council	LA	18.09.19	5 ↑	n/a	n/a	n/a	5 ↑	No	No
McGonagall House Rosebank (Dundee) Limited	P	18.06.19	4 ↑	4 ↑	5 ↑	4	4 ↑	No	No
Moyness Nursing Home Balhousie Care Limited	P	23.10.19	4	n/a	n/a	n/a	4	No	No
Orchar Nursing Home Orchar Care Ltd	P	03.04.19	5	n/a	n/a	n/a	5	No	No
Pitkerro Care Centre Hudson Healthcare Ltd	P	28.01.20	3 ↑	n/a	n/a	n/a	(3)	No	No
	P	08.08.19	2 ↓	n/a	n/a	n/a	3	Yes	No
Redwood House Kennedy Care Group	P	09.05.19	3 ↓	n/a	n/a	n/a	3 ↓	No	No
Riverside View HC-One Limited	P	21.06.19	3 ↓	n/a	n/a	n/a	4	No	Yes
Rose House Kennedy Care Group	P	17.01.20	3 ↑	3 ↑	n/a	3 ↑	3 ↑	No	No
	P	07.06.19	2 ↓	2 ↓	n/a	1 ↓	3 ↓	Yes	Yes
St Columba's Care Home Priority Care Group Limited	P	22.10.19	5 ↑	n/a	n/a	n/a	5 ↑	No	No

	Category LA/ Private/Vol	Inspection Date	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning	Requirements	Complaints
St Margaret's Home – Dundee Trustees of St Margaret's Home	V	02.10.19	4	4	4	3	3	Yes	No
Thistle Care Home Cygnet Healthcare	P	06.06.19	3 ↓	3 ↓	3 ↓	4	3 ↓	Yes	No
Turriff House Dundee City Council	LA	25.11.19	4	n/a	n/a	n/a	4	No	No

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

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DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP – CARE HOME SERVICES
CARE INSPECTORATE REQUIREMENTS 2019-2020

Date of Inspection	Name of Org/Service	Service Type	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning
27.08.19	Balhousie Clement Park	Care Home – Private	3 ↓	n/a	n/a	n/a	3 ↓

Requirements (2)

In order to ensure the health and wellbeing of people using the service, by 30 October 2019 the provider must ensure that people are protected by improving the assessment, treatment and monitoring of care. This includes, but is not restricted to hydration and wound management.

In order to ensure the health and wellbeing of people the provider must by 31 December 2019 ensure that individuals' personal plans clearly set out how their health, welfare and safety needs are to be managed and met. In order to do this the provider must ensure that:

- Staff are supported to become competent in the use of the electronic planning system.
- Personal plans and care records reflect a responsive and person-centred approach.
- The quality and accuracy of records detailing the management of healthcare needs are improved. This includes but is not restricted to hydration and wound care.
- The management team use their quality audit systems to monitor and improve practices.

31.05.19	Ballumbie Court	Care Home – Private	3 ↑	4 ↑	4 ↑	4	4 ↑

Requirements (1)

In order to ensure that all activities support plans are meaningful and person-centred and are used to inform and guidance staff practice, the provider must complete a quality review of all support plans. Planned support delivered by staff should meet the assessed need identified in the activity plans.

Date of Inspection	Name of Org/Service	Service Type	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning
30.04.19	Bridge View House	Care Home – Private	3 ↓	3 ↓	3 ↓	3 ↓	4

Requirements (4)

The provider must demonstrate by 30 June 2019 that there are suitable and sufficient meaningful activities for service users to engage in based on their personal choices and abilities.

The provider must ensure that safe systems are in place and followed for the administration of medications by 16 June 2019.

In order to ensure the service is operating legally, the provider must submit a formal application requesting to vary their conditions of registration by 30 May 2019. This must include reasons for the service variation; age group(s) and category of people who use the service and thereafter consult the Care Inspectorate each time any person is considered for admission that falls out with the scope of registration conditions.

In order to ensure high quality care and support the provider must by 16 June 2019 ensure that appropriate staffing levels, skill mix and deployment of staff are maintained to ensure service users are well supported at all times. This must take into account the complexity of people's needs, the layout of the setting and be linked to quality assurance processes including people's views, outcomes and experiences.

21.06.19	Ellen Mhor	Care Home – Private	3 ↓	4	4	4	4

Requirements (1)

The service should ensure that the recording and administration of medication is monitored and audited to minimise errors and ensure that records are accurate and complete. Staff should have practice observed, at regular intervals, to assist in this process. This requirement has been repeated from the previous inspection and a robust process to address the above issues should be in place by 31 July 2019.

28.11.19	Forebank	Care Home – Private	2 ↓	n/a	n/a	n/a	4

Requirements (1)

In order to ensure that people get the medication they need, the provider must put in place an effective medication management system by 30 January 2019.

Date of Inspection	Name of Org/Service	Service Type	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning
08.08.19	Pitkerro Care Centre	Care Home – Private	2 ↓	n/a	n/a	n/a	3 ↓

Requirements (2)

In order to ensure that all care is delivered according to the principles of the Health and Social Care Standards, the provider must ensure that staff are suitably qualified and receive appropriate training to ensure that they can provide care and support to people in a safe, respectful and supportive manner. This is also to ensure that all staff are upholding the Scottish Social Service Council's (SSSC) Codes of Practice. In order to comply the provider should:

- Demonstrate that all staff receive appropriate values-based training to carry out their work.
- Implement an action plan to meet the training needs identified.
- Ensure that there is an effective system to monitor staff practice and provide supervision and guidance when necessary.

In order to ensure that the provision of foods and fluids is adequate to meet people's needs the provider must:

- Ensure that staff practice and knowledge reflects current best practice guidelines for adapted and specialised diets.
- Ensure that adapted foods are presented in a dignified way and in accordance with best practice guidelines.
- Ensure that fresh water and fluids are available at all times and in a way which is accessible to all people living with the home (including those who require assistance or prompting to ensure their fluid needs are met).

08.08.19	Pitkerro Care Centre	Care Home – Private	2 ↓	2 ↓	n/a	1 ↓	3 ↓

Requirements (4)

People should expect to live in an environment that is safe and secure, is well looked after, and is well maintained. The provider must produce and thereafter implement a plan designed to improve the standard of the environment.

The service must ensure that the environment is homely in appearance and decorated and maintained to a standard appropriate for the care service. The provider should revisit the environmental assessment and make the necessary adjustments for people living with dementia or who experience sensory loss.

Maintenance checks must be thorough.

The provider must implement a detailed plan of works to improve the standard of the environment.

The provider must ensure that all radiators are fitted with suitable covers in order to prevent burns and scalds and injury to residents. In addition the provider must ensure that the dishwasher is replaced and fully functioning as agreed with the provider following submission of the maintenance action plan.

The provider must ensure that all wardrobes are securely fixed to walls in order to prevent them from toppling over and causing injury to residents. In addition suitable curtains and/or other window coverings must be installed in all bedrooms in order to maintain privacy and ensure the promotion of sleep for residents.

In order to protect residents and staff from harm when carrying out care and support and to reduce the risk of pressure related injuries the provider must demonstrate the following:

- That all beds used by residents are fully functioning and that essential repairs are carried out on beds that are not fully functioning. Where it is not possible to repair a bed so that it is fully functioning, the bed must be replaced.
- That residents and staff can summon help and assistance via the nurse call system from all areas of the home where care and support are carried out.
- That residents can open and close their bedroom windows with ease so that residents can control the ventilation and heating within their own bedroom.

Date of Inspection	Name of Org/Service	Service Type	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning
02.10.19	St Margaret's Care Home	Care Home – Private	4	4	4	3	3

Requirements (1)

In order to ensure that the environment meets with the Health and Social Care Standards set by the Scottish Government, the provider must put in place an improvement plan by 31 December 2019. This plan must detail both short and medium term environmental changes and improvements which are realistic, measurable and achievable.

06.06.19	Thistle Care Home	Care Home – Private	3	3	3	4	3

Requirements (1)

In order to ensure that peoples' health benefits from their support, the Provider must ensure that all medications are administered as prescribed by the prescriber and that any discrepancies identified through medication audits are acted upon by 30 June 2019.

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

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DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP
DUNDEE REGISTERED CARE SERVICES FOR ADULTS (EXCLUDING CARE HOMES)
CARE INSPECTORATE REQUIREMENTS 2019-2020

Date of Inspection	Name of Org/Service	Service Type	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
10.10.19	Hillcrest Futures Homecare	Support services –	4	n/a	4	3 ↓

Requirements (1)
In order to ensure ongoing service improvements, the Provider must make proper provision for the health and welfare of service users by ensuring that they have appropriate quality assurance systems in place which include:

- The formal review of care and support plans at least once every six months;
- Regular audits of care and support plans and risk assessments to help ensure sufficient detail is recorded to inform staff practice.

13.01.20	The Inclusion Group (Dundee)	Support services – care at home	(4)	n/a	3	2 ↓
13.06.19			4 ↑	n/a	3 ↑	3 ↑

Requirements (2) - 13.01.20
In order to ensure ongoing service improvements, the provider must make proper provision for the health and welfare of service users by ensuring that they have appropriate and robust quality assurance systems in place that are used regularly to help bring about improvements in the service by 28 February 2020.

In order to ensure that staff are suitably qualified and receive appropriate training to ensure they can deliver service users' care in a safe, respectful and supportive manner, the provider must:

- Produce a training needs analysis that reflects the training the staff team require.
- From this, develop a training plan that provides clearer details about the training staff are required to have (mandatory), and service specific (to meet people's individual needs). This should include the frequency of any training that requires to be refreshed or updated eg medication and moving and handling. The training plan should contain the same information in relation to the team leaders.
- Maintain accurate records that describe the training completed by staff.
- Ensure that there is an effective system in place to monitor that staff are implementing the care service's policies and procedures and to identify where further training and support is necessary and take the necessary actions to address identified deficits.

This must be implemented by 28 February 2020.

Requirements (2) - 13.06.19

The provider must take steps to ensure that only staff who are registered with the Scottish Social Services Council (SSSC) or another recognised regulatory body may carry out work in the care service in a post for which such registration is required by 30 June 2019.

In order to ensure ongoing service improvements, the Provider must make proper provision for the health and welfare of service users by ensuring that they have appropriate and robust quality assurance systems in place that are used regularly to help bring about improvements in the service by 31 July 2019.

Date of Inspection	Name of Org/Service	Service Type	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
08.07.19	Scottish Association for Mental Health	Support services – care at home	4 ↓	n/a	3 ↓	4 ↓

Requirements (1)

The provider must ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health, welfare and safety of service users.

28.08.19	Dudhope Villa and Sister Properties	Care at Home/ Housing Support Service	4	n/a	4	3 ↑

Requirements (2)

The provider must develop robust systems to ensure service users' funds are fully safeguarded at all times. In order to achieve this the provider must:

- Maintain clear, accurate and detailed accounting records for all individual service users' funds.
- Ensure that for all transactions there is a clear audit trail supported, where appropriate, for that service user by invoices, bank statements, receipts, etc.
- Ensure each service user has a clear plan of support which details the financial support they require.
- Carry out and record regular audits which takes account of general bookkeeping, presence of receipts or invoices and reconciles bank withdrawals with deposits.

In order to ensure the health, wellbeing and safety of service users, the provider must ensure that the Care Inspectorate are notified of specific events as per publication 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'. This relates (but is not limited to):- deaths in the home – incidents – allegations of abuse and to ensure that requests for updates on events from the Care Inspectorate are responded to promptly.

25.04.19	Hillcrest Futures – North Grimsby/ Priory Court	Care at Home/ Housing Support Service	4 ↓	n/a	4 ↓	3 ↓

Requirements (1)

In order to ensure ongoing service improvements, the Provider must make proper provision for the health and welfare of service users by ensuring that they have robust quality assurance systems in place that are effective at identifying areas for improvement and the action required to address these areas. The manager should ensure that these systems are used regularly to ensure progressed is ongoing.

Date of Inspection	Name of Org/Service	Service Type	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
13.01.20	The Inclusion Group (Dundee)	Housing Support Service – not care at home	3	n/a	3	2

Requirements (2)

See above – The Inclusion Group (Dundee) Support Service – Care at Home.
The requirements are the same although included in a separate report.

04.06.19	Transform Community Development	Care at Home/ Housing Support Service	2	n/a	4	2

Requirements (4)

To safeguard the health and wellbeing of service users, the provider must ensure that medication is administered safely and in line with good practice. To achieve this the provider must:

- Ensure that medication is administered to service users according to prescriber instructions.
- That if a regular medication is not given or taken that staff record the reason why along with any further action that was taken and the outcome of this action.
- That staff understand their responsibility to keep accurate and current records of administered medication.
- That staff have access to and adhere to good practice guidance relating to the safe administration and record keeping of medication.
- That a robust audit of medication is undertaken immediately and at regular intervals by a senior member of staff.

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:

- Carry out a full review of all financial policies, procedures and processes.
- Ensure that, where appropriate, accurate financial risk assessments are in place for service users and reviewed regularly.
- Ensure that steps are taken to obtain appropriate financial safeguards for each service user.
- Ensure regular audits are carried out on the funds held for service users. This must include a system to reconcile bank withdrawals and deposits.

To ensure the safeguarding and protection of service users the provider must ensure that:

- Concerns raised by service users are fully investigated and the outcome recorded;
- Where appropriate, concerns are escalated in line with adult support and protection legislation;
- Staff receive training in complaint handling and reporting responsibilities.

To safeguard service users the provider must ensure that staff are recruited in a way which demonstrates their fitness to undertake regulated work.

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

() This signifies that the theme was not assessed at this inspection therefore grade brought forward from previous inspection

Appendix 4

Glossary of Terms

Acute (Care) Hospital	A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).
Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health and social care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include Physiotherapists, Dieticians, Speech and Language Therapists, Psychologists, Occupational Therapists, Podiatrists, Audiologists, etc.
Anticipatory Care Planning	Anticipatory Care Planning is about thinking ahead and understanding your health. It's about knowing how to use services better and it helps people make choices about their future care.
Best Value	Best Value is about ensuring that there is good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public. The duty of Best Value applies to all public bodies in Scotland.
Carer	A person of any age who provides, or intends to provide, unpaid care for at least one other person. This could providing support for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse issues. Carers provide care for adults and/or children but the definition used here excludes people who provide care for a child or young person with similar needs to their peers.
Clinical Care and Professional Governance (CCPG)	The system which ensures that health, social work and social care services are person-centred, safe and effective.
Emergency Admission	An unplanned admission to an acute hospital which occurs when, for clinical reasons, a patient is admitted at the earliest possible time after seeing a doctor.
Enablement Support	Support services for people with poor physical and/ or mental health to help them re-learn skills, or develop new skills, support them to be independent and improve their quality of life. In Dundee the Enablement Service is a short term care at home service which is provided for a limited time period.

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

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

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

Get in touch:

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Dundee
Health & Social Care
Partnership