ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 JUNE 2019**

REPORT ON: **ANNUAL PERFORMANCE REPORT 2018/19**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB24-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to submit the Health and Social Care Partnership Annual Performance Report 2018/19 for approval.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Note the updates provided, including that a summary version of the Annual Performance Report 2018/19 will be produced for publication.

2.2 Approve the Annual Performance Report 2018/19 (attached as Appendix 1).

2.3 Approve the planned approach to formatting, publication and distribution (section 4.2.3).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Background Information

4.1.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states that Integration Authorities must prepare an annual performance report for each reporting year. A performance report is described as a report which sets out an assessment of performance by each Integration Authority in planning and carrying out its integration functions. The Public Bodies (Content of Performance Reports) (Scotland) Regulations 2014 sets out the prescribed content of an annual report prepared by an Integration Authority in terms of Section 42 of the Act.

4.1.2 There is a requirement for each Integration Authority to publish their annual performance report within four months of the end of the reporting year. The third annual report of the Dundee Health and Social Care Partnership (for 2018/19) is therefore due for publication by 31 July 2019.

4.2 Annual Performance Report 2018/19

4.2.1 The Annual Performance Report 2018/19 attached as appendix 1 fulfils the requirement of the regulations, including information regarding progress against the National Health and Wellbeing Outcomes and information at Partnership and locality level in relation to financial planning and performance, best value and scrutiny / inspection.

4.2.2 In line with the approach taken for the production of previous Annual Performance Reports, the production of this year's report has been undertaken in collaboration with a range of officers and stakeholders. An inclusive and collaborative approach has ensured that, as well as meeting regulations, the annual performance report will form a true representation of the diversity and breadth of activity and performance within the Partnership during 2018/19.

4.2.3 It is proposed that the full version is published on the Partnership website following approval by the IJB no later than 31 July 2019. Prior to this the document will be fully formatted by Dundee City Council Design Services. A press release will be developed by Dundee City Council Communications Service to accompany the publication of the report. In addition, a summary version of the report will be produced, following the format used in previous years, which will also be published on the Partnership website once complete.

4.2.4 Following publication of the full report it is proposed that it be formally submitted to the Scottish Government, Dundee City Council and NHS Tayside. In addition it is proposed that it is electronically distributed to key stakeholders of the Partnership under the direction of the Integrated Strategic Planning Group.

4.2.5 There is a range of work being progressed at a national level through the Ministerial Strategic Group for Health and Community Care and the Scottish Commissioning and Improvement Network to strengthen and align the approach to production and publication of Annual Performance Reports across all Health and Social Care Partnerships. It is anticipated that the Scottish Government will provide individual feedback on Annual Performance Reports to Partnerships for the first time this year. Actions are also being progressed to provide further guidance regarding the required content of reports and also to explore the possibility of standardised templates for some sections of reports (primarily in relation to quantitative data). These developments, alongside the need to review Dundee's approach to annual reporting subsequent to the agreement of the revised Strategic and Commissioning Plan will inform forward planning for the 2019/20 Annual Performance Report.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Chief Finance Officer, Head of Service - Health and Community Care, Professional Advisors, members of the Integrated Strategic Planning Group and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	**x**
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 29 May 2019

Clare Harper
Principal Information Development Manager

Kathryn Sharp
Senior Manager, Strategy and Performance

Appendix 1

UNFORMATTED DRAFT ANNUAL PERFORMANCE REPORT

2018-19

Dundee
Health & Social Care
Partnership

CONTENTS

TO BE INSERTED

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

During 2018/19 we have continued to work with our statutory partners, service users and their families, carers and communities to deliver this ambitious vision and to make real improvements to the lives of people in Dundee. We are particularly pleased with the reduction we have seen in the amount of time that people have spent unnecessarily in hospital through improvement work led by the multi-agency Home and Hospital transition group. Targeted investment has (for example) allowed us to work together with Acute, Third and Independent sector colleagues to implement the Dundee Enhanced Community Support Services, to develop a Home Care and Resource Matching Unit, to improve the effectiveness of assessments for home adaptation and provision of aids for daily living and to develop the integrated discharge hub. We have doubled our investment in the acute disability acute liaison nursing service to support adults, and their families, who are admitted to acute hospital care. Though this concerted partnership effort the number of days Dundee citizens spent in hospital as a result of an emergencies fell from almost 121,000 in 2016 to around 103,000 in 2018. Our integrated approach to reducing delayed discharges has demonstrated clearly that long term challenges can be successfully overcome with the necessary focused response and investment.

A major focus for the Partnership during 2018/19 has been the local implementation of the **Carers (Scotland) Act 2016**, and we have taken some big steps to recognise the invaluable contribution carers make in our communities. As well as expanding the range of services and supports available to carers, we have provided training to our workforce and partners to enhance their understanding of the Act, and created the "Carers of Dundee" website to provide information and support. We have introduced a Carers Interest Network for practitioners across health, social care, third and independent sectors to develop coordinated approaches to supporting carers and further developed locality models for supporting carers.

During the year we have reviewed our Strategic and Commissioning Plan and set out our strategic priorities for the years ahead. We have begun working with Partners to assess how we are taking forward integration locally and, with them, are developing an action plan to address jointly agreed priorities to increase the pace of integration.

We believe that our reviewed plan, along with our robust partnerships, will help us to address the challenges we face, taking advantage of our innovative and vibrant city and our strong cohesive and resilient communities to continue to improve the health and wellbeing of people in Dundee.

Trudy McLeay
Chair, Dundee Integration Joint Board

Ken Lynn
Vice Chair, Dundee Integration Joint Board

1.0 Who We Are

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

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

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

To deliver our vision and the National Health and Wellbeing Outcomes, the Partnership has focused on 8 Strategic Priorities during 2018/19:

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

1.1 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 individual and families, underpins everything that we do.

During 2018-19 the Performance and Audit Committee (PAC) continued to scrutinise the performance of the Partnership in achieving its vision and strategic priorities, including overseeing financial performance and other aspects of governance activities. Throughout the year the PAC has received quarterly local performance reports, including benchmarking data from other Health and Social Care Partnerships across Scotland. Benchmarking with other Partnerships assists the interpretation of data and identifies areas for improvement. Partnerships with similar traits,including population density and deprivation have been grouped into'family groups', which consist of eight comparator Partnerships. Dundee is placed in a family group along with Glasgow, Western Isles, North Lanarkshire, East Ayrshire, Inverclyde, West Dunbartonshire and North Ayrshire. You can see the Partnership's quarterly performance reports on our website.

The PAC has requested additional analytical reports in areas where performance has been poor, such as 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 analyzing variations in performance across the eight LCPPs in Dundee; this report is the first stage in a longer process to help the Partnership better understanding variations in performance by locality.

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 is an important aspect of our work to improve the wellbeing of people and communities by ensuring the safety and quality of health and social care services. During 2018-2019 work has continued to consolidate clinical, care and professional governance activities within all teams across the Partnership. Operational teams now report through the Governance Structure with Primary Governance Groups established under each locality manager ensuring a strong focus on governance activities on a regular basis. Further work is to be done across each Partnership area on the reporting of the hosted services through each of the governance systems.

Further work is underway to develop a single reporting structure for Primary Governance Groups and this will be embedded throughout 2019-20.

We recognise that our commitment to continuous improvements means that further work will be required during 2019-20 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 neighborhood level.

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 its communities and the people it supports. There are eight Local Community Planning Partnership (LCPP) areas with established communication and development plans and regular meetings between community representatives and statutory services. The 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 well we are performing' sections. We recognise that as well as identifying as a member of a neighbourhood or locality many people will also identify as a member of a non-geographical community based on personal characteristics or experiences, such as people from the same ethnic background or people who are carers.

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 and 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 across the Local Community Planning Partnerships to tackle deprivation and promote fairness.

The Equality Mainstreaming Progress Report 2016-2018 (https://www.dundeehscp.com/our-publications/news-matters/publication-equality-mainstreaming- progress-report-2016-2018.) describes progress towards our equality outcomes and mainstreaming the equality duty over the two year period. Our next Equality Mainstreaming Progress report will be published in March 2020.

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 to alongside all of the partners who employ our workforce to promote fairness.

Since April 2018 the Fairer Scotland Duty has placed a legal responsibility 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.

During 2018-19 the Partnership's existing equality outcomes were reviewed to reflect the desired outcomes of affected communities. Our new equalities 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-).

1.4 How we engage and communicate with our stakeholders

We continue to be committed to understanding the needs of different communities in Dundee. We recognise that meaningful engagement with and participation of our stakeholders 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".***

During 2018/19 we have continued to implement our Participation and Engagement Strategy. Our new Strategic and Commissioning Plan has identified the need for our Strategy to be reviewed to ensure it continues to meet the Strategic need of the HSCP and our Stakeholders.

Our services continue to engage directly with patients, service users and their carers to improve service delivery. We use a range of engagement methods including surveys, patient questionnaires, joint carer education/information sessions, feedback and interviews.

We have worked closely with our Community Planning colleagues as part of the Community Learning and Development (CLD) Strategy Group to develop and agree our Framework for Community Engagement which will:

- 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.

Discussions are ongoing between partners through the CLD Strategy Group to streamline and add structure to our engagement with local communities, maximising the value of our existing locality engagement groups (including the Local Community Planning Partnerships, Health and Well Being Networks and Local Learning Partnerships).

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 have contributed to a number of Dundee Partnership engagement activities. For example, we supported Dundee City Council and NHS Tayside to engage about British Sign Language provision in the city.

We have taken forward 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 are seeking to use our learning from this exercise to support other stakeholder representatives who are part of our decision making processes.

Our Strategic Planning Groups continue to maintain and improve their engagement with a wide range of stakeholders. For example the Strategic Planning Group for people with a Learning Disability and people with a Learning Disability and Autism

continues to support Advocating Together who employ adults with a Learning Disability and/or Autism and make up part of our commitment to put people at the heart of decision making. Work has progressed in relation to the Charter for Involvement in Dundee. https://arcscotland.org.uk/involvement/charter-for-involvement/ . A dedicated worker is now available to support the Dundee Involvement Network which gives people who get support in Dundee a chance to share ideas and experiences about being involved in things that matter to them.

Our Mental Health Strategic Planning group continues to ensure that its plans are co-produced with people who have lived experience of mental health challenges. The Making Recovery Real initiative supported by the Scottish Recovery Network has now been in place for 3 years. During this time we have created films and workshops to help share recovery stories with the public, service providers, and decision-makers, held events to share the learning and delivered Peer 2 Peer training courses.

2.1 Where our resources come from

The Partnership's 2018-19 integrated budget for adult health and social care services was confirmed at the IJB's meeting held in August 2018. 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 2018/19 had the effect of being a flat cash position from 2017/18 with additional resources passed to the budget to cover pay inflation and additional Scottish Government funding to fund new legislative and other national policies such as the implementation of the Carers Act, further payment of the living wage with an extension of this to sleepover arrangements and increases in free personal and nursing care payments totaling £3.2m. A funding reduction was applied to the delegated budget to the same value. The NHS budget included an uplift passed on directly from the Scottish Government which fully funded 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, new Scottish Government 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 £4.8m in resources in the Health and Social Care Partnership's 2018/19 budget at the budget setting stage. The IJB considered and agreed to a range of savings and interventions which would be applied throughout the year in order to balance the budget. This included the application of a significant amount of the IJB's reserves.

This section of the report sets out how the Health and Social Care Partnership performed in relation to these challenges throughout 2018-19.

2.2 How we have used our resources

Dundee Integration Joint Board received regular financial monitoring information throughout 2018-19 which continued to highlight the range of pressure areas and services which were likely to over or underspend. These overspend areas included the continued challenges of balancing the GP Prescribing budget, staff costs associated with hospital based services and the impact of pressures in the mental health inpatient service.

Under the terms of the Integration Scheme, the financial risk sharing arrangements changed in 2018/19 in that should a budget overspend be projected throughout the financial year, the IJB must implement a recovery plan, then utilise unallocated reserves before any residual overspend is funded proportionately by NHS Tayside and Dundee City Council. As an overspend was projected during the financial year, a recovery plan was requested and delivered in relation to NHS Services through the utilisation of non-recurring funding options. The IJB planned to have an over spend at the year-end given it had identified the application of reserves to fund its activities during 2018/19.

The actual financial position for the delegated budget for 2018-19 was as follows:

Dundee Integration Joint Board made an overall deficit of £1,794k in 2018-19 on the total delegated budget of £261,283k. This was a 0.7% variance against available funding.

In health budgets an underspend of £1,836k was reported which mainly consisted of underspends in Scottish Government ring fenced funding such as Primary Care, Mental Health Action 15 and Alcohol and Drug Partnership funding totaling £1,505k. This funding is carried forward in the IJB's general fund balances to 2019/20 to be invested in new services and service redesign in line with the Scottish Government's requirements and local plans. A further underspend of £331k was achieved in community based operational services including the net impact of hosted services recharged from Angus and Perth and Kinross IJB's, although financial pressures remain within prescribing and in-patient mental health services.

In council budgets an overspend of £3,630k was incurred mainly due to the planned use of reserves as part of the 2018/19 budget setting process of £1,983k and planned draw down from reserves as transition funding to support community based investment as part of the Reshaping Non Acute Care Programme of £757k. Overspends were incurred during the year in relation to staff costs of £460k, including the effect of a higher than budgeted pay award and the non-achievement of savings through the redesign of care at home services. In addition, high demand for community based social care support lead to an over spend in services provided by third and independent sector care providers of £319k.

The actual expenditure profile for integrated health and social care services for 2018-19 is shown in the table below:

Annual Expenditure Profile 2018-19

Service Type	2018-19 Net Expenditure / (Income) £000	2017-18 Net Expenditure / (Income) £000	Increase/ (Decrease) £000
Older People's Services	71,019	71,201	(182)
Mental Health	18,447	18,996	(549)
Learning Disability	33,186	31,215	1,971
Physical Disability	9,680	8,923	757
Substance Misuse	4,330	3,945	385
Community Nurse Services/AHP*/Other Adult	13,089	12,412	677
Community Services(Hosted)	11,463	10,151	1,312
Other Dundee Services/Support/ Management	7,314	5,799	1,515
Prescribing	33,620	35,818	(2,198)
General Medical Services (FHS**)	25,110	24,163	947
FHS - Cash limited & Non Cash Limited	18,083	17,155	928
Total of Costs Reported during 2017/18	**245,341**	**239,778**	**5,563**
IJB Operational Costs	287	267	20
Acute Large Hospital Set Aside	17,449	17,452	(3)
Total Cost of Services	**263,077**	**257,497**	**5,580**
Delegated Budget	(261,283)	(257,094)	(4,189)
Surplus on Provision of Services	**1,794**	**403**	**1,391**

The summary of this financial performance is shown below:

Financial Performance Summary

	2018-19 Expenditure £000	2017-18 Expenditure £000
Health Services - Hospital In-Patients	42,151	40,474
Other Health Care Services	117,465	115,194
Care Home and Adult Placement Social Care Services	29,451	29,474
Supporting Unpaid Carers	1,389	1,270
Other Social Care Services	72,621	71,085*
Total Expenditure	263,077	257,497

*restated from previous years report to remove impact of central support services recharge from Dundee City Council – not charged in 2018/19

You can read more about our financial performance in our Annual Accounts 2018-19.

Reserves:

As noted above, the IJB utilised some of its reserves in supporting its activities, including service redesign during 2018/19. This, in addition to the impact of financial performance during the year has resulted in a shift in the reserves position of £4,560k at the start of the year to £2,766k at the end of the year. Of this, around £1,500k relates to ring fenced funding which will be invested in the purposes for which they were intended during 2019/20 (e.g. primary care, mental health and Alcohol and Drug Partnerships).

Shifts in Resources:

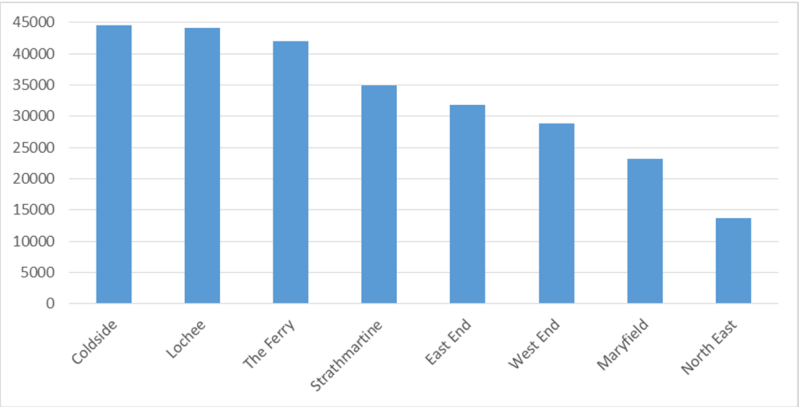
Over the last 12 months, the IJB has invested additional resources in social care and community based services across client groups while redesigning services to reduce spend on the hospital bed base and care homes in line with its strategic plan.

2.3 Community Care

The following graphs show the number of hours spent providing Homecare during 2017-18 (latest available data), by Locality and standardized by 1000 per population for those aged 16+.

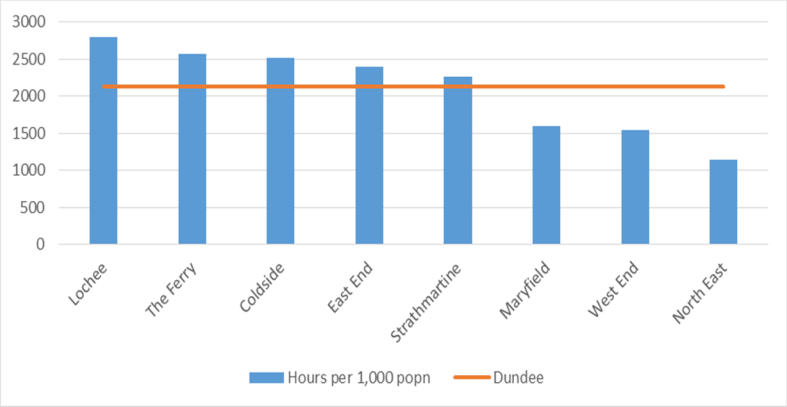
Also shown are the number of Community Alarms that have been maintained during 2017-18 for those aged 65+.

Homecare Hours by LCPP (age 16+)



In 2017-18, Coldside, Lochee and The Ferry used most resources, indicating these areas have a higher level of care and support needs. The high number of hours in the Ferry is most likely due to the fact this area has the highest population of people aged 65 and over.

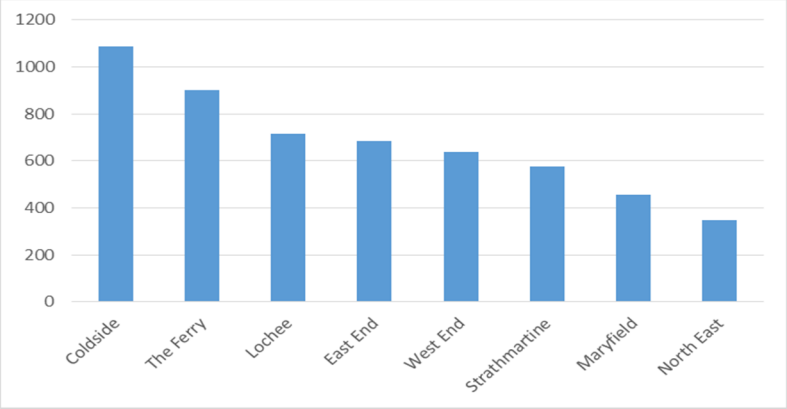
Home Hours spend by LCPP population (age 16+)



There is a variation in the hours per 1,000 population which reflect the needs by deprivation and frailty.

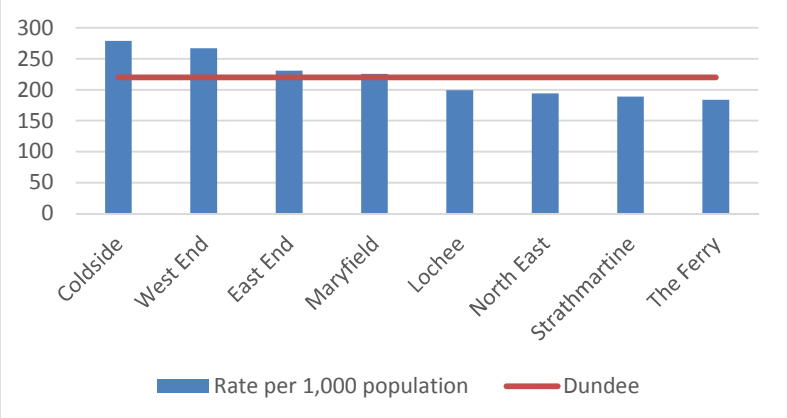
Source: Social Work system K2 data for the period Jan – Mar 2018 used for the submission of Source data.

Community Alarms by LCCP (age 65+)



The high number of community alarms in Coldside is due to the large number of sheltered housing located there. Response to the alarms is supported by the Social Care Response Service when there is no warden on duty.

Community Alarms by LCCP population (age 65+)



As a rate per 1,000 population, Coldside and West End have a high rate of community alarms. Even though The Ferry has a high number of people aged 65+, there is a lower number of community alarms per 1,000 population.
Source: Social Work systems Mosaic and PNC7, 2017-18

HEALTH & SOCIAL CARE PARTNERSHIP
STRATEGIC & COMMISSIONING PLAN 2019-2022

During 2018/19, the Integration Joint Board undertook a review of its Strategic and Commissioning Plan 2016-2021 as required under legislation and following an assessment of the Scottish Government's overview of the original plans across the country, the IJB's own learning from its own first three years of operation and a range of performance information developed over that period, agreed to revise the plan.

The process of revising the Strategic Commissioning Plan was led by the Integrated Strategic Planning Group (ISPG) and drew from continuous conversations over the last three years with communities, people accessing health and social care services, their families and with carers. This was supplemented by specific activities across the full range of health and social care stakeholders to consult on the Strategic and Commissioning Plan 2019-2022, including a 3 week public consultation exercise which drew 188 responses with two-thirds of respondents living within Dundee and the remaining third working within the city. Just under 40% of respondents identified as being a carer. The replacement plan was approved by the IJB in March 2019 and complements other strategic plans across the Community Planning Partnership and within the corporate bodies (NHS Tayside and Dundee City Council), while fully complying with legislation and national guidance in relation to health and social care strategic plans.

The vision for the Integration Joint Board remains the same in that "Every Citizen of Dundee will have access to the information and support that they need to live a fulfilled life"

The main change from the previous plan is to 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.

Following approval of the Strategic and Commissioning Plan, it is the responsibility of the Integrated Strategic Planning Group to oversee the implementation of the Plan on an ongoing basis. This includes directing the production of mid-year and future annual performance reports, which will continue to set out what progress is being made in delivering the priorities and vision reflected in the plan.

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

OUR PERFORMANCE

3.0

This section describes and analyses our performance. We have used the 23 national Health and Wellbeing Indicators and local indicators to demonstrate our performance against the nine National Health and Wellbeing Outcomes and our eight Strategic Priorities. 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 2018 to March 2019 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.

You can find more detail about how well we are performing against the 23 national Health and Wellbeing Indicators in our 2018-19 quarterly performance reports on our website.

A sample of Dundee citizens aged 16 and over participated in the Dundee City Council's 2018 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 2018 survey can be found on our website.

NOTE: As most of the performance data for Scotland has not yet been published, these figures have been suppressed in this Draft report until advised by NHS: Information Services Division (ISD) Scotland.

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 of the Partnership Strategic Priorities:

Work is progressing to realign 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 the services develop to meet the needs of local communities.

- The development of the locality approach to carers in Coldside and Strathmartine has been successful in increasing the number of carers of all ages identified and supported within the local community. The team have local bases where they can meet carers informally in the local community and have a good knowledge of the informal community supports available locally.

  Groups and drop in opportunities have also been developed, in partnership with local agencies, schools and community groups, enabling carers and their families to access information, advice and support int their local community. These include young carers groups in schools, a family cinema group for carers and drop-in cafes in Ardler and St Marys.

  Carers 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. Carers Centre currently rolling this out across all localities in Dundee.

  A Local Community Worker commented:

  > ***"Through working with the Carers Centre, I have a better understanding of who carers are and that many people who are carers and would be entitled to support, financial or otherwise, do not consider themselves to be carers. Examples of this would be couples and under 16's. Knowing this has helped me identify hidden carers. Now that I have a better understanding of who would be classed as a carer I am more confident to ask relevant questions. This helps me determine the correct signposting. However, I always let the person know about the carers centre in my signposting."***

- The Partnership is in the implementation phase of Transforming Primary Care Services. Part of this new work is to develop and embed a new model to provide treatment room care for patients in Dundee.

  Building on the work and experience of current community nursing teams, additional staff have been recruited to develop new roles in care and treatment. The new Community Care and Treatment Services (CCTS) Team will deliver treatment room care at sites across Dundee to support the shift in the balance of care from GP surgeries to locality based services.

  Pathways of care are being developed in 4 key areas; Leg Ulcer Care, Wound Care, Ear Care and Phlebotomy. The Community Leg Ulcer clinics are now established in two sites; East and West of the City. However unanticipated demand for this service has led to a waiting list, which the team are working to resolve.

A pathway of care for Wound Care Clinics for patients registered with 6 GP practices is also being testing. Any patient discharged from secondary care or receiving current treatment in their practice that requires follow up treatment for wound care or suture removal will be seen by the CCTS Team. In the first 3 months approximately 90 patients have been referred. All practices in the pilot area have now used the service.

In the next 6 months the team's priority is to plan and deliver a phlebotomy service, working with colleagues in General Practice to develop safe systems to support this. The team is also working with colleagues in both General Practice and Secondary Care to develop a model of ear care and wax removal which it is planned to test by the end of 2019.

The CCTS Team is also part of the eHealth test of change which will get underway in June 2019 for a new IT software program Vision AnyWhere. The system aims to improve real time communication between CCTS and General Practice.

The Community Care and Treatment Services Nursing Team

- It has been identified through Needs Analysis that the 'East End' locality is an area where the local population experience high levels of mental health issues. A range of developments have been coordinated to support people in this local community.

  The Community Health Team worked with local people to establish and support the Health Issues in the Community (HIIC) Group. Individuals in the group have had a major influence on service design and delivery through a number of activities including volunteering for local developments and sharing their lived experience with others. This work provides an excellent example of the community development approach which has resulted in co-produced, locally led mental health provision.

  The group developed a drama on self-harm and suicide which has been performed for people and professionals in the local community. The drama has had wider audiences too including the Cabinet Secretary for Health, Wellbeing and Sport, participants at the Community Health Exchange Conference and launch of the HIIC Youth Pack. Their

performance for the DHSCP Mental Health and Wellbeing Strategic Planning Group supported frank discussions about service provision in the city. The group has continued to have dialogue with strategic commissioning partners and helped produce a user friendly Mental Health and Wellbeing Briefing for people in local communities. Links have been made with local organisations like Volunteer Dundee and two group members undertook 'Peer to Peer' training as well as participating in the Tayside Mental Health Inquiry. Five group members achieved accreditation for completing Part 1 of the HIIC Learning Pack with three people are continuing to work towards Part 2.

East End HIIC group aim to continue to deliver the drama and recent performances have included Abertay University Mental Health Society, Aberdeen Town House, NHS Grampian, and Dundee University.

In partnership with local agencies Community HIIC group members provide support at the local 'Healthy Minds' Drop-In Service. 37 individuals have attended this Drop in service since April 2018. People who have come along have been supported to learn new skills; access health checks with Keep Well Nurses; hosted a co-design event, and organised input from visiting speakers.

This process is a good example of the community development approach resulting in a co-produced, locally led mental health provision.

HIIC Group members have shared their opinion of the group and the process. Here is what one person said:

> ***"….we find it hard to believe the impact we are having locally….. a government minister… pledged to do something about the terrible loss of young lives in Dundee particularly, but in Scotland as a whole. It's crazy to think we can make a difference but that is what is happening.***
>
> ***We…. benefit socially, mentally and physically….. This whole experience has certainly been a life changer….. we will be friends for life as we have grown very close in a supportive, learning, environment that has helped us grow as individuals as well as a group."***

- Helping Older People Engage (HOPE) is a service for people living in Dundee, who are over 55 and do not live in sheltered housing. The HOPE project's main aim is to help older people feel less lonely and isolated by encouraging participation in local groups and activities and providing advice on a range of issues. The service was originally set up in 2016 to provide a floating housing support services as the levels of sheltered housing lessened in Dundee. However the service has flourished and now provides a much more rounded sign posting service assisting a wide variety of people.

  Following a stroke, Mr R was feeling socially isolated and struggled with social activities and maintaining relationships. A meeting was arranged between Mr R, his daughter and a HOPE worker. Mr R was referred to a range of befriending services. He was supported to attend a local seated exercise class, he went on bus trips and joined a local support group for people who had had a stroke.

  His daughter wrote:

  "…You had so much information it was heartwarming to know is available…"

- Over the past year, the focus has been on establishing a culture of collaboration and the organisational conditions that will support and enable implementation of 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 (East and West Integrated Managers Independent Living; Hospital Discharge Improvement and Carers and Inpatient Occupational Therapy (OT) & Physiotherapy (PT) Integrated Manager) to enable effective leadership of change and redesign. Alongside this, PT and OT 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 centred care.

  Next steps for these services:

  - Further integration of Physiotherapy and Occupational Therapy services within both in-patient and community settings with a strong focus on person centred care.
  - Tests of change are being undertaken in A&E to improve patient pathways, supporting moving patients to the right place at the right time.
  - To develop new approaches to working with the Third Sector and other partners.
  - The commencement of a Major Trauma Centre based at Ninewells Hospital has supported role development and resource allocation across the Allied Health Professional Services.
  - 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. This three year project is in the early stages and will see two clusters supported by the end of 2019-2020.

- The multi-agency Humanitarian Protection Partnership (HPP) has been established to deliver the Syrian Vulnerable Persons Resettlement Scheme 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.

  Along with other agencies the Partnership has seconded employees to the HPP and support for resettled families is delivered in an ethos of joint-working which is enhanced by inter-disciplinary development and learning events. The introduction of cooperation and multi-skills discussions to help inform further service delivery.

  The HPP has been nominated for the Scottish Social Service Council award under the category: Silo Buster

> ***"This is about joined up thinking, working and delivering. Do you take the time to understand your colleagues, agree what each of you can contribute - and follow that through to make a difference to people's lives? At times of integration and change, these skills, which break through organisational barriers and cultures, are vital. It is not about sharing a space, but a common approach to support and care for people.***

Mrs W left Syria in 2011. She moved to Dundee with her husband and 2 children in June 2018 as part of the Vulnerable Persons Resettlement Scheme. Mrs W 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 her English speaking skills Mrs W also began volunteering at a local community café. After a short time it was recognised that Mrs W was so engaged with her language lessons and motivated with her volunteering, it was recommended that she should move into employment as soon as possible. Mrs W was referred by her ESOL tutors to the 'Get Ready for Work' course developed and facilitated by ESOL and Employability staff.

It was a steep learning curve for Mrs W but with the support of staff and volunteers she was able to construct a professional CV and learn how to update this in the future. She also greatly improved her vocabulary as well as her understanding of the UK job market. Mrs W continued to show exceptional ability and strong dedication to the English lessons and employability sessions. She was a huge asset to her peers and to the course within the classroom encouraging and assisting others.

Mrs W continued to work towards employment and she was invited to a selection interview for the position of Assistant Cook at a local restaurant. She was supported to prepare for the interview and was successfully appointed to the post. Employment has made her more independent, confident and financially better-off.

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

National Outcome 1 links to the following Strategic Priorities:

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

Local data provides strong evidence of the high levels of deprivation in Dundee. 28.6% of the population live within the data zones ranked in the 15% most deprived in Scotland. 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 your 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 well we are performing

Health & Care Experience Survey 2018/19: **"In general, how well do you feel that you are able to look after your own health?"**	Dundee - **93%** Scotland - **93%** very/quite well
Dundee City Council's Citizens Survey 2018: **"How good is your health overall?"**	**83%** very/fairly good

The Dundee Citizens Survey is analysed by ward and shows that those respondents living in the West End are most likely to rate their health as good or very good (91%) and those who live in the Ferry (75%) are least likely. The Ferry has a higher proportion of older respondents than other areas which may explain this variation in results.

Despite Dundee citizens giving a positive response to how good their health is and being able to look after their own health, emergency admission rates are high. This means that per head of the population a large number of people aged 18 and over are being admitted to an acute hospital in Dundee as an emergency. In 2018-19 for every 1000 people in Dundee who were aged 18 and over, there were 126 emergency admissions

Emergency admission rates vary across the city. The highest emergency admission rate was in East End (167 admissions per 1000 people) and the lowest rate was in West End (91 admissions per 1000 people). There is also high variation between the neighbourhoods within each LCPP. An in-depth analysis of emergency admission rates by neighbourhoods within LCPPs has been completed and can be found on our website.

Encouraging people to have choice and control over the services and supports they receive is a priority. Figure 9 shows that the number of people who received Self Directed Support

options 1 and 2 has shown an increase in 2018-19. The amount spent on delivering services and supports under options 1 and 2 has increased considerably from over £961k in 2015-16 to over £2.25M in 2018-19.

Figure 9 – Self Directed Support – Options 1 and 2

	2014-15		2015-16		2016-17		2017-18		2018-19	
Option	No. of people	Cost	No. of people	Cost	No. of people	Cost	No. of people	Cost	No. of people	Cost
Option 1										
Adults	40	£803,313	50	£865,451	52	£1,016,659	65	£1,413,326	79	£1,640,765
Total	49	£860,256	58	£928,673	60	£1,087,024	74	£1,522,412	103	£1,875,294
Option 2										
Total	12	£22,691	22	£96,279	30	£308,726	39	£287,817	70	£613,366

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 23% for Option 1 and 113% for Option 2.

Dundee has a high number of people living with dementia. During 2017, dementia was the leading cause of death for women in Dundee (15.4% of all deaths), while for men it was the third highest cause (8.5% of all 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 in order to equip people with dementia, their families and their carers with the tools, connections, resources and plans they need to live as well as possible with dementia and prepare for the future. Everyone diagnosed with dementia is entitled to receive at least 12 months of post diagnostic support. 277 people were referred for post diagnostic support, which was 100% of new diagnoses.

What we have achieved to deliver this outcome

There have been continued efforts to promote an outcomes focused approach which is asset based, focusing on all assets that people can draw upon in their own lives to be healthier and independent for longer in their own community. This may consist of help they can receive from family and friends, peers with similar issues, technology and professional information and advice. The Partnership will provide support in relation to any needs that cannot be met by community based assets. An asset based approach also involves working in partnership to co-design services with the statutory, third and independent sectors and with individuals, families and communities.

- 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. Care at home services are able to take prompt action to help reduce the risk of hospital admission for older people. 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.

Mrs S, a 91 year old lady, expressed a strong desire to avoid hospital 'at all costs'. Following a decline in her health DESCA was able to support her remain at home during her recovery, with the support of a highly skilled medical team. Professionals who came to visit Mrs S during her recovery at home included a medical consultant and nurse consultant for old people. The nurse consultant visited within two hours of notification by the GP and arranged care for her at home as well as arranging specialist equipment.

Mrs S and her family were given the opportunity to talk about what they want in the event of things taking a sudden bad turn. The team were able to advise and help with legal matters such as organising a power of attorney.

Mrs S said:

"I love being in my home... and everyone ensured I've had everything I've needed"

- During 2018 there have been significant developments to support those who are acutely unwell and cannot attend their GP surgery. As part of the developments of Primary Care improvement linked to the new GMS contract, alternative models to a GP doing 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 do 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 staff and patients in the care homes they are working with, and so this work is part of the wider care for the patient. The initial test of change has been with 2 practices and the 8 care homes associated with those practices. Once additional staff are recruited this will roll out to other practices and homes.

  For people at home who become unwell, the role of specialist paramedics to assess and support people is being tested. The specialist paramedics have been working with 3 practices and undertake assessments at home. This is a new way of working for everyone but the initial test of change has been positive and it is hoped to develop this further. A model that has GPs and advanced practitioners, nursing and paramedics, will be progressed as capacity is developed.

- V1P Tayside has been operating across Tayside for 4 years and continues to demonstrate the Partnership's commitment to the Armed Forces Covenant, ensuring that veterans – and particularly those with the most enduring health and welfare difficulties are able to access priority care and treatment from mainstream and specialist services.

  Although a small service, V1P Tayside has delivered care and treatment to over 300

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

While mental health concerns are the primary focus of interventions provided by the V1P Scotland services, co-ordination of care with physical health services and pain management services are also vital. V1P Tayside has been working on a number of developments to support veterans with co-current physical and mental health issues:

- Developing a Therapy Garden to encourage social and recreational activity and eventually a place to meet together;
- Expanding Drop-In sessions to include social activities. For example, a Music Group is held on a Friday and it is planned to start a gentle Walking Group in the near future;
- Signposting veterans to a range of specialism aimed at supporting their physical health needs and work with veteran charities for additional practical support and aids and adaptations;
- Collaborating with Public Health colleagues to develop a strategy to support male veterans to access health screening.

In light of both self-reported problems and those identified through assessment outcome measures, which indicate high levels of depression and anxiety which impacted on functioning and quality of life, the V1P Scotland Network of services have pursued the following developments:

- Training all V1P clinicians in Interpersonal Psychotherapy (IPT) which aims to reduce depressive symptoms and improve social functioning by focusing on interpersonally relevant issues.
- Training all V1P peer support workers in the delivery of Interpersonal Counselling, which is a short term intervention developed for delivery by non-clinical staff.
- Collaborating with pain management colleagues/experts to develop specific care pathways for the care and support of veterans with pain/mobility issues and adopting these pathways into local service provision.

High rates of unemployment are striking within the community. Veterans leave the armed services with many transferable skills which would be of great benefit to civilian life. V1P Centres are in a unique position to build partnerships with local business, regeneration programmes and wider civic life would create more opportunities for veterans to contribute to civilian life. To support this, V1P Scotland are working with the University of Strathclyde to build and test a measure of citizenship for veterans. This will inform future capacity and asset building streams of work within the Centres and across partnership areas.

- "Do You Need to Talk?" (DYNTT) is an asset based listening service based in GP surgeries. The aim of the service is to provide an early intervention based in a local context to empower self-management through reflective listening and an asset based approach.

During 2018 DYNTT in Dundee has:

- Provided over 900 attended appointments in GP surgeries.
- Trained and supported a team of 15 volunteers to assist in the provision of the service.
- Offered the service to every GP Surgery in Dundee.

Recent research from Scotland evidenced that:

- GPs found the service beneficial for patients and themselves.
- They found that patients with a range of sub-clinical but highly distressing conditions responded very well to the listening service.
- It was easy to provide referrals quickly due to the accessibility of the service.
- These patients then attended the GP surgery less, allowing GPs to concentrate on medical issues more generally.
- The service gave GPs more time with other patients, and reduced pressure on them to prescribe or refer to inappropriate services.

Patients have told us:

> ***"The listener helped me immensely and helped me think things through, particularly about bad past experiences."***
>
> ***"I feel that the listener was able to help me put things in perspective and helped me deal with the situation better and to open up more than I normally would."***
>
> ***"My listener was this wonderful person that spoke a calming common sense, the first thing that vanishes during the times of extreme stress and trauma. Wary when I went, with positivity when I came out. Something I thought I had lost***

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

National Outcome 2 links to the following strategic priority:

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

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

How well we are performing

Health & Care Experience Survey 2018/19: **"I was supported to live as independently as possible"**	Dundee - **84%** Scotland - **81%** Agreed

Dundee has a high rate of readmissions to hospital, where the patient had been discharged within the last 28 days. In 2018-19 12.4% of people discharged from hospital following an emergency admission, were readmitted within 28 days.

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 2018-19, for every 100 people aged 75 and over, 36.9 bed days were lost due to a delayed discharge. This is a slight deterioration on the 2017-18 figure, when there were 34.9 bed days lost for every 100 people aged 75 and over.

There is variation between the number of bed days lost to a delayed discharge across LCPPs. People aged 75 and over who live in the Lochee LCPP contribute to the largest rate of delayed discharge bed days for all reasons. For every 100 people aged 75 and over living in Lochee there were 59 bed days lost in 2018-19, which is more than double the rate in The Ferry. The lowest delayed discharge bed day rate was in The Ferry where for every 100 people aged 75 and over there were 25 delayed discharge bed days used in 2018-19. While Coldside had one of the lowest rates for Standard Delays at 21 delayed discharge bed days per 100 people aged 75+, they also had the highest rate for Complex Delayed Discharges at 21 delayed discharge bed days per 100 people.

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. Home care is one of the most important services available to partnerships to support people with community care needs to remain at home. This indicator measures the number of adults who are 65+ receiving care at home as a percentage of total number adults needing long term care. Using the most recent national data available for 2017-18, 59% of people aged 65 and over with long term care needs receiving personal care at home.

Despite Dundee citizens feeling that they were supported to live as independently as possible and preventative and rehabilitative services and supports being delivered in the community, emergency bed day rates for people aged 18 and over remain high. Dundee has a high rate of emergency occupied bed days for all hospital specialties – acute and mental health, although there has been a substantial reduction (7.6%) between 2017-18 and 2018-19. This is a positive change, meaning that, on average, for every 100 people in Dundee 125 bed days were occupied during 2018-19, compared with 135 bed days occupied in 2017-18.

Emergency bed day rates vary across the city. The highest emergency bed day rate was in Lochee (170 bed days occupied per 100 people) and the lowest rate was in West End (82 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.

During 2018, there were 1337 Power of Attorney (POA) registrations in Dundee per 100,000 population (18 and over) compared to 1934 registrations in 2017. 2017 had a high number of registrations in Scotland as whole. There was a big drop in applications in Dundee during the period April to June 2018. It is notable that those local authorities with a more aged population have higher numbers of new registrations.

What we have achieved to deliver this outcome

During the last twelve months the Partnership has increased investment in home based care services, by £1 million, in order to bridge the changes recommended from the review of homecare services.

- 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 2017-18, the Assessment at Home service supported 132 people to return home from hospital as an alternative to care home admission. Of these 132 people, 48% were enabled to continue to live independently in their own homes following the assessment period. In addition, the service was extended to support DECSA in the prevention of admission to hospital. Throughout the year, 122 people were supported at home while their Comprehensive Geriatric Assessment was carried out in their own homes. Of these 122 people, only 22% required admission to hospital and 60% continued to live independently in their own homes following this acute period of illness.

Between January 2018 and April 2019, the Assessment at Home Service supported 318 people to return home. A total of 37,382 visits took place over 44,456 hours.

Red Cross Assessment at Home Case Study

Mr R has a history of hospital admission as a result of Chronic Obstructive Pulmonary Disease and high levels of anxiety. When Mr R was recently discharged from hospital with a daily visit in the morning from a care provider. He was re-admitted in the early hours of the next morning with increased anxiety.

The view of the multidisciplinary team on the ward was that he would require admission to a care home where 24 hour support would be available. Mr R, a very private and independent natured man was not keen on the idea of a move to a care home as he saw this as an intrusion to his privacy.

The care manager requested the Assessment at Home service for a 24 hour package to complete the assessment in Mr R's own home. When the situation was reviewed the following day there was already evidence that Mr R was managing many aspects of his own care. Mr R had admitted that as soon as he felt better he usually stopped taking his medication. Care staff had been prompting his medication for him to ensure he was taking them at the correct times.

Mr R had previously refused to have a Community Alarm Social Care Support Service but having seen the benefits of support he acknowledged this would be a helpful alternative to phoning for an ambulance when he became breathless. He knows he can activate the alarm to enable him to get support, while remaining in his own home, and protecting his privacy. He also agreed to an Occupational Therapy assessment for equipment which help him maintain his independence.

5 days after discharge when a more formal review was undertaken, it was clear that Mr R's independence increased and the care provision was reduced. The community pharmacy were able to provide all his medication in a blister pack dispenser and Mr R's Care package was arranged for only 1 visit per day to support him with personal care. The assessment at home enabled professionals to see the specific times when Mr R needed support and so the final package of care was more suitable for his individual needs.

Mr R continues to live independently at home with a minimal social care package and has not been readmitted to hospital in the last 6 months.

- The Medicine for the Elderly (MfE) service currently support 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 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
- Bluebell intermediate care unit (a Private Sector Care Home Contracted Provision

- A new Acute Medicine for the Elderly (AME) Assessment Unit for 12 older people was set up in Ninewells Hospital for 4 months in December 2018 as part of the 'Winter Plan'. The Unit has proved successful and agreement has been made to continue this ward on a permanent basis adding the capacity for 6 more patients, utilising beds that previously were allocated to orthopaedic services. The aim of the unit is to improve the care pathway for the older person and builds on the work of the existing Acute Frailty Team. In order to optimise the professional resources the AME Unit is located as near as possible to the existing AMU.

  The new unit supports a range of patients including those who have had a fall, patients who have acute or chronic confusion, patients with poor mobility, patients who live in a care home , frail patients with acute functional decline and frail patients with acute illness where alternative specialty care would be less appropriate.

- The Dundee & Angus Independent Living Centre is a successful partnership between the HSCPs in Dundee and Angus. 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 site is produced in partnership with Dundee Voluntary Action. It includes information sections on Eating, Washing, Sleeping, Mobility, Enjoying Life, Community Alarms, and Sight and Hearing. There are links to many other local and national sites carrying useful advice and information. For example, the website provides a link to the Community OT Services Attend Anywhere online waiting room. The 'Get Assessed' page includes a form which people can fill in online to request advice.

Google Analytics show that typically 200 users visit the site in a month, although this varies significantly. Publicity online boosts the numbers briefly. The next action is to produce leaflets and posters for distribution to health & social care sites to drive more people to the website. Work on search engine optimisation will take place so that the site is more easily found.

The centre is located at Charles Bowman Avenue, Claverhouse Industrial Park West, Dundee DD4 9UB. The current opening hours are 9-5, Monday to Friday. Please check website for further details.

- 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; 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.

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

Outcome 3 links to all of the Partnership Strategic Priorities.

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

How well we are performing

Health & Care Experience Survey 2018/19: "I had a say in how my help, care or support was provided"	Dundee - **78%** Scotland - **76%** Agreed
"Overall, how would you rate your help, care or support services?"	Dundee - **82%** Scotland - **80%** Good/Excellent
"Overall, how would you rate the care provided by your GP practice?"	Dundee - **84%** Scotland - **83%** Positive

There was variation in responses across G.P. practices in Dundee ranging from 58% to 97%

Experience of care appears to be positive and this is particularly important when people reach the later stages in their life. Where possible, we try to predict the progress of disease in order to enable a planned approach to palliative and end of life care. However this remains challenging when there are multiple morbidities and altered cancer progression profiles. Integrated palliative care approaches allow the Partnership to support those who are living through their last days and weeks in a way that is responsive to each person's individual circumstances, wishes, hopes and priorities. Of the people who died during 2018-19, 89% of time in the last 6 months of life was spent at home. This is a positive result and could not be achieved without a strong partnership between acute and community teams, the third and independent sectors and patients and their loved ones. The Tay PEOLC Managed Care Network is further exploring information related to those who spent greater 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 2018-19 a total of 35 complaints were received regarding social work and social care services provided by the Partnership. Just under half of the complaints (48%) were resolved at the first stage of the complaint process, frontline resolution. For 60% 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 43% of complaints we agreed that the complainant had reason to complain so they were upheld or partially upheld.

In 2018-19 a total of 123 complaints were received about health services. 39% 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.

Figure 11 - Complaints regarding Health Services

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

For 54% 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 a Care Manager for Older People:

> ***"Right from the outset, he set about his work in a structured, sympathetic but above all professional manner. He kept my brother and I fully appraised of all developments which were likely to impact on my mother's care, and gave good advice and guidance at all times."***

This compliment was received about the Enablement Team:

> ***"The quality of care and expertise shown by the above team under the leadership of the Social Care Organiser is amazing. I hope you will pass on my thanks and praise of their efficiency, expertise, cheerful and tireless dedication.***

This compliment was received about a Social Worker in the Community Mental Health Team for Older People:

> ***"I just want to acknowledge the Social Worker's beautiful demonstration of relationship based practice today. The result of her style of intervention allowed a very distressed woman to step by step regain a little control in a potentially disempowering situation"***

This compliment was received about Craigie House:

> ***"Just a few lines to thank all staff at Craigie House for the care and attention given to our mother throughout the years. She was happy and cheerful all the time at home in Craigie – this small measure is down to you. All the staff make it what it is for the residents, a home."***

What we have achieved to deliver this Outcome

Throughout 2018-19, information gathered from people who use services and their carers were used to make continuous improvements. Some of these are described below:

- 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 know 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.

- The Kingsway Care Centre is an old age psychiatry facility in Dundee. There are two Community Mental Health Teams, the Care Home Team and the Post Diagnostic Service team based at the site. The inpatient part of the centre has capacity for 50 older people. There are 4 wards - 3 admission/assessment wards for older people with organic conditions; and an admission/assessment mixed gender ward for people with functional mental health difficulties.

  The Mental Welfare Commission (MWC) visited Kingsway Care Centre on 24th April 2018 to look at care and treatment in the inpatient areas. The Commission visitor's findings confirmed many positive aspects of the Centre. These included that:

  - The atmosphere was calm and quiet and the physical environment was good. A lot of work had been done to make the environments dementia friendly.
  - Patients and relatives spoke positively about their care, treatment and support.
  - Interaction between staff and patients including those patients who were displaying stressed or distressed behavior.
  - Care plans were of a good standard. These included consistently comprehensive and person-centred information.
  - Good information was recorded about the individual patients in Getting to Know Me and My Life Story forms.
  - There was an emphasis on recovery focused approaches.

- Compulsory measures under the Mental Health Act were being put in place when this was appropriate.
- Mental Health Act and Adults with Incapacity Act paperwork was well maintained with relevant copies and appropriate certificates which were acted on accordingly.
- there was good provision of activities in group sessions and on an individual basis

Commission visitors identified good practice relating to the emphasis on staff training and on reflective practice and learning. There was a clear focus on practice development for permanent staff as well as for Student nurses. There are very positive links between senior charge nurses and the practice development nurse. A number of innovative practices were identified.

The MWC made one recommendation:

'Managers should ensure that arrangements are put in place so that a number of specific bedrooms in each ward have facilities to allow patient observation without staff having to enter bedrooms.'

Outcome of recommendation:

'New doors with observation panels have been tested within ward 4 and are awaiting instalment within the unit.'

- During 2018-19 the Substance Misuse SPG developed four working streams to drive progress on each of the priorities within the Strategic & Commissioning Plan, including:

  - Children & Families – focusing on children and young people at risk of early initiation of substance misuse or at risk of harm from parental substance misuse;
  - Prevention & Protection – including a focus on trauma-based work, harm reduction and linking with Community Justice to reduce reoffending;
  - Recovery – continuing with the improvement of a recovery-focused care, treatment and support;
  - Resilient communities – focusing on supporting and developing community-based project to enable communities respond to the risk of substance misuse and support recovering individuals.

  The Alcohol & drugs Partnership, as well as front-line services and individuals across the city, have provided evidence and supported the work of the Independent Drugs Commission. The Commission has been set up to undertake a comprehensive review of drug misuse in Dundee and provide detailed recommendations on approaches to improvement.

  During 2018 funding was allocated to develop a multi-agency coordinated approach to learn from and utilize the experiences of individuals with lived experiences of substance misuse. The project is led by Volunteer Dundee on behalf of a voluntary-sector partnership. A volunteers' coordinator was appointed and has been developing a peer-mentor framework and training with the aims of improving engagement with services, increase the support to individuals and families, and progress recovery.

- During 2018 funding has been allocated to appoint a non-fatal overdose project worker to develop local pathways for a quick and effective responses to all non-fatal overdoses in Dundee. Work on improving partnership responses to non-fatal overdoses has been on-going in Dundee for a number of years and this post, which will be managed by Gowrie Care, will progress our efforts. Specific focus will be placed on working with individuals at risk of overdosing with the aim of preventing overdoses and supporting individuals into treatment and recovery.

- The Making Recovery Real (MRR) partnership continues to work together listening to people with lived experience (PWLE) of mental health challenges. As well as having a dedicated post based at Dundee Voluntary Action whose main role is to support the development of recovery locally, work is now progressing to recruit the equivalent of 4 full-time Peer Recovery practitioners to continue recovery story sharing and peer recovery activities.

  Peer to Peer training continues with the latest course having commenced in Hilltown Community Centre on the April 19. More than 20 volunteers have already been trained with some taking up voluntary roles in mental health organisations in Dundee, others going on to paid employment and one going on to university. The short film 'One City, Many Recoveries' is being used to promote recovery with front line staff and other PWLE and was recently used with staff and patients at Carseview to raise awareness. MRR Peer 2 Peer graduates and partner organisations also worked with the Dundonald Day Centre to launch 'Recovery at Dundonald' in which staff and service users worked together to introduce new initiatives which emphasise lived experiences of recovery and what supports recovery.

  Meetings are taking place to establish support for co-delivery of Wellness and Recovery Action Planning (WRAP) in a range of settings.

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

Outcome 4 links to all of the Partnership Strategic Priorities.

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

How well we are performing

Health & Care Experience Survey 2017/18: **"The help, care or support improved or maintained my quality of life"**	Dundee - **85%** Scotland - **80%** Agreed

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

Coldside had the highest rate of falls in Dundee with 37 per 1,000 of the 65 and over population closely followed by West End with a rate of 36. North East had the lowest rate of falls in Dundee with 19 per 1,000 of the 65 and over population.

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

What we have achieved to deliver this outcome

- 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.

There is now an established multiagency group meeting on a regular basis to share knowledge and skills and support the development of falls services across the City.

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 have 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.

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.

- Initial testing of a 7 day service from the supported discharge service demonstrated a 20% increase in weekend discharges, so the service provided by the Integrated Discharge Hub was mainstreamed over 7 days from July 2018. 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.

- 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. Alzheimer Scotland's Advanced Dementia Practice Model provides a framework so that the care and support given to people with advanced dementia and at the end of life is integrated and comprehensive. It incorporates The 8 Pillars Model of Community Support and introduces an Advanced Dementia Specialist Team for optimum care.

  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.

Identification Tools are being tested within identified care homes to determine if the use of the tools supports the identification of changes and decline in a person's presentation and whether this leads to a responsive and timely response in meeting the needs identified. Where deterioration is recognised from application of the tools and/or needs unmet the individual is escalated to the Care Home Team where a coordinated response can be delivered – accessing the Specialist Team where identified (Geriatrician, AHP, DN with Dementia experience, Psychiatrist, Psychologist and Palliative Care) in cases where additional intervention may be required to meet needs. Initial learning from the care homes is that where tools have been considered for an individual this supports decision making around interventions. Both tools are useful in communicating current presentation to other health professionals and focus teams on what needs to be addressed to meet patient outcomes and wishes.

Initial critical success factors:

- Focus on person at centre of care
- Communication
- Roles and responsibilities valued
- Clinical reasoning skills and support
- Leadership at all levels – person, service and organisations

Challenges:

- Acknowledgement that change is difficult.

- The Dundee Macmillan Improving the Cancer Journey (ICJ) was launched in November 2017. This is a joint venture between the Partnership and Macmillan Cancer Support. The service offers tailored practical, personal and emotional support to local people affected by cancer, based on a holistic needs assessment and what's important to the individual.

  At the time of the 2017-18 annual report, 69 people affected by cancer had been supported. Numbers have increased over the last year and now 262 people have used the service and 396 holistic needs assessments (HNAs) have been completed. The majority of people are over 65 years old, although increasing numbers of younger people are taking up the service.

  There has been good up take of the service from across the city. The Ferry and Coldside areas have most people making use of the service while there are lower numbers from West End, Maryfield and East End.

  3682 concerns have been identified by the service users to date. Money and finances, fatigue and moving around have consistently been the most raised concerns since the service was launched. The ICJ team has taken 4025 actions on behalf of its service users – an average of 10 concerns per HNA. The number of fully resolved concerns has held steady at 28%. Of the 263 concerns not resolved, over half of these are physical

concerns which the service can only help resolve with self-management information, referral to other organisations or signposting back to health care professionals.

The service has worked with over 40 different teams and organisations to support its service users. The most popular onward referrals are to the Macmillan Welfare Rights team, based within Council Advice Services, Maggie's and other parts of the Partnership.

Nearly £500,000 in financial gains has been secured for ICJ service users since April 2018.

Quote from someone who used the service:

> ***"I made contact with you early this year when I was in a very dark place. I had been left devastated by my husband's death and one month later I was diagnosed with lung cancer. Both tragic and emotional events caused me so much heartache, grief, anxiety, but I was fortunate to be visited at home by you and given help and advice. It has been an upward struggle, but your expertise in knowing in which direction to point me has made it all worthwhile. As suggested, I am now attending Maggie's Bereavement Group, the Creative Writing Group and I have also joined one of your Move More Walking Groups. With your help I can now face the future and my 'new life'."***

- In conjunction with Dundee Women's Aid, the Adult Psychological Therapies Service has established The Aspen Project. The Aspen Project provides specialist psychological assessment and treatment to women who are homeless or at risk of becoming homeless. The Project also provides advice and training to other organisations across the Violence Against Women Partnership. A large number of women have already directly benefitted from engaging in "Survive and Thrive" - a group based course for people who have experienced trauma. By training seven members of staff across organisations like the Women's Rape and Sexual Abuse Service and Addaction, the ability to offer this to women has vastly increased. Individual treatment is offered to women who find it impossible to engage with mainstream services.

  Here is an example of what is being said about The Aspen Project:

  > ***"People close to me have noticed a big change in my mood and how I'm handling issues that come up"***

- The Chronic Obstructive Pulmonary Disease (COPD) Team Support 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.

COPD SUPPORT

Mr F is an 81 year old man with COPD, low mood and high anxiety, living with his wife with no outside help and no family support. Initially he received support from the COPD nurse at his Medical Practice before his care transferred to the Community COPD Nurse following a high number of Hospital Admissions (9 in total over a 12 month period).

The COPD Community Nurse established that Mr F was not coping with his breathlessness and only safe in hospital. With support, Mr F set achievable goals to help him cope with his illness and symptoms. His wife was involved in these discussions. The Nurse arranged a nebulizer, home pulmonary rehabilitation programme and McMillan day care at Roxburgh House as well as weekly visits from a COPD support worker and a specialist nurse in every fourth week.

Mr F was prescribed medication to use when his anxiety worsened and this along with relaxation and use of the nebulizer reduced his symptoms. Mr F was supplied with a weekly dispenser for his regular medication and he learned how to use additional prescribed medications appropriately when his health deteriorated.

Following the first year of the COPD team visiting Mr F at home, considerable reductions in hospital stays was noted. From December 2018 to May 2019 Mr F was only admitted once for a period of one week. His care at home has remained the same although sometimes the support worker visits twice a week. When Mr F's wife is concerned about him she alerts the COPD team and a visit is made that day if possible, the following day if not. This has resulted in fewer hospital stays and an improved quality of life for Mr F, and his wife. It has also reduce the need for GP and Out of Hours Medical support for Mr F.

- In order to deliver good quality services to all our citizens the Partnership has a commitment to ensuring that our workforce are 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.

  In August 2018 information about 'contactSCOTLAND-BSL' (a BSL interpreting video relay service funded by Scottish Government) was widely circulated across colleagues in Health and Social Care and Third Sector. There were links to support individual learning by colleagues through contactSCOTLAND –BSL' website (contactscotland-bsl.org) as well as the offer of face-to-face training sessions. Thirty four colleagues across Public Bodies and third sector in Dundee attended a face to face training session. The participants worked mainly in reception and administration posts. Many of those who attended shared the information with their workmates and with BSL users, supported by the learning resources of 'contactSCOTLAND BSL'.

  NHS Tayside made further arrangements in early 2019 for the workforce (including Health and Social Care Colleagues) to attend face-to-face sessions and for local BSL users to learn more about the service.

- When Robert Couttie and Debbie Coulson married in the Renal Ward in Ninewells Hospital in October 2018, Health and Social Care Partnership colleagues were instrumental in planning and executing the wedding arrangements in 3 days.

  Robert's health has been affected by a long period of Kidney Dialysis and he has had numerous hospital stays over 30 years. He had a successful transplant but later needed treatment again and when his health deteriorated significantly in October 2018, Robert decided to make arrangements to marry his partner of 8 years

  Robert's social worker worked with him and Debbie to achieve his ambition despite his health challenges, with support from NHS Tayside colleagues, Tayside Kidney Patient Association and local businesses. This Social Worker's role is to support renal patients to live a fulfilled life as well as contributing to the work of the Hospital Discharge Hub. With the support of her team colleagues and manager she was able to make the wedding arrangements while continuing to manage other responsibilities and commitments.

  "The day itself was so special and I feel very privileged to be a small part of it."

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

National Outcome 5 links to the following Partnership strategic priorities:

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

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

How well we are performing

Dundee had the 3rd highest premature mortality rate in Scotland in 2017/18, with 554 unexpected deaths per 100,000 population aged 75 and under. This is a reduction of 3.15% from 2016/17. Historically, Dundee has always had a higher premature mortality rate than the Scottish rate which reduced by 3.41% between 2016/17 and 2017/18.

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. Six out of eight Dundee LCPP areas have higher deprivation than the Scottish average. Approximately half of those living in Lochee and East End live in the 15% most deprived areas of Scotland. Whitfield-Linlathen and Midcraigie are consistently in the most deprived 5% in 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 73.9 years for males and 79.4 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. The leading cause of death for females in Dundee in 2017 was Dementia and Alzheimer Disease (15.4% of all female deaths). For males it was the third leading cause of death (8.5% of all male deaths).

What we have achieved to deliver this outcome

- The The Keep Well service uses anticipatory care health checks to engage with populations who are at higher risk of health inequalities. The Keep Well nursing team offer carers over the age of 18 comprehensive Health and Wellbeing checks over one or

more appointments, depending on the need of the individual. Relevant person-centred information and advice is shared, as well as referral and signposting to other statutory and non-statutory services.

The team have attended Drop-in cafés and other events to engage with carers and provide information about carers' health checks. Workers at Dundee Carers Centre also encourage carers to attend a health check appointment and dedicated health check sessions are available at the centre. Information about Keep Well Health Checks is also promoted on Dundee Carers Centre website and social media platforms. There has been an increase in the number of Black & Minority Ethnic (BME) carers accessing health checks in the centre as a result of seeing the senior keep well nurse at the Drop-in café and receiving information and advice on where to access a health checks.

For those who lack confidence to engage independently with other services or positive community based activities, support to engage is offered by a Keep Well Associate Practitioner. During 2018-2019 131 Keep Well Health Checks were delivered to carers. During this period the Associate Practitioner engaged with and offered further support to 29 carers. The nurse sometimes engages in a health consultation(s) with carers prior to or beyond the health check.

Dundee Criminal Justice Service funds a 0.5 WTE Senior Keep Well Nurse who is co-located within this service. The nurse engages with individuals as they attend supervision, unpaid work, Throughcare appointments and/or when on home leave from prison. They are offered the same support as the carers. During 2018-2019 104 Keep Well Health Check were delivered to offenders. During this period the Associate Practitioner engaged with and offered further support to 29 offenders.

Feedback from a minority ethnic carer:

> ***"I met a Keep Well Nurse when I came to the Drop-in café at the Carers Centre. I signed up for a health check and the result was that I had high cholesterol and I needed to lose weight. I got referred to Active for Life (Leisure and Culture) and now access the swimming and gym to help me lose weight and it also gives me a short break allowing me to meet other people too.''***

- The second Dundee Fairness Commission (DFC) published its report in November 2018. The Commissioners focused on 3 key themes along with recommendations: Mental Health through the Lens of Poverty; People and Money; and Stigma.

  The recommendations set out practical action to deal with stigma, poor mental health services and poverty. Twelve of the Commissioners shared their lived experience of poverty, stigma and illness and a community theatre group used drama to reveal the frustration and depression that people feel when struggling with bureaucracy.

  The Commission suggested a 24/7 service offering clinical, non-clinical, therapeutic and peer support for mental health and called for the public service workforce to be provided with more learning about stigma. A third Commission is to be set up in 2019. Visit www.dundeefightingforfairness.co.uk for the latest information.

- The Adult Psychological Therapies Service is expanding to include a new Patient Assessment, Management and Liaison Service (PALMS). Already established in two GP practices in the City, 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 being seen within a few days. Anyone needing specialist mental healthcare will then be referred directly to the most appropriate team. Within the first three months of operation, PALMS had offered over 300 appointments to people seeking advice with their mental well-being. Over the next two to three years it is hoped that every GP practice in the City will have a PALMS specialist available to them.

96% of people seen thought that PALMS had deliver the help that mattered to them and 97% were satisfied with the help received.

Here are quote from someone accessing PALMS:

> ***''Great that the practice has this service now and I was able to be seen so quickly when I am having a difficult time. [Mental Health Specialist] was great and listened to what I had to say. I am happy with today's outcome and am very satisfied with the service!'***

- Health & Work Support is targeted at people struggling to stay at work, absent from work, or those who are recently unemployed and have a health condition or disability. The service advises and supports employers who require general or specific advice on health, disability and work issues. The service works alongside other employment supports in the Dundee area and signposts those who do not fit their remit to other agencies like DHSCP Employment Support Service.

  The service has been welcomed by people needing support and offers fast access to support such as physiotherapy, counselling, occupational therapy, workplace assessments, employer focused advice and tailored Case Management support.

  Physiotherapy and counselling services have had growth in demand and ways are being sought to enhance this provision.

  In early 2019 the service engaged with 400 Small Businesses in Dundee which generated referrals into the service. Local employers attended the Health & Work Support Conference on the 3rd May 2019.

DHSCP Employment Support Service

Ms A has autism and was feeling very isolated. She only went out of the house with her mother who she lives with. Her mother advised if she didn't encourage her daughter to do anything else she would spend all day in her room on her computer.

Ms A accepted a referral to the Employment Support Service (ESS) in the hope that she could find a voluntary work placement. The ESS were able to secure a six week work experience placement in Tayberry Café in partnership with Dovetail Enterprises. Ms A undertook an enjoyable and successful placement which allowed her to investigate other opportunities which might be appropriate for her.

Ms A thoroughly enjoyed the whole experience and is now being supported by the ESS to secure a longer term voluntary placement within a café.

- Representatives from the Mental Health and Wellbeing Strategic Commissioning Group (MHWSCG) recently visited the navigator project already established in A & E in Edinburgh Royal Infirmary. They also met with a representative of the Violence Reduction Unit, Police Scotland who is helping with the recruitment of 2 navigators.

  A room has been made available within A & E in Ninewells Hospital where the 2 navigators are to be based. The two navigators are to be funded via Action 15 of the MH Strategy 2017-2027 monies. (Monies made available to increase the workforce to give access to dedicated MH professionals to all A & E departments, all GP practices, every police station custody suite, and to our prisons.) Over the next 5 years there will be further investment of £35 million for 800 additional MH workers in key settings across Scotland. Further links will be made with other areas once the navigators are recruited. Both navigators are to undergo a 6 week induction process.

- The Sources of Support (SOS) service was piloted on a small scale in 2011 and expanded incrementally to the current position of 10 link workers across 14 GP practices as part of the Scottish Government national Community Link Worker Programme, and more recently in the context of the Tayside Primary Care Improvement Plan and Action 15 of the national Mental Health Strategy. Link workers take referrals from GPs and other health professionals for adult patients with poor mental health and wellbeing affected by their life circumstances. The service provides a synergy between medical and social models of health, focusing on social determinants and providing links for vulnerable people with a wide range of non-clinical community based services and activities that can help improve their health, wellbeing and quality of life, and reduce the need for health services. SOS sits within Dundee's integrated Health Inequalities Service.

Miss C had long term depression, felt alone and bored. She felt forgotten about by her family and was overwhelmed by the caring role she assumed for her older neighbour who suffers from dementia.

Miss C's Link worker sourced her a 'buddy' to help her try new activities and also referred her to the Carers Centre to help her in her caring role. This also enabled a delighted Miss C to go on a short break with her daughter. Together the link worker and Miss C worked through self-help resources which improved Miss C's self-esteem and positivity. Miss C spoke at a conference regarding the impact of having a 'buddy' and the difference it was making to her – something she would not have been able to do a few weeks before.

"I am now getting out of the house to get my nails done every 2 weeks and go to Bingo which is helping me meet new people. I feel a lot better now, thanks to the help which is ongoing.
The help is there - so I say to anyone who is feeling like I did to get help as the difference it has made to me is amazing. I didn't think I would feel happy again, so thanks to everyone."

- 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 which has been written in partnership with our partners across Health and Social Care Partnership, Housing and the third sector across Dundee.

  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) see link https://www.dundeecity.gov.uk/reports/reports/9-2019.pdf.

  The RRTP is also a funding bid to fast track homeless people in Dundee into permanent accommodation and was made to Scottish Government on the 31 December 2018. The plan recognises that a safe and secure home is the best place to build and live lives and cutting the time people spend homeless and in temporary accommodation reduces damage to their health and wellbeing.

  Dundee City Council and its Common Housing Register (CHR), Registered Social Landlords (RSLS) have approved and implemented 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 support 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 LAs. A Local Consortium has been created to deliver intensive housing support for the programme of 100 tenancies over 3 years. To date there has been 7 Housing First tenancies created and sustained.

  Performance against the above targets will be updated and reported in the next Annual Performance report.

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

Outcome 6 links to the following Partnership strategic priority:

- Quality of Life (Strategic Priority 4)

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

How well we have performed

The cost of Dundee's home care service is approximately £21.50 per hour. Of the total number of carers in Dundee at the time of the 2011 Census, there were 3,909 who were providing more than 50 hours of care each week. Those who were receiving this level of care from family or friends may otherwise have been unable to continue to live in their own homes and may have had to move to housing with care or to residential or nursing care, depending on the nature and level of their individual care and support needs. The costs of such provision is high and can require a significant financial contribution from the individual involved. With the rising number of older people, it is anticipated that the number of unpaid carers in Dundee will grow and we know that there will be a need to 'scale up' the level of carer support accordingly.

Health & Care Experience Survey 2018/19: **"I feel supported to continue caring"**	Dundee - **38%** Scotland - **37%** Agreed

There is variation in responses across GP practices ranging from 28% to 60%.

What we have achieved to deliver this outcome

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.'***

To achieve this vision it is important that Carers have the best possible access to information and advice.

- Information and advice services are commissioned through Dundee Carers Centre and a pivotal part of this is the 'Carers of Dundee' website which was launched in May 2018. http://carersofdundee.org/. The 'Carers of Dundee' website was initially created to host a campaign in 2016 to raise carer awareness in Dundee. The campaign group agreed that there was an appetite for developing the website further and recognised that it could be hugely beneficial for carers and professionals in Dundee, to enable them to access information and create an online community for carers. The group were keen that the website would also allow carers to find out about relevant support, events, courses and activities to support them in their caring role, without having to search through individual local and national support organisations' websites. The site also lets carers know their rights and how they can get further information and advice. The site has pages for professionals making sure those who provide support to carers also have access to the information they need.

  A marketing campaign to raise awareness of the 'Carers of Dundee' brand and website will also take place during National Carers Week 2019. The communications team at Dundee Carers Centre are working towards first issues of a 'Carers of Dundee' quarterly newsletter and e-newsletter for 2019. This will continue to strengthen the brand and allow for a wider reach of information relevant to carers and also promoting the Partnerships' activities and those of the carers support organisations in the city.

- Penumbra were awarded funding through the Dundee Carers Partnership to continue implementation of the Carers Scotland Act 2016. The pilot will run until May 2020. The ethos of the Project is that by providing an easily accessible point of information, carers will feel they can access support when they need it in a locality venue suitable for them. A range of information is provided so carers are aware of what's available to support them in their caring role and with their own wellbeing. This approach is also in line with a number of other local and national strategic priorities including early intervention and prevention alongside reducing health inequalities.

  Wellbeing Point activities started in January 2019 after some initial consultation and making connections in various community venues including: community cafes based in Whitfield, Lochee and Coldside areas; The Maxwell Centre; Brooksbank Centre; Broughty Ferry Library; Community Centres based in Kirkton, Menzieshill, Fintry and Charleston.

  During the first 3 months of the pilot, 43 individuals accessed the drop-in points and accessed support through our Worker. Of these, 72% were female and 28% male. 77% of contacts were in relation to mental health, 25% of contacts were experiencing, or had experienced suicidal thoughts and 21% of contacts were in relation to drug or alcohol issues. Other contacts related to finance and benefits issues, recent bereavement, physical health difficulties, isolation, housing problems, relationship issues and other practical difficulties in relation to their caring role. Contacts are provided with information and signposted to other agencies.

  With additional funding being allocated for the next financial year, further activities will include: additional venues including evenings; Wellbeing workshops for carers; setting up Wellbeing Points via existing public access computers; increased engagement with males; additional follow up support and supported access to other services if required.

penumbra
your way to a brighter future

A Wellbeing Point contact commented:

> *"It's been handy just being able to pop down the road to find out about what's available to help my son. It can be hard getting out and I don't have a computer at home"*

- Dundee Carers Centre have been working in partnership with young people and Dundee City Council to increase awareness of young carers. Young Carers Voice co- hosted 'Young Carer Roadshows' within all secondary schools in Dundee throughout March 2018. The roadshows were a mixture of workshops, assemblies and lunchtime events and reached over 1,200 pupils.

  The roadshows involved young carers at each school helping with the events, with an opportunity to take part in discussions about improving support for young carers in Dundee which included the Minister for Public Health, our local MSP, the Head of Schools, the Health and Social Care Partnership's Lead for Carers, the Convenor of the Children and Families Committee, and Carers Centre staff.

  The roadshows raised awareness of young carers, and the support available through the Policy for Young Carers in School, from Dundee Carers Centre and other local agencies. Through the roadshows an additional 34 young carers were identified. Additionally, a Pupils Survey was also circulated to the selected schools to capture baseline information regarding awareness of young carers, as well as knowledge of the Young Carers school policy and supports available to young carers.

  Young Carers Voice also consulted on the proposals for young carers in the new Carers Act to inform the Dundee Carers Partnership regarding the implementation of Young Carer Statements, and the development of supports for young carers in Dundee. Young Carers Voice are now working on a revised policy for Children & Families services and more roadshows planned for this year to make carers aware of their rights.

  Young Carer's Voice member:

  > *"Before the roadshows began I was worried people wouldn't listen, it was nerve wracking working with people roughly my own age. I was also excited and thought it would be interesting.*
  >
  > *During the roadshows I felt confident and enjoyed taking the lead of groups and was surprised I was able to make a difference. I felt good as I was able to share my experience of being identified as a young carer at 15, when I was actually a young carer from age 6, if I accessed the support sooner things would have been easier. After the roadshows I felt proud and like I actually accomplished something. I wanted to do more as it was a great experience. I can now talk to other young people more. This has helped me become the young person I am now."*

- The Dundee Short Breaks Service Statement was produced in 2018 through and extensive process of co-production with local carers and other stakeholders. This was accepted by the IJB and published in December 2018 as required by the Carers (Scotland) Act 2016 and can be found at **https://www.dundeehscp.com/sites/default/files/publications/short_breaks_services_statement_dundee.pdf.**

The statement gives advice and information about short breaks for carers of all ages and for the adults and children they support.

The Carers Partnership commissions Dundee Carers Centre to provide a Short Breaks Brokerage Service for Carers in Dundee. Demand for the service continues with 372 people awarded and benefitting from a short break during 2018-19.

The Health and Social Care Partnership co-hosted a Shared Care (Scotland) Lead Officer Event in late March 2018 where Dundee's work, in particular Short Breaks Brokerage, was highlighted as good practice model to Short Breaks Lead Officers across Scotland. The Leads were joined by local professionals in this learning event.

A carer accessing a short break commented:

> ***"We thoroughly enjoyed our weekend stay in St Andrews. We are grateful for the efforts of the Respitality team for arranging this short break for us, as it was really appreciated".***

- Short Breaks for carers who support people with mental health have been mainstreamed for over a year with regular applications being received. During the past financial year, over 100 short breaks for carers or supported persons have been authorised where there was an identified outcome for carers. This allows the carer to take time for themselves and relax doing something they enjoy, whilst not worrying about the supported person.

  Following the success of the short breaks for carers that support people with mental health, it has been agreed to extend this type of short breaks to the Learning Disability Service.

- Carer Positive is a Scottish Government initiative which has been developed to support carers in the workplace. The award incorporates 3 levels or stages, from 'engaged' to 'established' through to 'exemplary'. A number of important local Employers in Dundee have now received the award including: Engaged Stage- Scottish Social Services Council, Care Inspectorate, PAMIS, Police Scotland, Dundee Carers Centre. Established Stage: Dundee City Council, NHS Tayside. Exemplary- Royal Bank of Scotland, Scottish Courts & Tribunals Service, Scottish Water. Carers in Dundee who are part of these workforces are supported by their employers, their peers and local carer support services and the agencies continue to improve their approach to working carers.

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

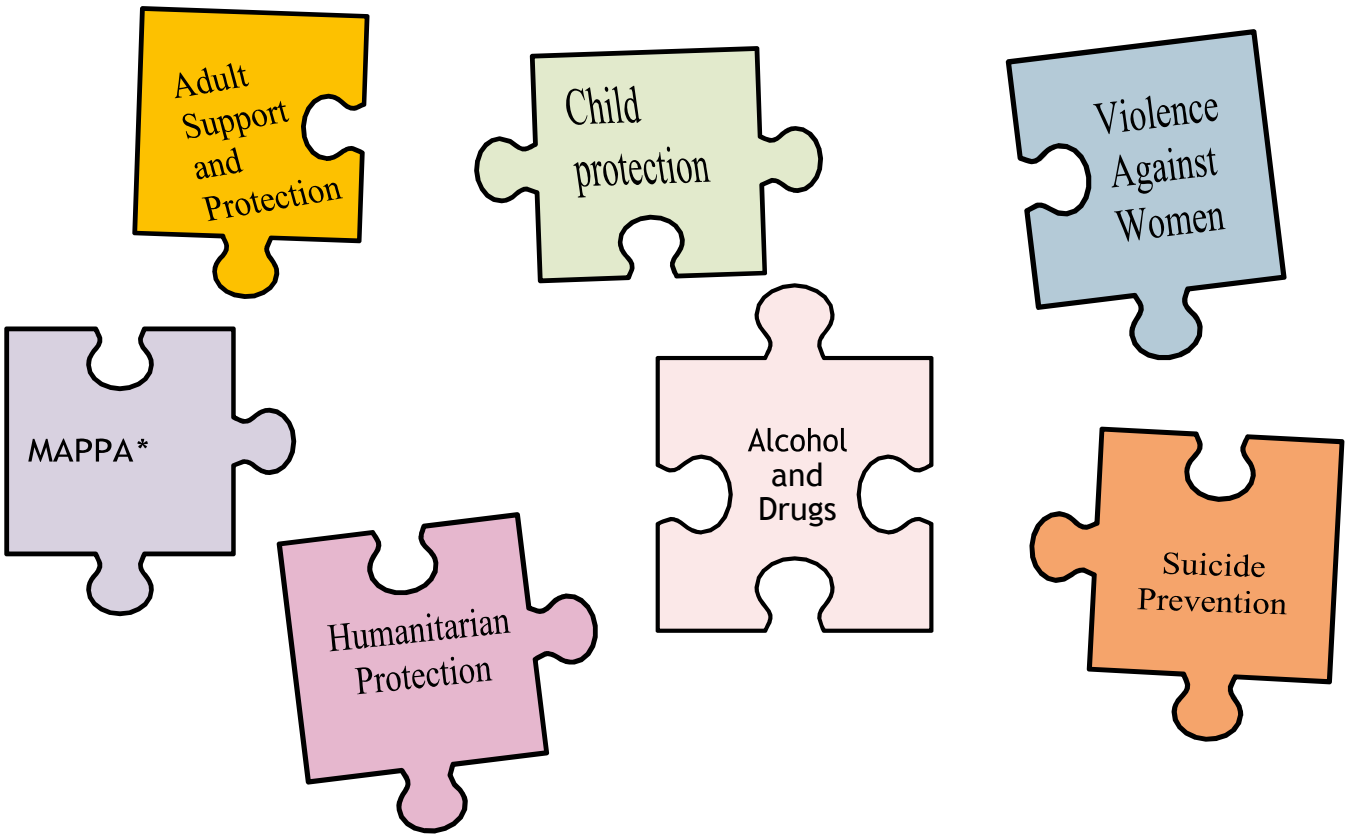
Outcome 7 links to all of the Partnership Strategic Priorities.

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

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

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

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



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

How well are we performing

Health & Care Experience Survey 2018/19: **"I felt safe"**	Dundee - **87%** Scotland - **83%** Agreed

2018-19 has seen a shift in focus of Adult Support and Protection activity as outlined in the recommendations contained in Independent Convenor's Biennial Report:

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 2018-19 the total number of referrals for adults at risk was 1548 representing a significant increase of 611 (39%). Police Scotland continue to be the primary source of referrals, 1325, representing an increase of 438 (33%). 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.

These changes demonstrate the impact of focused work with referring agencies to enhance the quality of early identification, assessment of adults at risk and the commitment to a proportionate response at the right time. One of the areas being developed across Dundee is our response to adults who do not meet the criteria for statutory Adult Protection intervention.

Adults at Risk Referrals

	Number ofReferrals
2018 - 2019	1548
2017 - 2018	937
2016 - 2017	914
2015 - 2016	1246

Referrals from Police Scotland

	Number ofReferrals
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 2018-19 there were 132 cases discussed at the Dundee MARAC.

What we have achieved to deliver this outcome

- The Caledonian System, an integrated approach to address domestic abuse by men towards a female partner or ex-partner, became operational in Dundee in April 2019. Criminal Justice Service (CJS) workers have been trained to assess for Caledonian suitability. Sheriffs have been fully informed about the Programme, and a longer period of time to produce Caledonian Court reports has been agreed by Sheriffs. The training commitment has been substantial: 27 Dundee CJS staff members have completed Spousal Abuse Risk Assessment (SARA) 3 training; 15 Dundee CJS workers trained to assess for Caledonian suitability: 11 Dundee CJS staff trained to be Caledonian case managers with more scheduled for later in 2019. Four Caledonian group workers are due to be trained by July 2019.

  There have already been indicators of a wider positive impact on the whole system to address Domestic abuse in Dundee. The SARA training was made available to the non-mandatory domestic abuse worker. Reference to SARA assessment within Court reports has been highlighted as good practice.

- In conjunction with Dundee Women's Aid, the Adult Psychological Therapies Service has established The Aspen Project. The Aspen Project provides specialist psychological assessment and treatment to women who are homeless or at risk of becoming homeless. The Project also provides advice and training to other organisations across the Violence Against Women Partnership. A large number of women have already directly benefitted from engaging in "Survive and Thrive" - a group based course for people who have experienced trauma. By training seven members of staff across organisations like the Women's Rape and Sexual Abuse Service and Addaction, the ability to offer this to women has vastly increased. Individual treatment is offered to women who find it impossible to engage with mainstream services.

Here is an example of what is being said about The Aspen Project:

"People close to me have noticed a big change in my mood and how I'm handling issues that come up"

- During 2018-19 the Partnership worked with wider Community Planning partners to establish the Transforming Public Protection Programme. The programme was set-up in response to the findings of the Joint Inspection of Adult Support and Protection that was carried out in 2017-18, as well as findings from previous inspections of services for Children and Young People and from Significant Case Reviews that have been carried out in Dundee.

  The programme aims to ensure that our approach to public protection is of a consistently high quality and is supported by the right range of resources. As well as focusing on improving the leadership of public protection responses, work will also take place to make sure that processes that provide immediate and longer-term responses to people in need of protection are as good as they can be.

  The first phase of the transformation programme has focused on 3 frontline practice teams leading activity to improve practice in relation to chronologies, risk assessments, support and supervision of frontline staff and quality assurance of our day-to-day protection work. These teams, with support from the Care Inspectorate, have been researching best practice and testing new approaches in their own practice. As these small tests of change develop the teams will be sharing their learning and successes with practice teams across the Partnership.

- In April 2018 the three teams supporting local care homes integrated and co-located to form the Care Home Team. The team includes a social work team manager; two advanced nurse practitioners; four mental health nurses; four general health nurses and five social workers. The team are able to maximize the opportunity for a professional from the right discipline at the right time to provide tailored support in achieving people's identified outcomes.

  In order to further integrate and improve services the team have held a number of team development and joint training sessions. The sessions have brought increased understanding each other's roles, supported the unification of team processes and built stronger links between colleagues each professional group in order to provide the best support care homes and people living there.

  The vision of the Care Home Team is:

  "For people living within care homes to have the best experience as possible".

CARE HOME TEAM CASE EXAMPLE

Mrs H moved into a care home after her husband died. Mrs H had a diagnosis of dementia and as her dementia progressed she frequently became distressed. When distressed she sometimes hit out at other frail residents. The workforce in the care home struggled with this, and the management stated that they would have to terminate her placement.

The Care Home Team undertook a joint adult protection investigation. The team identified processes which will better support the workforce in care homes in reducing risk to individuals like Mrs H and to the other residents.

Support and training was provided to the workforce by the mental health nurse. This increased workforce understanding of dementia and how best to manage the symptoms.

Mrs H's incidents caused by distress have been reduced and there is a reduced risk of further incidents with other residents. The general/physical health nurses will continue to support the workforce in the care home to identify changes/deterioration in Mrs H's overall health which may affect her levels of distress.

The social worker from the team reviewed the overall circumstances of Mrs H's care home placement and confirmed that Mrs H had become much more settled and the workforce in the care home were now more able to meet her needs. She has continued living in the care home.

- During 2017-18 procedures relating to Adults with Incapacity and Mental Health Acts were revised to support consistency of practice relating to these areas across the Partnership. Procedures relating to Adults with Incapacity (Scotland) Act and Mental Health (Care and Treatment) Act 2003 were developed. These aim to provide clear guidance and support to the workforce across health and social care.
- There have been challenges implementing these procedures during 2018-19. The Mental Health Officer (MHO) team is currently experiencing a high volume of requests for reports to accompany applications for Welfare Guardianship resulting in statutory duties not being met under AWI legislation. However, there is planning underway for the MHO service and Learning & Workforce Development Development to deliver some training "Across the Acts" which will include the Adults Support and Protection legislation to Social Work staff across the Partnership and Dundee City Council.

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

Outcome 8 links to the following Partnership strategic priorities

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

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

How well are we performing

- We continue to work closely with NHS Tayside to implement the 'i-Matter' continuous improvement model. I-Matter seeks to understand individual staff experience within their teams, allowing discussion about what is good (and to be celebrated) and what is not as good and needs improvement. All staff employed by NHS Tayside and those staff employed by Dundee City Council who work in Partnership teams have been offered the opportunity to participate in i-Matter.

  Dundee Partnership i-Matter results for 2018 showed an overall engagement index score of 77% with a response rate of 62%. This is considerably lower than the 2017 response rate (75%). A full NHS Tayside Board report for 2018 is not available due to the overall response rate falling below the required threshold. However, for NHS Tayside Board, the same or higher score was gained for all but one of the 28 questions asked when compared to the 2017 i-Matter survey. Individual teams implement their own action plans to address areas for improvement.

What we have achieved to deliver this outcome

- Our communications and engagement group continues to oversee corporate communications with our workforce. We have used a number of methods of engagement, including "News Matters" (our widely distributed staff newsletter), direct communication via e-mail, town hall events, NHS Tayside and Dundee City Council communication routes, social media and our local press. A subgroup of the communications and engagement group has been established to review our use of "News Matters" and to explore how we can make better use of social media to facilitate a 2 way dialogue with staff.

- Our locality managers have used a number of different methods to bring together the teams that they are responsible for supporting. This has included team briefings and breakfast meetings. These approaches have enabled locality managers to engage in a two-way dialogue with employees to support the establishment of new ways of working and to identify areas of improvement for the future. A communications framework to support this is in development.

- We are creating more opportunities for our workforce to be engaged with the communities in which they work. Our health and wellbeing networks bring together our workforce within the local community planning areas they are aligned to. Our networks have been central to the development of the local community plans and we are exploring how they can link with other locality networks.

- Our workforce has had access to a wide range of learning and development opportunities during the last year. Some examples include:

  - Quarterly integrated induction sessions that are open to all employees and volunteers who are part of the integrated workforce. These sessions bring groups together to learn more about what it means to be part of the HSC Partnership in Dundee.
  - Leadership Development opportunities including: Adaptive Leadership Programme; Business Coaching; Tayside Leaders Learning Platform; Succession Planning and Talent Management; Growth Mindset; Mentoring in Teams; Affina Team Journey and Team Development Activity.
  - Ongoing support to ensure that the social care workforce meets all its registration and governance compliance in terms of professional qualifications, CPD, reflective practice, etc.

  Activity underway or planned for 2019/20 includes the creation of a workforce area on the HSCP website that is specifically for the workforce that will host a range of materials to support the integrated workforce in their roles. There will also be work to support Service Redesign and the Tayside Primary Care Improvement Plan, supporting the development of peer learning in multi-disciplinary teams.

- In 2018, NHS Tayside adopted an approach known as 'Value Management' which enables staff on the frontline to own and measure their team's performance and identify relevant improvement actions. The Integrated Discharge Hub was identified as one of the pilot areas for this approach and embarked on this with the support of the NHS Tayside Improvement Team in summer 2018. This has enabled staff to work together autonomously to recognise and celebrate good practice as well as taking ownership of actions to improve the service they provide.

  A member of staff quoted:

  "I didn't understand initially why this was relevant and felt like it was another task, but now feel like I understand more clearly the wider Partnership vision and how my job relates to that."

- Nursing colleagues at Kingsway Care Centre Mental Health have made a major contribution to a project which supports newly qualified mental health and learning disability nurses. This work was recognised in the Innovations in Education category at the Mental Health Nursing Forum Scotland (MHNFS) Conference and Awards 2018.

  The initiative supports Newly Qualified Practitioners (NQP) in their transition from students to registrants and through their careers of lifelong learning. The Action Learning Set Facilitators support and enable the voice of NQPs and the delivery of this project provides and gives a forum for developing professional excellence.

  The award recognises a commitment to ensuring that nurses continue to be supported during their early practice to provide excellent care. Kingsway Care colleagues have been part of developing and facilitating the Action Learning Set experiences which contribute to the professional and educational development of newly qualified nurses.

l-r MHNFS chair Davy Thomson, action learning set facilitators Jenny MacDonald, Susan Hynes, Wendy Tait, Heather Robb and Jan Laing, and Johnathan MacLennan

Photo can be found at https://nhstaysidelowdown.com/2018/11/07/tayside-team-wins-national-mental-health-nursing-award/

- In April 2019 the Dundee HSCP maintained their Healthy Working Lives Silver Award for another year. The intention is to go for gold over summer 2019. The award includes actively promoting health and wellbeing in the workplace, such as supporting smoking cessation, physical exercise or healthy eating. It is also about making sure that health is not adversely affected by work or workplace hazards and providing access to advice and support for people who need it. The Dundee HSCP is committed to improving workplace health through the programme. As a silver Healthy Working Lives award holder, the partnership has demonstrated that a health, safety and wellbeing culture exists and evidences a commitment to continuous improvement.

  Healthy Working Lives offers a range of information, activities and opportunities: walking groups, yoga, reiki, mindfulness, sessions on healthy eating and speakers on different topics to name a few. The emphasis is very much on promoting self-care and encouraging individuals to take responsibility for their own health and wellbeing.

- The workforce across the Partnership has embraced an integrated model of teaching in relation to Palliative Care Training.

  The modules include First Principles, Communication, Pain & Symptom Management and Bereavement Care. The programme has received very positive feedback from the workforce.

  There have been a variety of target groups for the learning activities including:

  - Health Care Services who have embedded the programme into the core palliative care programme sessions over the year.
  - Care at Home Teams of whom 135 members of the social care workforce have completed the training. The training is considered mandatory and the programme delivery has been devised to suit service needs.
  - The Care Home team who have taken a critical role in promoting the training to the workforce of care homes and have supported training delivery to this sector.

  The Quality Improvement Project 'Improving Palliative Care Pathways for People Living with Dementia' has been welcomed by the Care Home workforce in Dundee. In the past year this project has been delivered to the four local authority care homes in Dundee- Turriff House, Craigie House, Menzieshill House and Janet Brougham House. At present 5 of the 8 cohorts of the social care workforce in these care homes have taken part in the training. A group of 8 trainers from within the Care Homes co deliver over 4 sessions to each cohort. The sessions are evaluated to inform future developments.

  The project has recently expanded to include an Independent sector care home, Harestane and there are plans to deliver this training to 60 staff of their workforce from June to Sept 2019.

- Training and awareness sessions to improve service and community responses to health inequalities were established by the Equally Well test site a number of years ago.

  The programme has been successful in engaging a wide range of participants across the city to explore health and wellbeing issues and implications for practice. Outcomes include raised awareness of inequalities, stigma and the impact of poverty, increased skills and confidence to initiate exploratory conversations with service users in a sensitive and supportive manner, improved signposting, and increased inequalities sensitive practice.

  The training programme has had 2021 individuals (predominantly frontline staff and over half from the Health and Social Care Partnership) take part in 164 sessions since 2015. The figures for 2018/19 are shown below:

Training session	No. of sessions	No. of participants
Poverty Sensitive Practice	12	235
Mind Yer Heid	6	75
Substance Use, Stigma and Supporting Recovery	5	68
Health Inequalities and Prevention	92	1073
Totals	115	1451

All sessions evaluate positively and follow up surveys have shown significant impact on practice:

> ***"By asking better questions I have realised that most of my clients don't have internet and a large majority of them cannot read - I would have never considered this before you mentioned it and now I ask all of the time. We have failed too many people for too long based on these two assumptions."***

- It is recognised that 50 % of our Macmillan Community Clinical Nurse Specialists will retire within the next few years, depleting the service of a level of advanced clinical skills and expertise, with limited expertise available to fill the gaps in service provision. The sponsorship and collaboration with Macmillan development posts enabled the Partnership to recruit 3 nurses, providing the opportunity to have protected time to develop their expertise with both theoretical and practical training, education and work experience over the duration of the fixed term to gain the knowledge and experience required to future proof the workforce from 2020 onwards. Risk will be minimised as patients will have skilled nurses working in advanced practice from the outset of their new substantive posts.

- The Carer Interest Network acts as a practitioners' forum 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 update on local Carers Act developments, 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.

  In supporting Carers (Scotland) Act developments, a session was held in April 2018 to share learning and receive practitioners feedback to input into the design of a resource being developed by Scottish Social Services Council (SSSC) to develop the '*Understanding Personal Outcomes SSSC Booklet'* that builds individuals and organisational capacity for outcomes focused support planning, meeting specific requirements within the Carers (Scotland) Act 2016.

  Learning Development Advisor, Scottish Social Services Council commented:

  > ***"I really enjoyed the Carer Interest Network meeting….it was wonderful to have the opportunity to hear and share thoughts and ideas on developing the SSSC outcomes focused support planning resource"***

- Following scrutiny activity relating to the Joint Thematic Inspection of Adult Support and Protection undertaken between July and December 2017, together with the inspection of Services for children and young people, an ambitious two year plan dedicated to the Transformation of Public Protection across Dundee was developed. This focused on embedding safe systems of practice that are resilient to changing resource pressures and promote consistency of practice and quality across all protection responses. As well as building on strengths, the programme draws upon best practice from across Scotland and the rest of the UK, including from neighbouring authorities.

The Transforming Protecting People Plan is being delivered in partnership with The Care Inspectorate who have committed to providing active support for the programme through the provision of advice as well as participation of their own staff in programme activities.

One of the work streams being progressed relates to a programme of practice improvement with frontline staff across social work functions and relevant multi-agency partners with a focus on:

- Improving understanding of, and adherence to, protection processes
- Promotion of trauma-informed practice
- Collaborative working at points transition
- Service user and carer involvement
- Embedding a culture of quality assurance and improvement.

The Community Care Adult Care Learning Disabilities Team within the Partnership were identified as an operational service who were well suited to progressing practice improvement activity relating to assessment and recording of risk. Since January 2019 the team have been leading on the design and development of improvements relating to the presence and quality of risks assessments. This is a direct example of people working in the partnership being supported to continuously improve the information, support, care and treatment they provide and being engaged with the work they do.

Representatives of the Learning Disabilities Team formed part of a delegation from Dundee that visited colleagues in Midlothian as a benchmarking / service improvement venture. A development day, hosted by the Care Inspectorate, was convened in January 2019 where the team set out the scope of the improvement project as well as key milestones towards achieving their agreed goals.

The team have developed a new work flow and Risk Assessment form on Mosaic and are piloting a risk assessment tool. There have been four further sessions with the Care Inspectorate as well as dedicated time set aside for team meetings. Direct support has been provided from the Protecting People and MOSAIC Teams and the team is well on its way to delivering on its agreed targets.

Depending upon the outcome of this test of change it is anticipated that these developments have the potential for application across the Partnership as well as elsewhere across the council and wider partnership.

Quotes from team members

> ***"I was a bit sceptical to begin with but, as we've moved forward, see this as an opportunity to improve things for our service users and the team as a whole."***

> ***"Sounds like a positive model to make change/improvements - would need time & commitment from workers & managers to be successful"***

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 8 links to the following Partnership strategic priorities

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

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

How well we have performed

Emergency hospital care, including readmissions to hospital where the patient had previously been discharged within the last 28 days, is one of the biggest demands on the Partnership budget. Many hospital admissions are avoidable and often people either remain in hospital after they are assessed as fit to return home or they are readmitted to hospital shortly after they were discharged. You can read more about our performance in relation to emergency admissions and readmissions under outcome two in this report. In 2018-19 27% of Dundee's health and care budget was spent on hospital stays which was the third highest in Scotland. Dundee spent approximately £40M on hospital inpatient stays and approximately £260M in total on health and social care.

Health & Care Experience Survey 2018/19: **"My health and care services seemed to be well co-ordinated"**	Dundee - **81%** Scotland - **74%** Agreed

What we have achieved to deliver this outcome

- April 2018 saw the introduction of a new General Medical Services Contract for GP's. Alongside this is a commitment to deliver a number of services to support practices working differently, with services which would traditionally have been delivered by GP's being delivered by staff and teams within the Partnership.

There are 7 key services that will be delivered 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 for many people the GP may no longer be the first point of contact when they are unwell, with another professional doing that initial assessment and diagnosis. Due to the specialist nature of the new roles, and knowledge of linked services, it is anticipated that people will have a supportive experience and be referred or

signposted to the most appropriate place, if they require on-going support.

These changes need to be in place across all practices by April 2021. Positive progress has been made in 2018/19 to start to test new ways of working. The work undertaken to date has highlighted a number of challenges to delivering this at scale and these are being considered carefully in all the planning within teams delivering these new services.

- Since 2017 the existing arrangements for overnight support provision to adults with either a Learning Disability and/or Autism, or experiencing mental health and wellbeing challenges who are supported by a range of Housing Support/Care at Home providers, have been analysed in relation to the impacts of legislative changes and the new opportunities for improving people's independence through the use of technology. Based on the information gathered it was agreed that a Test of Change would be designed and implemented. This Test of Change would be the introduction of a Specialist Overnight Support Service which would either complement existing waking night workers or meet the overnight needs of a number of people in a planned and informed way.

  In order to inform the design of the service a briefing and Q&A session was held for all providers within the agreed scope of the Test of Change. This was followed by the gathering of views of individuals, families, staff teams and Care Managers to identify existing risks as part of a Risk enablement process. This process also included identifying potential mitigations and actions required prior to the implementation of the Test of Change. These actions have all now been completed and we are now at the stage of considering the technology required to meet individual specific needs whilst also enabling and facilitating independent living.

- NHS Tayside can now offer outpatient appointments by video-link using a system provided and paid for by the Scottish Centre for Telehealth and Telecare. Branded as NHS Tayside Near Me, the system is in its infancy and only a small number of clinics are using the system at present. The expectation is that this will grow significantly over the next year when the infrastructure is in place to support it.

  Work over the past three years by the Technology Enabled Care (TEC) Project to promote Attend Anywhere through organised events and demonstrations, has influenced this development. Benefits include not having to take time off work to attend appointments and the ability to demonstrate performance and actions via the video link. The next phase is to make it possible for people to use Attend Anywhere from libraries, community centres and schools.

  Another TEC development is Florence, a simple computer system which supports and encourages people to monitor their health. For example, patients can send their blood pressure results to Florence via a simple text message, and get messages of advice in return. So far 450 patients have used Florence.

- Following the mainstreaming of the Integrated Discharge Hub at Ninewells Hospital in providing a 7 day service, a member of staff commented:

  "I can plan my work more effectively and make arrangements with the wards, patients and their families over the weekend to fit with their needs. This means Mondays are not so difficult"

- A renal supportive care approach and financial model has been developed. Work has been carried out with renal services to provide a Renal Supportive Care Team, who support patients to be supported with active treatment for renal care, symptom assessment and control, anticipatory care planning and spending less time in hospital, essentially all support except dialysis. This has resulted in a reduction of people starting dialysis inappropriately where they may have had no survival advantage. The funding has been provided by renal services, and has allowed a palliative care consultant to dedicate a session a week to the project, and has ultimately enhanced the integrated working, which is anticipated could be transferred to other chronic long-term conditions.

- As part of community based orders, individuals will be meeting regularly with staff and exploring what steps can be taken to achieve a reduction in reoffending through improving positive life choices. To build on a period of reflection, Partnership staff are co-located within the Community Justice Service (CJS) centre and can be called upon to support health interventions, as and when needed. The Scottish Government's National Strategy for Community Justice' states that:

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

  Ensuring that workers from different disciplines (including CJS and Health) communicate effectively and work together closely can help improve the health and wellbeing of service users at critical moments and it can also save lives.

  To strengthen the links between CJS and mental health support 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 Keep Well Initiative continues to thrive within CJS. This enables Keep Well and CJS to develop partnership working through testing and developing opportunities to engage and support clients of CJS. This partnership delivery is consistent with current research on desistance from offending and in reducing health inequalities. The partnership is now an accepted and respected part of service delivery to those who have convictions.

  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 number of Community Payback Orders (CPOs) with a substance misuse treatment requirement has remained steady over the past few years. The substance misuse nurses provide support to those on CJS statutory orders, working to National Outcomes and Standards. They are involved in Court Report assessment by providing information on a person's recent and current involvement with Integrated Substance Misuse Service (ISMS) as well as advising and consulting on someone's drug use generally and more specifically on their suitability for Opiate Replacement Therapy (OPT). If suitable to be assessed, then a period of deferment from the court will lead to a joint assessment of suitability for drug treatment and there is a clinical report provided to the court. On occasion the court will request a substance misuse assessment directly from ISMS. There is a local agreement that these are then picked up by CJS and with social worker colleagues the assessment is provided from this service.

While most of the substance misuse work tends to be around ORT there is also a proportion related to alcohol misuse. This is different in many respects from the above as those appearing before the court will often have already taken a voluntary route to addressing this and where they are not dependent then this does not require nursing input. For the year 2018/19 the nursing staff undertook 77 Substance misuse assessments at the request of the court, of these 6 were alcohol only with another 4 being both drug and alcohol. Of the 67 remaining 23 converted into a CPO with DTR.

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 ISMS and their treatment and recovery can continue in mainstream community delivery.

For those leaving prison on a parole, non-parole or extended sentence then for the majority engagement with mainstream community services would remain the best option for becoming 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.

The CJS substance misuse nurses contribute to the assessment of tolerance testing held at ISMS. One senior nurse has been involved in the overdose prevention group and both deliver Naloxone training across the service and as Tayside wide trainers. The nurses will also provide immediate aid in Friarfield when there are concerns of someone overdosing.

- The Partnership, supported by Volunteer Dundee and colleagues in the private sector, developed a recruitment and support plan for the involvement of volunteers. This was completed last year and culminated in a civic reception on the 28th September 2018 where both Craigie House and Menzieshill House became the first care homes in Scotland to achieve the Volunteer Friendly award.

Two of Dundee's care homes are the first in Scotland to receive Volunteer Friendly Award Plaques:

From left Angela Smith, Resource Manager Dundee Health & Social Care Partnership, Sarah Clark, Team Manager (Craigie House), Lynn Thain, Team Manager (Menzieshill House), Wendy Taylor, Team Leader Volunteer Dundee

> ***"As a manager who recruits the volunteers I think their contribution is invaluable to residents, staff and the volunteers themselves. The enthusiasm that the volunteers bring with them rubs off on staff and I see them wanting to be more involved. Residents are attending the sessions and are enjoying them. Staff are seeing the benefits as they can spend time with residents who do not want to participate and focus on them for an uninterrupted period of time. Volunteers are bringing skills into the home that staff may not have. All in all it is a win win situation."***

- Dial-Op commenced as an information helpline for older people, run by older people. Over the past few years it has become a valued service, which is run by volunteers and paid staff in Volunteer Dundee. The Dial Op umbrella now includes the Morning Call service and Blether Buddies.

  The Morning Call service aims to help vulnerable or isolated adults in Dundee feel more connected, safer and valued. To achieve this the service makes a short daily telephone call, currently during office hours Monday to Friday, to check on wellbeing. They seek to recruit volunteers to make these contact calls to our clients in the morning between 8 – 10 am. The role is flexible and volunteers can choose which/how many days they wish to be involved.

  In the past 12 months Morning Call has seen a 100 per cent service user's increase by the end of March 2019 (from 38 service users in March 2018 to 76 in 2018). The service uptake has progressively increased since its launch in January 2016, and the sources of referrals have diversified over time. From April 2018 to April 2019 the total number of morning calls was 13,960. This is an increase of 131% from 2017/18 when the total number of calls was 6032.

Feedback re Morning Call:

> *"Puts my mind at ease to know that someone is checking in on me each morning in case something happens overnight... It's a reassurance. "*

Blether Buddies makes weekly friendship telephone calls, currently during office hours Monday to Friday. The befrienders phone their befriendee and chat with them for a maximum of 20-30 minutes once per week.

Blether Buddies started the April 2018 with 10 matches, experienced a peak at the end of the financial year when the project sustained 15 matches. The figure dropped back to 12 matches early 2019, due to loss, ill-health and end of volunteer involvement. Of the 14 matches at the end of March 2019, 7 were new referrals in 2018/19. 15 additional referrals were received in 2018/19. Blether Buddies has tested new ways of connecting people and arranged two peer-to-peer befriending relationships for the first time. Matches proved successful and the project will monitor the progress of such relationships as a test of change.

Feedback re Blether Buddies:

> *“This friendly voice gives me piece of mind. I’m no longer alone with my fears and concerns. There is someone I can turn to.”*

THE QUALITY OF OUR SERVICES 4.0

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, 81 were inspected during the year, of which 23 were combined inspections, where both the Housing Support and Support Services were inspected together.

28 care homes were inspected and of these inspections 6 services received requirement(s) and 8 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

Of the 53 housing support and support services inspected, 8 services received requirement(s) and 10 had complaint(s) upheld or partially upheld. There were no enforcement notices issued in relation to these services.

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

This means that of the 81 services that were inspected during the last 12 months 83% received no requirements for improvement. This figure is an improvement on the 75% figure for 2017/18.

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.

Complaints received centred around:

- General health and welfare: care of property; record keeping – personal plan/agreements; loss of/missing property; effective use of care plan framework.
- Communication: information about the service.
- Environment: cleanliness; infection control practice
- Food: quality.
- Staff: staffing levels.
- Protection of People: restraint.
- Healthcare: inadequate healthcare or healthcare treatment; tissue viability; medication issues; clinical governance.
- Access to other services. eg Advocacy

Other key functions or services provided or commissioned by the Partnership are also regulated by Audit Scotland, Healthcare Inspection Scotland and Mental Welfare Commission. Four services were inspected by the Mental Welfare Commission during 2018-19. No requirements were highlighted. Nine recommendations were made in total. These can be found in Appendix 3.

LOOKING TO THE FUTURE

Our refreshed Strategic and Commissioning Plan for 2019-22 describes our priorities for the coming 3 years. We will continue to deliver what is working well, whilst also targeting resources across the agreed priority areas of Health Inequalities, Early Intervention/prevention, localities and engaging with Communities and Models of support/Pathways of care. Our refreshed strategic priorities will also maintain our focus on moving resources from hospitals to community based care, in order to provide easily accessed more personal support, closer to home.

There is however no doubt that the next three years will continue to be financially challenging. We need therefore to focus our resources in a more targeted way. By doing this we are confident that we can achieve the positive transformational change needed to improve the health and wellbeing of people in Dundee. The achievements outlined in this report demonstrate how transformation can still be delivered during periods of financial constraint and increasing demand for our services.

Over the next 3 years we will work ever more closely with our partners to integrate our collective resources and agree how best to use them to enhance the lives of people across our City. The ideas, creativity and commitment of our workforce and the citizens of Dundee will be central to our success. We look forward to collaborating with all partners as we work towards our vision of:

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

APPENDIX 1

National Health and Wellbeing Outcomes

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

APPENDIX 2

Performance against National Health and Wellbeing Indicators

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

National Indicator	2015-16 Dundee	2015-16 Scotland	2017-18 Dundee	2017-18 Scotland	Comparison with Scotland
1. Percentage of adults able to look after their health very well or quite well	93%	94%	93%	93%	↔
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible	88%	84%	84%	81%	▲
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	79%	79%	78%	76%	▲
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	76%	75%	81%	74%	▲
5. Percentage of adults receiving any care or support who rate it as excellent or good	84%	81%	82%	80%	▲
6. Percentage of people with positive experience of the care provided by their GP practice	90%	87%	84%	83%	▲
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	88%	84%	85%	80%	▲
8. Percentage of carers who feel supported to continue in their caring role	44%	41%	38%	37%	▲
9. Percentage of adults supported at home who agree they felt safe	85%	84%	87%	83%	▲

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

▲ Better than Scotland | ▼ Worse than Scotland | ↔ Same as Scotland

National Indicator Source: Core Suite of Integration Indicators	2015-16 Dundee (Scotland)	2016-17 Dundee (Scotland)	2017-18 Dundee (Scotland)	2018-19 Dundee	2018-19 Scotland	Comparison with Scotland 2018-19
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	N/A	Not available
11. Premature mortality rate (per 100,000 people aged under 75)	546 (441)	572 (440)	554 (425)	N/A	N/A	↓
12. Emergency admission rate (per 100,000 people aged 18+)	12,168 (12,281)	12,425 (12, 215)	12,815 (12,192)	12,610	x	
13. Emergency bed day rate (per 100,000 people aged 18+)	146,192 (128,630)	141,439 (126,945)	135,284 (115,518)	125,026	x	
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	122 (98)	127 (101)	127 (103)	124	x	
15. Proportion of last 6 months of life spent at home or in a community setting	87% (87%)	87% (87%)	89% (88%)	89	x	
16. Falls rate per 1,000 population aged 65+	25 (22)	26 (22)	29 (23)	31	x	
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	88% (83%)	86% (84%)	85% (85%)	86	x	
18. Percentage of adults with intensive care needs receiving care at home	50% (61%)	54% (62%)	55% (61%)	N/A	N/A	Not available
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)	369	x	
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%)	25	x	
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home	N/A (N/A)	N/A (N/A)	N/A (N/A)	N/A	N/A	Not available
22. Percentage of people who are discharged from hospital within 72 hours of being ready	N/A (N/A)	N/A (N/A)	N/A (N/A)	N/A	N/A	Not available
23. Expenditure on end of life care	N/A (N/A)	N/A (N/A)	N/A (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

Statutory Inspections during 2018-19

CARE INSPECTORATE PERFORMANCE GRADINGS 2018-2019
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											
Bield Housing Association	Housing Support Dundee	Housing Support	Vol	18.12.18	**5**	**n/a**	**5**	**(5)**	No	No	No
Caledonia Housing Association Ltd	Caledonia Housing Support	Housing Support	Vol	Last inspected 28.03.17							
Dundee Survival Group		Housing Support	Vol	Last inspected 19.01.18							
Dundee Women's Aid		Housing Support	Vol	21.01.19	**5**	**n/a**	**5**	**(6)**	No	No	No
Hillcrest Housing Association	Tenancy Support & Warden	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	24.04.18	**5**	**n/a**	**5↑**	**(5)**	No	No	No
Salvation Army	Strathmore Lodge	Housing Support	Vol	26.04.18	**5**	**n/a**	**5**	**(5)**	No	No	No
RESPITE											
Dundee City Council	Mackinnon Centre	Respite Unit	DHSCP	01.11.18	**5↓**	**5↓**	**(6)**	**(6)**	No	Yes	No
Dundee City Council	White Top Centre	Respite Unit	DHSCP	16.10.18	**6**	**(6)**	**(5)**	**6**	No	No	No
Sense Scotland (Fleuchar St)	Dundee Respite	Residential Short Breaks	Vol	06.08.18	**6**	**(6)**	**(6)**	**5**	No	No	No

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
Bield Housing Association	Housing Support North & East	Support services – not care at home	Vol	De-registered 30.09.18
Capability Scotland	Capability Scotland Dundee	Support services – not care at home	Vol	Last inspected 08.10.15
Dundee City Council	Mackinnon Skills Centre	Support services – not care at home	DHSCP	Last inspected 07.03.16
Dundee City Council	Oakland Centre	Support services – not care at home	DHSCP	Last inspected 28.09.16
Dundee City Council	White Top Centre	Support services – not care at home	DHSCP	Last inspected 10.12.15
Dundee City Council	Wellgate Day Support Service	Support services – not care at home	DHSCP	Last inspected 25.02.16
Gowrie Care Ltd	Dundee College Support	Support services – not care at home	Vol	Last inspected 12.11.15
Jean Drummond Centre	Jean Drummond Day Centre	Support services – not care at home	Vol	Last inspected 19.01.18
Mid-Lin Day Care Limited	Mid-Lin Day Care	Support services – not care at home	Vol	Last inspected 19.09.17
Penumbra	Dundee Nova Project	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	20.02.19	**5**	**n/a**	**5**	**(5)**	No	Yes *15.03.18	No
Nestor Primcare Services Ltd t/a Allied Healthcare	Allied Healthcare (Dundee)	Housing Support – care at home	Private	06.04.18	**4**	**n/a**	**(5)**	**3↓**	Yes	Yes	No
				De-registered 20.12.18							
Allied Health-Services Ltd	Allied Health-Services Dundee	Housing Support – care at home	Private	New registration 21.12.18							
Avenue Scotland Ltd	Avenue Care Services Ltd	Housing Support – care at home	Private	De-registered 08.08.18							
Avenue Care Services Ltd	Avenue Care Services – Perth/ Dundee	Support services – care at home	Private	New registration 09.08.18					No	Yes	No
Bield Housing & Care	Dundee Housing with Care	Support services – care at home	Vol	18.12.18	**5**	**n/a**	**5**	**(5)**	No	No	No
Blackwood Homes and Care	Blackwood Care – Tayside Services Housing Support	Support services – care at home	Vol	29.06.18	**3**	**n/a**	**4↑**	**3**	Yes	Yes	No
British Red Cross	British Red Cross Support at Home	Housing support service – care at home	Vol	23.05.18	**4**	**n/a**	**(4)**	**3**	Yes	Yes *20.03.18	No
Caledonia Housing Association Ltd	Caledonia Care at Home Service	Support services – care at home	Vol	07.02.19	**3↓**	**n/a**	**3**	**3↓**	Yes	No	No
Capability Scotland	Community Living and Family Support Services (Dundee)	Support services – care at home	Vol	23.04.18	**5**	**n/a**	**(5)**	**5**	No	No	No

Crossroads Caring Scotland	Crossroads Caring Scotland - Dundee	Support services – care at home	Vol	07.02.19	**5↑**	**n/a**	**4↑**	**4**	No	Yes	No
Dundee City Council	Homecare Social Care Response Service	Care at Home and Housing Support	DHSCP	19.10.18	**5**	**n/a**	**(5)**	**5**	No	No	No
Dundee City Council	Care at Home City Wide	Care at Home and Housing Support	DHSCP	17.12.18	**5**	**n/a**	**5**	**(5)**	No	No	No
Dundee City Council	Home Care Enable-ment and Support & Community MH Older People Team	Care at Housing and Housing Support	DHSCP	23.01.19	**5**	**n/a**	**5**	**(5)**	No	No	No
Elite Care (Scotland) Ltd	Dundee, Perth and Angus	Care at Home and Housing Support	Private	13.07.18	**5**	**n/a**	**5**	**(4)**	No	Yes	No
Elite Care (Scotland) Ltd	Dundee, Perth and Angus	Housing Support	Private	Additional new registration – 06.11.18 - Dundee service only					No	Yes	No
Gowrie Care Ltd	Gowrie Homecare	Support service – care at home	Vol	05.11.18	**4**	**n/a**	**(4)**	**4**	No	No	No
The Inclusion Group (Dundee)	The Inclusion Group	Support Services – care at home	Vol	05.07.18	**3↓**	**n/a**	**2↓**	**2↓**	No	Yes	No
My Care Tayside		Housing support service – care at home	Private	21.03.19	**5**	**n/a**	**5**	**5**	No	Yes	No
Oran Home Care Ltd	Oran Home Care	Support services – care at home	Private	23.05.18	**4**	**n/a**	**4**	**5↑**	No	No	No
Scottish Association for Mental Health	Dundee Specialist Mental Health Outreach	Care at home/ housing support	Vol	05.11.18	**5**	**n/a**	**5**	**(5)**	No	No	No

CARE AT HOME / HOUSING SUPPORT (COMBINED)

Balfield Properties t/a Westlands	Westlands	Care at Home/ Housing Support	Private	27.04.18	6	n/a	5↓	(6)	No	No	No
Caalcare Limited	Rose Lodge	Care at Home/ Housing Support	Private	23.04.18	6	n/a	(6)	6	No	No	No
Carr Gomm	Support Services 2	Care at Home/ Housing Support	Vol	07.02.19	4↓	n/a	3↓	(4)	Yes	No	No
Cornerstone	Dundee and Angus Services	Care at Home/ Housing Support	Vol	16.01.19	4	n/a	4↓	3↓	Yes	No	No
Dudhope Villa	Dudhope Villa and Sister Properties	Care at Home/ Housing Support	Private	01.11.18	4↑	n/a	4↑	4↑	No	No	No
Dundee City Council	Dundee Community Living	Care at Home/ Housing Support	DHSCP	20.09.18	6	n/a	(6)	6	No	No	No
Dundee City Council	Supported Living Team	Care at Home/ Housing Support	DHSCP	19.11.18	5↓	n/a	(6)	5↓	No	No	No
Dundee City Council	Weavers Burn	Care at Home/ Housing Support	DHSCP	17.08.18	5↑	n/a	5↑	5↑	No	Yes	No
Gowrie Care Ltd	Dundee Central	Care at Home/ Housing Support	Vol	Last inspected 16.06.17							
Gowrie Care Ltd	Dundee East	Care at Home/ Housing Support	Vol	19.09.18	6	n/a	(6)	5↓	No	No	No
Gowrie Care Ltd	Dundee North	Care at Home/ Housing Support	Vol	13.09.18	5↓	n/a	(6)	5↓	No	No	No
Gowrie Care Ltd	Dundee West	Care at Home/ Housing Support	Vol	10.05.18	5	n/a	5	(4)	No	No	No

~~Gowrie Care Ltd~~	~~Tayside South Services (as of Jan 2018) - formerly Homeless Services~~	~~Care at Home/ Housing Support~~	~~Vol~~	~~12.04.18~~	~~5↑~~	~~n/a~~	~~(5)~~	~~5↑~~	No	No	No
Gowrie Care Ltd	Tayside East Services	Care at Home/ Housing Support	Vol	25.05.18	**5**	**n/a**	**5↓**	**(5)**	No	No	No
The Jericho Benedictine Society	Jericho Society Dundee	Housing Support	Vol	07.11.18	**5**	**n/a**	**(5)**	**5↑**	No	No	No
Priority Care Limited	Magdalen House	Care at Home/ Housing Support	Private	07.03.19 Follow-up	**(3)**	**n/a**	**(3)**	**(3)**	No	No	No
				24.09.18	**3**	**n/a**	**3**	**3**	No	No	No
The Richmond Fellowship Scotland Ltd	Dundee Services	Care at Home/ Housing Support	Vol	12.09.18	**6**	**n/a**	**5**	**n/a**	No	No	No
Sense Scotland	Supported Living: Dundee 1 & surrounding areas	Care at Home/ Housing Support	Vol	06.09.18	**5**	**n/a**	**5**	**4**	No	No	No
Sense Scotland	Supported Living Dundee 2 & surrounding areas	Care at Home/ Housing Support	Vol	05.09.18	**5**	**n/a**	**5**	**5↑**	No	No	No
Sense Scotland	Supported Living Dundee 3 & surrounding areas	Care at Home/ Housing Support	Vol	24.08.18	**5**	**n/a**	**4**	**5↑**	No	No	No
Scottish Autism	Tayside Housing Support & Outreach Service	Support Services – Care at Home	Vol	03.12.18	**5**	**n/a**	**5↓**	**(5)**	No	No	No

Transform Community Development		Care at Home/ Housing Support	Vol	06.06.18	**4↑**	**n/a**	**4↑**	**4↑**	No	No	No
Turning Point Scotland	Dundee	Housing Support Service – Care at Home	Vol	03.10.18	**5**	**n/a**	**(6)**	**6**	No	No	No
Turning Point Scotland	Angus*	Housing Support Service – Care at Home	Vol	25.05.18	**5**	**n/a**	**5**	**5**	No	No	No

KEY:

6	excellent
5	very good
4	good
3	adequate
2	weak
1	unsatisfactory

↑ signifies that the grade has improved since the previous inspection

↓ signifies that the grade has fallen since the previous inspection
no arrow signifies the grade has stayed the same grade
() where there is no grade this signifies that the theme was not inspected

SUMMARY OF CARE INSPECTORATE GRADINGS FOR CARE HOMES IN DUNDEE - 1 April 2018 to 31 March 2019

	Category DHSCP/ Private/ Vol	Inspection Date	Quality of Care & Support		Quality of Environment		Quality of Staffing		Quality of Management and Leadership	Requirements	Complaints
Balcarres HC-One Oval Limited	P	19.06.18	6		5		6		6	No	No
Bridge View House Tayside Care Limited	P	13.07.18	4↑		5↑		4↑		4↑	No	Yes
Elder Lea Manor (formerly Bughties) Enhance Healthcare Ltd	P	16.01.19	(4)		(4)		3↓		(4)	No	Yes - Regraded
Elder Lea Manor (formerly Bughties) Enhance Healthcare Ltd	P	09.05.18	4↑		4↑		4↑		4↑	Yes	No
Ellen Mhor Oakview Estates Limited	P	19.10.18	4↓		(5)		4↓		(4)	Yes	No
Harestane Priority Care Group Limited	P	15.05.18	5		(5)		(5)		5	No	No
Orchar Nursing Home Orchar Care Ltd	P	02.05.18	5		(5)		5		(5)	No	No
Pitkerro Care Centre Hudson Healthcare Ltd	P	03.07.18	4↑		4		4↑		4	No	Yes
Redwood House Kennedy Care Group	P	10.04.18	5↑		(4)		(5)		4	No	No
Riverside View HC-One Limited	P	18.07.18	4↑		(5)		5		(4)	No	Yes
Thistle Care Home Oakview Estates Limited	P	02.07.18	4		(4)		(4)		(4)	No	Yes

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	Category LA/ Private/ Vol	Inspection Date	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning	Requirements	Complaints
Balhousie Clement Park Balhousie Care Limited	P	01.10.18	4	n/a	n/a	n/a	4	No	No
Balhousie St Ronan's Balhousie Care Limited	P	24.10.18	4	n/a	n/a	n/a	4	No	No
Ballumbie Court HC-One Limited	P	30.11.18	2	2	3	4	2	Yes	Yes
Benvie Duncare Ltd	P	21.01.19	5	n/a	n/a	n/a	4	No	No
Carmichael House Kennedy Care Group	P	29.01.19	4	n/a	n/a	n/a	4	No	No
Craigie House Dundee City Council	LA	22.11.18	5	n/a	n/a	n/a	4	No	No
Ferry House Residential Home Ferry House Cttee of Management	V	20.04.18	5	n/a	n/a	n/a	4	No	No
Forebank Forebank Ltd	P	11.12.18	4	n/a	n/a	n/a	4	No	No
Janet Brougham House Dundee City Council	LA	19.09.18	5	n/a	n/a	n/a	4	No	No
Linlathen Neurodisability Centre Living Ambitions Ltd	P	18.10.18	2	2	2	2	3	Yes	Yes
Lochleven Care Home Thistle Healthcare Limited	P	25.10.18	5	n/a	n/a	n/a	5	No	Yes

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Menzieshill House Dundee City Council	**LA**	**07.03.19**	**(3)**	**n/a**	**n/a**	**n/a**	**(4)**	**No**	**No**
Menzieshill House Dundee City Council	**LA**	**26.09.18**	**3**	**n/a**	**n/a**	**n/a**	**4**	**No**	**No**
McGonagall House Rosebank (Dundee) Limited	**P**	**24.01.19**	**2**	**3**	**4**	**4**	**3**	**Yes**	**No**
Moyness Nursing Home Balhousie Care Limited	**P**	**16.11.18**	**4**	**n/a**	**n/a**	**n/a**	**4**	**No**	**No**
Rose House Kennedy Care Group	**P**	**30.07.18**	**4**	**5**	**n/a**	**n/a**	**4**	**No**	**No**
St Columba's Care Home Priority Care Group Limited	**P**	**18.10.18**	**4**	**n/a**	**n/a**	**4**	**4**	**No**	**No**
St Margaret's Home – Dundee Trustees of St Margaret's Home	**V**	**09.10.18**	**4**	**4**	**4**	**3**	**3**	**Yes**	**No**
Turriff House Dundee City Council	**LA**	**11.12.18**	**4**	**n/a**	**n/a**	**n/a**	**4**	**No**	**No**

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DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP – CARE HOME SERVICES **Appendix 2**
CARE INSPECTORATE REQUIREMENTS 2017-2018

Date of Inspection	Name of Org/Service	Service Type	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
09.05.18	Elder Lea Manor	Care Home – Private	4↑	4↑	4↑	4↑

Requirements (1)
The service must make proper provision for the health, welfare and safety of service users. The service should meet the conditions of registration to carry out improvements as agreed with the care inspectorate.

19.10.18	Ellen Mhor	Care Home – Private	4↓	(5)	4↓	(4)

Requirements (2)
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. A robust medication management process should be in place by 31 December 2018.

The service should ensure that it notifies the Care Inspectorate, and other agencies as necessary, when incidents and occurrences demand it.

- -

Date of Inspection	Name of Org/ Service	Service Type	People's Wellbeing	Leadership	Staff Team	Setting	Care & Support Planning
30.11.18	Ballumbie Court	Care Home - Private	2	2	3	4	2

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

The provider must ensure adequate care and support in relation to wound care. In order to achieve this the provider must:

- Ensure wounds are photographed in order to assess healing
- Ensure the wound is subject to initial and ongoing assessment at each dressing change
- Ensure that a wound treatment plan is prepared and continuously reviewed
- Ensure where appropriate, other healthcare professionals are involved in wound assessment and treatment planning
- Ensure dressing are regularly changed in accordance with the wound treatment plan.

The provider must make proper provision for the health, welfare and safety of people using the service. In order to achieve this the provider must:

- Ensure that people using the service are fully supported with their nutritional and hydration needs. Including assessment of the support required with meals and how the support should be provided.

- Ensure that individual care plans fully detail the needs of people using the service and how these needs should be met
- Ensure that supplementary documentation fully supports the guidance provided in the care plan. This includes oral and personal care charts, and daily records to ensure that basic care and support needs are met.

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

- Malnutrition Universal Screening Tool (MUST)
- Food and fluid charts, including daily target to be achieved for adequate intake and actions noted if targets are not achieved
- Appropriate and meaningful evaluations, all staff should complete competency in completing records should be assessed on a regular basis.

18.10.18	Linlathen Neurodisability Centre	Care Home - Private	**2**	**2**	**2**	**2**	**3**

Requirements (3)

In order to ensure that people's concerns are responded to appropriately the provider must by 14 December 2018, ensure that staff including agency staff, have the necessary qualifications, skills and expertise to ensure people receive quality care and support.

The service and provider are required to undertake a review of all staff and implement the necessary actions, regularly reviewing skills, practice and competencies. The service must develop an action plan.

In order to ensure that people's concerns are responded to appropriately the provider must by 14 December 2018, ensure that staff including agency staff have the necessary qualifications, skills and experience to ensure people receive quality care and support.

In order to ensure that the concerns about the environment are responded to appropriately the provider must by 14 January 2019 ensure that the environment is user friendly, homely in appearance and decorated and maintained to a standard appropriate for the care service. The provider must implement a detailed plan of works to improve the standard of the environment.

24.01.19	McGonagall House	Care Home - Private	**2**	**3**	**4**	**4**	**3**

Requirements (2)

In order to ensure that people get the medication they need, the provider must ensure that:

- All medication is administered as prescribed
- That staff understand their role in, and accountability for monitoring medication and ensuring there is sufficient stock
- That the services policies and procedures reflect up-to-date best practice in Scotland
- That staff understand their responsibility to keep accurate and current records of medicines (including quantity) for the use of service users which are received, carried over from a previous month, administered, refused, destroyed or transferred out of the service
- Ensure there is a system in place for regular reviews of MAR charts to remove items no longer prescribed, used or needed
- That if a regular medication is not given or taken that staff record the reason why along with any further action that was taken including the outcomes of the action.

The provider must ensure that there are robust quality assurance arrangements in place that evidence improving outcomes for service users by 28 February 2019.

09.10.18	St Margaret's Home- Dundee	Care Home - Voluntary	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 14 December 2018. This plan should detail both short and medium term environmental changes and improvements which are realistic, measurable and achievable.

Legend:

6	excellent
5	very good
4	good
3	adequate
2	weak
1	unsatisfactory

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DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP **Appendix 2**
DUNDEE REGISTERED CARE SERVICES FOR ADULTS (EXCLUDING CARE HOMES)
CARE INSPECTORATE REQUIREMENTS 2018-2019

Date of Inspection	Name of Org/Service	Service Type	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
06.04.18	Allied Healthcare (Dundee)	Housing support – care at home	4	n/a	5	3↓
Requirements (2) The manager must ensure that support plans are reviewed at least once in every six month period, when there is a significant change in a service users health, welfare or safety needs or when requested by the service user or any representative. 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.						
29.06.18	Blackwood Care – Tayside Services Housing Support	Support services – care at home	3	n/a	4↑	3
Requirements (1) The service should ensure that where a person has a scheduled visit there are effective systems to ensure that this takes place and that if a visit is missed the service knows about it quickly and can take steps to ensure that person is safe and supported.						
23.05.18	British Red Cross Support at Home	Housing support service – care at home	4	n/a	(4)	3
Requirements (1) In order to ensure that all staff who are required to be registered with the Scottish Social Services Council (SSSC) or other regulatory body do so by the defined dates, the provider must ensure that they have a robust system to ensure that they are complying with the law.						
07.02.19	Caledonia Care at Home Service	Support services – care at home	3↓	n/a	3	3↓
Requirements (3) In order to ensure that personal plans contain all the necessary information to guide care and are reviewed regularly the provider must: - Put in place a system of regular audit and overview; - Ensure that the above system facilitates the process of identifying and addressing errors and omissions with the plans; - Ensure that the information held within the plans is sufficient to safely guide care; - Ensure that plans are reviewed and updated as people's needs change and/or at least every six months. In order to ensure that all staff are safely recruited the provider must implement their existing recruitment policy, ensuring that both Protecting Vulnerable Groups (PVG) documentation and references are received prior to the commencement of work with vulnerable people. In order to ensure that tenant's human rights are central to the organisation that supports and cares for them the provider must: - Compile and implement a policy on the use of restraint, in accordance with the Mental Welfare Commission guidance (Rights, Risk and Limits to Freedom 2013);						

- Ensure that clear guidance is available in tenant's personal plans where there is need for staff to intervene to protect safety.

05.07.18	The Inclusion Group	Support services – care at home	3↓	n/a	2↓	2↓

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18.05.18	My Homecare (Dundee) Ltd	Support Service	4↑	n/a	3↑	3↑

Requirements (1)
The provider must ensure all staff working in the service receive appropriate training which will equip them with the necessary skills and competencies required to meet the care and support of all service users. The provider must ensure newly recruited staff are given a comprehensive induction and are supported by appropriate and experienced staff until they are deemed competent.

07.02.19	Carr Gomm	Care at Home/ Housing Support	4↓	n/a	3↓	4

Requirements (2)
In order to ensure that people supported are receiving the correct medication to maintain their health and wellbeing by 31 March 2019 the provider must ensure that:

- Medication administration is prioritised by staff at busy times on shift;
- Medication administration sheets (MAR) are appropriate to enable clear and effective recording;
- Medication is given correctly and at the correct time, as prescribed;
- Staff receive guidance on how to respond to and record medication errors.

In order to ensure that people supported are treated with dignity and respect whilst their wellbeing is maintained upon receipt of this report, the provider must ensure that:

- The service's Adult Support and Protection policy is followed at all times;
- Staff are supported to respond to stress and distress using best practice.

16.01.19	Cornerstone Dundee and Angus Services	Care at Home/ Housing Support	4	n/a	4↓	3↓

Requirements (1)
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 19 July 2018.

Legend:

6	excellent
5	very good
4	good
3	adequate
2	weak
1	unsatisfactory

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

MENTAL WELFARE COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2018-2019

Inspection Date	Name of Org/Service	Service Type
24/04/2018 Announced	The Kingsway Care Centre	Old age Psychiatry Facility

Last visit 28/09/2016. At that time, recommendations were made about displaying information, and about the physical environment in the wards. A response indicated that appropriate actions were taken in relation to the recommendations.

Requirements
None

Recommendations (1)
Managers should ensure that arrangements are put in place so that a number of specific bedrooms in each ward have facilities to allow patient observation without staff having to enter bedrooms.

The Commission requires a response to these recommendations within three months of the date of this
Report.

Inspection Date	Name of Org/Service	Service Type
16/10/2018 Announced	Craigowl Centre and Flats 1 and 2/3, Strathmartine Centre	Learning Disability Assessment Unit

Last visit 16/03/2017. At that time, recommendations were made about care planning and some administrative issues, including keeping relevant documentation in individual patient files. An action plan was received which indicated that appropriate actions were taken to address these recommendations.

Requirements
None

Recommendations (2)
Managers should look at how nurse staffing levels can be maintained, given the local and national difficulties recruiting staff to fill nursing posts.

Managers should keep an index of Mental Health Act documentation, including dates indicating when reviews are due.

The Commission requires a response to these recommendations within three months of the date of this Report.

Inspection Date	Name of Org/Service	Service Type
15/11/2018 Unannounced	Wallace Hospital	Independent Hospital providing assessment and treatment for adults with learning disability and complex needs

Last visit 15/08/2017. At that time, recommendations were made about care planning, about 'specific persons' provisions and about access to outdoor spaces.

Requirements
None

Recommendations (3)
Managers should review care planning processes, looking at how the format of documentation can be simplified.

Managers should introduce an audit tool to monitor consent to treatment documentation, to ensure that all treatments are legally authorized.

Managers should audit s47 certificates, to ensure that they are accompanied by appropriate treatment plans.

The Commission requires a response to these recommendations within three months of the date of this
Report.

Inspection Date	Name of Org/Service	Service Type
27/11/2018 Announced	Wards 1,2 and the Mulberry Unit, Carseview Centre	General adult psychiatric acute admission wards

Last visit 22/11/2017. At that time, recommendations were made about care planning, activity provision, the electronic records system and issues relating to the environment. A response was received

Requirements
None

Recommendations (3)
Managers should review care planning processes, looking at how the format of documentation can be simplified.

Managers should introduce an audit tool to monitor consent to treatment documentation, to ensure that all treatments are legally authorized.

Managers should audit s47 certificates, to ensure that they are accompanied by appropriate treatment plans.

The Commission requires a response to these recommendations within three months of the date of this
Report.

APPENDIX 4

Glossary of Terms

Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include physiotherapists, dieticians, Speech and Language Therapists, psychologists, Occupational Therapists, podiatrists, audiologists, etc.
Carer	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 (of any age) who is ill, frail, disabled or has mental health or substance misuse issues. Carers can provide care for adults or children but the definition used here excludes people who provide care for a young person with similar needs to their peers.
Clinical Care and Professional Governance	The system which informs and supports the progress the improvement of health, social work and social care services ensuring they are person centred, safe and effective and based on best available evidence and practice.
Community Pay Back Orders (CPO)	A Community Payback Order (CPO) is an alternative to custody designed to support individuals (who commit an offence) to pay back to their local community, usually by carrying out unpaid work.
Emergency admissions	An unplanned admission to an acute hospital which occurs when, for clinical reasons, a patient is admitted at the earliest possible time after seeing a doctor.

Enablement 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 service which is provided for a period of up to a maximum of six weeks.

Equality Act 2010 An Act of Parliament of the United Kingdom which brought together all anti-discriminatory laws including The Equal Pay Act 1970, The Sex Discrimination Act 1975, The Race Relations Act 1976, The Disability Discrimination Act 1995 and three major statutory instruments protecting discrimination in employment on the grounds of religion or belief, sexual orientation or age.

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

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

Health Inequalities Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. They are avoidable and they do not occur randomly or by chance. They are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.

Health and Wellbeing Indicators A suite of indicators which draw together measures relation to health and social care integration. These were developed in partnership with NHS Scotland, COSLA and the third and independent sectors.

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

Home Care Help provided directly in the supported persons own home. Social Care/ Home Care Workers people employed to provide direct personal physical, emotional, social or health care and support to service users. This can also be described as Care at Home support

Integration Joint Board (IJB) Health and Social Care Partnership area has an Integration Joint Board which oversees the integrated arrangement sand service delivery.

LCPP	Local Community Partnerships a groups of professionals and citizens work in partnership to deliver priorities regarding a geographical area.
	drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.
Natural Neighbourhoods	54 small geographical areas where communities live which are aligned to the 8 Local Community Planning Partnership Areas in Dundee
Partnership	Dundee Health and Social Care Partnership
Post Diagnostic Support	The support a person receives following a diagnosis of dementia. In 2010's 'Scotland's National Dementia Strategy', the Scottish Government made a commitment to improving post-diagnostic support for those receiving a diagnosis of dementia. The Scottish Government endorsed a 12 month post-diagnostic support model that used The Five Pillars methodology developed by Alzheimer Scotland, and concluded with a person-centred support plan. The Scottish Government published their third national dementia strategy in 2017 which continues to support the post-diagnostic support entitlement.
Power of Attorney	A power of attorney is a document you can use to appoint someone to make decisions on your behalf. The appointment can be effective immediately or can become effective only if you are unable to make decisions on your own.
Premature Mortality	Premature mortality is a measure of unfulfilled life expectan

Self Directed Support

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

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

Service Delivery Areas

The service delivery model of supporting people in communities in Dundee.

Strategic Priorities

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

Technology Enabled Care

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

Dundee
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GET IN TOUCH:

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