TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

(See Distribution List attached)

Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

21st August, 2018

Dear Sir or Madam

**DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD**

I would like to invite you to attend a meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Tuesday 28th August, 2018 at 2.00pm.

Apologies for absence should be intimated to Willie Waddell, Committee Services Officer, on telephone 01382 434228 or by e-mail willie.waddell@dundeecity.gov.uk.

Yours faithfully

DAVID W LYNCH

Chief Officer

**A G E N D A**

**1 APOLOGIES FOR ABSENCE**

**2 DECLARATION OF INTEREST**

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

**3 MINUTES OF PREVIOUS MEETING - Page 1**

The minutes of previous meeting of the Integration Joint Board held on 27th June, 2018 is attached for approval.

**4 PERFORMANCE AND AUDIT COMMITTEE**

(a) MINUTES OF MEETING OF 31ST JULY, 2018 - Page 7

(Copy attached for information and record purposes).

(b) CHAIR'S ASSURANCE REPORT - Page 13

(Report No DIJB42-2018 by the Chair of the Peformance and Audit Committee, copy attached).

**5 ANNUAL PERFORMANCE REPORT 2017/18**

(a) Presentation by Lynsey Webster - Senior Officer, Diane McCulloch – Head of Service and Dave Berry – Chief Finance Officer.

(b) Report No DIJB44-2018 by the Chief Officer, copy attached. - Page 15

**6 JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION**

(a) Presentation by Kathryn Sharp - Senior Manager and Diane McCulloch – Head of Service.

(b) Report No DIJB29-2018 by the Chief Social Work Officer, copy attached. - Page 127

**7 REVIEW OF STRATEGIC AND COMMISSIONING PLAN - Page 135**

(Report No DIJB40-2018 by the Chief Officer, copy attached).

**8 SUBSTANCE MISUSE STRATEGIC AND COMMISSIONING PLAN FOR DUNDEE 2018-2021 - Page 141**

(Report No DIJB34-2018 by the Chief Officer, attached).

**9 PRIMARY CARE IMPROVEMENT PLAN UPDATE - Page 205**

(Report No DIJB45-2018 by the Chief Officer, copy attached).

**10 GENERAL PRACTICE PROVISION IN DUNDEE - Page 225**

(Report No DIJB46-2018 by the Chief Officer, copy attached).

**11 UPDATE ON DELAYED DISCHARGE AND UNSCHEDULED CARE IMPROVEMENT PROGRAMMES - Page 231**

(Report No DIJB36-2018 by the Chief Officer, attached).

**12 ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19 - Page 265**

(Report No DIJB49-2018 by the Chief Officer, copy attached).

**13 DUNDEE INTEGRATION JOINT BOARD 2018/19 BUDGET - Page 309**

(Report No DIJB30-2018 by the Chief Finance Officer, copy attached).

**14 FINANCIAL MONITORING AS AT JUNE 2018 - Page 317**

(Report No DIJB47-2018 by the Chief Finance Officer, copy attached).

**15 DUNDEE INTEGRATION JOINT BOARD DRAFT ANNUAL ACCOUNTS 2017/2018**

(a) DRAFT ANNUAL ACCOUNTS 2017/18 – DIJB51-2018

The Integration Joint Board's Draft Annual Accounts 2017/18 and Annual Governance Statement were presented and agreed at the Integration Joint Board meeting held on the 27th June, 2018 (Report DIJB28-2018). It has since been identified that an incorrect appendix was included with the report. The 2016/17 Funding Variations Summary shown as Appendix 1 of the report was shown instead of the 2017/18 version.

This was brought to the attention of the Chair and Vice Chair and under the Integration Joint Board's Scheme of Delegation, the Chief Officer has taken the measure of correcting the error and has arranged for the correct appendix to be included in the draft annual accounts. The revised appendix is shown as Report DIJB52-2018 on this meeting's agenda.

The Integration Joint Board is asked to note this amendment.

(b) 2017/2018 FUNDING VARIATIONS SUMMARY – DIJB52-2018 - Page 329

The revised 2017/2018 funding variations summary appendix is attached for information and noting.

**16 CARSEVIEW REPORT - Page 331**

(Report No DIJB50-2018 by the Director of Strategic Change, NHS Tayside, copy attached).

**17 MEETING OF THE INTEGRATION JOINT BOARD 2018 – ATTENDANCES – DIJB48-2018 - Page 335**

A copy of the attendance return for meetings of the Integration Joint Board held to date over 2018 is attached for information.

**18 DATE OF NEXT MEETING**

The next meeting of the Integration Joint Board will be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 30th October, 2018 at 2.00 pm.

# DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
# DISTRIBUTION LIST

## (a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

**(* - DENOTES VOTING MEMBER)**

| **Role** | **Recipient** |
|---|---|
| Elected Member (Chair) | Councillor Ken Lynn * |
| Non Executive Member (Vice Chair) | Doug Cross * |
| Elected Member | Councillor Roisin Smith * |
| Elected Member | Bailie Helen Wright * |
| Non Executive Member | TBC* |
| Non Executive Member | Munwar Hussain * |
| Chief Officer | David W Lynch |
| Chief Finance Officer | Dave Berry |
| Registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978(b) | Frank Weber |
| Registered medical practitioner employed by the Health Board and not providing primary medical services | Cesar Rodriguez |
| Registered nurse who is employed by the Health Board | Sarah Dickie |
| Chief Social Work Officer | Jane Martin |
| Third Sector Representative | Christine Lowden |
| Staff Partnership Representative | Raymond Marshall |
| Trade Union Representative | Jim McFarlane |
| Director of Public Health | Drew Walker |
| Person providing unpaid care in the area of the local authority | Martyn Sloan |
| Service User residing in the area of the local authority | Andrew Jack |

## (b) DISTRIBUTION – FOR INFORMATION ONLY

| **Organisation** | **Recipient** |
|---|---|
| NHS Tayside (Chief Executive) | Chief Executive |
| Dundee City Council (Chief Executive) | David R Martin |
| Dundee City Council (Head of Democratic and Legal Services) | Roger Mennie |
| Dundee City Council (Members' Support) | Jayne McConnachie |
| Dundee City Council (Members' Support) | Dawn Clarke |
| Dundee City Council (Members' Support) | Fiona Barty |
| Dundee Health and Social Care Partnership (Chief Officer's Admin Assistant) | Arlene Hay |
| Dundee City Council (Communications rep) | Steven Bell |
| NHS Tayside (Communications rep) | Jane Duncan |
| NHS Tayside (PA to Director of Public Health) | Linda Rodger |
| NHS Fife (Internal Audit) (Principal Auditor) | Judith Triebs |
| Audit Scotland (Senior Audit Manager) | Bruce Crosbie |

Dundee Health & Social Care Partnership

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 27th June, 2018.

Present:-

| **Members** | **Role** |
|---|---|
| Ken LYNN *(Chairperson)* | Nominated by Dundee City Council (Elected Member) |
| Doug CROSS (*Vice Chairperson*) | Nominated by Health Board (Non-Executive Member) |
| Roisin SMITH | Nominated by Dundee City Council (Elected Member) |
| Helen WRIGHT | Nominated by Dundee City Council (Elected Member) |
| David W LYNCH | Chief Officer |
| Dave BERRY | Chief Finance Officer |
| Cesar RODRIGUEZ | Registered Medical Practitioner (not providing primary medical services) |
| Frank WEBER | Registered Medical Practitioner (whose name is included in the list of primary medical performers) |
| Drew WALKER | Director of Public Health |
| Jim MCFARLANE | Trade Union Representative |
| Christine LOWDEN | Third Sector Representative |
| Andrew JACK | Service User residing in the area of the local authority |
| Martyn SLOAN | Person providing unpaid care in the area of the local authority |

Also in attendance at the request of the Chief Officer:-

| | |
|---|---|
| Dr David SHAW | Dundee Health and Social Care Partnership |
| Shona HYMAN | Dundee Health and Social Care Partnership |
| Andrew THOMSON | Dundee Health and Social Care Partnership |
| Alison BAVIDGE | Dundee Health and Social Care Partnership |
| Michelle RAMAGE | Dundee Health and Social Care Partnership |
| Jenny HILL | Dundee Health and Social Care Partnership |
| Arnott TIPPETT | Dundee Health and Social Care Partnership |

Ken LYNN, Chairperson, in the Chair.

**I APOLOGIES FOR ABSENCE**

| Member | Role |
|---|---|
| Munwar HUSSAIN | Nominated by Health Board (Non-Executive Member) |
| Sarah DICKIE | Registered Nurse |
| Jane MARTIN | Chief Social Work Officer |
| Raymond MARSHALL | Staff Partnership Representative |

**II DECLARATIONS OF INTEREST**

There were no declarations of interest.

**III MINUTE OF PREVIOUS MEETING**

The minute of meeting of the Integration Joint Board held on 24th April, 2018 was submitted and approved.

**IV PERFORMANCE AND AUDIT COMMITTEE**

(a) MINUTE OF MEETING OF 29TH MAY, 2018

The minute of meeting of the Performance and Audit Committee held on 29th May, 2018 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB45-2018 by Doug Cross, Chair, Performance and Audit Committee providing an assurance report to the Integration Joint Board on the work of the Performance and Audit Committee on instructions issued by the Committee, Performance Against Work Plan and any other major issues to highlight to the Integration Joint Board.

The Integration Joint Board agreed to note the content of the presentation.

**V TAYSIDE PRIMARY CARE IMPROVEMENT PLAN**

(a) Shona Hyman, Senior Manager, Service Development and Primary Care, Dr David Shaw, Clinical Director and Andrew Thomson, Medical Secretary, Tayside General Practitioners' Sub-Committee gave a joint presentation in supplement to the report.

The Integration Joint Board agreed to note the content of the report.

(b) There was submitted Report No DIJB26-2018 by the Chief Officer detailing the development of the Primary Care Improvement Plan and seeking approval of the Plan.

The Integration Joint Board agreed:

(i) to approve the Tayside Primary Care Improvement Plan (the Plan), which outlined the overall direction of travel and set out the first year of delivery, a copy of which was attached to the report as Appendix 1;

(ii) to note the specific actions for Dundee Health and Social Care Partnership, a copy of which was attached to the report as Appendix 2;

(iii) to direct NHS Tayside to implement with immediate effect the specific actions relevant to them a copy of which was attached to the report as Appendices 1 and 2;

(iv) to delegate the monitoring of the Primary Care Improvement Plan Fund (Dundee allocation) as detailed in paragraphs 3 and 4.4.1 of the report;

(v) to instruct the Chief Officer to provide a further report to the Integration Joint Board to be held on 28th August, 2018 which would include a full financial framework for the Direction to NHS Tayside at (iii) above;

(vi) to instruct the Chief Officer to provide a further report on progress made in the first year to a future meeting of the Integration Joint Board; and

(vii) to note that the Tayside Primary Care Improvement Plan would be submitted to the Scottish Government following approval of the Plan by the relevant parties by 1st July 2018.

**VI STRATEGIC AND COMMISSIONING STATEMENT FOR PEOPLE WITH PHYSICAL DISABILITY 2018-2021**

There was submitted Report No DIJB35-2018 by the Chief Officer seeking approval for the Strategic and Commissioning Statement for People with Physical Disability 2018 – 2021.

The Integration Joint Board agreed-:

(i) to note the contents of the report;

(ii) to note the breadth of service provision covered within this Statement and the engagement work undertaken over the last two years to ensure that the direction and language of this Statement reflected the needs and wishes of people with physical disability in Dundee; and

(iii) to approve the Strategic and Commissioning Statement for People with Physical Disability, a copy of which was attached to the report as Appendix 1, as the vehicle for the planning and development of services over the next three years.

**VII VETERANS FIRST POINT TAYSIDE (V1PT)**

There was submitted Report No DIJB32-2018 by the Chief Officer providing information about the hosted Veterans First Point Tayside (V1PT) service, which had been delivering welfare and specialist mental health services to veterans and their family members since 2015.

The Integration Joint Board agreed:-

(i) to acknowledge the very positive work of V1PT in operationalising the Armed Forces Covenant (as referred to in paragraph 4.1.1 of the report) across Dundee, Perth and Angus, ensuring better access to NHS services, including pathways for ensuring priority treatment for those veterans who should receive early treatment for health problems that had resulted from military service;

(ii) to acknowledge the steps that were being taken as outlined in paragraphs 5.4.1 – 5.4.3 of this report to determine the future model and financial framework for the service;

(iii) to note the content of the Scottish Veterans Commissioner's report; Veterans' Health & Wellbeing, a copy of which was attached to the report as Appendix 1; and

(iv) to remit to the Chief Officer to bring forward a further report, once future service modelling was complete, by April 2019.

**VIII RESHAPING NON-ACUTE CARE IN DUNDEE – UPDATE**

Reference was made to Article VIII of the minute of meeting of this Integration Joint Board held on 31st October, 2017 wherein the proposals in relation to the Reshaping of Non-Acute Care in Dundee were agreed.

There was submitted Report No DIJB31-2018 by the Chief Officer updating the Integration Joint Board to the work of the Reshaping Non-Acute Care Programme in Dundee and outlining progress towards the plans for non-acute care and residential care in Dundee.

The Integration Joint Board agreed:-

(i) to note the contents of the report; and

(ii) to instruct the Chief Officer to bring back to the Integration Joint Board the initial business case at its meeting on 28th August, 2018.

**IX ANNUAL REPORT OF THE DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP AND CLINICAL, CARE AND PROFESSIONAL GOVERNANCE GROUP**

There was submitted Report No DIJB38-2018 by the Chief Officer providing assurance to the Integration Joint Board regarding matters of Clinical, Care and Professional Governance. In addition,

the report provided information on the business of the Dundee Health & Social Care Partnership Clinical, Care and Professional Governance Group (The Group), and outlined the ongoing planned developments to enhance the effectiveness of the group.

The Integration Joint Board agreed:-

(i) to note the content of the report;

(ii) to note the work undertaken by the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group (R2) from April 2017 – March 2018 to seek assurance regarding matters of Clinical, Care and Professional Governance as outlined in Sections 4.3 – 4.5 of the report); and

(iii) to note the update in response to the Audit of Clinical, Care and Professional Governance systems as detailed in section 4.6 of the report.

**X DUNDEE PRESCRIBING MANAGEMENT POSITION**

There was submitted Report No DIJB41-2018 by the Chief Officer providing an overview to the Integration Joint Board of the prescribing position within Dundee and setting out the plans to meet the challenges associated with prescribing resources.

The Integration Joint Board agreed:-

(i) to note the content of the updated position in relation to prescribing activity in Dundee as set out in the report;

(ii) to note the proposed response to the challenging prescribing position as developed through the Tayside wide Prescribing Management Group in addition to the range of local interventions as set out in the report and associated appendices;

(iii) to instruct the Chief Finance Officer to reflect the prescribing financial position for consideration by Integration Joint Board as part of the final confirmation of the delegated budget to be presented to the meeting of the Integration Joint Board to be held on 27th August, 2018 and

(iv) to instruct the Chief Finance Officer to provide regular updates to the Integration Joint Board on the prescribing position throughout 2018/19.

**XI DRAFT ANNUAL ACCOUNTS 2017/18 AND ANNUAL GOVERNANCE STATEMENT**

There was submitted Report No DIJB28-2018 by the Chief Finance Officer presenting the Integration Joint Board's Draft Annual Statement of Accounts 2017/18 for approval to initiate the external audit process.

The Integration Joint Board agreed:-

(i) to the content of the Draft Final Accounts Funding Variations as outlined in Appendix 1 of the report;

(ii) to approve the Draft Dundee Integration Joint Board Annual Corporate Governance Statement as outlined in Appendix 2 of the report;

(iii) to note the Integration Joint Board's Draft Annual Statement of Accounts 2017/18 as outlined in Appendix 3 of the report;

(iv) to note the application of reserves during 2017/18 to meet the Integration Joint Board's liabilities and support its activities during the financial year as outlined in section 4.1.3 of the report; and.

(v) to instruct the Chief Finance Officer to submit the Accounts to the Integration Joint Board's External Auditors (Audit Scotland) to enable the audit process to commence.

**XII CONFIRMATION OF DUNDEE INTEGRATION JOINT BOARD BUDGET 2018**

Reference was made to Article V of the minute of meeting of this Integration Joint Board held on 30th March, 2018 wherein the Integration Joint Board noted the indicative delegated budget from Tayside NHS Board for 2018/19 and instructed the Chief Finance Officer to report back to the Integration Joint Board following receipt of formal notification from Tayside NHS Board of the budget offer with associated recommendations including any implications of the finalisation of hosted services budgets and the Large Hospital Set Aside.

There was submitted Agenda Note DIJB37-2018 reporting that Tayside NHS Board was due to formally consider its budget at its meeting to be held on 28th June, 2018 therefore the implications of this would be presented to the next Integration Joint Board meeting to be held on 28th August, 2018.

The Integration Joint Board noted the content of the note.

**XIII MEETINGS OF THE INTEGRATION JOINT BOARD 2018 - ATTENDANCES**

There was submitted Agenda Note DIJB43-2018 providing a copy of the attendance return for meetings of the Integration Joint Board held to date over 2018.

The Integration Joint Board noted the position as outlined.

**XIV DATE OF NEXT MEETING**

The Integration Joint Board noted that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 28th August, 2018 at 2.00 pm.

Ken LYNN, Chairperson.

Dundee Health & Social Care Partnership

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 31st July, 2018.

Present:-

| **Members** | **Role** |
|---|---|
| Doug CROSS *( Chairperson*) | Nominated by Health Board (Non Executive Member) |
| Roisin SMITH | Nominated by Dundee City Council (Elected Member) |
| Helen WRIGHT | Nominated by Dundee City Council (Elected Member) |
| Dave BERRY | Chief Finance Officer |
| Jane MARTIN | Chief Social Work Officer |
| Cesar RODRIGUEZ | Registered Medical Practitioner (not providing primary medical services) |
| Raymond MARSHALL | Staff Partnership Representative |

Non members in attendance at request of Chief Finance Officer:-

| | |
|---|---|
| Tony GASKIN | Chief Internal Auditor |
| Diane MCCULLOCH | Dundee Health and Social Care Partnership |
| Jenny HILL | Dundee Health and Social Care Partnership |
| Alexis CHAPPELL | Dundee Health and Social Care Partnership |
| Rosalind GUILD | Dundee Health and Social Care Partnership |
| Lynsey WEBSTER | Dundee Health and Social Care Partnership |

Doug CROSS, Chairperson, in the Chair.

**I APOLOGIES FOR ABSENCE**

Apologies for absence was submitted on behalf of:-

David LYNCH, Chief Officer.

**II DECLARATION OF INTEREST**

No declarations of interest were made.

**III MINUTE OF PREVIOUS MEETING**

The minute of meeting of the Committee held on 29th May, 2018 was submitted and approved.

**IV ANNUAL PERFORMANCE REPORT 2017/18 UPDATE**

There was submitted Report No PAC43-2018 by the Chief Finance Officer updating on progress towards producing the 2017/18 Health and Social Care Partnership's Annual Performance Report.

The Committee agreed:-

(i) to note the updates contained within the report;

(ii) to note that the summary version of the Annual Performance Report, which was attached to the report as Appendix 1, would be published on the Health and Social Care Partnership website on 31st July, 2018;

(iii) to note that the full version of the Annual Performance Report had been developed and would be submitted to the meeting of the Integration Joint Board on 28th August, 2018 for approval; and

(iv) that thanks would be passed on to all staff involved in the production of the Annual Performance Report.

**V PERFORMANCE REPORT – CARE INSPECTORATE GRADINGS – DUNDEE REGISTERED CARE HOMES FOR ADULTS 2017/18**

There was submitted Report No PAC26-2018 by the Chief Finance Officer summarising the gradings awarded by the Care Inspectorate to Dundee Registered Care Homes for Adults in Dundee for the period 1st April, 2017 to 31st March, 2018.

The Committee agreed:-

(i) to note the content of the report and the gradings awarded as detailed in the Performance Report which was attached as Appendix A and highlighted in section 4.2 of the report;

(ii) to note the range of continuous improvement activities progressed during 2017-18 as described in section 4.3 of the report;

(iii) to note that the position in relation to Helenslea and Bughties would continue to be monitored with a view to maintaining and improving on the level of performance;

(iv) to note that future reports would be set in the context of new standards now operated by the Care Inspectorate in terms of preparations; and

(v) that a report would be submitted to a future meeting of the Committee giving assurances that preparations were in hand in terms of the introduction of Care Standards.

**VI PERFORMANCE REPORT – CARE INSPECTORATE GRADINGS – DUNDEE REGISTERED CARE SERVICES FOR ADULTS 2017/18 (EXCLUDING CARE HOMES)**

There was submitted Report No PAC39-2018 by the Chief Finance Officer summarising the gradings awarded by the Care Inspectorate to Dundee Registered Care Services for Adults (excluding Care Homes) for the period 1st April, 2017 to 31st March, 2018.

The Committee agreed:-

(i) to note the content of the report and the gradings awarded as detailed in the Performance Report which was attached to the report as Appendix A and highlighted in section 4.2 of the report;

(ii) to note the range of continuous improvement activities progressed during 2017-18 as described in section 4.3 of the report; and

(iii) that a copy of the Care Inspectorate's self-assessment framework would be issued to the Committee for their information.

**VII PERFORMANCE REPORT – QUARTERLY COMPLAINTS 2018/19 – QUARTER 1**

There was submitted Report No PAC27-2018 by the Chief Finance Officer providing an analysis of complaints received by the Health and Social Care Partnership over the first quarter of 2018/19.

The Committee agreed:-

(i) to note the content of the report in relation to the performance of Dundee Health and Social Care Partnership's complaints process; and

(ii) to note that information in relation to complaints would be examined to ascertain what could be shared with the Committee.

**VIII OUTCOME OF CARE INSPECTORATE INSPECTION – CARE AT HOME CITY WIDE**

There was submitted Report No PAC42-2018 by the Chief Finance Officer advising of the outcome of the Care Inspectorate Inspection of the Home Care City Wide Service which was undertaken between 5th March, 2018 and 21st March, 2018. The report outlined the findings of the Care Inspectorate and gave a summary of the grades achieved.

The Committee agreed:-

(i) to note the content of the report and the content of the inspection report which was attached to the report as Appendix 1;

(ii) to note that the service received one recommendation for the care at Home City Wide Service as detailed at paragraph 4.11 of the report and the submitted action plan to address this which was attached to the report as Appendix 2; and

(iii) to note the grades awarded to the service, the strengths of the service, and the positive comments made by service users, relatives and staff as described in paragraph 4.13 of the report.

**IX MENTAL WELFARE COMMISSION REPORT ON HOMELESS PEOPLE WHO EXPERIENCE MENTAL ILL HEALTH**

There was submitted Report No PAC44-2018 by the Chief Finance Officer updating on progress in responding to recommendations made by the Mental Welfare Commission themed investigation report into homelessness and mental ill health.

The Committee agreed:-

(i) to note the content of the report and the recommendations made by the Mental Welfare Commission for Health and Social Care Partnerships outlined at section 4.1.2 and in Appendix 1 of the report;

(ii) to note progress made in response to the recommendations through the work of the Dundee Housing Options and Homeless Partnership and the implementation of the Housing Options and the Homelessness Strategic Plan as outlined in section 5.0 of the report; and

(iii) to note that a copy of the report on Not Just a Roof: Housing Options and Homelessness Strategic Plan 2017-2020 which was considered by the meeting of the Integration Joint Board at their meeting on 31st October, 2017 would be distributed to the Committee for their information.

**X OUTCOME OF MENTAL WELFARE COMMISSION FOR SCOTLAND VISIT TO KINGSWAY CARE CENTRE**

There was submitted Report No PAC45-2018 by the Chief Finance Officer advising of the outcome of the recent Mental Welfare Commission visit to Kingsway Care Centre.

The Committee agreed:-

(i) to note the content of the Mental Welfare Commission's report following their recent visit to Kingsway Care Centre which was attached to the report as Appendix 1;

(ii) to note the positive comments made in the report and the good practice identified in relation to service delivery contained within the report as described in sections 4.1 to 4.5 of the report;

(iii) to note the actions in relation to the formal recommendations contained within the report as described in section 4.6 of the report;

(iv) to note the wish of the Chair that staff be commended for their efforts in achieving the outcomes indicated in the report; and

(v) to note that the position would be monitored, that Dave Berry was a member of the NHS Asset Management Group and that reports on the outcome on the recommendation would be submitted to a future meeting of the Committee.

**XI DUNDEE INTEGRATION JOINT BOARD ANNUAL INTERNAL AUDIT REPORT 2017/18 AND ANNUAL GOVERNANCE STATEMENT**

There was submitted Report No PAC47-2018 by the Chief Finance Officer advising of the outcome of the Chief Internal Auditor's Report on the Integration Joint Board's internal control framework for the financial year 2017/18 and to agree the Integration Joint Board's revised Annual Governance Statement following this assessment.

The Committee agreed:-

(i) to note the content and findings of the Annual Internal Audit Report 2017/18 which was attached to the report as Appendix 1;

(ii) to instruct the Chief Finance Officer to develop an overall Governance Action Plan as recommended by the Chief Internal Auditor to be presented to the Performance and Audit Committee meeting to be held on 25th September, 2018;

(iii) to note and agree the revised Annual Governance Statement which was attached to the report as Appendix 2 to be incorporated into the Integration Joint Board's Draft Annual Accounts following the Chief Internal Auditor's conclusion that reliance could be placed on the Integration Joint Board's governance arrangements and systems of internal control for 2017/18;

(iv) to note that Raymond Marshall would identify some of the areas not currently governed by NHS and Dundee City Council in terms of staff governance and process this through the Partnership Forum; and

(v) to note that the governance framework for Chief Social Work Officers would be considered by Dundee City Council's Scrutiny Committee in September and would thereafter be reported to a meeting of the Performance and Audit Committee.

**XII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN 2018/19 AND AUDIT ARRANGEMENTS**

There was submitted Report No PAC48-2018 by the Chief Finance Officer on the proposed Dundee Integration Joint Board's 2018/19 Internal Audit Plan.

The Committee agreed:-

(i) to recommend approval to the Integration Joint Board of the continuation of the Internal Audit arrangements as outlined in section 4.1 of the report and appoints the Chief Internal Auditor of FTF Audit and Management Services as the Integration Joint Board's auditor for 2018/19; and

(ii) to note and approve the proposed Dundee Integration Joint Board 2018/19 Internal Audit Plan as outlined in Appendix 1 of the report.

**XIII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT**

There was submitted Report No PAC37-2018 by the Chief Finance Officer providing a progress update in relation to the current Internal Audit Plan.

The Committee agreed:-

(i) to note the progress of the current Internal Audit Plan as outlined in the report and Appendix 1 of the report; and

(ii) to note that the remaining outstanding actions would be reported to the Performance and Audit Committee to be held on 25th September, 2018.

**XIV MEETING OF THE PERFORMANCE AND AUDIT COMMITTEE 2018 – ATTENDANCES – PAC49-2018**

There was submitted Agenda Note PAC49-2018 providing a copy of the attendance return for meetings of the Performance and Audit Committee held to date over 2018.

The Performance and Audit Committee noted the position as outlined.

**XV DATE OF NEXT MEETING**

The Committee noted that the next meeting of the Committee would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 25th September, 2018 at 2 pm.

Doug CROSS, Chairperson.

**ITEM No …4(b)…….**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **PERFORMANCE AND AUDIT COMMITTEE CHAIR'S ASSURANCE REPORT**

**REPORT BY:** **CHAIR, PERFORMANCE AND AUDIT COMMITTEE**

**REPORT NO:** **DIJB42-2018**

**Instructions Issued by the Committee**

The Performance and Audit Committee (PAC) issued the following instructions to the Chief Finance Officer:

- To submit, to a future meeting of the PAC, a report giving assurances that preparations were in hand relating to the introduction of Care Standards.
- To develop an overall Governance Action Plan and present this to the PAC meeting on 25 September, 2018.

**Performance Against Workplan**

The Committee:

- Reviewed the summary version of the Annual Performance Report for 2017/18 and considered the summary was a user-friendly document which was a very informative summary of activity undertaken during 2017/18. The Committee noted the full report would be submitted to the IJB in August.
- Considered the 2017/18 Care Inspectorate gradings for Dundee Registered Care Homes for Adults. The Committee noted that overall the level of grades was very good. It expressed concerns over the performance of Helenslea and Bughties in particular, but noted close monitoring was being undertaken by the Health and social Care partnership (HSCP) and Care Inspectorate staff with a view to improving the service provided by these Homes.
- Considered the 2017/18 Care Inspectorate gradings for Dundee Registered Care Services for Adults. The Committee noted that overall the level of grades was very good, however the Committee expressed concerns regarding the performance of Avenue Care Services. It was reported that the poor grading reflected issues relating to a branch outwith Dundee and that while the same issues were not apparent in the Dundee Branch the position would continue to be monitored.
- Reviewed the performance of the Partnership in dealing with complaints and noted this was generally satisfactory. The Committee however sought further assurance on how the learning from complaints is being used to improve service delivery.
- Considered the outcome of the Care Inspectorate inspection of Care at Home City Wide. The Committee were pleased to note Very Good grades were received in respect of Quality of Care and Support and Quality of Staffing and also the positive comments made by service users and their relatives regarding the care they receive. There was a recommendation that periodic PVG checks should be carried out and the Committee received assurance that any risks related to this were addressed through Disclosure Scotland's on-going monitoring of Scheme members.
- Considered the Mental Welfare Commission Report on Homeless People Who Experience Mental Ill Health. The Committee were assured by the level of work going on in the Partnership

to address the issues referred to in the report and noted the Housing Options and Homeless Strategic Plan was approved by the IJB in October 2017.

- Reviewed the outcome of the Mental Welfare Commission visit to the Kingsway Care Centre, noted the positive comments received from the Commission.
- Noted the content and findings of the Annual Internal Audit Report for 2017/18, and in particular the Chief Internal Auditor's conclusion that reliance can be placed on the IJB's governance arrangements and systems of internal control. The Committee agreed the revised Annual Governance Statement which will be incorporated into the IJB's draft Annual Accounts. As stated above, the Chief Finance Officer was tasked with developing an overall Governance Action Plan. There was a view that the governance arrangements did not pick up on some aspects of staff governance and it was agreed this should be looked at and if required progressed through the Partnership Forum.

**Issues to highlight to the Board**

- The Committee recorded its thanks to all staff involved in the production of the Annual Performance Report.
- The Committee recorded its appreciation of the efforts and good work by staff in achieving such positive outcomes following the Mental Welfare Commission for Scotland visit to the Kingsway Care Centre.
- The Committee emphasised its expectation that the issues reflected in the one recommendation made during the Mental Welfare Commission for Scotland visit to the Kingsway Care Centre would be addressed with partners and resolved within a reasonable timeframe.
- The Committee recommended approval to the IJB of the continuation of the Internal Audit arrangements for 2018/19. The Committee also approved the 2018/19 Internal Audit Plan and noted progress against the 2017/18 and 2018/19 Internal Audit Plans.

**Doug Cross**
**August 2018**

**ITEM No …5(b)…….**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **ANNUAL PERFORMANCE REPORT 2017/18**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB44-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to submit the Health and Social Care Partnership Annual Performance Report 2017/18 for approval.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the updates provided, including the publication of the summary version of the Annual Performance Report 2017/18 (attached as Appendix 1) on 31 July 2018.

2.2 Approves the Annual Performance Report 2017/18 (attached as Appendix 2).

2.3 Approves the planned approach to publication and distribution (detailed in sections 4.2.3 and 4.3.4).

## 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 second annual report of the Dundee Health and Social Care Partnership (for 2017/18) was therefore due for publication by 31 July 2017.

### 4.2 Annual Performance Report 2017/2018 – Summary Version

4.2.1 Regulations require that an annual performance report be published by the Partnership no later than 31 July 2018. As was the case for the 2016/17 report this has proved to be a challenging deadline given the availability of data regarding performance against the national indicators, for which the Partnership is reliant on validated data from NHS National Service Scotland Information Services Division (NSS ISD) rather than local data from NHS Tayside. Due to the publication dates for this data and the pre-arranged schedule of Integration Joint Boards (IJB)

the earliest time at which the Annual Performance Report can be submitted for approval is at the IJB scheduled for 28 August 2018.

4.2.2 In order to meet the regulations the Partnership published a summary version of the Annual Performance Report on 31 July 2018, following approval of content and format by the Chairperson, Vice-Chairperson and Clerk of the IJB, Chief Officer, Chief Finance Officer and the Head of Service - Health and Community Care. The summary version was also submitted to the Performance and Audit Committee on 31 July 2018. This version fulfils the key requirements of the regulations, including information regarding progress against the National Health and Wellbeing Outcomes and key headlines at Partnership and locality level in relation to financial planning and performance, best value, and scrutiny/inspection. The Scottish Government has indicated that this approach is acceptable, as has the Clerk of the IJB.

4.2.3 The summary version is appended to this report (appendix 1). This version was published on the Partnership website on 31 July 2018, accompanied by a press release. It is proposed that, under the direction of the Integrated Strategic Planning Group, a limited number of hard copies of the summary version are printed and distributed to sites that will facilitate public access to the information (for example, sites of service delivery, public libraries and GP practices).

**4.3 Annual Performance Report 2017/18 – Full Version**

4.3.1 A full version of the annual performance report has also been developed. This expands on the headline information in the summary version, providing broader context and further detail regarding performance, improvements and outcomes as required by the regulations. The full version is appended to this report (appendix 2) for approval by the IJB.

4.3.2 In line with the approach taken for the production of the first Annual Performance Report, 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 2017/18.

4.3.3 It is proposed that the full version is published on the Partnership website following approval by the IJB. A press release has been developed by Dundee City Council Communications Service to accompany the publication of the report.

4.3.4 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.

4.3.5 During 2018/19 a review of the Partnership's Strategic and Commissioning Plan is to be undertaken in-line with legislative requirements (item 7 of this agenda refers). In parallel with this the Strategy and Performance Service will review the approach taken to production of the Partnership's Annual Performance Report to ensure that the report for 2018/19 reflects the content and style of the revised Strategic and Commissioning Plan and is further enhanced in terms of accessibility for all stakeholders, particularly members of the public.

**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 a status update and 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 6 August 2018

Lynsey Webster
Senior Officer, Strategy and Performance

Kathryn Sharp
Senior Manager, Strategy and Performance

**Appendix 1**

Dundee
# Health & Social Care Partnership

# Annual Performance Report
## SUMMARY 2017-18

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

This is the second statutory Annual Performance Report of the Dundee Integration Joint Board (IJB), established on April 1st 2016 to plan, oversee and deliver adult health and social care services through the Dundee Health and Social Care Partnership.

The Dundee Health and Social Care Partnership consists of Dundee City Council, NHS Tayside and partners from the third sector and independent providers of health and social care services. The Partnership is responsible for planning and delivering a wide range of adult social work and social care services, and primary and community health services for adults. The Partnership is also responsible for some acute hospital care services.

## Our Big Achievements

Invested **£1.1 million** of additional resources in home care services and secured **additional** national investment of over £600k for 3 years to pilot a Health and Work Support service in Dundee and an **additional** £480k to increase the number of community link workers to support reducing inequalities within the city.

In **8 out of 9** National Health and Wellbeing Indicators regarding health and care experience, Dundee performed better than the Scottish average. For the remaining indicator, Dundee performed the same as the Scottish average.

Developed Community Services that have reduced the length of time people spend in hospital when they have been admitted in an emergency. We reduced the number of hospital bed nights required by **10,342** during 17-18.

Reduced the variation in performance between our most and least deprived localities across key national performance indicators, including emergency bed days, delayed discharges and 28 day hospital readmissions.

Over the last 12 months we have **reduced by more than one half** the number of bed days occupied where the person's discharge from hospital was delayed (further improvement from 16-17).

Demonstrated that we are embedding a culture of listening to service users and their families and improving our services based on what they say and suggest to us.

## Where we have made progress...

The creation of a multi-disciplinary discharge hub and assessment at home service, introduction of 7 day working within the Acute Frailty Team and further development of the Enhanced Community Support Team has enabled us to speed up the safe discharge from hospital of people who are frail and acutely unwell.

Created a shift from the more traditional 'medical model' and service led approach, to a more integrated and holistic approach to improving quality of life and outcomes by further developing recovery, asset-based and outcome focused approaches.

The redesign of health inequalities activities in the city has contributed to improved health outcomes by promoting healthier lifestyles and increasing the availability of health checks, as well as ensuring services are accessible to the most vulnerable citizens.

The location of Welfare Rights services within GP practices has resulted in 734 patients receiving £1.5M of additional benefits.

Increased the spend on Self Directed Support Options 1 and 2 from £1.3M in 2016-17 to £1.7M in 2017-18.

25 new models of accommodation have been developed which support people to secure their own tenancy. This has been made possible due to the ongoing work between partnership representative and neighbourhood services colleagues as part of the Strategic Housing Investment Plan.

Strategic Commissioning Plans for Carers, Technology Enabled Care and Homelessness were developed collaboratively and published. These describe in detail our plans for service delivery and improvement in these areas.

A move to more integrated services - the integrated discharge hub and the integration of occupational therapy services within the community.

A number of services were recognised at local award ceremonies, including the Dundee Carers Partnership which won an Outstanding Service and Commitment Award from Dundee City Council and the Leg Ulcer Clinic which received a NHS Star Award.

## What you have told us...

**84%** of adults supported at home agreed they are supported to live as independently as possible.

**82%** of adults receiving any care or support rated it as excellent or good.

**93%** of adults said that they can look after their health very well or quite well.

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

(Care Management Team for Older People)

**84%** of people said they have had a positive experience of care provided by their GP practice.

**85%** of adults supported at home agreed that their services and support had an impact in improving or maintaining their quality of life.

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

(Dundee Health and Social Care Partnership Care Home)

**87%** of adults supported at home said they feel safe.

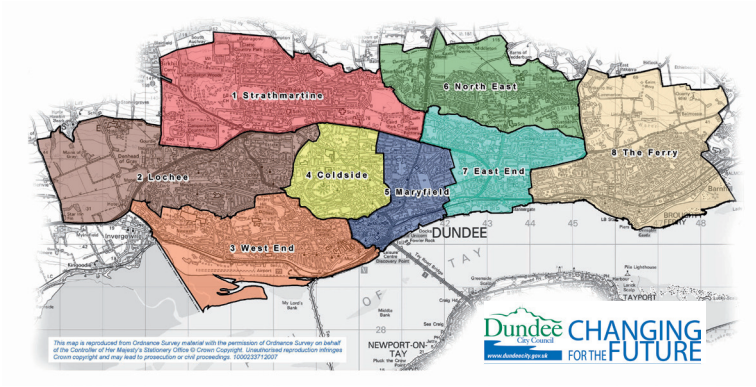
**78%** of adults supported at home said they had a say in how their help, care or support was provided.

**81%** of adults supported at home said that their health and care services seemed to be well co-ordinated.

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

(Psychological Therapies Service)

# Working in localities




We have enhanced our focus on targeting resources, planning and delivering services in service delivery areas. Examples are; the development of a locality approach to carers in Coldside and Strathmartine, the roll out of the 'MacMillan Improving the Cancer Journey' in Coldside and Lochee, the roll out of the leg ulcer clinic to a second locality, a whole system approach to supporting children and families in Lochee and an East End health and wellbeing drop in initiative.

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The established four GP Clusters continue to support quality improvement and shared learning. In addition, the development of a Primary Care Improvement Plan will support the implementation of the recent GP contract which includes development in: pharmacotherapy, care and treatment services, vaccinations and travel advice, urgent care and support for mental health, musculoskeletal conditions and wider social and wellbeing issues.

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Work has commenced to identify where resources are spent within locality areas in the city. The next step during 2018-19 is for us to expand the use of data to better understand how resources should be allocated, taking into account health inequalities, demand on services and demographics projections.

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The enhanced community support and dementia post diagnostic support teams work in localities to identify people at an early stage of their journey and provide comprehensive assessment, early intervention and anticipatory care.

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Plans have been developed to improve how we support people experiencing distress. The availability of 24/7 community mental health support, the strengthening of pathways between accident and emergency department, primary and community mental health supports, the provision of a safe place including accommodation, a 24/7 phone line offering mental health support, drop in facilities, are all included within these plans.

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The development of a more community – based service model to improve the journey to employment for local people. This includes an expansion of services in Finmill Centre and the Lochee Community Hub.

# Where we need to improve...

## Realign
Statutory services to the four service delivery areas in order to ensure services are located where they are needed most.

## Continue
The large scale mental health services redesign in order to improve timely access to services which are integrated and focussed on recovery.

## Improve
Responses to people at risk of harm, including those who do not meet the statutory definition of an adults at risk of harm, as defined in The Adult Support and Protection (Scotland) Act 2007.

## Increase
The level and range of services delivered in localities, in line with the Primary Care Improvement Plan.

## Redesign
Services for adults with substance misuse problems to improve access to recovery orientated treatment services and supports and improve outcomes for people and their families.

## Increase
The proportion of carers who feel supported to continue caring by implementing the Carers Act and further developing the range of supports for carers.

## Better
Articulate our future locality planning through the review of the Strategic and Commissioning Plan.

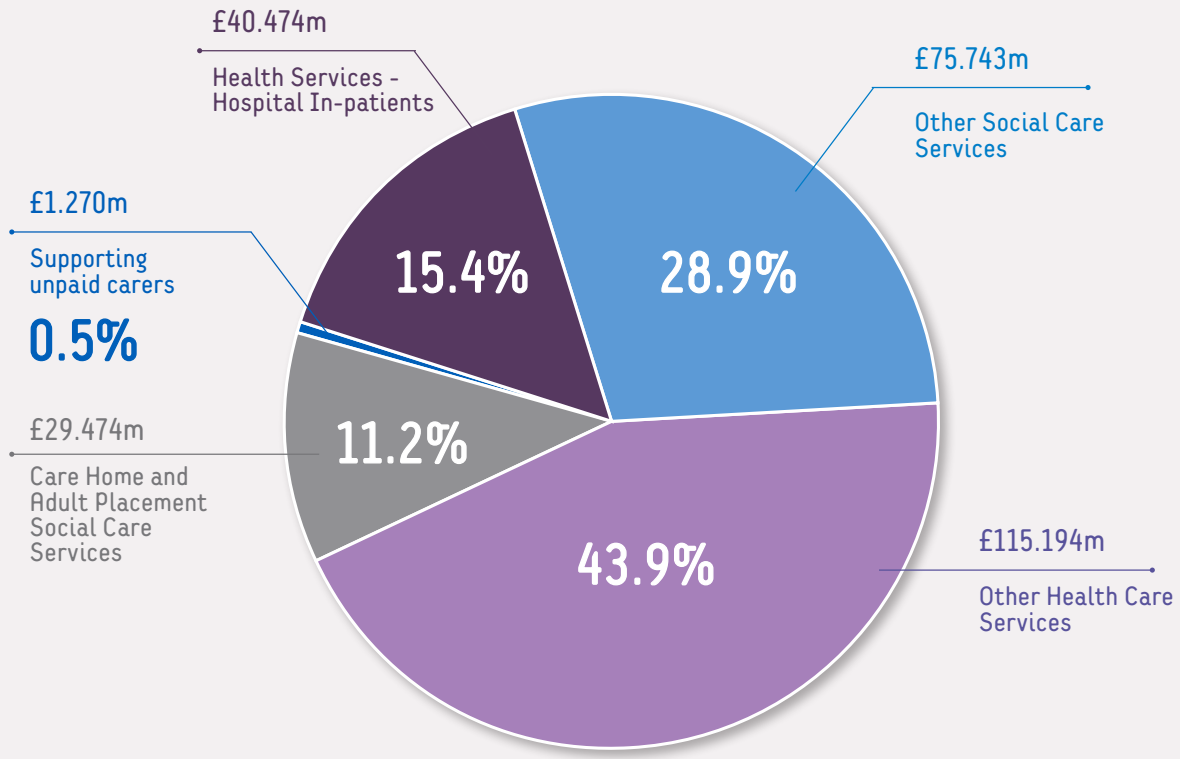
## Reduce
The length of time people are delayed in hospital due to complex reasons regarding; accommodation, specialist individualised support or legal reasons.

## Develop
Pathways for adults who experience long term conditions, including regular users of specialist acute services.

# How we have spent our resources

Dundee Integration Joint Board spent £262.2 million on integrated health and social care services during 2017-18

## The Actual Expenditure Profile for Integrated Health & Social Care Services for 2017/18 was:




This resulted in an underspend of £29,000 in 2017-18. This overall underspend has been carried forward into 2018-19 through the Integration Joint Board reserves, mainly to support the further development of new models of care.

The IJB Transformation Programme continued into 2017-18 to ensure resources are used effectively and in line with Strategic Priorities.

## Quality of our services

In 2017-18 there were **149** services for adults registered with the Care Inspectorate in Dundee. Of these services, **81** were inspected during this year. **21** of these inspections were combined inspections where both the Housing Support and Support Services were inspected together.

Of the 81 services that were inspected **77%** received no requirements for improvement.

None of the services inspected received an enforcement notice.

Of the 12 services directly provided by the Partnership that were subject to inspection by the Care Inspectorate over the last year, **75% received grades of 'very good' or 'excellent'**

If you have any questions about the information contained in this document, please email: dundeehscp@dundeecity.gov.uk or phone 01382 434000

Appendix 2


# ANNUAL PERFORMANCE REPORT

## 2017-18

Dundee
Health & Social Care
Partnership

# CONTENTS

# FOREWORD

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

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

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

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

**Ken Lynn**
**Chair, Dundee Integration Joint Board**

**Doug Cross**
**Vice Chair, Dundee Integration Joint Board**

## 1.0 Who We Are

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

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

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

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

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

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

**Figure 1**

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

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

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

## 1.1 This Report

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

This Annual Performance Report includes

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

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

## 1.2 What we do

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

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

Additionally Dundee, Angus and Perth and Kinross Health and Social Care Partnerships have mutual hosting responsibilities. Hosting arrangements were agreed for highly specialist or area wide services. On behalf of the three Tayside Health and Social Care Partnerships, Dundee hosts and leads the planning and delivery of a number of services such as sexual and reproductive

health, specialist palliative care the Centre for Brain Injury Rehabilitation, medical advisory services and nutrition and dietetic services.

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

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

## 1.3 How we measure our performance

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

During 2017-18 the Performance and Audit Committee (PAC) continued to scrutinise the performance of the Partnership in achieving its vision and strategic priorities, including overseeing financial performance and other aspects of governance activities. Throughout the year the PAC has received quarterly local performance reports, including benchmarking data from other Health and Social Care Partnerships across Scotland. Benchmarking with other Partnerships assists the interpretation of data and identifies areas for improvement. Partnerships with similar traits, including population density and deprivation have been grouped into 'family groups', which consist of eight comparator Partnerships. Dundee is placed in a family group along with Glasgow, Western Isles, North Lanarkshire, East Ayrshire, Inverclyde, West Dunbartonshire and North Ayrshire. You can see the Partnership's quarterly performance reports on our website.
The PAC has requested additional analytical reports in areas where performance has been poor, such as unscheduled hospital care, complex delayed discharges, waiting times and falls, to support an improved understanding of underlying challenges and the development of more detailed improvement plans.

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

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

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

## 1.4 How we deliver services in communities

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

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

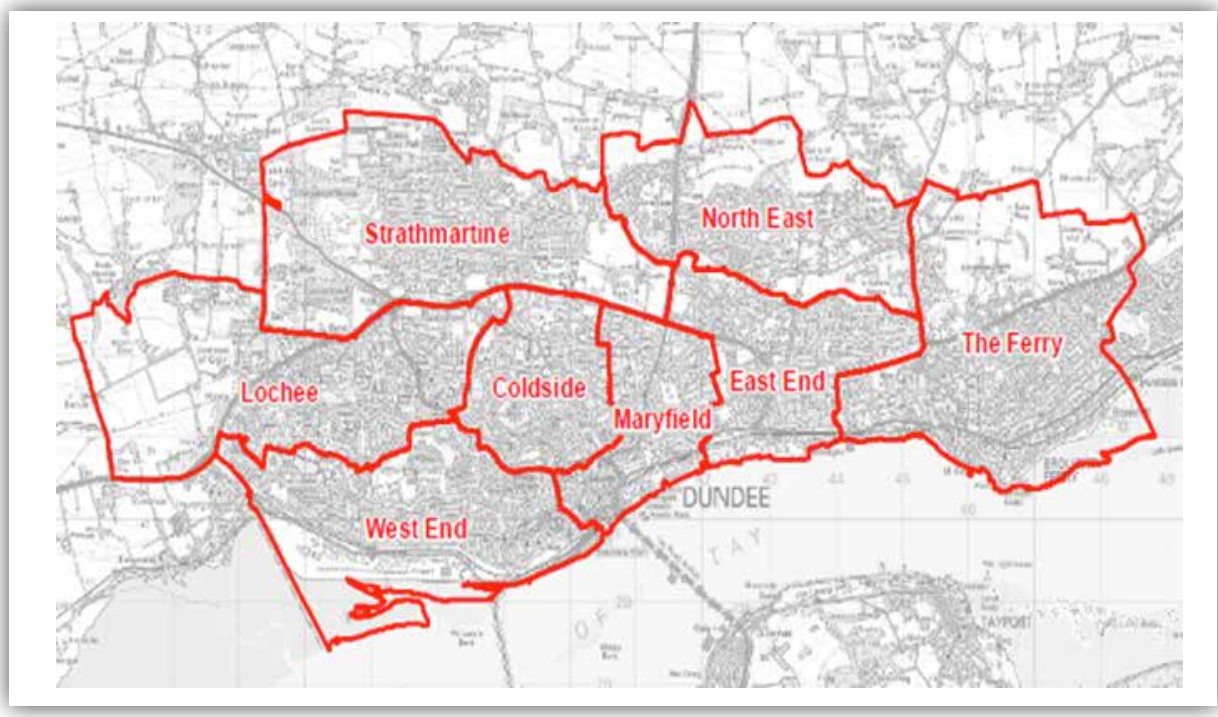



**Figure 2 - Map of 8 LCPP areas in Dundee**

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

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

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

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

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

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

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

There are a number of key areas of development

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

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

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

## 1.5 How we promote equalities and human rights

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

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

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

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

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

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

## 1.6 How we engage and communicate with our stakeholders

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

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

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

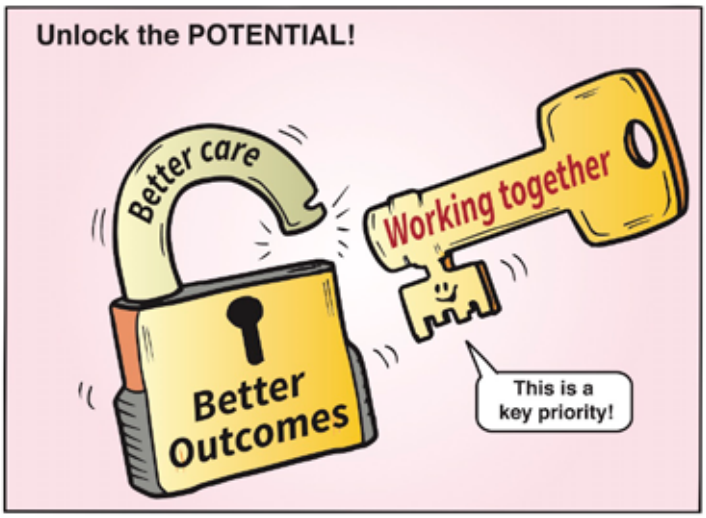
We are working to include stakeholders and communities at all stages of the Strategic commissioning cycle; planning, doing, reviewing and analysing.

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

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

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

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



## 2.1 Where our resources come from

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

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

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

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

## 2.2 How we have used our resources

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

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

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

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

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

**Figure 3 – Annual Expenditure Profile 2016-17**

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

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

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

**Figure 4 – Financial Performance Summary**

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

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

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

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

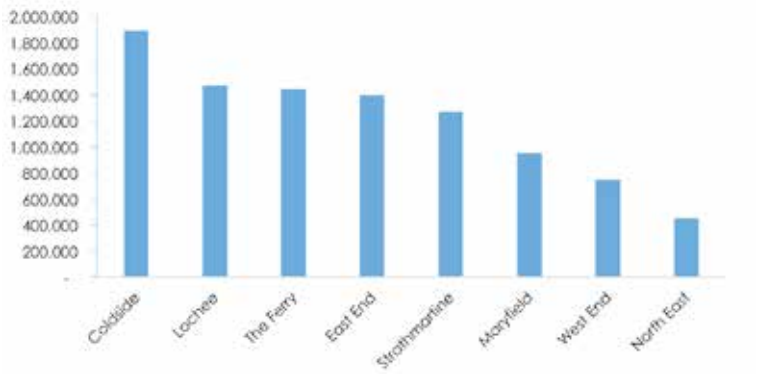
Shifts in Resources:
Over the last 12 months, the IJB has invested additional resources in social care and community based services across client groups while redesigning services to reduce spend on the hospital bed

base in line with its strategic plan. This is reflected in the figures above.

## 2.3 What we have spent in communities

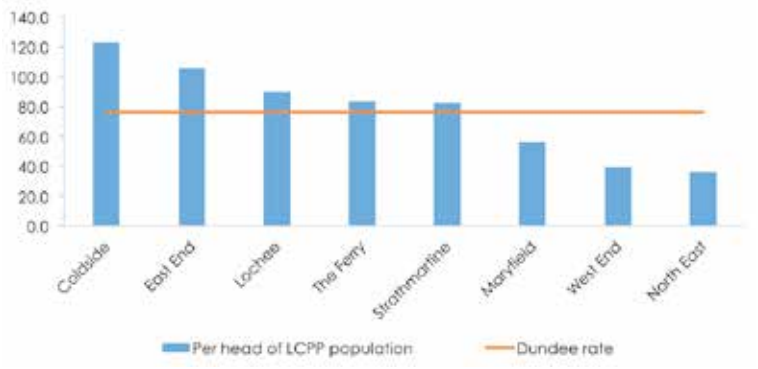
The Partnership's service delivery areas continued to develop throughout 2017-18.
Future performance reports will reflect these new structures and service delivery area expenditure profiles once these arrangements are embedded. During 2017-18, work commenced to identify where resources are spent within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

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



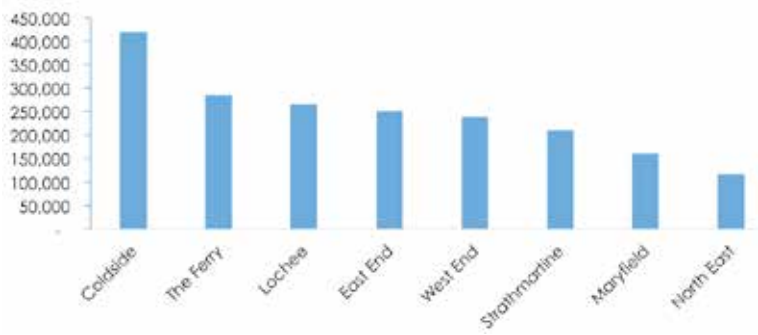

- The most financial resources are spent in Coldside, Lochee, The Ferry and East End.
- The higher spend in Coldside indicates that Coldside population has greater levels of care and support needs.
- The high spend in Lochee and East End is due to the two localities being the most deprived areas in Dundee,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

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



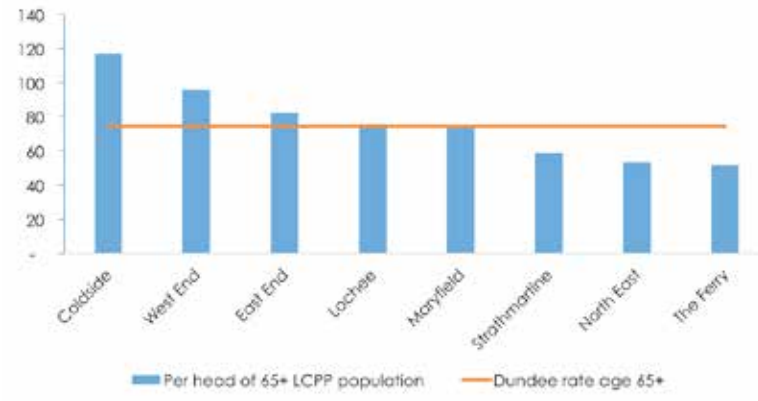

- There is variation in the spend per head of locality population, which reflects the different needs between the LCPP areas.
- Coldside is the LCPP area with the highest spend per head of the locality population, followed by East End and Lochee. The lowest spend per head is in North East.

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




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

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




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

# OUR PERFORMANCE



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

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

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

National Outcome 1 links to the following Strategic Priorities:

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

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

### How well we are performing

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

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

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


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

***"How good is your health overall?"***

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

Despite Dundee citizens giving a positive response to how good their health is and being able to look after their own health, emergency admission rates are high. This means that per head of the population a large number of people aged 18 and over are being admitted to an acute hospital in Dundee as an emergency. In 2017-18 for every 1000 people in Dundee who were aged 18 and over, there were 128 emergency admissions. This is higher than the Scottish rate and was the 9th poorest performing Partnership in Scotland, out of all 32 Partnerships. For every 1000 people in Scotland who were aged 18 and over, there were 120 emergency admissions in 2017-18.

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

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

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

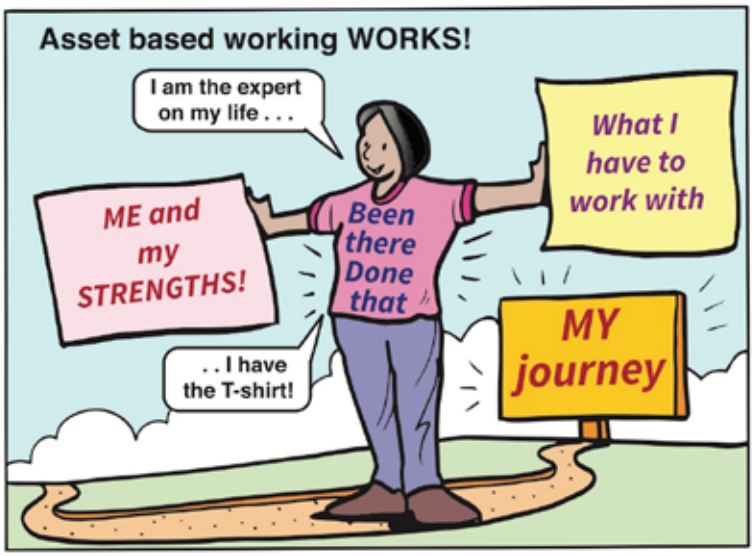
**Figure 9 – Self Directed Support – Options 1 and 2**

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

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

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

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




## What we have achieved to deliver this outcome

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

**PERSON CENTRED CARE AND SUPPORT**

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

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

**EARLY INTERVENTION AND PREVENTION**

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

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

**PERSON CENTRED CARE AND SUPPORT**

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

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

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

**EARLY INTERVENTION AND PREVENTION**

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

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

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

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

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

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

**BUILDING CAPACITY**

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

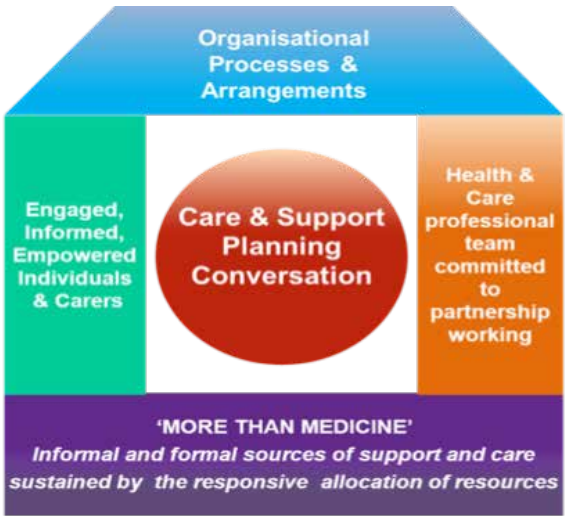
His mother referred him to the Community Companion service and after an assessment he was matched to a volunteer.

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

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

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

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




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

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

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

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

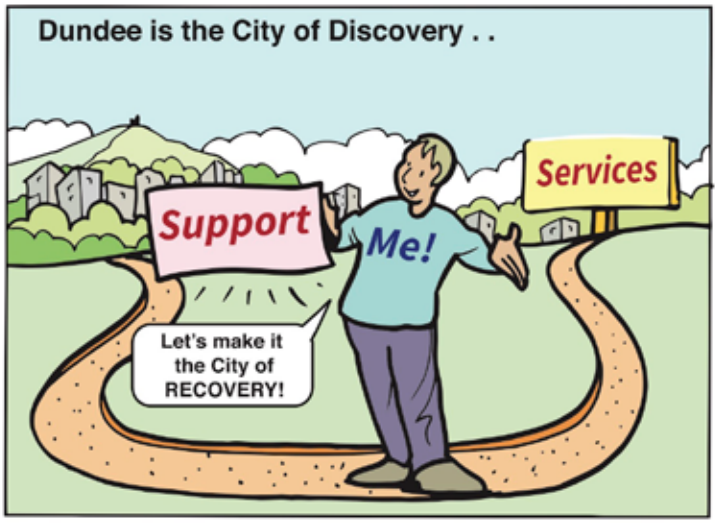
**CSP processes (roof)** – developed and refined to support CSP conversations


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

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

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

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




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

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

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

National Outcome 2 links to the following strategic priority:

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

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

### How well we are performing

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

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

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

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

Despite a high rate of readmissions to hospital, the number of bed days lost to delayed discharges for people aged 75 and over is relatively low. Lost bed days are counted from the day the patient was assessed as medically fit to return home to the date they were discharged. In 2017-18, for every 100 people aged 75 and over, 34.7 bed days were lost due to a delayed discharge. This is an improvement since 2016-17, when there were 75.5 bed days lost for every 100 people aged 75 and over. In 2017-18 Dundee was the 8th best performing Partnership in Scotland.

There is variation between the number of bed days lost to a delayed discharge across LCPPs. People aged 75 and over who live in the Coldside LCPP contribute to the largest rate of delayed discharge bed days. For every 100 people aged 75 and over living in Coldside there were 34 bed days lost in 2017-18, which is more than double the rate in The Ferry. The lowest delayed discharge bed day rate was in The Ferry where for every 100 people aged 75 and over there were 15 delayed discharge bed days used in 2017-18. A statistical analysis of this data was completed which demonstrated that although there is variation across LCPP areas, the gap between the highest and lowest LCPPs narrowed over 2017-18.

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

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

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

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

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

## What we have achieved to deliver this outcome

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

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

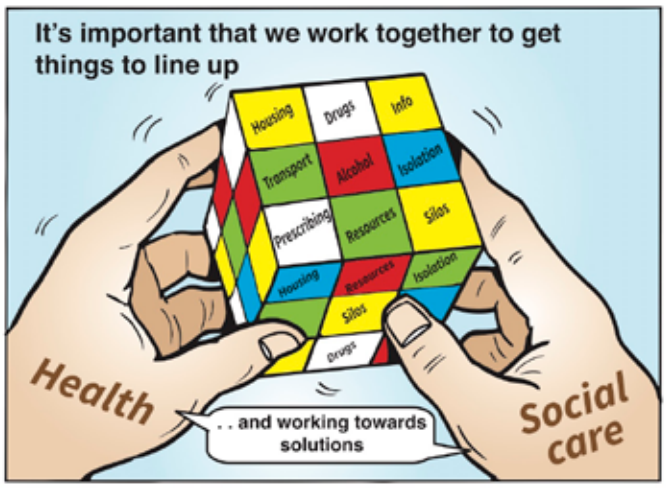
- The youth housing options service is a model of early intervention, conflict resolution and support to assist young adults and their families to repair and rebuild relationships. In 2017-18 there were 245 young adults who presented for housing options advice from a range of sources such as housing,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

**PERSON CENTRED CARE AND SUPPORT**

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

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

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



**EARLY INTERVENTION AND PREVENTION**

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

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

Outcome 3 links to all of the Partnership Strategic Priorities.

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

### How well we are performing

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

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

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

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

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

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


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

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

In 2017-18 a total of 46 complaints were received regarding social work and social care services provided by the Partnership. Just over half of the complaints (54%) were resolved at the first stage of the complaint process, frontline resolution. For 65% of the total complaints received, the Partnership was able to respond within target dates set out in our own procedures or agreed directly with the complainant. Complaints related to a number of different aspects of social work and social care service provision and these are categorised in figure 10.

**Figure 10 - Complaints regarding Social Work and Social Care services**

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

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

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

**Figure 11 - Complaints regarding Health Services**

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

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

## Compliments

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

This compliment was received about the blue badge service

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

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

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

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

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

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

This compliment was received about Ward 4, Victoria Hospital:

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

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

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

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

## What we have achieved to deliver this Outcome

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  Some examples of the feedback are:

***"I like my new flat"***

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

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

***"I am always happy here."***

***"The staff are really good".***

***"The team handles complex issues really well".***

***"There is a high quality of care".***

***"This is a well- run service".***

***"They are good communicators".***

Examples of improvements made include:

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

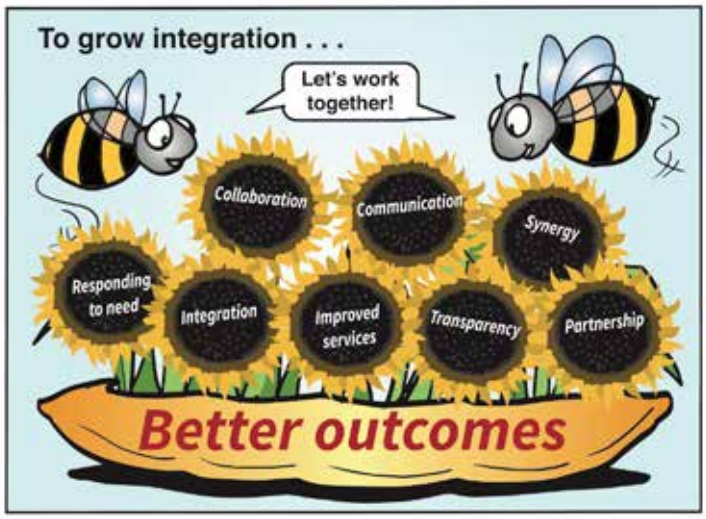
**POSITIVE EXPERIENCES AND OUTCOMES**

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

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

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

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



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

  Some examples of the feedback are below:

  ***"I like going to football matches"***

  ***"I tell staff where I like to go".***

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

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

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

  ***"excellent communication with staff".***

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

  Examples of improvements made include:

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

**EARLY INTERVENTION AND PREVENTION**

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

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

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

*(continued...)*

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

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

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

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

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

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

### Castles

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

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

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

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

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

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

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

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

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

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

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

**POSITIVE EXPERIENCES AND OUTCOMES**

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

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

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

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

*(continued...)*

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

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

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

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

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

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

Outcome 4 links to all of the Partnership Strategic Priorities.

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

### How well we are performing

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

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

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

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

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

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

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

### What we have achieved to deliver this outcome

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

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

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

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

## PERSON CENTRED CARE AND SUPPORT

### DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM

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

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

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

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

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

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

### DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM

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

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

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

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

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

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

**DUNDEE ENHANCED COMMUNITY SUPPORT ACUTE TEAM**

**Lessons learned**

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

**Summary**

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

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

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

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

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

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

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

The aims and outcomes of Health and Work Support

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

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

**PERSON CENTRED CARE AND SUPPORT**

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

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

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

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

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

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

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

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

National Outcome 5 links to the following Partnership strategic priorities:

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

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

### How well we are performing

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

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

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

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

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

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

## What we have achieved to deliver this outcome

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

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

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

*(continued...)*

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

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

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

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

Walking Group at Baxter Park

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


Launch of the Dundee Macmillan Improving the Cancer Journey Service

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

**Actions:**

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

**Outcomes:**

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

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

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

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

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

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

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

Outcome 6 links to the following Partnership strategic priority:

- Quality of Life (Strategic Priority 4)

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

### How well we have performed

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

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

***"I feel supported to continue caring".***

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

### What we have achieved to deliver this outcome

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

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

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

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

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

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

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

**CARERS**

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

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

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

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

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

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

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

**CARERS**

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

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

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

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

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

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

*(continued...)*

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

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

The short break included

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

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

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

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

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

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

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

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

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

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

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

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


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

The Carers Partnership was recognised as

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

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

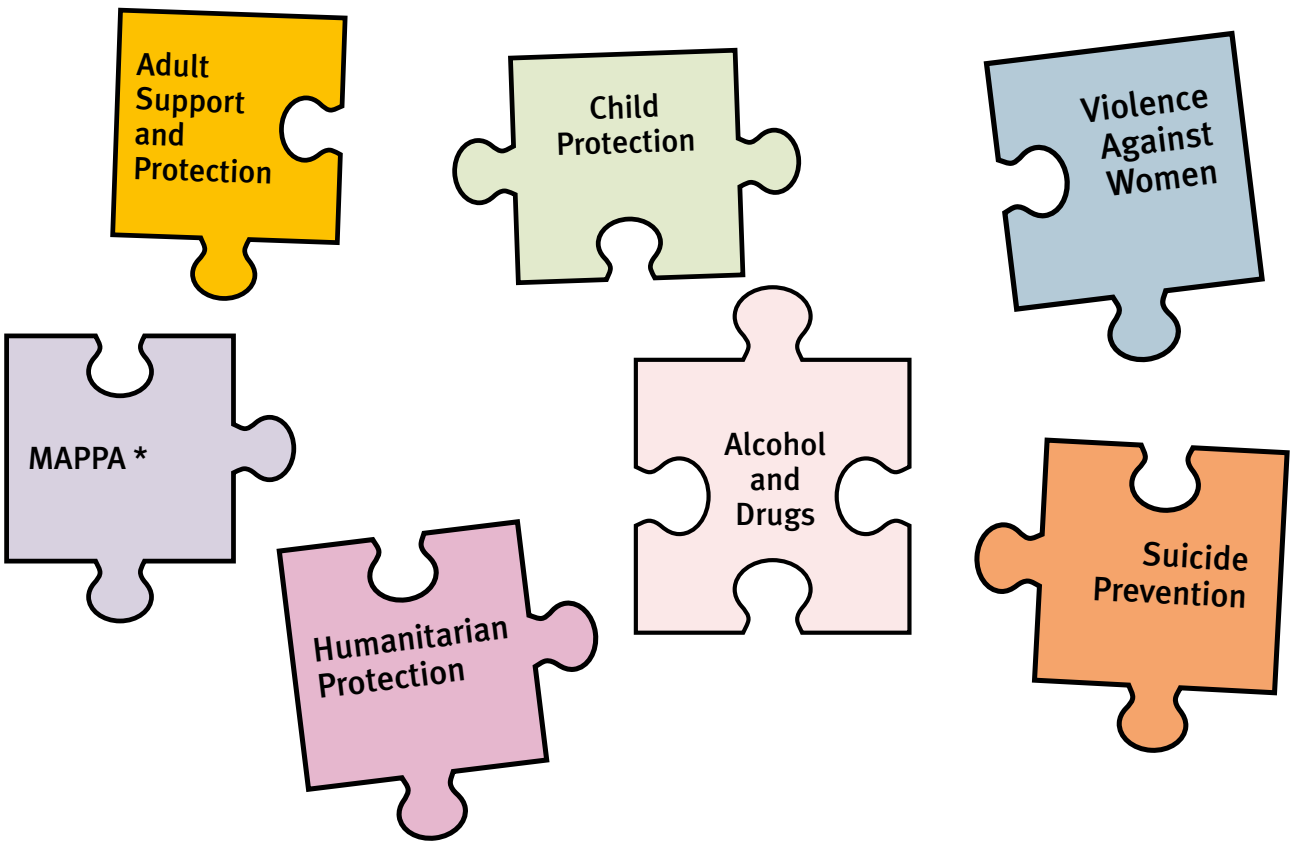
Outcome 7 links to all of the Partnership Strategic Priorities.

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

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

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

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




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

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

## How well are we performing

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

***"I felt safe".***

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

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

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

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

**Adults at Risk Referrals**

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

**Referrals from Police Scotland**

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

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

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

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

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

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

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

## What we have achieved to deliver this outcome

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

  1 Self-directed Support
  2 Hate Crime
  3 Financial Harm

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

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


Stand at the World Elder Abuse Awareness Day

Engagement Event " Transitions - Protecting People of All Ages"

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

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

**PERSON CENTRED CARE AND SUPPORT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outcome 8 links to the following Partnership strategic priorities

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

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

### How well are we performing

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

### What we have achieved to deliver this outcome

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

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

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

**MANAGING OUR RESOURCES EFFECTIVELY**

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

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

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

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

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

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

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

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

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

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

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

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

Outcome 9 links to the following Partnership strategic priorities:

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

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

### How well we have performed

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

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

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

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

### What we have achieved to deliver this outcome

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

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

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

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

**MODELS OF SUPPORT, PATHWAYS OF CARE**

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

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

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

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

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

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

**MODELS OF SUPPORT / PATHWAYS OF CARE**

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

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

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

These can be viewed on our website.

# THE QUALITY OF OUR SERVICES



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

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

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

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

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

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

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

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

# 5.0 LOOKING TO THE FUTURE

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

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

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

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

# APPENDIX 1

## National Health and Wellbeing Outcomes

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

# APPENDIX 2

## Performance against National Health and Wellbeing Indicators

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

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

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

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

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

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

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

# APPENDIX 3

## Statutory Inspections during 2017-18

**CARE INSPECTORATE GRADINGS TO SERVICES DELIVERED DIRECTLY BY THE PARTNERSHIP**

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

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

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

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

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

**Requirements**

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

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

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

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

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

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

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

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

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

**Requirements**

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

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

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

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

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

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

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

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

**Requirements**

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

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

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

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

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

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

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

This must include (but is not limited to):

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

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

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

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

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

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

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

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

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

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

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

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

**Requirements**

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

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

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

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

**Requirements**

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

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

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

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

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

(I) plan and confirm infection control training dates

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

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

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

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

**Requirements**

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

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

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

**Requirements**

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

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

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

**Requirement**

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

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

**Requirement**

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

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

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

↑ Signifies that the grade has improved since the previous inspection

↓ Signifies that the grade has fallen since the previous inspection

No arrow signifies that the grade has stayed the same

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

**Requirements**

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

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

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

**Requirements**

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

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

**Requirements**

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

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

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

**Requirements**

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

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

| | |
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| 6 | Excellent |
| 5 | Very Good |
| 4 | Good |
| 3 | Adequate |
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| Inspection Date | Name of Org/Service | Service Type | Quality of Care and Support | Quality of Environment | Quality of Staff | Quality of Leadership and Management |
|---|---|---|---|---|---|---|
| 05/06/17 | Oran Home Care Ltd | Housing support service - care at home | 4 | N/A | (4) | 4 |

**Requirements**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| 6 | Excellent |
| 5 | Very Good |
| 4 | Good |
| 3 | Adequate |
| 2 | Weak |
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| Inspection Date | Name of Org/Service | Service Type | Quality of Care and Support | Quality of Environment | Quality of Staff | Quality of Leadership and Management |
|---|---|---|---|---|---|---|
| 30/01/2018 | Carr Gomm - Support Services 2 | Care at Home/ Housing Support | 5 | N/A | 5 ↑ | (4) |

**Requirement**

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

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

**Requirements**

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

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

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

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

**Requirements**

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

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

**Requirement**

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

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

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

**Requirements**

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

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

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

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

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

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

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

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

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

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

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

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

| | |
|---|---|
| 6 | Excellent |
| 5 | Very Good |
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**MENTAL WELFARE COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2017-2018**

No inspections

**HEALTHCARE IMPROVEMENT SCOTLAND REQUIREMENTS AND RECOMMENDATIONS 2017-18**

No inspections

**AUDIT SCOTLAND AND ACCOUNTS COMMISSION REQUIREMENTS AND RECOMMENDATIONS 2017-18**

No inspections

# APPENDIX 4

## Glossary of Terms

**Allied Health Professional (AHP)** — A person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include physiotherapists, dieticians, Speech and Language Therapists, psychologists, Occupational Therapists, podiatrists, audiologists, etc.

**Carer** — Someone who provides, or intends to provide, unpaid care for another individual (the "cared-for person"). This could be caring for a relative, partner or friend (of any age) who is ill, frail, disabled or has mental health or substance misuse issues.

**Clinical Care and Professional Governance** — A system to inform and progress the improvement of NHS services ensuring they are person centred, safe and effective and based on best available evidence and practice.

**Community Regeneration Area (CRA)** — A locality which has been identified for regeneration as a result of multiple deprivation.

**Due Diligence** — A process of enabling the organisation to identify the resources delegated to it and to quantify the financial, legal and operational risks associated with them to provide the necessary assurance that these can be managed effectively.

**Emergency admissions** — An unplanned admission to an acute hospital which occurs when, for clinical reasons, a patient is admitted at the earliest possible time after seeing a doctor.

**Enablement** — Services for people with poor physical or mental health to help them re-learn skills, or develop new skills, support them to be independent and improve their quality of life. In Dundee enablement is a short term service which is provided for a period of up to a maximum of six weeks.

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

**Equally Well** — National Action Plan for reducing health inequalities in Scotland published in June 2008.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Power of Attorney** ..... A power of attorney is a document you can use to appoint someone to make decisions on your behalf. The appointment can be effective immediately or can become effective only if you are unable to make decisions on your own.

**Premature Mortality** ..... Premature mortality is a measure of unfulfilled life expectancy.

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

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

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

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

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

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

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

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

Dundee
**Health & Social Care**
Partnership

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**dundeehscp@dundeecity.gov.uk**

**ITEM No …6(b)…….**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION**

**REPORT BY:** **CHIEF SOCIAL WORK OFFICER**

**REPORT NO:** **DIJB29-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to inform the Integration Joint Board (IJB) of the outcome of the Joint Inspection of Adult Support and Protection of the Dundee Community Planning Partnership and of the participation of the Health and Social Care Partnership in the Transforming Public Protection Programme, including commitment of IJB resources.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the outcome of the inspection (detailed in section 4.3).

2.2 Notes the participation of the Health and Social Care Partnership in the Transforming Public Protection Programme (section 4.4 and Appendix 1).

2.3 Instructs the Head of Finance and Strategic Planning to submit a report detailing progress in this area to the Performance and Audit Committee no later than 31st December 2018.

## 3.0 FINANCIAL IMPLICATIONS

The cost of implementing the Transforming Public Protection Programme will be funded through additional resources identified by Dundee City Council.

## 4.0 MAIN TEXT

### 4.1 Adult Support and Protection Overview

4.1.1 The Adult Support and Protection (Scotland) Act 2007 seeks to protect and benefit adults at risk of being harmed. The Act requires local authorities and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights. The Act defines adults at risk as people aged 16 years or over who:

- Are unable to safeguard their well-being, rights, interests, or their property;
- Are at risk of harm (eg physical harm, psychological harm, neglect, financial harm or sexual harm); and,
- Because of a disability, mental disorder, illness of physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

4.1.2 Community Planning partners have a range of responsibilities for the protection of vulnerable groups which are discharged through operational and strategic arrangements for adult support and protection, alcohol and drugs, child protection, humanitarian protection, the management of high risk of harm individuals, suicide prevention and violence against women. This area of work is led by the Chief Officers Group (COG) supported by the multi-agency Committees/Partnerships which correspond to the areas of public protection. The COG is

chaired by the Chief Executive of the Council and comprises senior representation from health, police, fire and rescue, chairs of the various committees and key officers, including the Chief Officer of the Health and Social Care Partnership and the Chief Social Work Officer. This group individually and collectively is responsible for leadership, scrutiny and direction of public protection.

4.1.3 Over the last two years (2016-18) there have been 1,855 adult protection concerns referred to the Health and Social Care Partnership for screening alongside partner agencies. In the same period 7% of these referrals were assessed as meeting the 'three-point test' and proceeded under the Adult Support and Protection legislation.

**4.2 Adult Support and Protection Thematic Inspection Overview**

4.2.1 Between July and December 2017 the Care Inspectorate, working jointly with Her Majesty's Inspectorate of Constabulary Scotland and Healthcare Improvement Scotland, undertook a joint thematic inspection of adult support and protection arrangements in six local community planning partnerships across Scotland, including the Dundee Community Planning Partnership. This activity was focused on three quality indicators:

- Outcomes for adults at risk of harm and their unpaid carers.
- Key adult support and protection processes.
- Leadership for adult support and protection.

4.2.2 Inspection activity included two distinct phases; a range of pre-inspection self-assessment returns (including analysis of adult protection referrals) and an on-site activity (including case file reading and a series of interviews/focus groups with key stakeholders).

4.2.3 A report of the findings of the thematic inspection was published together with evaluations (using a six-point scale evaluation for each of the three quality indicators) on 3 July 2018. An assessment of each Community Planning Partnership inspected was included, alongside an overview chapter highlighting key themes from across Scotland. The inspection report can be read in full at:
http://www.careinspectorate.com/images/documents/4453/Review%20of%20adult%20support%20and%20protection%20report%20April%202018%20Interactive.pdf

**4.3 Assessment of Adult Support and Protection Arrangements in Dundee**

4.3.1 The Dundee Partnership was assessed as:

| | |
|---|---|
| Outcomes for adults at risk of harm and their unpaid carers | ADEQUATE<br>(strengths just outweigh weaknesses) |
| Key adult support and protection processes | WEAK<br>(important weaknesses) |
| Leadership for adult support and protection | ADEQUATE<br>(strengths just outweigh weaknesses) |

4.3.2 The inspection report recognises that multi-agency partners work well together to deliver positive outcomes for adults at risk of harm and their carers. It acknowledges that as a Community Planning Partnership we respond timeously to adult protection referrals and adults at risk of harm; work hard to support all vulnerable people; carry out effective work on financial harm; and, support involvement and inclusion of adults at risk of harm and unpaid carers. The involvement of the full range of Community Planning partners, including the third sector, fire and rescue service and banking sector in adult protection activity was recognised as an area of good practice by the inspection team. The inspection team were also supportive of programmes of improvement led by the Health and Social Care Partnership in areas such as the introduction of the 'lead professional' model, development of the Early Screening Group and Inter Agency Referral Discussions/case conference practice.

4.3.3 Whilst the report confirms that adults at risk in Dundee are safer, have enhanced wellbeing and an improved quality of life as a result of adult support and protection processes the inspection team found a number of areas of the Dundee Partnership's key processes that require significant improvement. On this basis the report makes three specific recommendations for improvement:

- The partnership should make sure that full implementation of its Information and Communication Technology (ICT) system is achieved in order to meet the user needs of council officers and other users to record all adult protection information clearly and effectively.
- The partnership should make sure that its key processes for adult support and protection follow a clearly defined path, which council officers and other staff fully understand and implement.
- The partnership should make sure that it prepares valid chronologies, risk assessments and risk management plans for adults at risk of harm who require them.

4.3.4 The report highlights that, following recent self-evaluation activity, partnership leaders had already identified that further improvements were required in these areas. Many of the areas for improvement for the Dundee Partnership are also in the overview section of the inspection report as shared challenges across Scotland.

**4.4 Transforming Public Protection Programme**

4.4.1 The areas for improvement highlighted within the inspection report have some similarities to those from the Joint Inspection of Services for Children and Young People (published in 2016) and findings within Significant Case Reviews completed during the last two years. This suggest that a focused programme of improvement and transformation is required across operational and strategic public protection processes.

4.4.2 The Transforming Public Protection Programme (attached as Appendix 1) will be 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. It will include aspects of practice development and improvement, service re-design and organisational development. The programme will be supported by the Care Inspectorate who will provide advice and the involvement of their staff in activities. In the initial 3 month planning period, their focus will be on supporting co-production with the workforce to develop a detailed project plan informed by the experience and expertise of the workforce and other relevant stakeholders, including groups representing the views and interests of people at risk and their carers.

4.4.3 Officers from the Health and Social Care Partnership will also be working with the Adult Support and Protection Committee to identify any specific improvement actions that can be progressed in the short-term in relation to multi-agency adult protection processes.

4.4.4 A report on the Transformation Programme was considered by the Policy and Resources Committee of Dundee City Council on 20th August 2018 where agreement was reached to establish two additional posts to generate additional capacity to deliver the programme. The cost will be £58,000 in 2018/19 and £100,000 in a full financial year. The posts will be at grade 11 and grade 12 with costs met from the Council's General Contingency. The expectation is that any further resource implications will be shared by relevant community planning partners.

**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 is status update and does not require any policy or financial decisions at this time.

**7.0 CONSULTATIONS**

The Chief Finance Officer, the Clerk, Professional Advisors, and Head of Service - Health and Community Care 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

**9.0 BACKGROUND PAPERS**

None.

Jane Martin
Chief Social Work Officer 6 August 2018

Kathryn Sharp
Senior Manager

**Transforming Public Protection Programme Outline Proposal - July 2018**

**Context**
The recent Inspection of Adult Support and Protection identified a number of strengths with three key recommendations for improvement:

- The partnership should make sure that its key processes for adult support and protection follow a clearly defined path, which council officers and other staff fully understand; and,
- The partnership should make sure that it prepares risk assessments and risk management plans for adults at risk of harm who require them;
- The partnership should make sure that full implementation of its ICT system is achieved in order to meet the user needs of council officers and other users to record all adult protection information clearly and effectively.

There are similarities to findings from the Joint Inspection of Services for Children and Young People (2016) and findings in other Local Authority areas. Whilst ICT implementation was not a feature in the Children's Services Inspection it is accepted that elements of Children and Families are also experiencing challenges in achieving full implementation.

Social Work Services typically work with more vulnerable people and play a lead role in relation to the development and co-ordination of protection processes. Good practice in the assessment and management of risk is dependent upon an effective multi-agency approach and whilst there should be a clear focus on practice relating to service users with higher levels of risk and needs, practice relating to those presenting with concerns which do not require statutory interventions also needs to be consistent and defensible. A focused programme of improvement and transformation is required, initially in relation to social work practice to address key elements of practice and decision-making, specifically in relation to:

- Use of chronologies;
- Joint and defensible risk assessment;
- Targeted risk management/protection plans;
- Timely and well attended decision making meetings; and
- Service user and carer involvement, including through independent advocacy services.

Scrutiny activity highlights that change has not been progressed at sufficient scale or pace and, from a leadership perspective, Chief Officers (Public Protection) Strategic Group (COG) and Protecting People Committees/Partnerships and their Chairs need to operate in a way that supports continuous improvement providing an appropriate level of scrutiny and accountability.

**Transformation Programme**
A targeted two year programme is required to ensure sustained improvement on a range of distinct but interlinked priorities focusing on three key areas of transformation:

1 **Driving culture change within services towards continuous improvement and quality assurance, including embedding a culture of expectation of excellence including:**
   - Development programme for operational managers to support a culture of continuous improvement and quality assurance.
   - 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;
     - Collaborative working at points of transition;
     - Service user and carer involvement; and,
     - Embedding a culture of quality assurance and improvement.
   - Development of a programme of single and multi-agency case file auditing/case-based self-evaluation.

- Ensuring that ICT implementation addresses the needs of protection processes and performance reporting and enhancing the use of digital technologies.

**2 Significantly enhancing leadership support and scrutiny for public protection issues including:**

- Ensuring Protecting People Committees / Partnerships and COG focus on scrutiny and quality assurance, including:
  - Development of Committee / Partnership risk registers;
  - Enhanced provision of data and analysis,
  - Reviewing reporting mechanisms to Committees/ Boards, as well as participation of members in strategic protecting people activities.
- A programme of communication

**3 Re-design of protection processes to ensure streamlined and co-ordinated processes that respond flexibly to the inter-linked needs of vulnerable people and families including:**

- Exploring options to more closely align approaches across children and adults in terms of screening and addressing immediate responses to concerns.
- Review co-ordination of key protection processes to more clearly align and integrate functions such as chairing of case conferences.
- Full consideration of the implications of General Data Protection Regulations (GDPR) for protection processes and remedial action where required.

**Governance Arrangements**

The programme will be overseen by the COG. The CSWO, as professional lead for social work, will also have a key role in leadership and oversight of the transformation programme. Detailed governance arrangements for the programme will be developed during the first three months and a performance monitoring framework which evidences the impact of transformation activity against targets for improvement will be developed to support the approach.

The Care Inspectorate have committed to act as a "critical friend" by providing both advice and the direct involvement of their staff. They will also help to identify appropriate national improvement bodies to support specific actions and Community Planning Partnerships where examples of best practice are available.

**Phased Implementation**

The programme will last for 2 years and the advice from the Care Inspectorate is that there should be a phased, targeted approach with clearly articulated priorities.

In the first 3 months the focus will be on driving cultural change with Care Inspectorate input focusing on co-production with staff to develop a more detailed project plan. Staff will work alongside Care Inspectorate Improvement Advisors to establish statements of ambition for each work stream. At the end of the planning phase a detailed plan will be agreed by the COG; this will provide the work plan for the designated programme lead and form the basis of the improvement plan submission for the adult support and protection inspection which is required by October 2018.

Work in relation to enhancing leadership and scrutiny will be phased in over the following three months, however preparatory work has started with COG and Committee/Partnership members. Redesign of protection processes will be planned and implemented from 2019/20, with some preparatory work being undertaken prior to this.

**Initial Resource Investment**

Investment will be required over 18/24 month period as follows:

- A dedicated Lead Officer Post will be established, on a temporary basis, in the Protecting People Team to drive the programme forward; and,
- An additional senior officer will be established, on a permanent basis, in the Protecting People Team to enhance data and analytical capacity to support service redesign, quality assurance and the work of Committees/Partnerships.

A range of other resource issues may arise as planning and implementation progresses which will be fully scoped. Some elements of this work may, in the longer term, result in efficiencies for re-investment to address current resource pressures. The programme will also require commitment of resources from partner agencies and flexibility in application of these resources to support the aims, objectives and outcomes of the programme. This will include:

- protected learning and organisational development capacity;
- IT support, beyond Mosaic implementation within Dundee City Council / Dundee HSCP, to support increased investment in digital technologies; and,
- Collaborative working with support services across to support practice improvement.

**ITEM No …7……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **REVIEW OF STRATEGIC AND COMMISSIONING PLAN**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB40-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to inform the Integration Joint Board of plans to undertake a full review of the Strategic and Commissioning Plan, as required under section 37 of the Public Bodies (Joint Working) (Scotland) Act 2014, prior to 31st March 2019.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report and the requirement to review the Strategic and Commissioning Plan at least every three years (section 4.1).

2.2 Notes the planned approach to undertaking the review under the leadership of the Integrated Strategic Planning Group (section 4.2).

2.3 Instructs the Chief Officer, following appropriate engagement and collaboration with stakeholders, to submit the revised Strategic and Commissioning Plan for approval no later than 31st March 2019.

## 3.0 FINANCIAL IMPLICATIONS

None.

## 4.0 MAIN TEXT

### 4.1 Requirement to Review Strategic and Commissioning Plans

4.1.1 The Partnership's first Strategic and Commissioning Plan was agreed and published in April 2016 following a process of co-production led by the Integrated Strategic Planning Group (ISPG). Although the plan covers the period 2016-2021, section 37 of the Public Bodies (Joint Working) (Scotland) Act 2014 sets out a requirement that plans be revised as necessary and at least every three years. As 2018/19 is the third year of the current Strategic and Commissioning Plan there is therefore a need for the ISPG to lead a full review of the current plan by 31st March 2019.

4.1.2 Section 37 of the 2014 Act sets out that in carrying out a review of their strategic and commissioning plan Integration Authorities must consider:

- The national health and wellbeing outcomes;
- The indicators associated with the national outcomes;
- The integration delivery principles; and,
- The views of the ISPG.

It is also expected that performance information and information relating to risks or significant changes in trends that emerge from ongoing strategic needs assessment will be considered as part of any review.

4.1.3 In 2016 the Scottish Government published an overview of all strategic commissioning plans produced by Integration Authorities across Scotland. This report included a number of key messages for consideration when producing strategic commissioning plans. Informal feedback to Dundee from the Scottish Government suggests that the Dundee plan was seen as amongst the strongest of those published in 2016, however some of the key messages from the overview document could helpfully inform the review of the plan to further strengthen it for the future. Some of the most relevant key messages include the need to:

- set-out ambition for change at an appropriate scale and pace;
- clearly articulate how the Health and Social Care Partnership is working within wider Community Planning Partnership structures;
- ensure plans and accompanying documents are accessible once complete and published;
- integrate information from the third and independent sector in strategic needs assessment work;
- include more detailed information regarding the financial impact of re-modelling services, the methods by which decisions will be made about allocation of resources and the large hospital set-aside;
- include a much greater level of detail regarding locality working arrangements and workforce planning issues; and,
- provide a clearer articulation of interfaces with primary care and the acute sector.

4.1.4 In addition to the main Strategic and Commissioning Plan, the Partnership also published a number of companion documents: a housing contribution statement, strategic needs assessment, participation and engagement strategy, workforce and organisational development strategy, equality outcomes and mainstreaming equalities framework, equality impact assessment and market facilitation strategy. The 2014 Act and Scottish Government guidance does not comment specifically on the need to also review supporting documents at least every three years. The requirements of the Equality Act 2010 mean that the equality outcomes and mainstreaming equality framework must be reviewed during 2018/19 and a revised equality impact assessment undertaken. The Partnership's strategic needs assessment has recently been revised and expanded to include locality profiles. In the first instance resources will be prioritised to complete reviews of the housing contribution statement, workforce and organisational development strategy and equality outcomes and mainstreaming equalities framework by 31st March 2019, with review of the participation and engagement strategy and market facilitation strategy being undertaken subsequently.

**4.2 Project Plan for Review Process**

4.2.1 Taking into account feedback that has been received regarding the Strategic and Commissioning Plan, both formal and informal, alongside the key messages from Scottish Government (outlined at 4.1.3), information regarding the approach taken by other Integration Authorities gained through national networks and the level of resource available during 2018/19 to support a review process, it is proposed that the review of the plan should:

- have a primary focus on enabling and driving forward the shift to locality working;
- contain clear content in relation to specific commissioning intentions and the underpinning financial framework;
- be significantly informed by the new Health and Social Care Standards, Public Health Priorities for Scotland and other relevant national outcomes, priorities and standards;
- place an emphasis on producing a plan that is primarily written for and accessible to services users, carers and community members as the primary stakeholders of the Health and Social Care Partnership; and,
- more clearly articulate interfaces with primary care, community planning and hosted services and the role and priorities of the partnership within these settings.

4.2.2 The Partnership's Strategy and Performance Team will take a lead role in supporting the review of the plan, working to the agreements and guidance of the ISPG. Whilst the team can provide

a central point of support to the process the active participation of all stakeholders will be required, with appropriate supports put in place to enable where this is needed. Resources will be prioritised to create capacity to co-ordinate the review process and to provide for a lead author for the plan and companion documents. A short-life working group will be established formed of stakeholders leading identified workstreams within the project plan (see section 4.2.4).

4.2.3 The lead author and wider Strategy and Performance Team will work in collaboration with stakeholders throughout the review process. There will be a particular emphasis on collaboration through the Third Sector Interface with community based organisations and third sector services at locality, and where possible neighbourhood level, including people with lived experiences of health and social care issues and their carers. Strong links will also be developed to ensure that the review compliments and supports the ongoing development of the children's services commissioning strategy. It is intended that the review will be informed by a mature approach to co-production which focuses on enabling informed conversations and decision making regarding future options for planning, commissioning and delivering health and social care services. Best use will be made of existing sources of information such as the range of rich data already available through engagement and co-production approaches in areas such as mental health, substance misuse and social prescribing. This will enable available resources to be focused on areas where there are gaps in this regard, with particular priority being given to engagement and co-production with individuals and communities in areas of deprivation and / or experiencing health inequalities.

4.2.4 Appendix 1 sets out a high level assessment of the activity that will be required to review each of the substantive sections of the current plan. This overview has been developed into a detailed project plan by the Strategy and Performance Team. Given that the review must be completed by 31 March 2019 a final draft will be required for consultation and formatting in early January 2019 for submission and approval at both the ISPG and IJB prior to the deadline date.

## 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 a status update and does not require any policy or financial decisions at this time.

## 7.0 CONSULTATIONS

The Chief Finance Officer, the Clerk and members of the Integrated Strategic Planning Group 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 25 July 2018

Dave Berry
Chief Finance Officer

Kathryn Sharp
Senior Manager

**Appendix 1**

| Section | Required Activity | Timescale for Draft |
|---|---|---|
| Introduction and background information | • Review and update by Strategy and Performance Team | End of October 2018 |
| Who we are | • Review and update by Strategy and Performance Team, in collaboration with relevant colleagues<br>• Expansion of content regarding Community Planning in-line with developments since 2016 | End of October 2018 |
| Conversations with you | • Review and update by Strategy and Performance Team, in collaboration with relevant colleagues, to reflect activity undertaken as part of the review | Mid December 2018 |
| National and local outcomes and indicators | • Review and update by Strategy and Performance Team | End of October 2018 |
| The case for change | • Partnership strategic needs assessment has recently been fully updated<br>• First version of locality strategic needs assessment are available<br>• Additional information from third and independent sector to be scoped<br>• Section will require substantive review by Strategy and Performance Team and proposed to reduce overall length of this section (with full strategic needs assessments at partnership and locality level being published as separate documents) | End of November 2018 |
| Strategic priorities and shifts | • To remain as is | Not applicable |
| Working in localities | • Program of engagement and co-production will be required to inform review to support shift in focus from care groups to localities / neighbourhoods. This will be informed by:<br>○ Collation of stakeholder views from engagement and co-production activity undertaken to date for example in areas such as substance misuse, mental health, carers<br>○ Further targeted engagement and co-production activity | End of September 2018<br><br>End of November 2018 |
| Action plans for each strategic priority | • Proposed to remove this section as detailed content is held within | Not applicable |

| Section | Required Activity | Timescale for Draft |
|---|---|---|
| | individual SPG Strategic Commissioning Statements and intention to shift emphasis to commissioning intentions and financial framework rather than planned actions | |
| Implementation of the plan at a care group level | • Proposed to remove this section as shift in emphasis from care groups to localities / neighbourhoods | Not applicable |
| Financial framework | • Substantive review required to significantly expand and enhance content<br>• Required content would be generated through programme of engagement and co-production – including collation of activity already undertaken and further activity where required | Mid December 2018 |
| Commissioning | • Substantive review required to significantly expand and enhance content<br>• Required content would be generated through programme of engagement and co-production – including collation of activity already undertaken and further activity where required | Mid December 2018 |
| Workforce and organisational development | • Review and update by Learning and Organisational Development | End of October 2018 |
| Measuring improvement and ensuring success | • Review and update by Strategy and Performance Team | End of October 2018 |

**ITEM No …8……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **SUBSTANCE MISUSE STRATEGIC AND COMMISSIONING PLAN FOR DUNDEE 2018 - 2021**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB34-2018**

## 1.0 PURPOSE OF REPORT

To seek agreement from the Dundee Integration Joint Board to publish the Substance Misuse Strategic Commissioning Plan for Dundee in partnership with the Dundee Alcohol and Drug Partnership.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the content of the Substance Misuse Strategic and Commissioning Plan for Dundee as attached at Appendix 1 and the engagement and collaboration approaches used to produce this as detailed in sections 4.1.3 and 4.1.4.

2.2 Notes the good practice within current service areas.

2.3 Approves the publication of the Substance Misuse Strategic and Commissioning Plan for Dundee and notes that the Dundee Alcohol and Drug partnership has approved the Substance Misuse Strategic Commissioning Plan for Dundee.

2.3 Instructs the Chief Officer to provide a mid-term report on the implementation of the plan.

## 3.0 FINANCIAL IMPLICATIONS

The Substance Misuse Strategic and Commissioning Plan for Dundee will be implemented within the financial framework which includes financial resources available to both the Dundee Alcohol and Drug Partnership and the Dundee Health and Social Care Partnership.

## 4.0 MAIN TEXT

### 4.1 Background

4.1.1 Substance misuse has been identified as one of the key priorities to be addressed within the Dundee City Plan, due to its negative impact on the health and wellbeing of those who use substances, as well as that of their families and carers, and the wider communities in which they live.

4.1.2 In April 2017 a report was presented to the IJB outlining proposals for future governance arrangements for the planning and commissioning of substance misuse services to support the emerging relationship between the Alcohol & Drugs Partnership (ADP) and the IJB. This report

also recommended that a Strategic & Commissioning Plan (the Plan) be developed and signed off by both the ADP and the IJB.

### 4.2 Development of the Strategic Commissioning Plan

4.2.1 The Substance Misuse Strategic Planning Group (the SPG) was established and meets on a monthly basis to ensure progress is being made. The Head of Service for Health & Community Care chairs the SPG and membership includes representation from all the substance misuse services (public and third sector organisations) as well as other key organisations/services, including Children & Families, Neighbourhood Resources and Housing, Violence Against Women, and carers' support. The SPG also includes representation from Carers' groups and representation from individuals accessing services. The SPG holds responsibility for the development of the Plan, including the development of an action plan. Following publication, the SPG will take responsibility to oversee, progress and monitor the implementation of the Plan.

4.2.2 The Plan is based on consultations with individuals accessing services, with family members and carers, with local communities and service providers. The engagement included focus groups, consultation with community groups and forums; online consultation and feedback from individuals accessing substance misuse services. In summary, people told us that there remained high levels of stigma and negative attitudes and perceptions in communities; that there was a need to improve information and access to support; that there were concerns regarding the impact on communities and that people often felt unsafe and that there was a need to better manage the access to substances including alcohol availability. It was noted that people wished to better understand the recovery process and how interventions might best help people.

4.2.3 In developing the plan, information regarding the nature and extent of substance use in Dundee and the related harm, was used to inform the strategic direction set. The information indicated the links between deprivation and the adverse effects of substance misuse; that alcohol is too widely available in the city and therefore we have high levels of consumption and subsequent harm; that there were a high level of drug deaths in the city, that we need to focus on prevention among young adults and promote Recovery across all ages. The plan builds on the strengths already in place within the city and through the case for change recognises areas where there has been significant progress made, such as the work through sexual health services to reduce Blood Borne Viruses.

4.2.4 The Plan extends to the full reach of the lead strategic partnership's respective areas of responsibility as follows:

- **People** – children & young people at risk of early initiation of substance misuse/ affected by parental misuse. Adults, older people using alcohol and drugs in harmful ways; those with additional support needs - mental ill health, blood borne virus, vulnerable to sexual exploitation/domestic abuse, homelessness, poverty and deprivation. People in prison and those subject to community based sentences.
- **Carers and families** – in recognition of their key role in contributing to the recovery of people using services, as well as their own support and wellbeing needs.
- **The workforce across all specialist and generic service providers** - supporting and providing learning and development opportunities and core competencies for statutory, third sector, and independent sector agencies, peer workers and volunteers alike.
- **Area** - Dundee City with a focus on the specific demographic needs of localities and areas of greatest deprivation, Tayside-wide 'hosted' services - Psychology, In-patient Unit, Scottish Prison Services Healthcare and commissioned services.

### 4.3 Substance Misuse Strategic and Commissioning Plan for Dundee

4.3.1 By taking an approach which takes a greater focus on the prevention of substance misuse, the Plan responds to the issues experienced by individuals, families and communities affected. It seeks to improve responses to protecting children and young people affected by parental substance misuse and focuses on early intervention. At the heart of the Plan is a strengthened multiagency approach to recovery and harm reduction. The Plan is attached at Appendix 1.

4.3.2 Contained within the Plan is a shared vision to tackle substance misuse in Dundee:

*People will thrive within safe, nurturing and inclusive communities, supported by accessible and effective alcohol and drug services that focus on prevention, protection, harm reduction, resilience and recovery.*

4.3.3 Four key strategic priorities and shifts are outlined in the Plan:

- **Children & families**
  Children who are at risk of early initiation into alcohol and drug use, and / or are at risk of exposure to harm in family settings where substances are misused - will have improved life chances and will be safer.

- **Prevention & Protection**
  Prevention and early intervention approaches, including Harm Reduction, Trauma-based work and a clear link to Sexual Health and BBV are implemented to prevent and minimise the harm to children, families and individuals in Dundee.

- **Recovery**
  A well-coordinated and effective Recovery Oriented System of Care with integrated pathways through services that promote safety, health, wellbeing and help people achieve their personal goals.

- **Resilient communities**
  Individuals and communities are knowledgeable about the harmful effects of alcohol overconsumption and drug misuse, and are supported to build resilience.

4.3.4 To support the implementation of the Plan, each Strategic Priority has an associated strategic work-stream which is developing the action to implement the strategic priority. These action plans will provide the basis for the further redesign of services, including the redesign of Dundee Health and Social Care Partnership and commissioned services and tests of change which promote new ways of working. Included within the redesign will be a shift to aligning service delivery to locality areas. The Plan also describes the learning and workforce development approach to embed a Recovery Orientated System of Care at all levels.

4.3.5 The Plan does not sit in isolation and the SPG recognises the importance of the Dundee Drugs Commission and the work it will produce. As the development of the Plan commenced prior to the announcement of the Drugs Commission, it was agreed that the Plan would continue to progress to publication during 2018. This is in recognition of the collaborative approach to the development of the Plan and in the knowledge that the Plan covers a broader spectrum, such as alcohol services, than the scope the Commission allows. The SPG will embed the findings and recommendations of the Drugs Commission into the work-stream action plans. The work of the SPG will continue to develop in line with new national guidance and local initiatives. The Plan sets out a vision for the next 3 years and will be reviewed midway through the implementation phase.

## 5.0 POLICY IMPLICATIONS

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

## 6.0 RISK ASSESSMENT

| | |
|---|---|
| **Risk 1 Description** | That the plan is not fully implemented and does not achieved the desired outcomes. |
| **Risk Category** | Operational |
| **Inherent Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 |
| **Mitigating Actions** (including timescales and resources ) | Work has commenced to develop both the priority action plans and the service redesign across DH&SCP and commissioned services. The service has developed a risk framework which describes the service risks and are seeking mitigating actions to address these. Over the next year, use will be made to test new models through the use of resources available across the partnership. |
| **Residual Risk Level** | Likelihood (2) x Impact (3) = Risk Scoring 6 |
| **Planned Risk Level** | Likelihood (2) x Impact (3) = Risk Scoring 6 |
| **Approval recommendation** | This risk should be accepted. |

## 7.0 CONSULTATIONS

The Chief Finance Officer 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

None.

David Lynch
Chief Officer

DATE: 13 August 2018

Diane McCulloch
Head of Health and Community Care

**Appendix 1**

# SUBSTANCE MISUSE
# STRATEGIC & COMMISSIONING PLAN FOR DUNDEE

**2018-2021**

**CONTENTS**

## FOREWORD

This plan outlines the vision, key priorities and actions to improve the lives of individuals and families in Dundee affected by substance misuse. It presents a way forward for developing and improving the responses to the impact of substance misuse on communities in Dundee.

This plan should be considered alongside the City Plan for Dundee (2017-2026); the Dundee Health & Social Care Strategic and Commissioning Plan (2016-2021); the Tayside Plan for Children, Young People and Families (2017-2020); the Dundee Community Justice Outcomes Improvement Plan (2017-2021); and the Dundee Community Safety Outcomes improvement Plan (2017-2022). All of these plans recognise the impact of substance misuse on individuals, families and communities and the importance of collective action across the whole system to address adverse outcomes.

***"Dundee is a city on a journey - and you only have to look around the amazing Waterfront to see how far we have already come"*** **(City Plan for Dundee 2017-2026)**

***"We want to make a difference to the lives of those who need our support. Our collective ambition is to achieve the best outcomes for families and communities, so people are at the heart of everything we do. Our communities are unique and their sense of place defines our work".*** **(Dundee Health & Social Care Strategic and Commissioning plan 2016-2021).**

In order to improve lives and provide meaningful support that individuals and families deserve, we are committed to focus on children and young people who are at risk of early initiation of substance misuse. We will increase the focus on prevention and early intervention approaches, including a specific focus on trauma-based work. We will support individuals to progress with their recovery and achieve their personal goals. We will work with communities to improve knowledge about the harmful effects of substance use and build resilience.

We want to work with local people to challenge what has been seen as the inevitability of substance misuse in some of our communities and to achieve significantly improved outcomes in terms of prevention, prevalence, drug related deaths and recovery. We know that we will need to work in a radically different way. Transformation is an overused word, but there can be no doubt that services in Dundee need to be transformed if we are to achieve the better outcomes we seek, and which are so badly needed.

# 1. INTRODUCTION AND BACKGROUND INFORMATION

**This section of the plan sets the scene regarding the need for having a specific plan for substance misuse. We outline the guiding principles that are being followed throughout the plan and the outcomes it has been designed to achieve.**

## 1.1 WHY DO WE NEED A PLAN FOR SUBSTANCE MISUSE IN DUNDEE

The Alcohol & Drugs Strategic and Commissioning Plan (2018-2021) presents a way forward for developing and improving the responses to the impact of substance misuse in Dundee.

Substance misuse has been identified as one of the key priorities to be addressed within the Dundee City Plan, due to its negative impact on the health and wellbeing of those who use substances, as well as that of their families and carers, and the wider communities in which they live.

This plan proposes an approach that has a greater focus on the prevention of substance misuse. It responds to the issues experienced by individuals affected by their own substance misuse, their families and children. This plan responds to the issues experienced by communities, including the increased availability and use of New Psychoactive Substances, and the increase of alcohol consumption by the general population.

More specifically, this plan focuses on improving responses to protect children and young people affected by parental substance misuse, increasing the focus on early intervention and avoiding the escalation of problems, strengthening the multi-agency approach to recovery and working jointly with local communities to protect them from harm.

In addition, this plan emphasises the importance of a harm reduction approach, including Injecting Equipment Provision (IEP), providing safer alternatives to injecting practices and having a clear focus on early access to Opiate Substitution Therapy (OST). This emphasis is both in terms of increasing the safety and minimising the harm caused to individuals, and also as a first step to a Recovery Oriented System of Care (ROSC).

**Our shared vision to tackle substance misuse in Dundee:**

> ***People in Dundee thrive within safe, nurturing and inclusive communities, supported by accessible and effective alcohol and drug services that focus on prevention, protection, harm-reduction, resilience and recovery.***

## 1.2 BUILDING ON IMPROVEMENT

Improvement actions within this plan build on earlier achievements progressed through the *Dundee Alcohol and Drugs Review 2014*. In July 2013, the Dundee Alcohol & Drugs Partnership (ADP) embarked on a comprehensive review of all alcohol and drugs issues in the city. This brought about a change-plan for the delivery of services. The Review was co-produced; entailing consultation with a wide variety of stakeholders (including individuals who use services, carers and families affected by substance misuse, local communities and service providers). The Review was also informed by an assessment of needs and the collation of evidence describing the impact of substance misuse in Dundee.

## 1.3 THE SCOPE OF THIS PLAN

This plan extends to the full reach of the lead strategic partnership's respective areas of responsibility. In brief, the scope is as follows:

- **People** – children & young people at risk of early initiation of substance misuse/ affected by parental misuse. Adults, older people using alcohol and drugs in harmful ways; those with additional support needs - mental ill health, blood borne virus, vulnerable to sexual exploitation/ domestic abuse, homelessness, poverty and deprivation. People in prison and those subject to community based sentences.
- **Carers and families** – in recognition of their key role in contributing to the recovery of people using services, as well as their own support and wellbeing needs.
- **The workforce across all specialist and generic service providers:** supporting and providing learning and development opportunities and core competencies for statutory, third sector, and independent sector agencies, peer workers and volunteers alike.
- **Area** - Dundee City with a focus on the specific demographic needs of localities and areas of greatest deprivation, Tayside-wide 'hosted' services - Psychology, In-patient Unit, Scottish Prison Services Healthcare and commissioned services.

## 1.4 GUIDING PRINCIPLES AND KEY THEMES IN THE PLAN

A number of principles and important themes underpin this plan. These have been adopted because they are either derived from local needs and national policy identified through the process of consulting stakeholders or through fact-finding exercises.

| |
|---|
| **Strengthening Governance:** partners working together to improve the safety, performance, quality of services and outcomes for people who need care and support – Alcohol and Drug Partnership, the Integration Joint Board, Community Planning Partnership and the Chief Officer's Group. |
| **Delivering Service Improvements** through a fair and consistent approach to strategic commissioning, high quality and robust performance management. |
| **Improving Service User / Carers' Involvement and opportunities for Community Activism** to ensure people with lived experience contribute to the process of measuring performance outcomes, quality, and efficacy of services; also ensuring supports are 'person-centred' where people are involved in care and treatment, and treated with dignity and respect. |
| **Value for Money** as a key strategic commissioning principle and feature of all service agreements and plans, quality standards and performance management. |
| **Integrating Services** in locality settings and between adults and children's services; ensuring they are accessible from the service user point of view**.** |
| **Co-producing Developments** and service improvements; working alongside communities and people who have lived experience of substance misuse. |
| **Promoting Best Practice and Improving Quality** building upon successes, ensuring models of provision are evidence-based and follow best-practice, and improving compliance with national quality standards. |
| **Increased Focus on Prevention** is a key strategic shift for services in Dundee.<br><br>As highlighted in the Christie Report (2011)*: "The costs to Scotland and its public services of negative outcomes such as excessive alcohol consumption, drug addiction, violence and criminality are substantial. Addressing the 'failure demand' that results from focusing on consequences rather than causes, and approaches which alienate or disempower service users, has a high cost for society and high costs for public services. This will be increasingly difficult to sustain into the future."*<br><br>This plan is informed by the Christie Report (published 2011) and the Dundee ADP Prevention Strategy (2017). |

## 1.5 THE OUTCOMES THIS PLAN FOCUSES ON

Set against the national outcomes for substance misuse, and from the information gathered for the *Case for Change* (see section 3 below), a number of outcome priorities have been identified that shape this Plan. These include:

| Outcomes | Improvement Actions outlined in this plan |
|---|---|
| **Health** | Addressing health **inequalities, improved interventions** for people with complex needs, reducing harm, tackling the contributory factors associated with drug deaths, developing more trauma based therapeutic interventions |
| **Accessibility** | Ensure all services are accessible to those who needs them and are located within community settings |
| **Prevalence** | Increasing focus on **prevention** and early intervention; shifting the balance of resources invested in these approaches; develop the whole population approach to **reducing alcohol consumption** |
| **Recovery** | Improving the Recovery Oriented System of Care (ROSC) - the open **access**, supporting **engagement** with and **retention** in services, involving service users, developing peer supports, mutual aid and SMART Recovery. This includes effective through-put, people recovering in their own communities, supported through employability and to full citizenship. |
| **Families & Children** | Increasing **prevention interventions targeting children and young people at risk** of early initiation into substance misuse and those affected by parental substance misuse, supporting carers and family members, developing family focussed interventions |
| **Quality** | Improving compliance with national **quality** standards, developing **integrated pathways** of care and a locality approach, strengthen joint working between substance misuse and generic services |
| **Community Safety** | **Involving communities**, building resilience and capacity, working with the Dundee Community Justice Partnership, improving the Community Justice pathway for alcohol and drugs. Working together to address the negative impacts of substance misuse, for example its link to offending. |
| **Local Environment** | **Reducing alcohol availability**, encouraging responsible drinking, supporting communities to influence alcohol licensing |

## 1.6 WHAT WILL CHANGE

**The Vision and Key Strategic Priorities for Dundee (see more details in section 4 below):**

| | |
|---|---|
| **Vision for Dundee**<br>**People in Dundee thrive and prosper within safe and nurturing communities supported by accessible and effective alcohol and drugs services focusing on prevention, protection, resilience and recovery.**<br><br>***SEEK / KEEP / TREAT*** | |
| **Strategic Priority 1**<br>**Children & Families**<br><br>***SEEK / KEEP / TREAT*** | Children who are at risk of early initiation into alcohol and drug use, and / or are at risk of exposure to harm in family settings where substances are misused - will have improved life chances and will be safer. |
| **Strategic Priority 2**<br>**Prevention & Protection**<br><br>***SEEK / KEEP*** | Prevention and early intervention approaches, including Harm Reduction, Trauma-based work and a clear link to Sexual Health and BBV are implemented to prevent and minimise the harm to children, families and individuals in Dundee. Co-ordinated activities between Substance Misuse services and Community Justice services to reduce the risk of reoffending where substance use is a factor. |
| **Strategic Priority 3**<br>**Recovery**<br><br>***TREAT*** | A well-coordinated and effective Recovery Oriented System of Care with integrated pathways through services that promote safety, health, wellbeing to help people and families achieve their personal goals. |
| **Strategic Priority 4**<br>**Resilient Communities**<br><br>***SEEK*** | Individuals and communities are knowledgeable about the harmful impact of alcohol overconsumption and drug misuse, and are supported to build resilience and reduce stigma. |

## Working in Localities

In line with the Dundee Health and Social Care Partnership's approach to place-based working, this plan proposes the adoption of a locality-model for alcohol and drug services.

## 2. WHAT INFORMED THIS PLAN

**In this section we outline details of the consultation process that took place, and we list the documents, and other research papers, that inform this plan.**

### 2.1 CONVERSATIONS WITH YOU

Local communities, individuals and families affected by substance misuse, and staff delivering services have been consulted as part of the development of this plan.

The writing of this plan has been shaped and informed by the conversations we held with the following groups and individuals:

- People who use services
- Their Carers and Families
- Children and Young people
- Peer Workers and Volunteers
- Drug & Alcohol Workforce, and other professionals working with people with substance misuse-related problems
- Citizens and Communities
- Elected Members

We utilised the following consultation methods to gather the information:

- An Online Survey that was open to all citizens of Dundee (July – August 2017)
- Questionnaires and suggestion boxes in service areas (July – August 2017)
- Face to face conversations with community groups
- Focus groups with carers
- Focus Groups with individuals accessing services through community hubs
- Engagement Event for key partners, service providers and Elected Members (26 May 2017)
- Seminars and meetings with Elected Members (June – August 2017)

#### 2.1.1 Participation and Engagement Process and Feedback

**Summary of key points**:
Individuals using services, carers, professionals and community members, highlighted a number of key issues, including:

- Individuals and families affected by substance misuse often experience **high levels of stigma and other negative attitudes** within their communities. This is often a serious barrier to people coming forward to use services and progressing with their recovery
- Services can be inaccessible and are often not delivered at the required time and location
- There is a lack of communication between services, creating duplication and a disjointed recovery process (for example, individuals are asked to provide information time and again to different professionals and do not feel involved in the assessment process)
- Information is often not being shared with individuals and their families
- Individuals experience difficulties maintaining engagement with services

- Individuals who collect methadone from community pharmacies on a daily basis often do not engage with any other recovery-focused services and struggle to progress with their recovery.

**Feedback from focus groups**
People told us there should be **greater emphasis on individuals being able to access mental health and suicide-support services** and getting the right support from the right service (which may not be the specialist substance misuse services).

People felt that for many individuals affected by substance misuse, existing treatment options are not working and wanted to see an honest re-think in Dundee of our approach to providing services.

> *"The fact there are no rehab facilities within Dundee or even a detox clinic within the city is not helpful to support people to recovery".* Focus Group Lochee Hub

People told us that they would like to see a restriction on the length of time individuals are allowed to remain on a methadone prescription. They also said that stopping individuals' prescriptions without having the right support in place should also stop. It was highlighted that some individuals currently having to access a service from pharmacies in other locations due to the Dundee pharmacies being full.

> *"More promotion of recovery from people who have went through the process. Promotion of all the different recovery paths that are available".* Focus Group Lochee Hub

In the context of children and families affected by substance issues, people told us they would like to see more support offered to keep families together rather than removing children and making families "jump through various hoops" to see their children. It was suggested the approach to supporting families should be by support-workers who would have positive relationship with the whole family and offer support to parents (in relation to their recovery) and to their children.

However, feedback we received also highlighted a perception that on occasions children are being left in families where there is substance misuse for too long. Often in these occasions, information is not being shared with carers (e.g. grandparents) who can help to keep the children safe. It was highlighted that there is a need to have more specialist support for children and young people.

We have been told that those caring for family members affected by substance misuse are often not being fully recognised as carers and are subject to higher levels of stigma and negative attitudes from communities and service providers. This is often linked to beliefs that individuals are making a choice to use substances and are therefore not 'deserving' help.

> *"People need more information, there is a lot of ignorance about the issues in the community".* Focus group with Carers

## Meetings with community groups

During the meetings with community groups, participants spoke of the need to better manage the availability of alcohol in the city. Participants also described the extent of anti-social behaviour endured by local communities due to substance misuse. However, people also spoke of the contributions that licensed establishments, including pubs and clubs, make to their local communities and suggested that this could be better utilised. More generally, the message was that local citizens want a greater focus on responding to the impact of alcohol misuse.

Community members were aware and concerned by the fact that some individuals have been banned from local pharmacies and need to travel to neighbouring authorities to access methadone. Unanimously the view was that services should be delivered to people and their families within localities. At the same time, participants also raised the issue of the negative daily impact of drug-dealings and wanted to see greater focus on those dealing in drugs and more police presence in their neighbourhoods.

Participants asked that there is more regular communications with local communities to help them understand the recovery process and the interventions delivered by services. For example, participants were keen to have a better understanding regarding why it is the case that some people need to be taken off their methadone scripts.

## Feedback from the online community consultation:

183 people completed the online survey about the proposed priorities and actions for substance misuse.

The majority of people agreed that harmful alcohol (72%) and drug (61%) use is common in their community and that crime and social problems are worse in their community because of alcohol (64%) and drugs (70%).

**Safety:** A large number of people reported feeling worried about going out alone or at night because of alcohol (34%) and drug (40%) use in their communities. This highlights concerns that many have about personal safety due to drug and alcohol use.

**Knowledge:** Most people agreed that they know where to get help and advice if they or someone they know is experiencing problems with drugs (84%) or alcohol (87%). In addition, the vast majority of people stated that they know about alcohol units and safe levels of drinking (92%).

**Stigma:** The majority of people agreed that people find it difficult to ask for help when they experience problems with alcohol (84%). Furthermore, people did not think their community is understanding and supportive of people in recovery from drugs problems (88%). This suggests that stigma relating to alcohol and drug problems is still very prevalent.

Generally, people were very supportive of the direction proposed in the draft version of the plan that was used for the consultation. Specific comments from community members included:

*"Making help more easily available and helping to reduce the stigma on substance misuse and also on people in recovery is key to any strategy working. There is also a need to streamline the agencies providing care and treatment. There is a danger of 'too many cooks spoiling the broth'…. Different philosophies and ways of working cause too much confusion"* Community member

*"Involving communities is essential, problem drug users need to be seen as part of the communities in which they live and supported by those communities to recover"* Community member

*"I would like to see more support for people affected by drug misuse. Safe places to go to in the city to let drug wear off or to get help and support"*. Community member

*"What can we do to help prevent injecting in tenement closes and other public places"?* Community member

*"In my view a massive step towards dealing with drug use is understanding that there is no 'war on drugs' as has been the typical government rhetoric"* Community member

*"Utilising families and individuals with lived experience throughout the plan will be essential"* Community member

In Addition, drug and alcohol misuse was highlighted by Dundee citizens as the main cause of anti-social behaviour in their areas (Dundee City Plan).

**Feedback from individuals accessing substance misuse services consultation:**

During October and November 2017, 24 individuals who were accessing substance misuse services also completed the survey about the proposed priorities and actions for substance misuse.

The majority of service users agreed that harmful alcohol (79%) and drug (75%) use is common in their community and that crime and social problems are worse in their community because of alcohol (74%) and drugs (75%). These attitudes are similar to those in the community consultation however service users agreed even more strongly.

**Safety:** A large number of service users reported feeling worried about going out alone or at night because of alcohol (42%) and drug (62.5%) use in their communities.

**Knowledge:** Most service users agreed that they know where to get help and advice if they or someone they know is experiencing problems with drugs (92%) or alcohol (88%). Service users were less likely to agree that they know about alcohol units and safe levels of drinking (67%) then those from the community consultation.

**Stigma:** Almost all service users agreed that people find it difficult to ask for help when they experience problems with alcohol (96%). Around about half of service users agreed that their community is understanding and supportive of people in recovery from drugs problems (55%).

As a whole individuals accessing services were very supportive of the direction proposed in the draft version of the plan. Stigma surrounding substance misuse and access to drugs and alcohol 'being too easy' were two issues repeatedly identified as problematic by service users. Specific comments from service users included:

*"Recovery in Dundee is growing. We should have people in recovery doing more in services."* Service User

*"Drug use in Lochee is getting worse. The hub has been a great way to support vulnerable people."* Service User

*"The help is there if people feel safe to admit they have a problem"* Service User

*"Through my experience drugs are readily available. This makes it difficult to stay away from them."* Service User

## 2.2 ADDITIONAL SOURCES OF INFORMATION

Building a case for change and improvement involves a number of fact finding exercises and conversations with people who use services, those who provide them and others in our communities who experience the effects of substance misuse in their everyday lives. Different tools are used to quantify levels and types of needs, to gauge the quality of services and whether these services provide the right type of support and help to meet the needs of the population.

- Review of Substance Misuse Issues in Dundee: Consultations with Stakeholders 2013-2014 (Dundee ADP)
- Profile of the Substance Misusing Population in Dundee 2017 (NHS Tayside)
- Dundee Report on the Alcohol Overprovision (updated 2017)
- Alcohol and Drug Partnership Prevention Strategy 2017
- Validated Self Evaluation of Dundee ADP 2016 – Quality Standards 2014
- Tayside Drug Death Report 2016
- Staying Alive in Scotland June 2016
- NHS Tayside *Make It Good*: Research Project and Report
- NHS Tayside Sexual Health & Blood Borne Viruses Framework and Blood Borne Viruses Prevention Framework
- Dartington Research Unity – 'Children Count' Wellbeing Survey 2017
- Conversations with You – Stakeholder Engagement Plan 2017

# 3. THE CASE FOR CHANGE

**In this section we describe the reasons for change relating to substance misuse in Dundee. It includes presenting the current demographic and other specific information on substance misuse in Dundee and outlining the drivers for change.**

## 3.1 DRIVERS FOR CHANGE

In the context of substance misuse, the following drivers for change have been identified:

- Dundee has a high prevalence of individuals misusing substances which is higher than expected even after adjusting for deprivation
- Many of the individuals in Dundee affected by substance issue are also affected by other underlying issues and risk factors, including childhood trauma, abuse and more
- In Dundee there is a high level of harm caused to individuals, families and children, as a result of substance misuse. Those living in the more deprived area of the city are significantly more likely to be affected by substance misuse related harm
- In Dundee has one of the highest levels of drug and alcohol-related deaths in Scotland
- Communities in Dundee are adversely affected by substance misuse
- In Dundee there is high level of drug and alcohol related crime
- There is a need to identify mechanisms that demonstrate the impact of prevention interventions and improve the quality of prevention activities.

## 3.2 ANALYSIS FOR CHANGE

### 3.2.1 Dundee General Demographics

The most recent estimate of Dundee's population is 148,270 (National Records of Scotland 2016 Mid-year population estimate).

**Deprivation, mental health and substance misuse:**
A significant proportion of the difference in life expectancy between Scotland and the rest of the UK can be accounted for by deaths at a young age from drugs, alcohol, violence and suicide. Substance misuse disproportionately affects the most vulnerable and socioeconomically deprived in our community and is associated with other aspects of adversity, including mental health problems, crime, domestic abuse and child neglect and abuse. Substance misuse is therefore recognised both at national and local level as a major public health issue and as both s consequence and driver of entrenched health inequity.

Overall Dundee is the third most deprived local authority in Scotland, with only Glasgow and Inverclyde having higher deprivation. Levels of poverty and deprivation which make everyday life a struggle for many individuals, families and communities.

In Dundee, 28.6% of the population live within a data zone which is ranked within the 15% most deprived in Scotland. 35% of children in Dundee live within one of the

15% most deprived data zones. There are also wide divisions in health and life expectancy between the richest and the poorest communities in the city. Based on the Scottish Index of Multiple Deprivation, Dundee has six of the city's eight local authority wards identified as community regeneration areas.

It is estimated that in Dundee 6,319 individuals aged 16-64 have mental health conditions.

**For more information on the Dundee City Profile, please see the Dundee City Plan 2017-26 https://www.dundeecity.gov.uk/city-plan-for-dundee-2017-2026**

### 3.2.2 The Impact of Substance Misuse on Individuals and Communities in Dundee

Dundee has the third highest prevalence of drug misuse in Scotland. It is estimated that there are around 2,800 problem drug users in Dundee - 59% of whom are men and 41% of whom are women. Dundee has a significantly higher proportion of female problem drug users than Scotland where only 30% of problem drug users are female. The high proportion of women who are drug users is significant, given the known impact of substance misuse on parenting capacity and the ability to keep children safe.

**It is estimated that alcohol-related harm cost to Dundee City is approximately £71million per annum.**

### ALCOHOL CONSUMPTION, AVAILABILITY AND RELATED HARM

### Alcohol Availability in Dundee and Scotland

- In 2015, there was 20% more alcohol sold in Scotland than England and Wales
- Three-quarters of alcohol sold in Scotland is in ***off-sales trade*** (shops and supermarkets)
- **Areas in Scotland with higher numbers of alcohol outlets have a higher rate of alcohol-related harm**
- Dundee has the fourth highest alcohol availability in Scotland

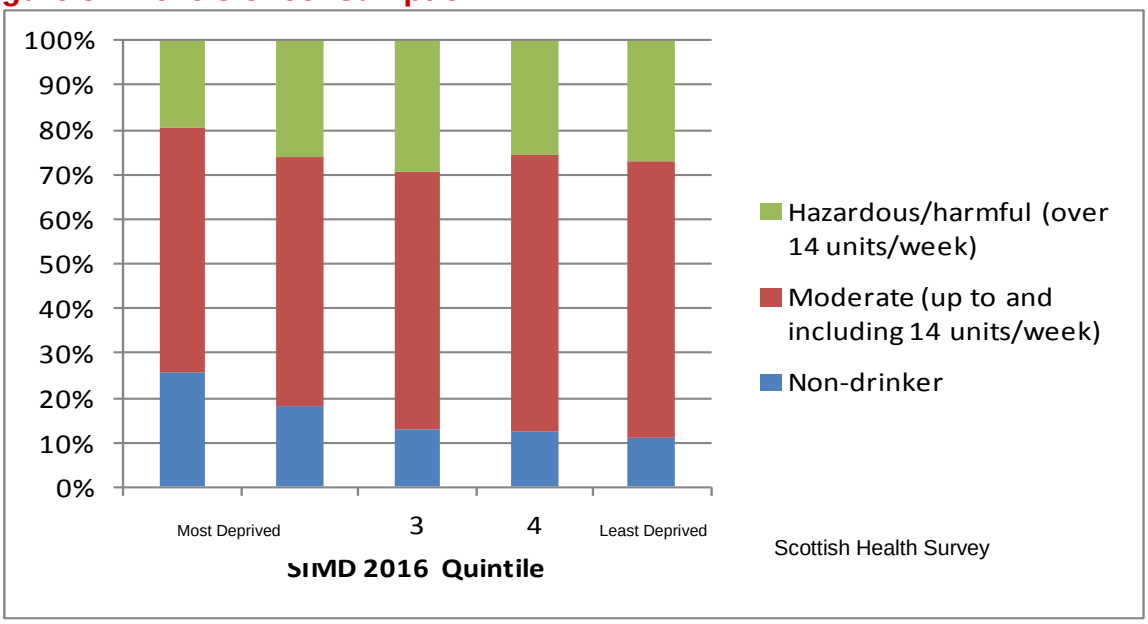
*For additional information on alcohol availability and harm see the Dundee Overprovision Report (2016 update).*

A considerable proportion of adults in Tayside drink alcohol in excess of safe government guidelines. The Scottish Health Survey showed that for Tayside, during the period 2013-2016, 29% of men and 14% of women were drinking alcohol at levels that are considered hazardous or harmful (over 14 units per week).

Generally, those living in more affluent areas consume more alcohol than those in more deprived areas (see figure 3.1 below). Within the most deprived areas more individuals report abstaining from alcohol completely.

However, harm to the health of individuals caused by the overconsumption of alcohol tends to be greater amongst those living in areas of deprivation. Reasons for this are thought to include differences in how alcohol is consumed and co-existing health conditions.

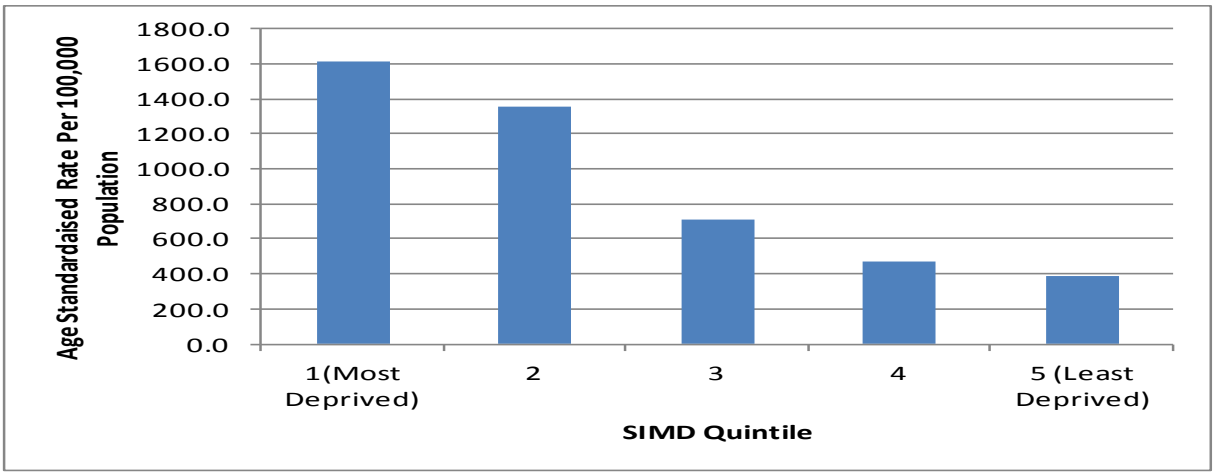
**Figure 3.1: levels of consumption**




In general, individuals living in the most deprived areas are around 6 times more likely to attend A&E due to alcohol-related harm (see figure 3.2 below), 5 times more likely to have an acute hospital stay as a result of alcohol and 2.4 times more likely to die with an alcohol related diagnosis than those from the least deprived areas.

Figure 3.2: alcohol-related attendance at Accident & Emergency

***Tayside Alcohol Related Attendances (2015) at A&E by SIMD 2016***



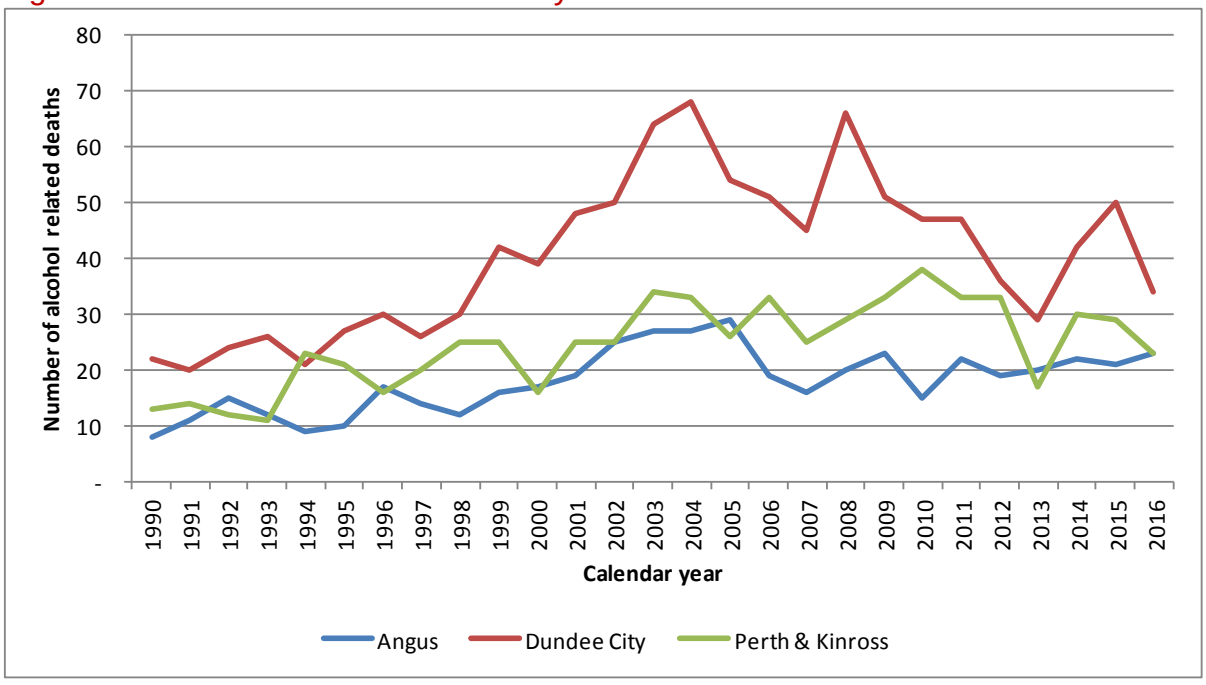

NHS Tayside Business Ur

There were 1,035 alcohol related attendances at A&E in Dundee during 2015/16.

## Alcohol-related deaths

Figures released in 2015 showed Dundee to be amongst the worst Local Authorities in Scotland for alcohol-related deaths rates – 38 per 100,000 population. By comparison, the average for Scotland is 23 per 100,000 population. As indicated in figure 3.3 below, in recent years there has been a moderate reduction in the alcohol-related deaths in Dundee, which mirrors national trends. However, the decrease in rates of alcohol-related deaths is stalling and showing signs of increasing again. Overall rates of alcohol-related deaths are still much higher than those seen in the early 1980s, and the Scottish rates are much higher than those seen in England and Wales.

Figure 3.3 Alcohol-related deaths in Tayside 1990-2016



### Alcohol-related crimes

The number of alcohol related crimes increased from 1,377 recorded in 2012/13 to 1,434 in 2013/14. Alcohol was thought to be a contributory factor in 58% of serious assaults committed in Dundee in 2013/14. However, it is likely that the impact of alcohol on criminal behaviour is greater than current figures suggest. For example, the recording of domestic abuse incidents does not include information on whether or not alcohol was a contributor.

## DRUG MISUSE AND RELATED HARM

It is estimated that in Tayside there are 4,600 problem drug users and 2,800 (61%) live in Dundee city. Heroin is the most common main problem drug amongst adults, although most drug misusers use a range of drugs in combination with alcohol. It is also estimated that just under half of the individual drug users in Dundee are not in touch with care and support services. It is important to recognise that many who are not in formal drug treatment services, may be accessing low threshold and anonymised services, such as Injecting Equipment Provision (IEP). Out of the individuals who are in touch with services, it is known that the overwhelming majority live in deprived areas of the city and are also more likely to be affected by childhood trauma and other mental health issues. In addition, a large proportion have children who may or may not be under their care.

### Children and Young People

- Out of the 135 children placed on the child protection register between January to December 2017, 58 (43%) were placed on the register due to parental substance misuse
- It is estimated that many more children in Dundee are neglected due to parental substance misuse
- In 2013 in Dundee, 3% of 13 year olds and 13% of 15 year olds reported ‘ever using drugs’ (Scotland; 4% and 18%).

### Individuals receiving substitute prescriptions

Substitute prescribing and contact with care and support have a positive impact on levels of drug use, offending behavior, risk of overdose and are important in reducing the spread of blood-borne viruses. The aim is therefore to increase individuals’ safety, support them to stabilise their lifestyle and support / enhance their recovery.

In 2016-17 in Dundee, 1,714 individuals (61% of the estimated problem drug users) received a substitute prescription (e.g. Methadone).

### Drug Deaths in Dundee 2001 – 2016

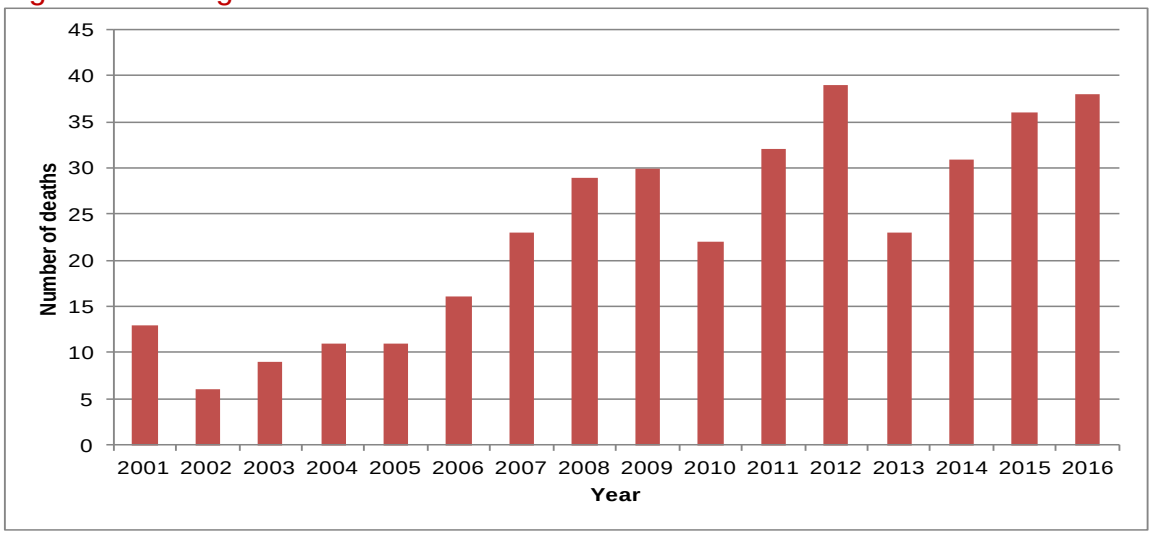
Scotland has one of the highest rates of drug-related deaths per head of population in Europe. Significant efforts have been made in Scotland to understand these deaths, including the development of local processes to investigate the nature, health and social circumstances of all individuals who have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

Over the period 2010-16, for Scotland as whole, the average of 659 drug related deaths per year represented a death rate of 0.12 per 1,000 of population. In Dundee

drug deaths have been rising almost every year since 2001 to an average of 34 deaths per year (Figure 3.4). This represents a death rate of 0.23 per 1,000 of population – the highest rate of all Local Authorities in Scotland.

A drug death is a death that has occurred from the presumed non-intentional overdose of illicit (or illicitly obtained) controlled substances in Tayside. The number of drug deaths in Dundee has increased since the early 2000s and in 2016 there were 38 drug deaths in Dundee. The highest number of deaths was in the 35-44 age group

Figure 3.4: Drug Deaths in Dundee 2001 - 2016




## Reviews and analysis of drug deaths in Dundee

The Tayside Drug Deaths Report Review Group has been collating information on the individual victims of drug deaths over a number of years. Over time as data has been collected, some distinctive characteristics emerge repeatedly to present the following profile:

- **Birth:** living in a deprived community
- **Childhood:** unstable living conditions and school environment; parental substance misuse and mental health issues; physical and sexual abuse
- **Age 16:** leaves school, employment, drinking at weekends
- **Age 20-26:** use of cannabis → LSD→ ecstasy→ cocaine→ smoking heroin
- **Age 27-36:** unstable relationships, children, estranged from family, crime, cocktail of drugs, known to GP and services, in treatment
- **Age 37 (time of death):** single, unemployed and living alone; often with chronic health issues, poor mental health and experience of at least one adverse life event

Profiling in this way helps planners and managers of services to target resources, and to focus on the characteristics that indicate a person to be at particular risk of harm or death.

## Prevention of drug deaths

The entire Recovery Process in Dundee aims to prevent drug deaths. In addition, there are specific drug-deaths prevention measures that are in place, including the provision of the take-home naloxone programme. Naloxone is an emergency antidote to opiate overdose and provides a quick and effective way to reverse the effect of the overdose temporarily, giving more time for the emergency services to respond. A range of interventions are also provided by the NHS Tayside acute services.

During 2016 there were **218 non-fatal overdoses** recorded and it is estimated that there will be more unrecorded incidents of non-fatal overdoses that are not seen by emergency services. This is an indication that measures such as the take-home naloxone programme are increasingly effective at preventing drug deaths. In 2015 – 16 there were **731 naloxone kits issued** in Dundee. In addition, during 2015 -16 there were **304 drug-related episode**s were recorded in the acute hospital settings. There is nevertheless much more that is needed to address complex and multifactorial contributors to drug related deaths in the city.

## Harm Associated with injecting and Blood-borne Viruses (BBV)

The practice of injecting drugs can often lead to wound and bacterial infection that can also result in vein damage and amputation and an increase in hospital admissions. Sharing or unsafe injecting also has a serious risk of BBV – HIV, Hepatitis B and C - transmission.

The availability of clean needles and other injecting equipment and the availability of harm reduction services is another essential measure helping to keep individuals safe and also can be the start or ‘gateway’ to recovery. In 2015-16 there were **183,881 clean needles/syringes** distributed, this fell to 164,893 in 2016-17. The World Health Organisation (WHO) has set a global target as part of its Hepatitis Elimination Strategy of providing 300 needles/syringes per PWID per annum by 2030. Tayside and Dundee, whilst having amongst the higher rates in Scotland, still fall far short of the global target. In Dundee, there were 3,384 unique identifiers registered with IEP sites, which would suggest a rate of 49 per PWID per year. As a result, we are taking steps to review Injecting Equipment Provision (IEP) with the aim of increasing and uptake.

## Hepatitis C

Hepatitis C is an infectious disease that if untreated can be fatal, however recent dramatic improvements in treatment mean that it can be cured in almost all cases. In Tayside 90% of all new transmissions of Hepatitis C are in people who inject drugs and, an estimated 29% of people who inject drugs (and an estimated 40% of those on OST) have chronic Hepatitis C virus. The risk of Hepatitis C transmission can be significantly reduced by ensuring that there is high coverage of IEP to enable individuals to practice safer injecting as well as ensuring that there is adequate access to Opiate Substitution Therapy (OST).

The Sexual Health and BBV Managed Care Network has pioneered whole systems approaches to prevent transmission, identify, test and diagnose individuals at risk and to develop streamlined pathways to care together with Treatment as Prevention (TasP) for people who actively inject drugs. This has contributed to lower prevalence rates than for Scotland overall. However, hepatitis C remains a significant public health challenge and the Partnership therefore needs to sustain and scale up harm reduction, proactive case-finding and access to treatment to meet the goal of elimination in this population.

### HIV

The main transmission route for HIV is sexual, however there remains a risk through sharing injecting equipment. We have continued to test for HIV in this population and prevalence of HIV in PWID in Tayside is extremely low.

The recent significant outbreak of HIV in PWID in the city of Glasgow, predominantly in homeless individuals not in contact with care, exemplifies the importance of routine testing in this population, together with access to harm reduction, OST and BBV treatment and support.

### Drug misuse and crime

Drug related offences data recorded by Police Scotland show that in 2016/17, there were 1,208 drug related offences in Dundee. This equated to a rate of 81.5 per 10,000 population and was an increase of 20% from 2015/16.

## 3.3 THE CASE FOR CHANGE – CONCLUDING REMARKS

In almost every respect, Dundee has a high prevalence of substance misuse. This includes levels of use, the availability of substances and the levels of harm – especially the impact of harm on the more deprived communities. The high level of harm also includes individuals and families experiencing stigma and negative attitudes, which also impacts on individuals liberated from prison.

The information presented above indicate a links between deprivation and the adverse effects of substance misuse. We know that individuals, children, families and communities within the most deprived areas of the city are disproportionately impacted by substance misuse. We are therefore committed to directing resources to where they can make the most positive impact.

More specifically, the above figures indicate that alcohol is too widely available in the city. Research conducted over a number of years and presented by Alcohol Focus Scotland demonstrates the direct link between the availability of alcohol and the increase in levels of consumption and subsequent harm. The Partnership will continue to focus on a population-wide approach to reduce the consumption of alcohol and support all Dundee citizens to develop responsible patterns of alcohol consumption.

In terms of drug misuse, as well as continuing to do everything possible to prevent drug deaths, and strengthening the Recovery care pathway, the ADP will also focus

on effective prevention interventions (especially for those aged 13 and above – which is a key stage for the onset of substance use).

We know that children living in households where there is substance misuse could be at risk of neglect and harm, and are more likely to misuse substances themselves in later life. The feedback we received from those with caring responsibilities indicates that many are willing and able to provide more support to their children and families and we will support them to do so.

Communities and citizens in Dundee have highlighted to us the impact of substance misuse on them but have also indicated a willingness to be part of the solution.

## 4. WHAT NEEDS TO CHANGE

Drawing from the case for change (presented in section 3 above) – including the analysis of the demographic information, the consultations/ conversations we held and the feedback we received, **Four Key Strategic Priority Areas** have been developed to form the response to the impact of substance misuse in Dundee.

### Key Strategic Priorities

| **Vision for Dundee**<br>**People in Dundee thrive and prosper within safe and nurturing communities supported by accessible and effective alcohol and drugs services focusing on prevention, protection, resilience and recovery**<br><br>***SEEK / KEEP / TREAT*** | |
|---|---|
| **Strategic Priority 1**<br>**Children & Families**<br><br>***SEEK / KEEP / TREAT*** | Children who are at risk of early initiation into alcohol and drug use, and / or are at risk of exposure to harm in family settings where substances are misused - will have improved life chances and will be safer. |
| **Strategic Priority 2**<br>**Prevention & Protection**<br><br>***SEEK / KEEP*** | Prevention and early intervention approaches, including Harm Reduction, Trauma-based work and a clear link to Sexual Health and BBV are implemented to prevent and minimise the harm to children, families and individuals in Dundee. Co-ordinated activities between Substance Misuse services and Community Justice services to reduce the risk of reoffending where substance use is a factor. |
| **Strategic Priority 3**<br>**Recovery**<br><br>***TREAT*** | A well-coordinated and effective Recovery Oriented System of Care with integrated pathways through services that promote safety, health, wellbeing to help people and families achieve their personal goals |
| **Strategic Priority 4**<br>**Resilient Communities**<br><br>***SEEK*** | Individuals and communities are knowledgeable about the harmful effects of alcohol overconsumption and drug misuse, and are supported to build resilience |

## Working in Localities

**In line with the Dundee Health and Social Care Partnership's approach to place-based working, this plan proposes the adoption of a locality-model for alcohol and drug services.**

This will enable collaborative working with complementary services for children and families.

It is proposed that specific staff groups and/or teams will be linked to a locality. Accordingly, they can develop a better understanding of the local communities and their people, target the resources according to need and make closer links to local resources. This model of working will ensure local people affected by substance misuse and their families can have easier access to the services they need. These services will be confidential; will include specialist treatment services and all other supports people require to aid their recovery.
It is recognised that some services will need to continue to be delivered at a city-wide or pan Tayside level; i.e. Psychology, in-patient units.

Under each of these four priorities there are a range of strategic shifts that have been identified. It is recognised that all of these priorities, and their associated strategic shifts, are 'cross cutting' and will impact on each other. For the purposes of clarity, however, the following are the strategic shifts which are most strongly related to each of the four priorities identified.

## 4.1 STRATEGIC PRIORITIES AND SHIFTS

### 4.1.1 Children and Families Affected by Substance Misuse

***"Our children and young people will have the best start in life and Tayside will be the best place in Scotland to grow up"*** (Tayside Plan)

The *Tayside Plan for Children, Young People and Families* focuses on reducing inequalities and disadvantages, protecting vulnerable children and young people from harm, providing effective and early interventions, and promoting educational attainment. The plan aims to address the key issues which can act as barriers to children and young people achieving their full potential as they move towards and into adulthood.

Children and young people can be affected by their own substance misuse and by their parents and/ or carers' substance misuse. Although the 2015 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) reported a decrease in young people reporting that they use alcohol and / or drugs, the early initiation of substance use remains a significant issue affecting children and young people. The Dartington surveys (2017) identified that 41% of the young people in Dundee reported at least one occasion of smoking cigarettes, drinking alcohol or taking illicit drugs. Children and young people further reported that the majority of this substance misuse related to alcohol, and the average age at which they first drunk more than a small amount of alcohol was 12 years old.

In terms of Child Protection, parental substance misuse is considered to be when one or both parent(s)/carer(s) are unable to meet the basic needs of the child due to their problematic use of alcohol and/or drugs and its impact on their parenting capacity. In addition, the death of a parent or a carer due to substance misuse has a serious and detrimental impact on children and young people.

A recent Scottish Government report reviewing the SALSUS 2015 data found that the factors with the strongest association to substance misuse included: exclusion from school, truanting, number of evenings spent with friends, age of friends and degree of 'parental' supervision. Taken together, this would suggest a crucial role for schools and youth work; engaging young people in structured activity that they value and which fosters prosocial behaviour.

Where children are assessed as at higher risk of substance misuse NICE guidance advocates offering parents and carers information to develop their parenting skills, such as problem-solving, communication skills, advice on setting boundaries and teaching children how to resist peer pressure.

**Our aim:**

> **Children will have improved life chances and are safer where there is a risk of early initiation into alcohol and drug use, or exposure to harm in family settings where substances are misused**

**To do this we will:**

**Strategic action 1:**

**Focus on providing services and support to children at risk of harm due to parental substance misuse**

**Specific actions:**

- Improve identification and responses to children at risk of harm from parental substance misuse
- Increase family-focussed services that also support parents to recover from substance misuse
- Work with partners to strengthen support to first-time parents affected by substance misuse
- Ensure effective links with the new Tayside Children's Services Collaborative (TCSC) Priority Groups; established to achieve improved outcomes for children
- Strengthen the whole-family approach through joint working between children services and adult services, and increasing support to carers
- Develop responses to support the children whose parents died due to their drug or alcohol misuse

**Strategic action 2:**

**Delay the initiation of substance use amongst young people in Dundee**

**Specific actions:**

- Target and support groups of young people at risk of early initiation into alcohol/drug use
- Improve joint-working between Named Persons and specialist substance misuse services
- Work collaboratively with the new TCSC Health & Wellbeing Priority Group to support the development and implementation of a framework to prevent and address early initiation into substance misuse
- Agree trigger points for intervention, e.g. number of truanting episodes and appropriate mechanisms/interventions
- Work with NHS Tayside Public Health to implement the recommendations of the *Make It Good* research project
- Work with partners to engage young people in structured activities that they value
- Create links with Parenting programmes in the city, and with the implementation of the Dundee Parenting Strategy, ensure joint working between those generic programmes and measures to specifically targeting early harmful drinking/other substance misuse.

### 4.1.2 Prevention and Protection

***"A cycle of deprivation and low aspiration has been allowed to persist because preventative measures have not been prioritised…"* (Christie Commission report 2010)**

**The Dundee Substance Misuse Prevention Strategy (2017-2027)***: 'Stop People Starting & Supporting People to Recovery'* aims to prevent substance misuse in the city and embed the recovery of individuals and families in all activities (a full copy of this strategy is available from the PP Team).

Following the recommendations of the Christie Commission (report published 2010), the Dundee Substance Misuse Prevention Strategy focuses on the need for a fundamental shift towards prevention, and on the need to develop a coherent framework for prevention as part of the overall Recovery approach.

The Prevention Strategy considers any activity which is designed to delay, reduce and potentially prevent onset and escalation of substance misuse and reduce associated risk as prevention activities. Such activities can target the entire population of Dundee (e.g. measures to reduce levels of alcohol consumption) or target specific populations (e.g. young people or those at risk of drug deaths).

Furthermore, based on the ***European Prevention Standards***, the Prevention Strategy outlines the following elements as necessary for effective prevention activities, including:

- **Relevant activities** - focusing on responding to the needs of the target population whilst making reference to relevant policy;
- **Ethical activities** - incorporates the principles of ethical conduct;
- **Evidence-based activities** - making use of the best available scientific evidence;
- **Evidence-providing activities** – to help inform and develop activities;
- **Cost Effective activities** – aimed at achieving set goals and objectives without causing harm and with appropriate use of resources;
- **Feasible activities** – that are achievable with available resources and developed with an internally consistent logic;
- **Sustainable activities** – that are sufficiently resourced to ensure they can continue as long as necessary in order to respond to the target population needs.

#### Prevention and Young People

Looking specifically at prevention activities designed to focus on young people - the available literatures (including the SALSUS report, the NICE guide for those under 25, and NHS Health Scotland) identify the following groups of young people (0-25) as at increased risk of misusing substances:

- those whose family members that misuse substances
- those with behavioural, mental health and social problems
- those excluded from school and those that truants
- young offenders
- Looked After Children
- those who are homeless

- those from some black and minority ethnic groups

It is therefore proposed that preventative activities aiming specifically at young people will take place within the following strands:

**Schools and youth work:** engaging with children and young people within a broader context of health, wellbeing and prosocial behaviour to strengthen resilience and prevent the early initiation of substance misuse. This also includes offering support to parents and providing family-focused interventions.

**Services providing care and support:** this strand includes harm-reduction, treatment and recovery initiatives focusing on specific risk groups, parents affected by substance misuse and communities.

**A whole family approach:** recognises that identification, treatment and recovery of substance misusing parents is likely to have a positive generational impact. Evidence presented by NHS Health Scotland (2014) identifies an approach combining parenting initiatives and treatment/ support interventions as the most effective.

**This national and local prevention landscape will inform, and be reflected, within the Tayside Multi-Agency Framework to Prevent and Address Early Initiation into Substance Misuse by Young People.**

### Links to BBV & Sexual Health Prevention

There is clear synergy and inter-dependence between substance misuse, Blood Borne Virus (BBV) and poor sexual and reproductive health and it is often the case that these issues affect the same populations (especially so in respect of hepatitis C). Given the common root causes or risk factors, there is a requirement and significant benefit from collaboration to ensure that evidence-based preventative interventions are in place and at sufficient scale that also include opportunities for the delivery of integrated care.

### Prevention of Drugs Deaths and Non-Fatal Overdoses

Evidence presented within the Prevention Strategy suggests that taking a longitudinal approach to prevention – and utilising opportunities for preventative interventions at a range of stages along individuals' lives is effective at reducing future problems including drug deaths. Such a longitudinal view increases the likelihood that effective work with children, adolescents, and their families now could, amongst many other outcomes, reduce the toll of drug deaths in decades to come. **Preventing early initiation into substance misuse should therefore be seen as contributing to tackling Drug Deaths, through early intervention.**

The focus on the prevention of drug deaths will continue to be a top priority for the ADP. In addition to improving the Recovery focused services (see section 4.1.3 below), the take-home naloxone programme and the harm-reduction approach, there will also be an increased focus on the specific characteristics making a person more at risk of drug deaths.

## Secondary Prevention

Individuals affected by alcohol and substance misuse can experience high levels of harm, which often leads to emergency interactions with Acute Healthcare Facilities, including Accident & Emergency, Acute Medical Admissions, the Liver Wards and Orthopaedic Wards. The individuals accessing these acute facilities are those who are experiencing the most harm, morbidity and mortality. It is our intention to provide specific intensive support to these individuals to prevent the escalation of harm to themselves and work with them to progress their recovery.

## Focus On Alcohol

The Focus on Alcohol (FOA) project was created in 2011 in response to the Scottish Government strategy: *Changing Scotland's Relationships with alcohol: Framework for Action*.

FOA is a preventative / early intervention approach, which uses a whole population approach to promote responsible attitudes to alcohol. Through a focus on community engagement FOA aims to reduce alcohol related issues and harm and develop a co-ordinated response to alcohol misuse in localities.

To date the FOA project has followed a health promotion approach focusing on education, public information campaigns and awareness-raising about the impact of alcohol over-consumption. **Increasingly evidence suggest that although such activities are effective in increasing the knowledge of the population, they are ineffective in changing long-term behaviour and reducing consumption and harm**. We therefore propose that in addition to organising awareness raising activities, our focus will shift to measures that would help reduce the availability of alcohol at a local level. This would include working with and supporting the Dundee Licensing Board and Licensing forum.

### Our aim:

***Prevention and early intervention approaches, including Harm Reduction, Trauma-based work and a clear link to Sexual Health and BBV are implemented to prevent and minimise the harm to children, families and individuals in Dundee.***

### To do this we will:

**Strategic action 1:**

**Increase the resources allocated for prevention, early intervention and harm reduction activities**

**Specific actions:**

- Hold a review of the resources allocated to substance misuse with a view to shifting resources towards prevention and early interventions
- Increase education / prevention activities within schools and other relevant settings engaging with children and YP to delay the onset of substance misuse

**Strategic action 2:**

**Ensure harm-reduction and early intervention services are available and accessible to all individuals and communities across the city**

**Specific actions:**

- Ensure individuals are not deterred from approaching services by work with local communities and professionals to address the stigma (and negative attitudes) impacting on individuals and families affected by substance misuse
- Work with the Sexual Health and BBV MCN to improve access and uptake of harm reduction services – IEP and specialist nursing (including timeliness, availability, treatment options)
- Increase IEP coverage to meet the WHO global target (300 n/s per PWID per year)
- Improve responses to non-fatal overdoses, including the issuing of naloxone and the development of an effective pathway of care
- Hold a public event focusing on reducing and preventing drug and alcohol deaths in the city
- Work with the Sexual Health and BBV MCN to increase access and uptake of sexual and reproductive healthcare, including contraception, especially Long Acting Reversible Contraception (LARC), and STI screening

**Strategic action 3:**

**Reduce the harm to individuals, families and the community caused by the over-consumption of alcohol**

**Specific actions:**

- Review the Focus on Alcohol Project to identify ways it can increase support to early intervention/ prevention
- Support the Dundee licencing Board to reduce the availability of alcohol in the city
- Strengthen and support the work of the Dundee licensing Forum to ensure joint working with local license holders
- Ensure teachers, other education and youth workers are provided learning and workforce development opportunities to help the delivery of prevention work within schools
- Strengthen the links between Substance Misuse services and Community Justice Services to provide the most effective interventions and support to individuals where substance misuse is a factor in reoffending
- Ensure that Community Justice staff have widespread training in Alcohol Brief Interventions (ABI) and that assessments for Drug Treatment Requirements or Alcohol Treatment Requirements, as part of Community Payback Orders are timeously and appropriately carried out by staff.

### 4.1.3 Recovery Oriented System of Care

***"A Recovery Friendly Dundee is a city where everyone feels valued, respected and supported rather than defined by their health condition or life circumstances" (Dundee Fairness Commission action plan).***

Recovery is defined as a process through which a person identifies the underlying causes of their substance misuse, addresses the impact drug and/or alcohol use has on their lives to become well and enjoy being an active and contributing member of society.

This concept of Recovery is underpinned by the belief that people can and do achieve full recovery from the impact of the harmful alcohol and drugs use.

**Distinguishing features of an effective Recovery Oriented System of Care (ROSC) include:**

- Inclusive of family and significant others
- Support the Public Protection agenda - keeping people safe from harm
- Ensure access to other key services such as housing, employability etc.
- Services are well connected to localities and communities
- Offer psychological supports that are trauma-informed

At its centre there is a strength-based assessment that takes account of individuals' recovery potential. There is usually a commitment to peer recovery support services, and most importantly, it is inclusive of the voices and experiences of individuals in recovery, and their families.

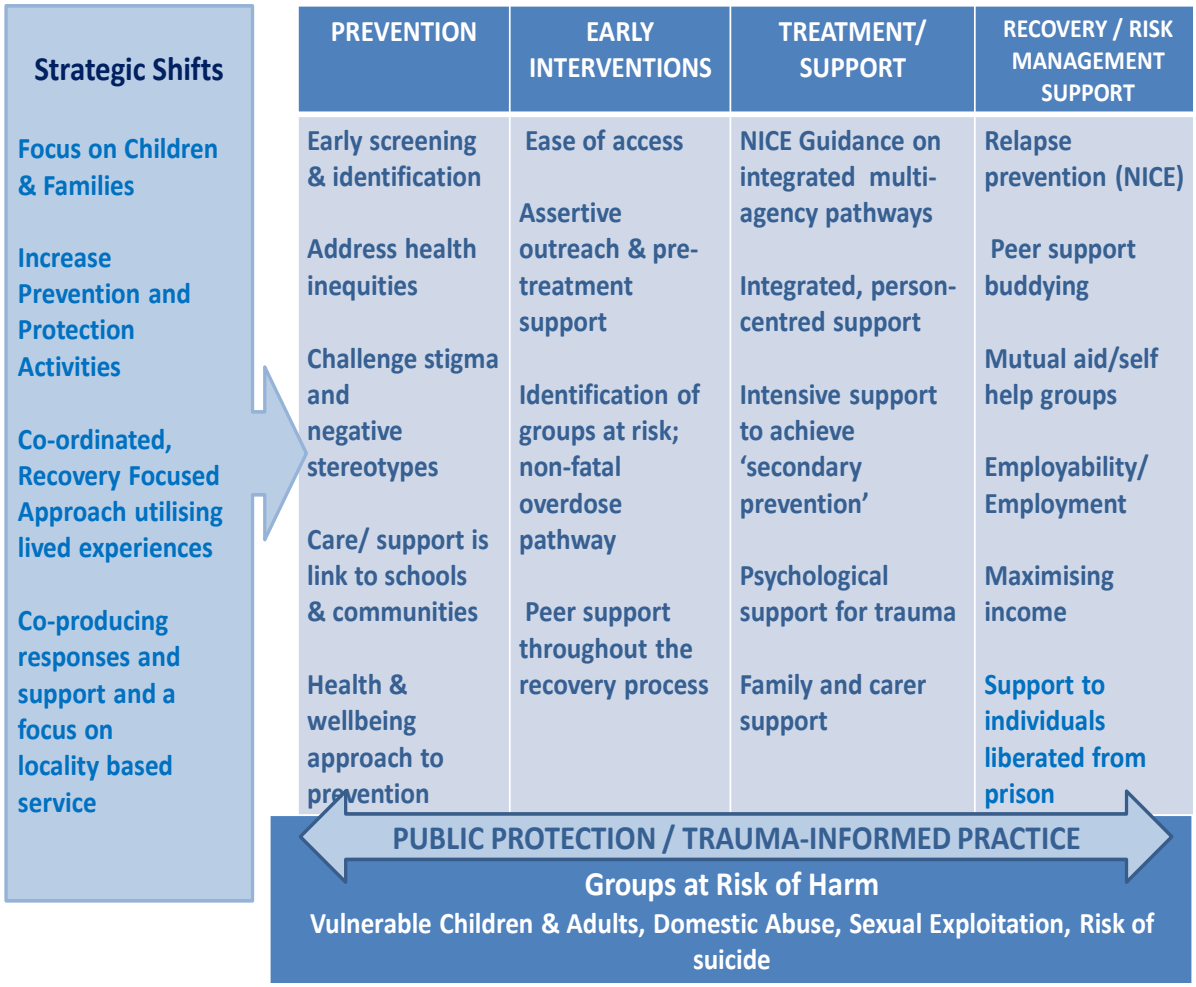
Because issues related to substance use are constantly evolving, a commitment to continuous improvement is essential to ensure individual's needs are met.

In Dundee, the *ROSC* will be further developed through the plan to ensure it is flexible and responsive to these challenges, and supports the critically important *Public Protection - Supporting People* agenda – including specific focus on children affected by parental substance misuse, vulnerable adults, and women affected by domestic abuse, sexual violence and prostitution.

The plan also details a commitment to enhancing the *Prevention* service model that will begin to refocus and target resources towards evidence-based approaches to prevent problems from occurring in the first instance.

The ROSC will reflect the Strategic Assessment of Needs and presents the Case for Change which are mapped onto the diagram below:

## Proposed key areas for development for a Recovery Oriented System of Care (ROSC):
## Seek/ Keep/ Treat




### Our aim is:

**To create an inclusive, accessible, co-ordinated and integrated Recovery Oriented System of Care (ROSC) for people and communities affected by substance misuse. This System of Care will provide the necessary person-centred support to enable everyone to achieve recovery.**

### We will do this by:

**Adopting the following core principles, including:**

- ✓ **All developments will be informed by lived experience**
- ✓ **Community based support will be the norm, including for individuals liberated from prison**
- ✓ **We will evidence how we meet Quality Standards**

- ✓ **Our focus will be on improving outcomes for individuals, families and communities**

- ✓ **Our underpinning belief is that recovery is not just possible but desirable and the visibility of Recovery in Dundee needs to increase**

**Strategic action 1:**

**Accessibility** – the Dundee ROSC will be easily accessible, dynamic and highly visible. It will include a range of evidence-based support, services and activities shaped by lived experiences. The ROSC will also include specific intensive support to individuals experiencing the highest level of harm to prevent deaths.

**Specific action:**
- Support and services will be located in the community and be inked to the Locality Plans
- Individuals (including those liberated from prison) will be able to access the range of support they need, including intensive support, trauma-based support, housing, benefits, domestic abuse, exiting prostitution and more
- Support will be available 7 days a week
- We will review community-based services and other generic (i.e. non substance misuse specialist) services to ensure they are designed to support recovery and are not stigmatising

**Strategic action 2:**

**Focus on the quality of services** – we will ensure that the care and support available as part of the ROSC, will be delivered to the highest standards and by suitably qualified staff. The provision of services will be person-centred and shaped by the experiences of the individuals that access them.

**Specific actions:**
- We will implement the National Quality Standards of Care & Support for drug and alcohol services in Dundee
- We will create a Learning & Workforce Development (LWFD) strategy
- We will implement a Lead Professional model and ensure that individuals are fully involved in the development of their own recovery plans
- We will support individuals, and their networks, to maintain control of their recovery plans at all stages of their recovery

**Strategic action 3:**

**The visibility of recovery** – the ROSC will focus on supporting individuals to develop the tools to initiate and sustain their recovery. It will promote social inclusion and encourage personal responsibility, including active engagement and participation of individuals with lived experience.

**Specific actions:**

- Promote a culture change and increase awareness about the process of recovery and reduce the stigma associated with it. This would be done jointly with the Sexual Health & BBV MCN to also reduce stigma around hepatitis C and HIV
- Ensure the principles of the new ROSC model in Dundee are shared and individuals, providers and communities are aware of their roles and responsibilities
- Promote the value of peer support as a key to both initiating and sustaining recovery and encourage the involvement of carers and families

### 4.1.4 RESILIENT COMMUNITIES

**Dundee's Communities are more resilient as a result of developing a recovery-friendly approach within localities, which recognises and builds on the strengths and assets currently available in the city.**

According to the Dundee City Plan, the quality of Life in the neighbourhoods of Dundee has remained consistently high according to our annual citizen surveys, maintaining the overall satisfaction levels since 2013. The proportion of residents who are very satisfied with the quality of life in their neighbourhood increased from 61% in 2015 to 69% in 2016. This trend is also seen when looking at quality of life in Dundee overall with 62% of respondents to the survey being very satisfied in 2015 increasing to 72% in 2016. The overall satisfaction with the physical environment has remained consistently high, with at least 96% of people rating their neighbourhood as a good or very good place to live since 2012 (Source: Dundee Citizen Survey).

We do know that substance misuse has a direct impact on the lives of communities. But some communities (e.g. communities affected by deprivation) are disproportionately affected by the adverse impact of substance misuse. This impact includes Community Safety, anti-social behaviour (including serious disorder), the health and wellbeing of community members and the opportunities for communities to prosper.

The Dundee Community Plan states that the number of reported cases of antisocial behaviour has remained fairly static over the last five years. The Plan outlines a commitment to developing innovative and proactive ways of responding to antisocial behaviour. This would include an element of responding to anti-social behaviour linked to substance misuse.

Following the locality model outlined in the Dundee Health & Social Care Plan, regular engagement, and co-productive activities will be developed to support communities to respond to the impact of substance misuse. In addition, there will be an increased focus on linking to the Dundee locality-model by delivering community-based services to individuals and families affected by substance misuse. In addition, key emphasis of *Recovery Friendly (Dundee)* is to reduce the stigma associated with substance misuse.

The feedback we received from the consultation suggests citizens would like to see a greater focus on tackling alcohol misuse in the city. We were also told that individuals and families are still affected by the stigma associated with substance misuse. We will engage widely to encourage workers, citizens and communities to believe that recovery is possible for all.

Reporting on the development of a 'Recovery Community' in Scotland,

> "*A man describes doctors crushing his hope by saying he had "zero chance of recovery". Another talks about the daily experience of walking past newspapers with headlines about "junkies", deepening his shame about illness and making him even more reluctant to seek help"* (from a report on BuzzFeed News September 2017).

**Our aim:**

**Individuals and communities are knowledgeable about the harmful impact of alcohol overconsumption and drug misuse, and are supported to build resilience and reduce stigma.**

**To do this we will:**

**Strategic action 1:**

**Develop a communication strategy and implement targeted actions to support individuals, communities and organisations to promote safe use of alcohol and substances.**

**Specific actions:**

- Work with *Recovery-Friendly Lochee* (as a model that could be rolled out city-wide) to promote positive recovery messages that also focus on reducing stigma
- Develop a Dundee campaign to raise awareness about the safe consumption of alcohol
- Work with local media to improve the coverage of these complex issues and reduce stigmatising reporting
- Work with local business, including licenced premises, to support safe use of alcohol consumption through display of materials (charter)
- Review the alcohol overprovision assessment to manage the availability of alcohol

**Strategic action 2:**

**Bring a culture change around the consumption of alcohol**

**Specific actions:**

- Manage the availability of alcohol through a revised alcohol overprovision assessment
- Organise an engaging campaign to raise awareness about the safe consumption of alcohol at license premises and with local Communities.
- Review FOA project to ensure messages about the safe consumption of alcohol are more visible

**Strategic action 3:**

**In partnership with communities and their representatives identify the impact of alcohol and substance misuse in their area and take appropriate actions.**

**Specific actions:**

- Through local community partnerships identify key issues arising from alcohol and substance misuse within communities and develop joint local action plans to address this
- Ensure individuals collecting clean needles and other paraphernalia receive clear instruction on safe discarding
- Ensure a rapid and efficient response to discarded needles.

- Working with partner agencies implement approaches which ensure the responses to disruptive behaviours in communities include the ability to highlight and address concerns
- Utilising established Engagement Strategies (including the CPP, the H&SCP, the Protecting People Team and NHS Tayside) to ensure an on-going engagement process with local communities to facilitate joint responses to the impact of substance misuse.

**Strategic action 4**

**Support communities to build resilience by developing a community based recovery approach within localities which recognises and builds on the strengths and assets currently available.**

**Specific actions**

- Work with communities and community groups to develop a better understanding of recovery approaches and how this can be applied at a community level
- Map current community resources to identify gaps, develop local resources and support the promotion of group work.
- Deliver services at a community level to support the health and wellbeing needs of those affected by alcohol and substance misuse.
- Support Recovery and make it visible in Dundee (ensure people know where meetings take place and how to join them).
- Ensure communities in Dundee are aware of Recovery
- Work with local communities to change views about Recovery and challenge stigma
- Develop agreed consistent messages in relation to the ROSC and work with the local media to portray these messages.

## 5. ACCOUNTABILITY AND REPORTING ON PROGRESS

We will use four broad types of indicators to report on the progress we make, including:

- Context Indicators
- Input Indicators
- Activity Indicators
- Outcome Indicators

**Context indicators,** although not measuring performance directly, enable us to understand the scale or nature of the problem/ situation around substance misuse that we are all working to address. Examples of context indicators include the number of problematic drug users in Dundee / the number of children affected by parental substance misuse / the number of individuals reporting to exceed the recommended levels of alcohol consumption.

**Input indicators** provide information on what we invest in Dundee (e.g. staff / budgets) to enable us to provide the activities / support and services to those affected by substance misuse and to prevent further escalation.

**Activity / Output indicators** measure the range of activities (e.g. number of referrals to specialist services / number of assessments / number of individuals receiving services) we are able to deliver to individuals.

**Outcome indicators** measure the impact that the activities and interventions we provide have on the lives of individuals, families and communities.

| **Inputs** | → | **Outputs** | → | **Outcomes - Impact** | | |
|---|---|---|---|---|---|---|
| | → | Activities | → | Short-term | Medium - term | Long-term |
| What we invest | | What we do | | What change happens in the short term | What change happens in the medium term | What change happens in the long term |

### High Level outcomes we will be working to:

- Children have improved life chances and are safer where there is risk of early initiation into substance misuse or harm resulting from a family environment where substances are misused;
- A prevention service model and delivery system incorporating recovery based-prevention, universal prevention, targeted prevention, and early intervention;
- Recovery Outcome System of Care (ROSC) with integrated service pathways that reduce harm and support individual through the entire recovery journey

- Strong, mutually trusting and cohesive communities where citizens can build resilience and live lifestyles free from problematic substance use

**A performance-reporting framework will be developed to monitor progress with the implementation of this plan.**

## 5.1. PROTECTING PEOPLE IN DUDNEE

The Protecting People structure in Dundee is a well-established multi-agency support and interventions to protect people of all ages. The Dundee Protecting People structure reflects the following vision:

*"Dundee's people will have the protection they need, when they need it, to keep them safe from harm".*

The Protecting People strategic themes include: Child Protection, Adult Support and Protection, Violence Against Women, Alcohol and Drugs, Suicide Prevention, Humanitarian Response and Tayside Multi Agency Public Protection Arrangements (MAPPA).

There are clear crossovers between these strategic themes and it is recognised that to successfully tackle the issues related to drug and alcohol use in the city we must consider the full impact of life challenges on individuals and how they are supported.

The linking of substance misuse to the Protecting People structure reflects the increasing recognition that individuals, families and children affected by substance misuse are also affected by a range of other underlying issues. These issues include mental health, existing and historical trauma, learning disabilities, and victims of domestic abuse, prostitution and child sexual exploitation.

## 5.2. GOVERNANCE ARRANGEMENTS FOR STRATEGIC PARTNERSHIP

The Alcohol & Drugs Partnership (ADP) continues to take overall strategic responsibility and leadership on all issues relating to substance misuse in the city. The ring-fenced substance misuse funding allocated to Dundee by the Scottish Government (through NHS Tayside) will be placed with the Dundee Health & Social Care Partnership (H&SCP). The H&SCP, Children & Families Services, NHS Tayside and the voluntary sector will be the key service delivery agencies. The ADP will continue to strengthen its links and collaborative working with the Sexual Health and BBV MCN to maximise the impact of collective prevention and harm reduction interventions.

### 5.2.1 Strategic Planning Group (SPG)

The Substance Misuse SPG has been established and will have responsibility for the implementation and monitoring of the improvement and change processes outlined in this plan. The Head of Service for Health & Community Care chairs the SPG and membership includes representation from all the substance misuse services (public and third sector organisations) as well as other key organisations/ services, including Children & Families, Neighbourhood Resources and Housing, Violence Against Women, and carers' support. The SPG also includes representation from Carers' group and individuals accessing services. The SPG will report to the ADP and the IJB.

### SPG work-streams

To allow the SPG to oversee the progress and monitor the implementation of the Plan, four Work-Streams have been established. These Work-Streams coincide with the four strategic priorities of this Plan and include: Children & Families/ Prevention/ Recovery system of care/ Resilient Communities. It is planned that each work-stream will be co-chaired.

### 5.3 Finance and Resources

In the light of resource challenges for drug and alcohol services, the ADP and IJB are currently undertaking a comprehensive review of resources to ensure they demonstrate Best Value, and to identify the level of funding available to continue further innovation and tests of change.

### 5.4 A 'Whole System Approach' to the Development of Services

The integration of health and social care services has already demonstrated a significant improvement in both service delivery models and outcomes for people. Drug and alcohol (NHS Tayside) services were managed through the Mental Health Directorate and transferred to the IJB at the latter part of 2016. The social work/care services and health services, alongside the commissioned services will be managed through a single management and service structure. This change provides an ideal opportunity to consider integrated pathways, redesign service models at both a statutory and commissioned level, and develop stronger links across the wider partnership arrangements (Community Planning Partnership and Integrated Children Services).

By bringing both strategic and operational functions closer together and aligning the IJB, ADP and partnership funding into an aligned budget it will be possible to make best use of the available resources while delivering the strategic priorities within a reduced financial framework.

### 5.5 COMMUNICATIONS

The Partnership is committed to ensure that individuals and communities will be kept updated about the progress being made with the implementation of this plan.

This commitment also include ensuring that the Dundee public is kept informed regarding up to date and relevant issues in respect of substance misuse.

A range of communications approaches (including the new **Protecting People Website** and other forms of social media) will be utilised to ensure communities in Dundee have the opportunity to express views, share experiences and request additional information.

More generally, the **Protecting People Communication and Engagement Strategy** includes a commitment to developing and delivering awareness raising campaigns focusing on different groups and individuals at risk of harm. This commitment would include a programme of communications events with the Chief Officers' Group, providing a range of staff the opportunity to discuss topical issues with the Chief Officers, and a number of engagement events with Elected Members.

The cross cutting nature of the Protecting People approach will ensure that substance misuse features in any activity relating to adult and child protection, violence against women, suicide prevention and more.

Building on the progress achieved to date in respect of Substance Misuse Strategic Planning Group (SPG), there will be a greater focus on the involvement of practitioners across the partnerships in the development of strategy and services in respect substance misuse.

## 6. LEARNING AND WORKFORCE DEVELOPMENT APPROACH

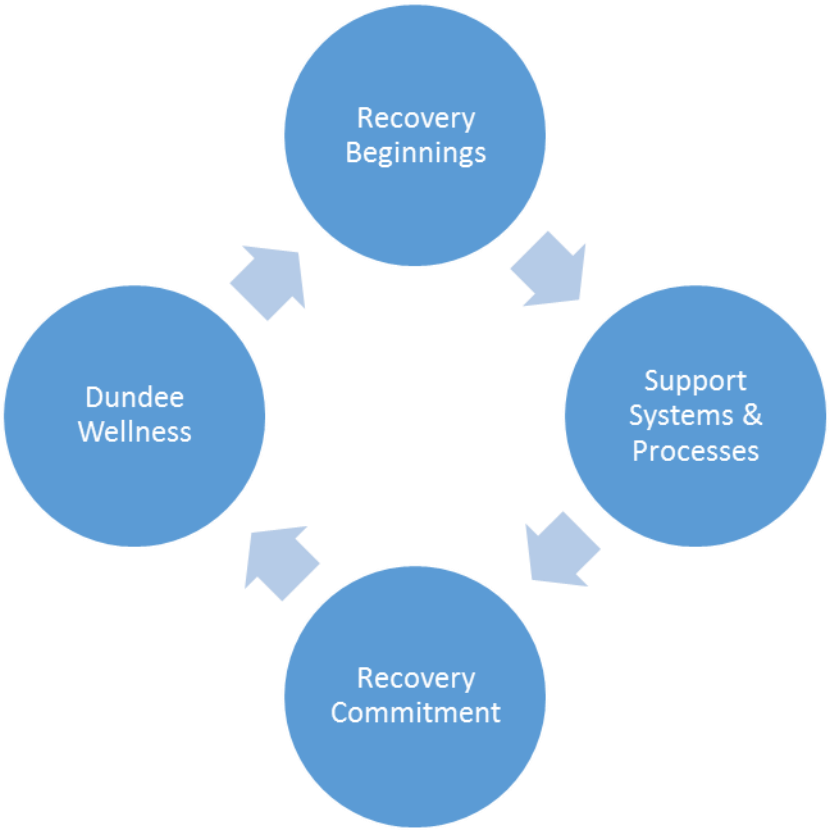
This Strategic & Commissioning Plan outlines a commitment to establish a Recovery Oriented System of Care (ROSC) in Dundee. As part of the establishment of the ROSC, we will ensure that the workforce in Dundee (including staff, volunteers and managers working in a wide-range of organisations) is supported to implement the ROSC. The approach to Learning & Workforce Development (LWFD) outlined below will be integrated to the Protecting People LWFD framework which is underpinned by the requirement to fulfil Public Projection statutory duties.

Five qualities have been identified that apply equally to the whole workforce, regardless of organisation or role within that organisation. These include:

- ✓ Demonstrable belief that recovery is possible
- ✓ Commitment to own learning
- ✓ Enthusiastic/ Relentless Optimism
- ✓ Interested
- ✓ Curious/Inquisitive

### Learning and Development (LD) Plan

Our LD Plan includes four inter-related themes:




### Recovery Beginnings

This theme includes how people gain access to the support they will need to initiate their recovery. How we ensure access is as simple and flexible as possible, including promotion of outreach services and locality working. This also includes

understanding the role of relapse prevention, harm reduction, family and peer support as well as how services such as housing, welfare reform, primary care, criminal justice, mental health and children's services are involved.

### Support Systems & Processes

This theme covers the referral pathways, eligibility criteria and discharge protocols for the different support services across the city. A key area priority is to jointly identify and implement the conditions for integrated working and for each member of staff/volunteer to understand their contribution to an individual's recovery. This will cover issues such as building trust, knowledge, information sharing and our value base. It will also establish partnership-wide agreements regarding missed appointments, lateness etc.

### Recovery Commitment

This theme covers what each "party" can expect, what their role and responsibilities are in supporting their own and/or another's recovery. It will support the establishment of the necessary mutual respect between all involved. By being open and clear about what each "party" contributes and their expectations we can collectively demonstrate what our recovery orientated system of care means.

### Dundee Wellness

This theme covers all those wider aspects of support necessary to sustain and maintain recovery. This includes those services listed under Recovery Beginnings as well as mutual aid, sport & leisure and employment & training.

***For the full plan please contact the Protecting People Team***

## 7. FINANCIAL FRAMEWORK AND STRATEGIC SHIFTS

### 1. THE SHIFTS WE NEED TO DELIVER INCLUDE:

**Health:** Addressing health inequalities, improved interventions for people with complex needs, reducing harm, tackling the contributory factors associated with drug deaths, developing more trauma based therapeutic interventions

**Accessibility:** Ensure all services are accessible to those who needs them and are located within community settings

**Prevalence:** Increasing focus on prevention and early intervention; shifting the balance of resources invested in these approaches; develop the whole population approach to reducing alcohol and drug consumption

**Recovery:** Improving the Recovery Oriented System of Care (ROSC) - the open access, supporting engagement with and retention in services, involving service users, developing peer supports, mutual aid and SMART Recovery. This includes effective through-put, people recovering in their own communities, supported through employability and to full citizenship.

**Families & children:** Increasing prevention interventions targeting children and young people at risk of early initiation into substance misuse and those affected by parental substance misuse, supporting carers and family members, developing family focussed interventions

**Quality:** Improving compliance with national quality standards, developing integrated pathways of care and a locality approach, strengthen joint working between substance misuse and generic services

**Community Safety:** Involving communities, building resilience and capacity, working with the Dundee Community Justice Partnership, improving the Community Justice pathway for people who use alcohol and drugs. Working together to address the negative impacts of substance misuse, for example its link to offending.

**Local environment:** Reducing alcohol availability, encouraging responsible drinking, supporting communities to influence alcohol licensing

### 2. TO ACHIEVE THESE SHIFTS WE HAVE IDENTIFIED 4 KEY PRIORITIES

**Children & families:** Children who are at risk of early initiation into alcohol and drug use, and / or are at risk of exposure to harm in family settings where substances are misused - will have improved life chances and will be safer.

**Prevention & protection:** Prevention and early intervention approaches, including Harm Reduction, Trauma-based work and a clear link to Sexual Health and BBV are implemented to prevent and minimise the harm to children, families and individuals in Dundee. Co-ordinated activities between Substance Misuse services and Community Justice Services to reduce the

risk of reoffending where substance use is a factor.

**Recovery:** A well-coordinated and effective Recovery Oriented System of Care with integrated pathways through services that promote safety, health, wellbeing to help people and families achieve their personal goals.

**Resilient communities:** Individuals and communities are knowledgeable about the harmful impact of alcohol overconsumption and drug misuse, and are supported to build resilience and reduce stigma.

**Within these 4 priorities, resources will be prioritised towards:**

- Implementing family-focused interventions and work to strengthen parenting capacity to prevent harm to children.
- Improving our responses to non-fatal overdoses and develop effective pathway of care, treatment and support which prevent drugs deaths.
- Development of approaches to reduce drug diversion, promote wellbeing, recovery and protect children and adults from harm linked to a transformation of primary care.
- Development of integrated locality multi-disciplinary and multi-agency teams providing services and support from community-settings and following the principles of the ROSC to increase accessibility, engagement and full recovery.
- Working in partnership Scottish Prisons Services and the development of the PAUSE approach, develop specific and targeted interventions to support women in Dundee recover from substance misuse.
- Increasing non-medical prescribers to increase accessibility of services and range of treatment options available.
- Promoting culture change and increase awareness about the process of recovery, reduce the stigma associated with it and support local communities.
- Peer support, volunteering, learning from those with lived experiences, including involvement of carers and families linked to integrated locality multi-disciplinary teams.

## 3. FINANCIAL FRAMEWORK

To support the delivery of drug and alcohol treatment and support services in Tayside, the funding allocation for 2018-19 is £4,158,654. Some of this funding supports cross Tayside substance misuse services with the balance allocated to individual ADP's for local commissioning decisions. The formula for this allocation is currently undergoing a review and final local allocations have yet to be determined.

The Scottish Government announced that a further £20m is to be made available in 2018/19 for drug and alcohol services however the allocation to Integration Authorities has as yet to be communicated by the Scottish Government.

## 8. APPENDICES

**Appendix 1:** A summary of the sources of information used to develop the 'case for change' and the strategic outcomes expected

| Sources of Information | The Case for Change | Strategic Outcomes |
|---|---|---|
| **ADP Review (2014): consultations with Stakeholders (Dundee ADP)** | • Improve access to services in communities<br>• Work in more joined up ways to help people with complex needs<br>• Improve coordination and consistency when assessing people's needs and planning care | • Quicker access to services, support and advice - within Community Hubs<br>• Experience higher quality services – Support & Connect Approach<br>• Increased choice and opportunity to access recovery-based services<br>• Increased focus and investment in prevention interventions.<br>• Reduced duplication and increase joint working and integration |
| **Profile of the Substance Misusing Population in Dundee 2016 (NHS Tayside)** | • Reduce alcohol consumption/drug use<br>• Increase preventative approaches<br>• Health harm/social harm<br>• Integrate Recovery pathways<br>• Needs of children and families<br>• Capacity and response times in services | • Fewer people will be drinking harmful levels of alcohol<br>• Fewer people will be using drugs<br>• People live in positive, health-promoting environments where alcohol and drugs are less available<br>• Reduced levels of health harm (i.e. casualty visits)<br>• Increased numbers of people progressing through a Recovery pathway |
| **ADP Prevention Strategy 2017** | • Increase indicated, selected and universal prevention services and activities<br>• Aiming, over time, to achieve decisive shift to prevention advocated by The Christie Commission | • Fewer young people inducted early into substance misuse<br>• Reduction in the contributing factors leading to drug deaths<br>• Fewer people progressing into problematic use of alcohol and/or drugs<br>• There is an increase in the resources invested in prevention/ early interventions |
| **Tayside Sexual Health & Blood** | • Early intervention to address the wider determinants of health | • Fewer newly acquired BBV and sexually transmitted infections and unintended pregnancies; |

| Sources of Information | The Case for Change | Strategic Outcomes |
|---|---|---|
| **Borne Virus (BBV) MCN's BBV Prevention Framework 2013** | • Focussing on the needs of marginalised and excluded groups<br>• Awareness raising, education and behavioural interventions with a focus on de-stigmatisation<br>• Reducing transmission from those who are already infected | • A reduction in the health inequalities gap in sexual health and blood borne viruses;<br>• People affected by blood borne viruses lead longer, healthier lives;<br>• Sexual relationships are free from coercion and harm; and<br>• A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive |
| **Validated Self Evaluation (Care Inspectorate) 2016** | Support services to improve compliance with all national Quality Principles | • Alcohol and drugs prevention, treatment and support services are effective, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into recovery<br>• Services develop a culture of *self-evaluation* – a constant cycle of review and improvement actions<br>• Stakeholders views (in particular services users) and recommendations are fully accounted for in policy development and service improvement |
| **Self - Evaluation NICE Alcohol Pathway** | Address gaps in services, improve integrated working - psychological support/ trauma focussed services, relapse prevention, | • More people recover from harmful drinking and alcohol dependency<br>• Children and family members of people misusing alcohol are safe, well-supported and have improved life-chances |
| **Tayside Drug Death Report 2015** | Support services to improve focus on groups identified at risk of harm or drug death | • More people supported to reduce harm and risk of drug death<br>• Families and carers are supported to cope with the challenges of caring |
| **Staying Alive in Scotland 2106** | Support services to implement best practice in reducing drug deaths | • People supported to reduce harm and risk of drug death<br>• More families and carers are supported to cope with the challenges of caring |
| **Dartington Research Unit - Children Count Wellbeing Survey 2017** | Services and activities to avert children and young people from early substance misuse | • Children and young people protected from harm due to early initiation into substance misuse<br>• Children exposed to parental substance misuse are identified and supported more quickly |

| Sources of Information | The Case for Change | Strategic Outcomes |
|---|---|---|
| | | • Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances |
| **Conversations with You – Consulting Our Stakeholders** | Individual citizens in Dundee, local communities, carers and individuals affected by substance misuse are given the opportunity to determine and influence the direction of change | • Establish mechanism for on-going consultation and communications<br>• Increase the visibility of Recovery in Dundee<br>• Communities in Dundee are involved in, and have a sense of ownership of the strategic approach to substance misuse |

Appendix 2 Bibliography

Alcohol: school-based interventions, Public health guideline (PH7), NICE, 2007

Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland.

International Standards on Drug Use Prevention, 2015, United Nation's Office on Drugs and Crime.

NHS Health Scotland briefing on attachment sourced at: http://www.healthscotland.com/documents/5755.aspx

Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland.

Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland.

International Standards on Drug Use Prevention, 2015, United Nation's Office on Drugs and Crime.

The International Standards on Drug Use Prevention rate the evidence base for these interventions as Very Good (****). indication of reduced marijuana use at 18 and potentially also impact on other illicit drug use and smoking.

BuzzFeed News: https://www.buzzfeed.com/jamieross/this-is-how-scotlands-recovering-addicts-organised-to-fight?utm_term=.ogVMzdkN0#.pkBmopnKa

Tayside Sexual Health & Blood Borne Virus (BBV) MCN's BBV Prevention Framework 2013

NICE substance misuse interventions for vulnerable under 25's: http://pathways.nice.org.uk/pathways/substance-misuse-interventions-for-vulnerable-under-25s/substance-misuse-working-with-vulnerable-under-25s#content=view-node%3Anodes-identification-and-support

Dundee city Plan 2017-2026

Dundee Health & Social Care Strategic & Commissioning Plan 2016-2021 https://www.dundeehscp.com/sites/default/files/publications/dhscp_strategic_and_commissioning_plan_0.pdf

The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services

Report on the *Future Delivery of Public Services by the Commission chaired by Dr Campbell Christie. Published on 29 June 2011*

**ITEM No …9……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **DUNDEE PRIMARY CARE IMPROVEMENT PLAN UPDATE**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB45-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to provide additional information on the Dundee aspects of the Primary Care Improvement Plan from that provided in the report (Report No DIJB26-2018 – Tayside Primary Care Improvement Plan) submitted to the Integration Joint Board held on 27 June 2018, and seek approval, including the financial framework for the Direction to NHS Tayside.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the Tayside Primary Care Improvement Plan (the Plan) has been approved by the Local Medical Committee (LMC) and endorsed by NHS Tayside Board and has been submitted to the Scottish Government after approval by Dundee IJB;

2.2 Notes the updated action plan, and associated financial implications, for Dundee Health and Social Care Partnership as described in Appendix 1;

2.3 Notes the requirement to submit further information to the Scottish Government in September 2018;

2.4 Agrees to direct NHS Tayside to implement with immediate effect the specific actions relevant to them in the Tayside Primary Care Improvement Plan as outlined in the Dundee Action Plan (Appendix 1) and as described in section 8;

2.5 Instructs the Chief Officer to provide a further report on progress made in the first year to a future IJB.

## 3.0 FINANCIAL IMPLICATIONS

The overall financial context was outlined in the previous report (DIJB26-2018). This report sets out the initial estimated costs of implementation of a range of developments as reflected in the Primary Care Improvement Plan (Appendix 1 - Table1).

## 4.0 MAIN TEXT

### 4.1 Context

4.1.1 The IJB has previously considered papers setting out the context and challenges within primary care (Report No DIJB51-2017 - General Practice and Primary Care presented at the meeting held on 19 December 2017) and the implications of the General Medical Services (GMS)

contract and related memorandum of understanding (Report No DIJB9-2018 presented at the meeting held on 27 February 2018) as well as a report which detailed the Tayside Improvement Plan DIJB26-2018 on 27 June 2018.). The Tayside Improvement Plan was agreed by Dundee IJB, the local Medical Committee and endorsed by NHS Tayside Board prior to its submission to the Scottish Government. This paper builds on these previous papers by outlining how developments will be taken forward to support the changes required within Dundee and the current projections for finances related to this. As noted previously many of these developments build on work already underway in Dundee as part of the Strategic and Commissioning Plan. However, a number of areas are significantly different and less developed in terms of building blocks.

**4.2 Dundee Commitments**

4.2.1 The Dundee Action Plan which builds on the Tayside Primary Care Improvement Plan is in Appendix 1. It outlines the key areas of work, the finance associated with the initial work for year 1 for these areas, and some of the related issues and risks.

4.2.2 The Dundee Primary Care Improvement Group has been established to agree and monitor the developments as outlined in the Plan. This group links with a number of Tayside wide groups which are supporting the GMS Contract implementation as well as wider issues for Primary Care. The Tayside wide elements of the Plan, particularly for the Vaccination Transformation Programme, and the Pharmacotherapy Service, will be monitored via the new GMS Contract Implementation and Advisory Group. All aspects of the Plan will be monitored and reviewed by the Dundee group.

4.2.3 There are close links between the Primary Care Improvement Fund and funding which is to support the implementation of Action 15 of the National Mental Health Strategy. There are also links to the funding IJBs are receiving for Out Of Hours care, emphasising the need to look at consistent pathways for people regardless of the time they require that care.

4.2.4 At this stage of planning it has not been feasible to develop costs for years 2 and 3. Given the services described are new as centralised services there is a significant amount of work to test the initial proposed models and assess how best to progress this longer term, to deliver at scale across Dundee, in the most efficient model we can. However it is anticipated that the funding from the Scottish Government will be insufficient to meet the requirements to deliver this work at scale.

4.2.5 As noted in section 6 there remain key risks across the programme which will impact on delivery. Aspects of these risks sit with NHS Tayside and there is a requirement for NHS Tayside to support the delivery as outlined in section 8. Further detail of risks is contained within the Action Plan.

4.2.6 Given the evolving nature of the developments, and the finance associated with this, there is an ongoing requirement to consult widely as learning is gained to develop and refine the delivery models. A communication and engagement plan will support this work going forward, particularly around how the public are supported to change how they expect services to be delivered.

**4.3 Next Steps**

4.3.1 Service managers are planning implementation as relevant to their area of care. There are a significant number of tests of change planned which will inform the development of services as the implementation develops. This will inform the future model of delivery, and financial planning. It is anticipated that the costs to fully implement the areas of care as highlighted in the memorandum of understanding will significantly exceed the funding being received from the Government. Once these costs are more fully understood further consideration will be required to plan how to fund this work.

## 5.0 POLICY IMPLICATIONS

Each area of the plan will require to have an ongoing assessment of EQIA. This paper has been screened and there are no significant implications of the paper.

## 6.0 RISK ASSESSMENT

The following key high level risks were identified in the previous paper and remain. Risks will be identified and managed within each service in more detail and managed by the Dundee Primary Care Improvement Group. Further information on risk associated with each development are noted in appendix 1.

| | |
|---|---|
| **Risk 1 Description** | There is a significant risk that Dundee may not recruit or develop the workforce to deliver all of the commitments in this plan given the scale and breadth of the plan. This applies across a number of professions, including pharmacy, nursing and Allied Health Professionals (AHPs). This will directly impact on the delivery of services described. |
| **Risk Category** | Workforce, operational |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 |
| **Mitigating Actions** (including timescales and resources ) | All services are planning with this risk at the forefront and looking to maximise skill mix as much as possible to reduce this. Longer term national work to provide increased undergraduate training will support this but not within the timescales of the 3 year plan. |
| **Residual Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 |
| **Planned Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 |
| **Approval recommendation** | This risk should be accepted. |

| | |
|---|---|
| **Risk 2 Description** | There is a risk that we will have inadequate infrastructure to support the delivery of the Plan, both in terms of IT infrastructure and systems, and buildings/premises. |
| **Risk Category** | Technological, Environmental, Financial |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 |
| **Mitigating Actions** (including timescales and resources ) | Investment in year 1 for IT infrastructure and systems need to be prioritised to allow dependant aspects of delivery to progress.<br>Some services may need to be delivered from Practice premises.<br>Consideration needs to be given to where premises are required and capital bids may be required to progress any gaps. |
| **Residual Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 |
| **Planned Risk Level** | Likelihood (3) x Impact (3) = Risk Scoring 9 |
| **Approval recommendation** | This risk should be accepted. |

| | |
|---|---|
| **Risk 3 Description** | There is a risk that the finance allocated via the primary care improvement fund will not adequately meet all the costs to implement the plan, and that resource will have to be identified from other sources. This will impact the scale and pace of roll out of services across the city. |
| **Risk Category** | Financial |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 |
| **Mitigating Actions** (including timescales and resources ) | Other sources of funding will be identified as opportunities arise. Finance is a key component of planning and ensuring the most cost effective models are progressed. Where models with variation in costs are tested in different parts of Tayside there will be a judgement made as to cost effectiveness of these models prior to roll out. |
| **Residual Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 |
| **Planned Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 |
| **Approval recommendation** | This risk should be accepted. |

**7.0 CONSULTATIONS**

The Chief Finance Officer and the Clerk were consulted in the preparation of this report. A significant number of groups have informed and been involved in the development of both the Tayside Plan and the local plans that are emerging. This includes:

- Practice staff at a protected learning event
- Dundee cluster/LMC meeting
- Individual cluster meetings
- Practice managers' meeting
- A number of service/team meetings
- Integrated Strategic Planning Group (ISPG)
- Mental Health and Wellbeing Strategic Planning Group (sub-group)
- Frailty Strategic Planning Group
- Dundee HSCP Staff Forum.

There has been no direct public consultation on the Plan to date but going forward there will be significant engagement with communities as part of the wider development of the Plan, particularly to inform local models of delivery.

**8.0 DIRECTIONS**

8.1 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.

8.2 A number of key areas of the plan are predicated on the availability of staff, and appropriate infrastructure. These areas remain within the responsibility of NHS Tayside. Delivery systems are being developed around patient pathways which often cross primary, secondary and community care. Information systems require to support this. There are a number of areas of the plan where this is challenging, partly as this is new work to be delivered in this setting, (as opposed to in general practice,) and the systems which can share information across these

systems is not yet in place. A number of developments in both hardware and software require development and investment.

8.3 In moving work from general practice suitable premises are required. This may be in general practice or in other settings. The ambition to have a multi-disciplinary team with the GP as the key clinical leader would ideally be supported within general practice buildings. However we know that very few practices have spare capacity for space. Locality models will also support this work, but again there is limited availability of any clinical space in other health care premises. There will therefore be a requirement for NHS Tayside, who retain this responsibility, to identify or develop appropriate space.

8.4 Staff are our key asset and the workforce requirements to support the plan are significant. This is predominantly for health staff across a range of disciplines. As the employing body NHS Tayside will require to support the development and employment of suitably skilled staff to support these new and emerging models. It is of note that this is a competitive area given that all other boards are looking to develop similar models. There is likely to be high demand on specific aspects of training, particularly in the context of advanced practice, which may not be met by current provision of training.

8.5 As the actions noted above are central to the delivery of the Primary Care Improvement Plan the flowing direction is applied to NHS Tayside.

| Direction Required to Dundee City Council, NHS Tayside or Both | Direction to: | |
|---|---|---|
| | 1. No Direction Required | |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | ✓ |
| | 4. Dundee City Council and NHS Tayside | |

**9.0 BACKGROUND PAPERS**

None.

David W Lynch
Chief Officer

DATE: 6 August 2018

Shona Hyman
Senior Manager
Service Development & Primary Care

David Shaw
Clinical Director

Dundee Health & Social Care Partnership

# DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

| | | |
|---|---|---|
| 1 | Reference | DIJB45-2018 |
| 2 | Date Direction issued by Integration Joint Board | 28th August 2018 |
| 3 | Date from which direction takes effect | 28th August 2018 |
| 4 | Direction to: | NHS Tayside |
| 5 | Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s) | No |
| 6 | Functions covered by direction | Specific actions relevant to NHS Tayside in the Tayside Primary Care Improvement Plan. |
| 7 | Full text of direction | Dundee IJB directs NHS Tayside to implement, with immediate effect, the specific actions relevant to them in the Tayside Primary Care Improvement Plan as outlined in the Dundee Action Plan (Appendix 1). |
| 8 | Budget allocated by Integration Joint Board to carry out direction | To be confirmed. |
| 9 | Performance monitoring arrangements | To be monitored every 3 months. |
| 10 | Date direction will be reviewed | November 2018 |

**Appendix 1**

**Dundee Primary Care Improvement Plan**

**1. Vaccination transformation programme (VTP)**

Dundee Health & Social Care Partnership (H&SCP) support the NHS Tayside commitments and funding will be allocated to support this. This includes the additional vaccinations for children not already undertaken, and a test of midwifery support for vaccination of pregnant women.

**2. Pharmacotherapy Service**

Dundee H&SCP support the NHS Tayside commitments and funding will be allocated to support this. There will be an initial test of change in 2 practices in Dundee to assess the required skill mix longer term, and allow planning for recruitment of appropriate staff to support this. Initial recruitment will be progressed in the interim.

**3. Musculoskeletal (MSK) services**

Dundee H&SCP support the NHS Tayside commitments. In year 1 a model will be tested in a small number of practices, building on the test of change started in one practice in June. This test is already under review and evolving. This, or an alternative model based on comparison with other models in Tayside, will be rolled out across Dundee based on this learning, over the following two years, aiming to provide a service to all practices/patients by the end of year 3.

**4. Mental Health services**

Dundee H&SCP support the NHS Tayside commitments in year 1. A model will be tested which provides initial assessment and triage for patients presenting with mental health issues, (although not children or older people initially). As part of this work pathways of care will be reviewed and how referrals across the system are made to try to streamline and simplify where we can, increasing the access to the right services first time. This will be compared with alternative models in the other areas of Tayside and based on this broader perspective the model will be rolled out across other practices/clusters as capacity/ funding is available. There is likely to be a significant challenge for workforce development/ recruitment of this aspect of delivery, regardless of the professional who does the initial assessment. We are therefore unable to commit to full roll out in 3 years. This area of delivery links to developments within mental health, and linked to funding for Action 15 of the national Mental Health Strategy.

**5. Link workers/social prescribing.**

Dundee H&SCP support the NHS Tayside commitments. In year one we will embed the link workers who have already been recruited as part of an early adopter programme into practices and review the model to ensure it is the best fit for the change in focus with the Primary Care Improvement work. As part of this we will consider skill mix and links across sectors, as well as scoping wider social prescribing initiatives in Dundee and how we maximise the impact across the system.

**6. Urgent care.**

Dundee H&SCP support the NHS Tayside commitments. We will work with colleagues across Tayside to scope the role of advanced practitioners in supporting urgent care, and plan a test linked to this. This is likely to be in year 2 but some aspects will be progressed in year 1. This will be closely linked to out of hours urgent care and SAS. It may be feasible to test a paramedic model in year 1.

In year 1 we will build on the redesigned care homes team to increase the nursing component of assessment when residents are unwell. This includes training and up skilling of the current nursing team to develop their knowledge and skills around clinical assessment and diagnosis. This will work towards a nursing assessment being the first contact for all care home visit requests in the longer term, (where appropriate to do so.)

In year one the current Enhanced Community Support (ECS) and Enhanced Community Support Acute (ECSA) models will be reviewed to assess how to best support patient pathways when patients deteriorate, and where different roles best support that pathway. This review will inform developments going forward.

In year 1 the Advanced Nurse Practitioner (ANP) role in the team will be enhanced to start and develop supporting frameworks and clinical tests. This will be supported by a nurse consultant post in urgent care, which will both have a clinical role and support the development of capacity in the nursing profession to support this work, including directly in general practice.

**7. Care and treatment services**

Dundee H&SCP support the NHS Tayside commitments. The current team who support leg ulcer work will be developed to deliver an expanding role as systems develop to support this. The team will be integrated longer term with anti coagulant and catheter care, to start to provide a more unified team working in localities and with clusters of practices. Clinical priorities to move work from general practice teams include further leg ulcer work, wound care, such as pilonidal sinuses, and starting to test phlebotomy. Some of these developments are closely linked to the development of information systems, and governance linked to that. Training of the team is required. A system has been identified to support a test of change. This should coincide with the time frame to recruit staff.

There are issues around delivering this model to capacity with the current community and primary care premises we have. So work will be undertaken in year 1 to scope what capacity we have, linked to the development of a H&SCP Property Strategy. This will inform how the model progresses, and if it can be rolled out on a community/cluster basis.

Given this will be a fairly sizeable service longer term it is proposed to recruit to posts at all anticipated grades for this in year 1 to ensure focus and drive for this, and a senior nurse role to manage the team going forward. We need to ensure the clinical development of the team and management of the care is planned well from the start. The skill mix for this team is difficult to ascertain until the test of the model is underway.

**8. Premises, infrastructure and IT systems**

A number of pieces of work are being progressed on a Tayside wide basis which will inform planning within Dundee for this aspect of delivery. This includes plans to undertake a comprehensive review of all GP premises to assess suitability and sustainability. This will inform longer term planning of sites going forward, particularly as we look to develop new models of care in communities. We will also utilise this as an opportunity to assess if we have underutilised space which could be used differently.

In terms of information developments and management there is recognition of the requirement for significant change culturally and we will look at how we use technology to support different ways of working. So mobile devices will be utilised and data shared as much as is practical to support patient care and delivery. This helps to create a mobile and flexible workforce. Systems we use are not currently suited to the new models of working being proposed and will need to be developed, along with hardware required for this. Aspects of this will be tested in the redesigned Lochee Health Centre.

**9. Workforce planning and development**

Recruitment and retention of GP's is being led at a Tayside level but we need to adopt a flexible approach to GP recruitment given the issues currently faced. Much of the focus of the plan is on roles which can work alongside GP's, across a wide range of professional groups. This is clearly detailed in the Tayside plan. However we need to consider how this works alongside wider developments, especially for our local workforce, in Dundee. We need to plan across services within the primary care context, but it also across our whole system given the breadth and range of services being considered as part of GP portfolios.

**10. Sustainability/scalability**

Developments need to be both sustainable and achievable at scale. This is challenging for some aspects of the workforce in particular. However if we do not set off with a vision we will never achieve the degree of progress we require to support care in the most effective way longer term. The approach taken should include taking a risk that things may not work, but by testing it we will establish that, and we will refine how we deliver.

**11. Practice staff development** (in general practice)

- Practice admin role to support a range of the above work streams, particularly around a more advanced role in assessment for redirection to other health care professions, as well as signposting to support social prescribing aspects of care.
- Development of nursing roles around advanced practice, disease management etc, including ANP

**12. Evaluation**

Monitoring of the developments to assess progress, and evaluating their impact, is critical to the progress of the plan. However we do not want to create hugely complex systems to do this. It needs to be achievable as part of routine data collection required for clinical purposes as much as possible. The LIST team will support the data aspects of this work, especially where things are focused at cluster level. Wider support will be required to allow key decisions around priority and impact going forward, particularly given the scale of change required, which is not managed by the level of funding.

**13. Communication and engagement**

Communication and engagement is key to the success of much of the change being proposed, along side involving our local communities in shaping our plans. Key messages will be developed on a Tayside basis for public messaging around the culture change required for accessing services. More detailed plans will be developed around communication and engagement for each part of the development as more detailed plans are progressed, to ensure that how the plan is delivered is co-produced.

**14. Funding**

At this stage of planning and testing it is difficult to make any accurate assessment of investment requirements beyond year 1 as there are a significant number of variables. However it is of note that there will be challenges in terms of funding the programme at scale within the 3 years of the plan. The current figures are estimates and subject to change as planning develops. Funding for Primary Care Improvement from the Scottish Government will be utilised, and this can be carried forward from year 1 to 2, but not beyond this. There is a small fund still available from the previous Primary Care Transformation Fund which will be used to support aspects of this work. Other sources of funding are being scoped. The LMC approval of this plan and funding is required prior to submission to the Scottish Government but as plans are not yet finalised this has not been completed. There is currently still an unallocated amount from this years funding, but also a number of proposals which have not yet been costed and are being considered. This is being modelled along with the expansion of the funded projects which require to be rolled out at scale. Currently £987k has been allocated provisionally with £435k unallocated. This will allow greater expansion in year 2 based on tested models.

**Table 1**

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| 1 Vaccination Transformation Programme | • As per Tayside plan will add in "mop up" immunisation for children, and start to test midwifery role<br>• Community based models to be developed as capacity and space allow<br>• Work to identify which practices have space if required | Julia Egan<br>Danny Chandler | £124 | • Ongoing issues with information systems and ability to share data in a timely manner.<br>• Staff recruitment and retention<br>• Uptake rates have been lower when care has been transitioned and there is a risk this continues |
| 2 Pharmacotherapy services | • As per Tayside plan<br>• Test pharmacotherapy service in 2 practices as a test of change and assess the skill mix required for roll out.<br>• Recruit to additional posts to start to create capacity to deliver the service | Jill Nowell/ Elaine Thomson | £256 | • Recruitment of trained pharmacists has been an ongoing issue with an increasing pressure because of the national development of this service where all boards are looking to recruit pharmacists. |
| 3 Musculoskeletal (MSK) services | • As per Tayside plan<br>• Test pilot in Dundee in one cluster in year 1, 2 further year 2, final cluster year 3 (= 2, then 4 then 5 staff in total). Refine model based on tests.<br>• Train staff esp in year one to start to create capacity<br>• Backfill (staff) for NMP course required and may be a limiting factor | Janice McNee/ Matthew Kendall | £55 | • Skill mix of team not known at this stage but recruiting physios to senior posts to work at advanced practice level may be challenging<br>• Providing a service which can replicate the accessibility of general practice for acute |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| | • Identify community based venues with capacity to deliver the service. | | | presentations will be challenging. |
| 4. Mental Health services | • As per Tayside plan<br>• Test assessment for initial contact by MH team (clinical psychologist) as pilot –Patient Assessment and Liaison Mental Health Service (PALMS)<br>• Roll out skill mix/model<br>• Develop new ways of working across pathways<br>• Develop linked roles to direct to most appropriate person from first contact<br>• Ensure close working with development of link worker posts<br>• Ensure we have Listening service/Do You Need To Talk in all Dundee practices (funded via ICF currently) | Arlene Mitchell/Linda Graham<br><br>Sheila Allan<br><br>Alan Gibbon | £36 | • Create capacity beyond year one will be challenging given the challenges to recruit skills mental health professionals.<br>• Sits with wider work to support action 15 of the mental health strategy and requires to be integrated with that. |
| 5. Link workers/social prescribing | • As per Tayside plan<br>• Link workers are already in post due to the early adopter nature of Dundee for this work.<br>• Establish these roles fully and ensure maximising the impact of these roles on practice workload and patient outcomes, across a spectrum of conditions<br>• Develop streamlined processes for recording, monitoring and evaluation<br>• Develop model (processes) to support wider social prescribing in practices, building on the training programme delivered to date | Sheila Allan | n/a | • The link workers are already in post but there are issues with longer term funding due to changes within SG funding processes<br>• Support across wider partnerships to maintain a database of services, but requires investment to scope requirements and information. |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| | • Develop practice teams ability to refer directly where feasible to other agencies<br>• Develop information systems to support this referral and signposting service, both for professionals, the public and patients /carers<br>• Embed welfare rights workers in teams which support clusters | Clare Lewis Robertson<br><br>Craig Mason | Not yet costed | • Welfare rights team are working with a number of practices but a number of competing priorities mean that this is not feasible for all practices. |
| 6. Urgent care | • As per Tayside plan<br>• Review ECS and DECSA to consider how maximise the initial assessment of frail/older people when unwell/ deteriorate, (including how this links with out of hours processes/capacity)<br>• Develop the integrated care home team to be more responsive to supporting varying needs of those in care homes. This includes upskilling of current nursing team to take on a more advanced role, and developing a greater skill mix in the team. A test is planned to start September with one care home and this will be rolled out over the coming months based on this test of change.<br>• Work with colleagues across Tayside to develop a model of advanced practitioners supporting urgent care. Plan to start to test aspects of this in year 1 with subsequent testing a development in year 2 and 3. . This will involve development of new nursing and paramedic roles for Tayside. Work with Scottish Ambulance Service to test additional value of specialist paramedic role in year 1. | Shawkat Hasan/ Jenny Hill<br><br>Shawkat Hassan/ Wendy Reid/ Stuart Payne | NA<br><br>£138 (TBC)<br><br>£24 (paramedic)<br><br>£20 (nursing) | • The current care home team do not currently have a skill mix which supports this level of input to a model as an alternative to GP provision. It is likely to take some time to develop these skills.<br>• There is limited availability of specialist paramedics, ANP's, or a nurse consultant, who can undertake this work. These may need to be developed at trainee roles initially which will delay implementation to the degree planned. |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| | Develop nurse consultant role for urgent care to provide clinical support, develop a nursing model, and support the wider development of urgent care practitioners, in both NHS employed teams and in general practice nursing. | | | |
| 7. Care and treatment services | • As per Tayside plan<br>• Develop a nursing team who can deliver the range of services (as defined in Tayside doc) required to delver care and treatment services in both community based and practice based settings if required. This will build on teams who already work in the community, who will be integrated longer term with the team delivering the new services. Services will be added as staff with suitable skills, and processes to support care, are in place across the parts of the system required.<br>• Link this with work to develop community hubs in Dundee with a wide range of coordinated services across sectors<br>• Identify gaps in premises availability which will limit service provision on a locality/cluster basis, and link this to the evolving H&SCP property strategy, progressing plans for further development of premises when required<br>• Utilise the opportunity of the Lochee development to test this model late in year 1. | Beth Hamilton/Alison Carnegie | £95 | • Availability of space in community venues, and general practice, will limit how we can develop the expanded MDT as described in the contract.<br>• Information systems create a challenge for this work where to create maximum patient choice in Dundee teams will be caring for patients form all Dundee practices in almost all locations. If workable systems can not be quickly established this will have a major impact on delivery of this aspect of developments. |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| 8. Premises, infrastructure and IT systems | • As per Tayside plan<br>• Work with colleagues in NHS Tayside and Dundee City Council to develop a plan for future development of primary care sites, including general practice and community hubs, based on the premises survey to be undertaken, and building on the Dundee H&SCP Property Strategy, once completed.<br>• Work with clusters to consider boundaries for general practice to ensure all areas of the city have adequate access to general practice and care and treatment services, recognising that teams are increasingly geographically based<br>• Continue to look for opportunities locally to maximise the use of technology, particularly around supporting health e.g. roll out Attend Anywhere videoconferencing consultations<br>• Work with colleagues in E-Health to develop information systems to support these new ways of working<br>• Undertake test of change for care and treatment services in Lochee<br>• Complete a test of change for Vision Anywhere to scope in more detail the requirement for an information system which supports care and treatment services, and other aspects of the PCI work. | Tracey Wyness/ Arnot Tippet | £98 (still under review)<br><br>£22 (TBC) | • Initial scoping suggests that there is not a system currently in use which will deliver what is required for care and treatment services, or the other aspects of the PCI work. The feasibility of developing a new system to do this is limited and so an assessment is required of current system suitability and how it can be adapted or linked to other system to provide a useable system.<br>• The lack of community hospital infrastructure in Dundee gives very limited community space. Funding any new building requirements is likely to take a number of years, if it is possible at all. |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| 9. Workforce planning and development | • As per Tayside plan<br>• Work with lead nurses to progress how develop the nursing workforce in particular for new and expanded roles, both in primary care teams and general practice settings<br>• Work across professional groups around this agenda, and agree a more detailed local workforce plan<br>• Staff need to be fully engaged and we will work with HR and staff side colleagues to ensure that staff are fully involved in developments<br>• There has been significant work undertaken to recruit and retain GP's, including a new career start model. This needs continued/expanded to increase the diversity of roles which attract GP's to work in Dundee | TBA | Not costed<br><br>£119 (may receive other source of funding) | • There are issues of recruiting and developing staff across a number of professions, in addition to general practitioners. Support form colleagues in HR is required to ensure that we maximise our opportunities to both recruit externally and develop current staff to support this major development. |
| 10. Sustainability /scalability | • The primary care improvement plan is about long term sustainable change which can be delivered at scale across Dundee. The approach taken will be to test new ways of working and build on learning of these models. Developing at a reasonable pace to fit with the 3 year time frame will be challenging. It requires dedicated time to ensure the programme is coordinated and managed as a whole. Management support for this is required.<br>• Consideration of how services can be redesigned, or additional resource identified, to deliver this at scale | ALL/ Shona Hyman | Not costed | • The approaches taken need to be fully integrated into service development and redesign. This requires strong leadership from all the senior managers involved. |

| Commitment | Actions (in addition to Tayside wide actions in plan) | Lead officer | Finance year 1 (current estimates) PCIF only (£000) | Risk/issues |
|---|---|---|---|---|
| 11. Practice staff development | • Practice admin roles are key to many of the changes in the contract, including pharmacotherapy, link workers and many of the linked roles where patients will need assessed and redirected from GP appointments.<br>• A programme of development for admin staff will be progressed, based on national findings or work elsewhere, to progress this role. Consideration is being given to a specific role to support this development. | TBA | Not yet costed/ developed | • There is variation across practices as to how they have historically developed reception and admin staff. This wider role development may have implications for pay scales in the staff group involved. |
| 12. Evaluation | • Evaluation and monitoring will be coordinated as much as possible at a Tayside level.<br>• We will work with the LIST team in particular to support this work going forward, as well as internally from NHST | TBA | Not yet costed | • Monitoring and evaluation needs to be clearly defined form the outset and measures used arcos all aspects of this work to ensure it supports this wider change |
| 13. Communication and engagement | • There has been limited public engagement in the initial development of the plan but going forward the detail of each aspect will be proactively planned with a wide range of key stakeholders, including patients, carers and the public<br>• Key messages around the range of services we provide, and how and where these are provided will need to be shared widely, including how we change the culture of the GP as the first point of contact by default. | Coms team | Not yet costed | • Initial tests, such as the MSK pilot, have shown that even when another professional is able to assess and treat a condition there is still a public perception that they need to see a GP. This requires a concerted effort to change this cultural norm. |

**ITEM No …10…..…..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **GENERAL PRACTICE PROVISION IN DUNDEE**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB46-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to outline the current issues with general practice provision in relation to Mill Practice and note the practice's request to close the Fintry Mill branch surgery.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report including the current issues with safely staffing two general practice sites for Mill Practice.

2.2 Supports the aim of Mill Practice, that all current Patients will have the opportunity to remain registered with Mill Practice and continue to see their current GP team.

2.3 Notes the preferred option is for Mill Practice to consolidate its services on one site with a view to achieving the stated aim in recommendation 2.2 and in addition offer a number of additional services which are available at Arthurstone Terrace as noted in paragraph 4.2.3.

## 3.0 FINANCIAL IMPLICATIONS

There are no direct financial implications of this paper for the IJB.

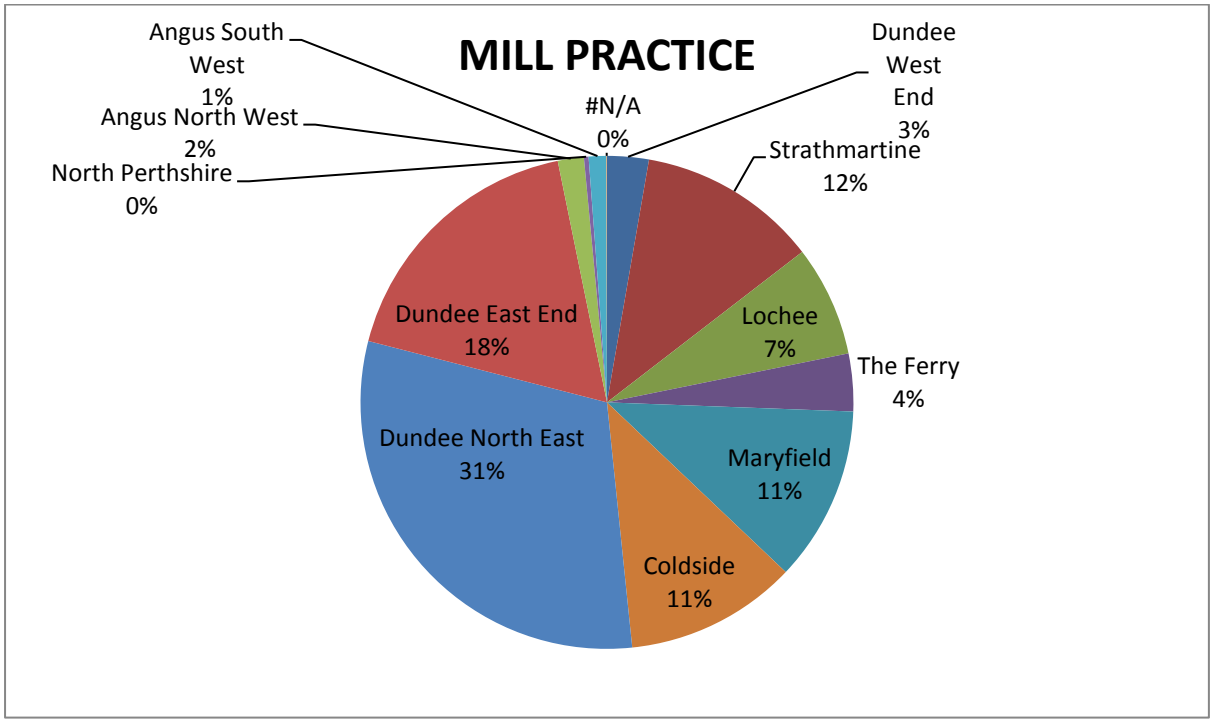
## 4.0 MAIN TEXT

### 4.1 Context

4.1.1 The IJB has previously considered papers setting out the context and challenges within primary care (report number DIJB51-2017 – General Practice and Primary Care), the implications of the new General Medical Services contract and related memorandum of understanding (report number DIJB9-2018 – Delivering The New 2018 General Medical Services Contract in Scotland) and the Tayside Primary Care Improvement Plan (report number DIJB26-2018). These papers outlined the challenges for delivery of general practice services and the proposed plans to improve this situation over the coming years. However, the plans are likely to be long term in their impact. Some of the service developments outlined will replace services currently provided by GPs but GPs remain at the core of general practice. The aim to recruit more doctors into the profession is one which is unlikely to change significantly in the next two to three years. There are a number of practices in Dundee, and more widely in Tayside, which have been unable to recruit to GP vacancies, including those who would normally attract a high number of applicants. Mill Practice has had three GPs, (who provided 20 clinical sessions) leave the practice, which has had a significant impact on their ability to provide GP appointments and support.

4.1.2 The practice has a list size of cc8,834 patients of whom almost 3,300 patients (37%) are recorded as having chosen Fintry Mill as their preferred surgery site to access general medical services. The areas patients within Mill Practice reside in is noted in table 1 below. Most services are run from both Fintry Mill and Arthurstone Terrace, however there is often only one GP or nurse and receptionist at Fintry Mill. This has created difficulty not just providing appointments but in terms of ensuring the safety of both staff and patients. These staff, because of the current limited staffing, have limited support available to them on-site.

Table 1 Area of residence for Mill patients.




4.1.3 The practice has had to invoke business continuity plans over both the Easter and summer holiday period and have at these times agreed with Primary Care Services that the branch surgery could be closed for two and six weeks in each case. In each case all of the practice services provided in Fintry Mill have been accessed at the Arthurstone Terrace site.

**4.2 Implications of the proposed closure**

4.2.1 The practice is proposing to consolidate all services on one site, allowing it to maximise the limited GP resources it has, while ensuring the safety of both patients and staff. All staff would work from the one site. Although there would be no direct increase in staff numbers in this context, it is anticipated that having staff on one site will increase the flexibility to support the range of demands on the team. It will also allow all team members to have support on site.

4.2.2 Other teams are based at Fintry Mill, some of whom deliver clinical services from the building, including some community nurses and midwives. Most of these services are being delivered during the temporary closure from Arthurstone to ensure that care is not disadvantaged for the patients. Services are putting plans in place for alternative accommodation should the proposal to close Fintry Mill be approved.

4.2.3 Patients will remain registered with Mill Practice and will continue to see the GP team they have been seeing. This has been one of the main areas of concern received from patients during the consultation phase. A number of additional services are available at Arthurstone Terrace including pharmacist, psychologist, welfare rights, listening service and routine Electrocardiogram's (ECG's).

### 4.3 Feedback on proposal to close the branch surgery

4.3.1 In considering the impact of the request for closure a range of mechanisms have been used to seek feedback from patients about any concerns they have about this proposal and any mitigation they would like to be put in place. The Health and Social Care Partnership (HSCP) and the Practice jointly wrote to all 3300 patients registered to receive services from Fintry Mill, and directly affected by the proposed changes, to seek feedback and advise of drop-in sessions. Four drop in sessions, supported by the Practice and the HSCP, were held in community venues, open to all patients of Mill Practice. A feedback form was developed and made available at the practice and at community venues. A freepost address was made available for written responses. Social media was used to raise awareness of the events. In addition there has been considerable local media interest.

4.3.2 Around 15 people attended the drop-in sessions and six people submitted written comments either on the day or to the freepost address provided. There was one email enquiry, no phone enquiries and few comments on social media. Comments were made through the local media.

4.3.3 Feedback was very positive about the services people receive from the practice, other than a number of frustrations at the appointments system, (common across any general practice feedback). There was a lot of discussion about why the proposal was being made and the issue with recruiting GPs. The national and local context of GP recruitment was well known and people empathised with this. The key issue raised was the fear of a lack of local facilities and the convenience that the Fintry Mill surgery gives people who live close to it. This was most strongly felt by those who were older or less mobile. Although there is a good bus service from Fintry to Stobswell, with the Arthurstone Terrace building being only 1.5 miles away from Fintry Mill, there is concern that when people are unwell they might be able to get to a very local building but not to one further away, which may increase home visit requests. A number of people raised the issue of increased travel costs.

4.3.4 There are new houses being built in Fintry at the moment. There were concerns that people moving to these houses would not be able to register with a local practice. The nearest practice would be at The Crescent in Whitfield. However, it is anticipated that many of those moving to these houses will already live in Dundee and are likely to choose to stay with their current practice, as this is the pattern normally seen.

4.3.5 There were a number of questions about the building itself. The Practice owns the building and if this proposal is approved the Practice intends to sell the building.

4.3.6 There has been limited feedback from other services that may be impacted by the closure. However, community pharmacy teams have noted concerns about the impact for the local community of the closure while noting actions that pharmacy could undertake which would help to support patients with access to their medicines, and other forms of advice and support.

4.3.7 The local community council had raised some concerns, which are consistent with those raised through other routes. A meeting was held to discuss the challenges faced in continuing to provide safe services. The local community officers have also supported the engagement process and helped link up with the local community.

### 4.4 Consideration of options

4.4.1 The practice has requested to vary their General Medical Services (GMS) contract to allow the closure of the branch. In considering the implications of this request other options have been considered:

- **Option 1 - status quo** - If the Practice is not granted authority to close the branch surgery there are a number of risks, as highlighted in the report. Additionally there is a risk that this would further destabilise the Practice and the Practice becomes unsustainable longer term. This could then have a domino effect on other Practices.
- **Option 2 – all services move to Fintry** - This is of specific note as there are a number of Practices in the area of Arthurstone Terrace and that geography is well serviced. However

the current Fintry Mill building is not large enough to accommodate all services, and would require significant development to allow it to do so. This is not a feasible option for the GP partners in the current financial climate. The building at Arthurstone Terrace is modern and well equipped, and feedback from the periods of temporary closure has been positive about the experience of attending this site.

- **Option 3 - all services move to Arthurstone Terrace** - close the Fintry Mill branch. This is the preferred option by the practice as all patients will retain the same General Practice Team providing a level of continuity of care and the change would enable the practice to be sustainable. From the consultation process it is assumed that the majority of the patient population will remain with the practice, which will support the wider Primary Care services to retain the current level of stability.
- **Option 4- the Mill Practice be granted authority to close Fintry Mill, subject to the HSCP commissioning another Practice to deliver services in the area** - this is not seen as a viable option for a range of complex reasons. No other Practice has the capacity to take on this number of additional patients. Losing up to 37% of the patient list would be destabilizing for the practice.

**4.5 Next Steps**

4.5.1 The Mill Practice wrote to NHS Tayside in March 2018 to request a contractual change and to close the Fintry Mill branch for the reasons described in the report. It was agreed with the practice to complete a full consultation with patients, supported by the HSCP. Details of which are contained in this report. Following this, the potential options would be considered by the key partners involved, including the practice.

4.5.2 It is recommended that the IJB notes the reasons for the request by the Mill Practice to close the Fintry Mill branch and supports the request. If the proposal to close is supported by the IJB, this will be confirmed with NHS Tayside, (and it would subsequently be for NHS Tayside Board to approve as the holders of the contract with the Practice). An agreed closure date would be agreed with the Practice and the patients notified of this. If they choose to, patients could register with an alternative practice.

**5.0 POLICY IMPLICATIONS**

An integrated impact assessment has been undertaken. This proposal has potential implications for some protected characteristic groups. Those with a physical disability, along with older people and those with young children (who are more likely to have mobility issues) may be negatively impacted because of the issues for travel. Those on low incomes may also be impacted negatively because of travel costs. However it is anticipated that the number of people affected will be small for the former, and limited for the latter. The practice has recognised the risk of requiring more home visits.

**6.0 RISK ASSESSMENT**

| | |
|---|---|
| **Risk 1 Description** | Risk Associated with not consolidating to one site.<br><br>If the proposal to close the branch surgery is not agreed the Practice would continue to have significant periods where they cannot safely staff two sites, and would require short term closures. It would reduce the likelihood of recruiting new partners. It would also lead to ongoing issues in terms of safety for patients and staff in the Fintry Mill building. |
| **Risk Category** | Operational |
| **Inherent Risk Level** | Likelihood (5) x Impact (3) = Risk Scoring 15 |

| | |
|---|---|
| **Mitigating Actions** (including timescales and resources ) | Centralise all services on one site |
| **Residual Risk Level** | Likelihood (3) x Impact (3)= Risk Scoring 9 |
| **Planned Risk Level** | Likelihood (3) x Impact (3)= Risk Scoring 9 |
| **Approval recommendation** | If this paper is supported there is no requirement to approve this risk. |

| | |
|---|---|
| **Risk 2 Description** | Risk Associated with consolidating to one site<br><br>If the proposal is agreed the key risk is potential difficulty for some to access services at Arthurstone. This is described in the paper. The distance is relatively small, although does have challenges for those with a disability or low income. |
| **Risk Category** | Operational |
| **Inherent Risk Level** | Likelihood (5) x Impact (2) = Risk Scoring 10 |
| **Mitigating Actions** (including timescales and resources ) | Longer term the discussions around transport may support this risk. |
| **Residual Risk Level** | Likelihood (4) x Impact (2) = Risk Scoring 8 |
| **Planned Risk Level** | Likelihood (3) x Impact (2)= Risk Scoring 6 |
| **Approval recommendation** | The balance of risk is such that this risk should be accepted. |

## 7.0 CONSULTATIONS

Engagement work carried out has been described in 4.3 above.

Teams who are based in or deliver services from Fintry Mill have also been involved in discussion about the options going forward. Some of these services have already relocate because of the temporary closures.

The Clerk, the Chief Finance Officer and Head of Health and Community Care have been consulted in the development 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

**9.0 BACKGROUND PAPERS**

None.

David W Lynch
Chief Officer

DATE: 20 August 2018

Shona Hyman
Senior Manager
Service Development & Primary Care

David Shaw
Clinical Director

**ITEM No …11…….**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **UPDATE ON DELAYED DISCHARGE AND UNSHEDULED CARE IMPROVEMENT PROGRAMMES**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB36-2018**

## 1.0 PURPOSE OF REPORT

1.1 This report sets out the improvement actions across the Dundee Health and Social Care Partnership to tackle delayed discharge and unscheduled care. The report details the Home and Hospital Transition Improvement Plan and updates the Integration Joint Board on the work of the Unscheduled Care Board.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the progress made against the 2017/18 Home and Hospital Transition Improvement Plan as reported in section 4.2.3 and agrees the proposed improvement plan for 2018/19 as detailed in Appendix 1.

2.2 Agrees the continued funding allocated to the delayed discharge projects as detailed in Appendix 2 and instructs the Chief Finance Officer to include recommendations for this funding in the 2019/20 budget statement.

2.3 Notes the work of the Unscheduled Care Board and the change projects associated with this work-stream as detailed in section 4.3.

2.4 Notes the requirement to produce a Winter Pressures plan and requests that this be submitted for IJB consideration prior to submission to the Scottish Government and notes the winter pressures outcome report for 2017/18 attached at Appendix 3.

## 3.0 FINANCIAL IMPLICATIONS

3.1 There are no financial implications, the improvement plan will be delivered within current budgets, and through resources allocated to the Partnership through Unscheduled Care funding to test new models of working. The cost of delayed discharge change projects of £694,000 as outlined in Appendix 2 will be fully funded from Delayed Discharge Funding allocated to Dundee Health and Social Care Partnership.

## 4.0 MAIN TEXT

### 4.1 Background to Discharge Management

4.1.1 A delayed discharge is a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date (ISD Delayed Discharges Definitions and Data Recording Manual).

4.1.2 The focus on effective discharge management is reflected through the National Health and Wellbeing Outcomes and their indicators. There are two indicators that relate directly to effective discharge management:

- National Indicator 19: Number of days people spend in hospital when they are ready to be discharged;
- National Indicator 22: Percentage of people who are discharged from hospital within 72 hours of being ready.

4.1.3 Standard delays are defined by ISD Scotland as delays where the standard maximum delay period applies. This includes patients delayed due to awaiting assessment, care packages, housing, care home or nursing placements. The standard maximum delay period is now 72 hours. Code 9 Complex delays are used by ISD Scotland to describe delays where the standard maximum delay, therefore 72 hours, is not applicable. This is in recognition that there are some patients whose discharge will take longer to arrange and would include patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, Patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation

4.1.4 The partnership's performance in relation to discharge management is reported quarterly to the Performance and Audit Committee. Over the last year our performance has highlighted a positive trend towards an overall reducing number of people who are delayed where the standard maximum delay period applies with our current performance halved since 2016/17. Where the standard maximum delay period applies the partnership has maintained a sustained reduction in the bed days lost for older people. For adults who have a complexity of circumstances the main reasons for delay is where a person has a complexity of circumstances are due to awaiting completion of Guardianship processes, awaiting a place in specialist facility, awaiting completion of complex care arrangements and exercising their statutory right of choice. We continue to work towards developing a range of supports and options which will further improve our position.

4.1.5 In May this year a detailed analysis of unscheduled care admissions was submitted to the Performance and Audit Committee. The report noted that Dundee has a high 28 day readmission rate although this varied by speciality and age; that there was a high level of preventable admissions with Chronic Obstructive Pulmonary Disease identified as a particular area if significance and an above average emergency bed day rate, although again this varied by age. The partnership will work to improve these areas across this financial year.

**4.2 Home and Hospital Transition Improvement Plan**

4.2.1 Within Dundee a Home and Hospital Transitions Group (the Group), chaired by the Head of Health and Community Care, oversees performance and improvement actions in relation to Discharge Management. The Group aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be. Each financial year the Group sets out the improvement actions for the following year. These actions reflect the previous year's performance, identified gaps and new national targets. A copy of the Home and Hospital Improvement Plan for 2018/19 is attached at Appendix 1.

4.2.2 The Scottish Government allocated a ring fenced budget for the improvement of delayed discharges at a local level. This budget was mainstreamed as part of the 2017/18 budget settlement, however as the partnership had allocated the funding to projects and redesign work with a 2 – 3 year span, it was agreed to maintain the fund as a change fund until the completion of the project and redesign phase.

4.2.3 The funding has been successful and an initial evaluation of the projects at the end of the last financial year identified the following improvements:

- Introduction of a daily conference call between the Integrated Discharge Hub and the Resource Matching Unit identified patients who require a care package upon discharge at an earlier stage and facilitated more timely discharge.
- Further step down accommodation supported people awaiting alternative housing to move into temporary accommodation. This accommodation can also be used to support a phased assessment as people work towards discharge

- Further development of step down options as a means of enabling patients to have a period of intermediate care and rehabilitation in a non-acute setting
- Allocation of a budget for funding care home placements to the Integrated Discharge Hub and implementation of resources to support assessment for 24 hour care to take place in a more homely setting. This has resulted in timeous decision making and a reduction of delays for this reason.
- The introduction of the Resource Matching Unit has ensured better use of in-house and external resources with services planned to be available in line with the Planned Date of Discharge process.
- Recruitment of two additional Mental Health Officers so continue to reduce delays due to awaiting guardianship reports.
- Promotion of the Power of Attorney Campaign as a means of reducing requirement for Guardianship will reduce future delays as a result of Guardianship requirements.
- Development of a range of specialist accommodation through strategic commissioning so as to support adults with a mental disorder/learning disability to be able to leave hospital when they are ready.
- Introduction of the Moving Assessment into the Community has facilitated more timely discharges.
- The Step Down to Assess Model has supported older people who might have been discharged directly from hospital to a care home to return home with wrap around care.
- The Mackinnon Centre for Brain Injury project supports people to continue their rehabilitation within a community setting.

4.2.4 A copy of the allocated funding for 2018/19 is attached at Appendix 2. Projects will be asked to submit their final evaluation during this financial year. From this, the Group will make recommendations for sustainable continuation of the project or for projects to work towards their exit strategies. It is envisaged that these recommendations will be included within the 2019/20 budget statement.

**4.3 Unscheduled Care**

4.3.1 Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government. Through the National Unscheduled Care, 6 Essential Actions Improvement Programme, the aim is to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community, aiming to ensure that 95% of patients attending Emergency Departments anywhere in Scotland are seen, treated and discharged or admitted with four hours, ultimately working towards 98%. Significant improvements have been made across NHS Scotland however it was recognised that more needed to be done to ensure these successes are sustainable; as such, the launch of the new improvement focused approach Unscheduled Care Programme in May 2015, based on six fundamental actions is aimed at progressing and sustaining improvements.

4.3.2 The Unscheduled Care Programme is aimed at achieving safe and effective care delivered to every patient, every time without unnecessary waits, delays and duplication through the implementation of six essential elements:

1. Clinically Focused and Empowered Hospital Management
2. Capacity and Patient Flow Realignment
3. Patient rather than Bed Management – Operational Performance
4. Medical and Surgical Processes arranged for Optimal Care
5. Seven day services targeted to increase weekend and earlier in the day discharges
6. Ensuring patients are cared for in their own homes or a homely setting.

4.3.3 The Scottish Government recognise that for NHS Boards to maintain progress they must increase their whole system focus, with engagement and alignment of primary, secondary, voluntary and third sector organisations, which are vital to a whole system approach as well as supporting the ambition of safe, effective and person-centred care. In 2017, NHS Tayside established an Unscheduled Care Board (the Board) which has secondary and primary care representation and which includes the three Health and Social Care Partnership areas. This collaborative working group provides a leadership role to the improvements across both acute and community care. A number of the Dundee redesign programmes are aligned to

this work. The Board takes a leadership role in supporting the development of the NHS Tayside Integrated Clinical Strategy.

4.3.4 The Scottish Government allocated additional financial resources to progress the Unscheduled Care programme. This resource is in part pre-prescribed in that the resources are to be used to develop an improvement team which includes clinical leadership, improvement and data analysis and project management. The remainder of the resource can be utilised to support local change projects.

4.3.5 Over the last year the following projects were tested:

- Implementation of Whole System Safety and Flow Triggers
- Implementation of multidisciplinary Daily Dynamic Huddles across acute sites
- Testing of a Discharge Lounge in Ninewells Hospital and Perth Royal Infirmary
- Further development of the Professional to Professional model
- Testing of seven day discharge with increased Allied Health Professionals, Hospital Co-ordinators, Pharmacy and Scottish Ambulance Services resources
- Testing of a new Chronic Liver Disease pathway
- Further embedding of the Dundee Enhanced Community Support – Acute
- Improving approaches to Anticipatory Care Planning

4.3.6 The Scottish Government confirmed to NHS Tayside on 3rd August 2018 that the Tayside Unscheduled Care funding allocation would be £470,894. This resource will be used to continue the clinical and improvement leadership with the remainder allocated to further improvement projects. As with many change funds, the Board has received a higher level of proposed change initiatives than the fund can support. A process of assessment and criteria matching has commenced and the Board will confirm the successful change projects shortly. Within Dundee we will seek to further embed seven day discharges and work with both general and specialist medicines to support the development of new discharge and unscheduled care pathways.

**4.4 Winter Pressures Plan**

4.4.1 NHS Boards and Health and Social Care Partnerships are required each year to submit a report to the Scottish Government setting out their intended actions to manage the season pressures occurring in winter. These pressures can include an increase in respiratory infections and injuries from slips and falls. While the extended partnership recognises that the level of demand across the full year requires a similar response, the plan sets out the actions to be taken to address and increase in demand across Emergency Departments, the impact of extended public holiday close down of services, actions to be taken should weather conditions deteriorate and the potential need for additional inpatient beds and community services.

4.4.2 The winter of 2017/18 tested the plan for Tayside with an increase in reported incidents of flu and deteriorating weather. Dundee performed well and the escalation of the plan ensured that the wider Dundee Partnership (Dundee City Council ,NHS Tayside and Dundee Health & Social Care Partnership) supported actions which ensured that people were safe in their homes and when travelling, unnecessary admissions to hospital were avoided through the introduction of alternative assessment, diagnosis and treatment models in the community and that people were supported to leave hospital as soon as possible to ensure that inpatient services could treat those in need.

4.4.3 A copy of the 2018 winter report for Tayside which sets out the performance during this period is attached at Appendix 3.

4.4.4 The Scottish Government has confirmed their intention to release additional financial resources to Board areas to address winter pressures and support the plans. The completion of the Tayside Winter Pressures Plan will be developed and agreed by the Unscheduled Care Board and signed off by NHS Tayside and Health and Social Care Partnerships. A copy of this plan will be presented to the IJB for consideration prior to submission to the Scottish Government. The Scottish Government are yet to confirm the financial allocation for the Tayside area.

## 5.0 POLICY IMPLICATIONS

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

## 6.0 RISK ASSESSMENT

| | |
|---|---|
| **Risk 1 Description** | That the Home and Hospital Transitions Improvement Plan and the Unscheduled Care Action Plan are not fully implemented and do not achieved the desired outcomes. |
| **Risk Category** | Operational |
| **Inherent Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 |
| **Mitigating Actions** (including timescales and resources ) | The plans sit across a range of service areas and are aligned to a number of other redesigned work. In assessing the programmes the ability to implement proposed changes has been used as a key criteria. |
| **Residual Risk Level** | Likelihood (3) x Impact (3) = Risk Scoring 9 |
| **Planned Risk Level** | Likelihood (3) x Impact (3) = Risk Scoring 9 |
| **Approval recommendation** | This risk should be accepted. |

## 7.0 CONSULTATIONS

The Chief Officer 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

None

David Lynch
Chief Officer

DATE: 13 August 2018

Diane McCulloch
Head of Health and Community Care

Appendix 1 Home and Hospital Improvement Plan

**HOME & HOSPITAL TRANSITION IMPROVEMENT ACTION PLAN**

| National Health And Wellbeing Outcomes | Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes | Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator | Lead Officer |
|---|---|---|---|
| National Outcome 1: Healthier Living<br><br>and<br><br>National Outcome 5: Reduce Health Inequalities | • **National Indicator 1**: % of adults able to look after their health very well or quite well<br>• **National Indicator 12**: Emergency Admission Rate (per 100,000 people aged 18+)<br>• **National Indicator 13**: Rate of emergency bed days for adults | Use Unscheduled Care Information to clarify and understand local performance, gaps in service and redesign pathways in one specialist area. | Diane McCulloch<br>Lynne Morman |
| | | Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health. | Alexis Chappell |
| | | Further embed Enhanced Community Model for support for Older Adults and consider the Community Model for Support with Adults as a means of reducing emergency admissions and enabling people to live independently and look after their health in their own home or homely setting. | Locality Managers |
| | | Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult. | Jacqueline Thomson |
| | | Test and further develop models of self-care | Shona Hyman |
| National Outcome 2: Independent Living | • **National Indicator 18**: % of adults with intensive care needs receiving care at home<br>• **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting | Expand the 'Moving Assessment into the Community' project for older people to develop a frailty model for people of all ages. | Jenny Hill |
| | | Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. | Lynne Morman |
| | | Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults. | Locality Managers |
| | | Further develop discharge planning arrangements for adults with mental ill-health and learning disabilities. | Arlene Mitchell |
| | | Further develop discharge planning arrangements for adults with physical disability and acquired brain injury. | Beth Hamilton |
| | | Evaluate current project and seek further investment in resources which support assessment for 24 hour care taking place at home or home like settings. | Mike Andrews<br>Lynne Morman<br>Craig Willox |
| | | Redesign services to ensure rapid access to palliative services. | Beth Hamilton<br>David Phillips<br>Karen Lesslie |

| National Health And Wellbeing Outcomes | Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes | Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator | Lead Officer |
|---|---|---|---|
| | | Review access to end of life services so that people are supported in their place of choice. | Beth Hamilton |
| | | Review patient pathways between Carseview Hospital and the community. | Arlene Mitchell<br>Lynne Morman |
| | | Support the redesign of specialist services discharge pathways through redesign of referral and response models | Jenny Hill |
| | | | |
| National Outcome 2: Independent Living | • **National Indicator 18**: % of adults with intensive care needs receiving care at home<br>• **National Indicator 15**: Proportion of last 6 months of life spent at home or in a community setting | Further expand the fully Integrated Discharge Management Team by incorporating specialist workers to improve communication, facilitate better outcomes and further develop opportunity for discharge assessment for all patients at Ninewells. | Karen Gall<br>Lynne Morman<br>Lee Foggarty |
| | | Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge. | Alexis Chappell |
| | | Review and remodel care at home services to provide more flexible responses | Beth Hamilton<br>Karen Lesslie<br>David Phillips |
| | | Further develop models of Community Rehabilitation to support transitions between home and hospital | Alexis Chappell<br>Matthew Kendall |
| | | Further embed seven day discharge. | Lynne Morman<br>Jill Crichton |
| **National Outcome 3: Positive Experiences and Outcomes** | • **National Indicator 5**: % of adults receiving any care or support who rate it as excellent or good | Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge. | Lynne Morman |
| | | Establish and implement a Discharge Management Learning Framework and Learning Networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home. | Lynne Morman |

| National Health And Wellbeing Outcomes | Indicators which Demonstrate Improvement and Contribute To National Health And Wellbeing Outcomes | Actions To Achieve Indicators and Outcomes Cross Referenced by National Health and Wellbeing Outcome Indicator | Lead Officer |
|---|---|---|---|
| | | Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being | Karen Lesslie<br>David Phillips<br>Gill Reilly |
| **National Outcome 6: Carers are Supported** | • **National Indicator 8**: % of carers who feel supported to continue in their caring role | Implement a statement and pathway for involving Carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations | Lynne Morman |
| **National Outcome 7: People are Safe** | • **National Indicator 14**: readmission to hospital within 28 days | Further implement the planned date of discharge model so that patients , carers are involved in a well-planned discharge and have coordinated follow up care where required upon discharge | Lynne Morman<br>Karen Gall |
| | • **National Indicator 16:** Falls rate per 1,000 population in over 65's | Further develop post discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and readmission to hospital. | Beth Hamilton<br>District Nursing<br>AHP |
| | | Further develop local fall pathway initiatives to reduce risk of falls. | Matthew Kendall |
| **National Outcome 9: Resources are used Efficiently and Effectively** | • **National Indicator 20**: % of health and care resources spent on hospital stays where the patient was admitted in an emergency. | Establish integrated systems and processes which support information sharing and improved communication (All Indicators) | Alexis Chappell<br>Lynne Morman<br>Lynsey Webster<br>Joe Donnelly |
| | | Review the systems and mechanisms for reporting around discharge management and provide regular reports into the Performance and Audit Committee. | Alexis Chappell<br>Lynne Morman<br>Lynsey Webster |
| | | Work with the Unscheduled Care Board to implement the Unscheduled Care board Action Plan | Diane McCulloch |
| | | Work with Partners to develop the 2018/19 Winter Pressures Plan and ensure arrangements are in place to support any escalation of the plan | Diane McCulloch |

**Appendix 2 – Delayed Discharge Funding – Change Projects – 2018/19**

| | PROJECT | DESCRIPTION | LINK TO UNSCHEDULED CARE | FUNDING (£s) |
|---|---|---|---|---|
| 1 | Increased Home Care | To improve flow from Enablement Services to longer term care. | 6 | 160,000 |
| 2 | Resource Matching Unit | Management and organisation of social care referrals; service providers and quicker identification and makes best use of resources. | 6 | 122,000 |
| 3 | Extension of the COPD Team | Dedicated team to improve follow up support following admission to hospital and promote and sustain self-care approaches. | 6 | 100,000 |
| 4 | Community Nursing – Advanced Nurse Practitioner Post | Community Nursing input into multi-disciplinary team approach to assessment and treatment. | 6 | 40,800 |
| 5 | Increased Mental Health Officer (MHO) Input. | MHO based with Hospital Team to facilitate guardianship application and reduce delays in hospital. | 6 | 44,000 |
| 6 | Nursing Co-ordinator (Delayed Discharge Team) | Increased nursing input with facilitated quicker assessment and support discharge from hospital. | 2 | 45,000 |
| 7 | Acute Frailty Service | Medical input to support the approach to Acute Frailty Service, including community outreach. | 4 | 72,000 |
| 8 | Step Down Housing (Magdalen Yard Road) | Step Down Housing supports people delayed in hospital awaiting alternative accommodation and /or assessment in a home environment. | 6 | 10,000 |
| 9 | Step Down Housing (Gourdie Place) | Step Down Housing supports people delayed in hospital awaiting alternative accommodation and /or assessment in a home environment. | 6 | 11,000 |
| 10 | Step Down Housing (Craigmont Road) | Step Down Housing supports people delayed in hospital awaiting alternative accommodation and /or assessment in a home environment. | 6 | 10,900 |
| 11 | Step Down Housing (Mental Health) | Step Down Housing supports people delayed in hospital awaiting alternative accommodation and /or assessment in a home environment. | 6 | 10,900 |
| 12 | Winter Pressures Resource | Resources held to manage demand during winter. | 6 | 67,400 |
| | | | | 694,000 |

Appendix 3

# Tayside 2018 Winter Pressure Response Group Report

**FINAL**

**Executive Summary**

## Introduction

Between mid-December and mid-January 2018, NHS Tayside and the three Tayside Health and Social Care Partnerships (HSCPs), experienced an exceptional demand on services. In anticipation of such events, NHS Tayside and the three Integration Joint Boards prepare an annual Winter Plan. On 3rd January 2018 the Winter Plan was activated by the four Chief Operating Officers/Chief Officers and the Tayside Winter Pressures Response Group (TWPRG) was established to manage the non-hospital related issues particularly where additional support might help achieve the objective of reducing demand on health and care services

## Impact

Services experienced an increase in demand from the latter part of the week of 4th – 11th December as a result of a rise in trauma related admissions attributable to the sub-zero temperature between 10th and 11th December 2017. From 11th December there was a rapid rise in respiratory related attendances and across Tayside, the number of positive flu diagnoses increased four-fold from the 18th to 25th December.

## Outcome

The daily meetings and strict adherence to infection control protocols both in hospital and in the community ensured that bed capacity was well managed, discharge processes were maintained, mortuary facilities were addressed sensitively and staffing for critical areas was at all time secured. The Tayside response is being considered as a model of good practice at a national level.

## Recommendations

- NHS Tayside Board, Angus, Dundee City and Perth & Kinross Integrated Joint Boards are each asked to note this report.

**Dr Jackie Hyland**, Consultant in Public Health Medicine on behalf of the Tayside Winter Pressures Response Group

April 2018

# Tayside 2018 Winter Pressure Response Group Report
# FINAL

## 1. Introduction

Between mid-December and mid-January 2018, NHS Tayside and the three Tayside Health and Social Care Partnerships (HSCPs), experienced an exceptional demand on services. In anticipation of such events, NHS Tayside and the three Integration Joint Boards prepare an annual Winter Plan. On 3rd January 2018 the Winter Plan was activated because there was:

- An exceptional number of patients presenting to hospital, GP practices and in the community with respiratory conditions and flu-like illnesses;
- A high number of medical admissions were impacting on available capacity in all acute and community hospitals;
- There was a high demand on primary care and social care services;
- Acutely unwell inpatients' length of stay was impacting on patient flow.

Given the extent of the pressure the incident was escalated to draw in additional support from partners in the Local Resilience Partnership, in line with Tayside Resilience Planning process. The purpose of this extended support is to take action to reduce unnecessary contact with health and social care, and seek additional staffing and supplies out with the Winter Plan procedures.

## 2. Process

On 4th January the NHS Tayside Consultant in Health Protection was advised that exceptional measures had been put in place on 3rd January 2018 to manage the very high demand for clinical care affecting service delivery in the acute sector, primary care and Integrated Health and Social Care Partnerships in Tayside. The Tayside Winter Plan had been activated and the Chief Officers had started holding Huddles at 0830, 1330, 1630 and 2130.

### 2.1 Risk Assessment

An initial assessment by the Health Protection Team (HPT), based on laboratory notifications for influenza (ECOSS) indicated that since 15th December 2017 there had been a three-fold increase in influenza A diagnoses in the community in Tayside. In addition, the number of cases was three times the number at the same time in 2016/17. As influenza A case numbers are an indicator of respiratory illness in the community, this provided an explanation for some of the very high demand on services.

### 2.2 Risk Management

It was agreed that Tayside Winter Pressures Response Group (TWPRG) (Appendix 1) would be established to manage the non-hospital related issues so that the Huddles could focus on bed management and staffing in collaboration with care services. The key areas of work for the TWPRG were to:

- Reduce where possible, less urgent demands on NHS and care staff time through the provision of public messaging about the appropriate service for health related concerns;
- Support the provision of public messaging about caring for flu at home;
- Promote awareness amongst core businesses and services of the need to take early action to prevent spread of infection amongst staff;

- Identify at-risk individuals and agree support to prevent illness and hospital admission.

Membership of the TWPRG was drawn from a standing group which had been in operation under the title of the Tayside Significant Infections Group. This had been set up and running since 2015 to manage such an eventuality. The membership of this group was adjusted to reflect the demands from partner organisations in the Winter Pressure Incident.
The TWPRG met by teleconference on Monday 8th- Thursday 11th on a daily basis, and then once on Monday 15th and Thursday 18th January 2018. By the 18th January it was agreed that the impact of flu had peaked and was reducing, and this was reflected in a progressive reduction in health and care service demands. Summary notes and supporting materials were circulated following each meeting.

## 2. Outputs

Members of the TWPRG reported on issues where additional support might help achieve the objective of reducing demand on health and care services. The Table below summarises the key actions and timescales for completion.

**Table 1. TWPRG Actions and outputs**

| Specific Services | | | |
|---|---|---|---|
| **Services** | **Action** | **Progress** | **Outcome** |
| **NHS Tayside hospital services** | NHST hospitals prioritising services and stopping non-urgent clinical services | Ongoing at 18/01/2018 but demands decreasing. | Releasing service provision for care of critically ill patients. |
| **IHSCP** | Acceleration in community support including increasing support from the liaison service and agency use. | Rapid assessment and discharge managed on a daily basis to free up hospital beds. | At all times the hospital maintained some capacity for urgent admissions. |
| **Primary Care** | Increase in GP demands from Care Homes so letter sent by Primary Care to Care Homes, requesting bundling of cases to reduce frequent GP visits. | GP service demands high but not increasing. | Urgent assessments maintained. |
| **GP and IHSCP** | GPs referring to acute frailty team in Dundee area to reduce preventable admissions. | Rapid assessment for home care and support. | Reduce preventable admissions. |
| **Local Authorities** | In anticipation of further ice Local Authorities arranged for priority gritting to reduce accidents outside Residential and Care Homes. | Focussed gritting implemented to reduce falls. | Trauma emergency department attendances remained stable despite freezing temperatures and attendances below previous years for the week 01/01/18-08/01/18. |
| **NHS Tayside, Local Authorities and Resilience Co-ordinator** | Mortuary capacity reviewed. | Data from death registrations collected to provide early estimate of demand for mortuary, funeral service and crematorium demands. | Mortuary capacity at Ninewells approaching capacity so additional capacity sought within Tayside. Despite rising number of deaths adequate facilities maintained. Plans prepared should further capacity be required. |

| | | | |
|---|---|---|---|
| **NHS Tayside laboratory** | Monitoring of virology samples to determine stages of the incident | Virology results reported positivity rate of 47% for flu sample results at the peak of the incident (week of the 25th December) and remained high until the week of the 8th January. | Positivity dropped to 27% for flu samples by 18/01/2018 and the contribution of other viral infections decreased.<br>Weekend staff put in place; came in 7.5 hours on Sundays<br>During the week staff set up a 3rd run overnight to report first thing, (on top of daily duties) |
| **NHS Tayside Estates and Facilities** | Confirmation of fuel stocks, risk prioritization of Planned and Reactive maintenance to maintain essential plant, equipment and facilities and liaison with Local Authority Partners to ensure grounds were kept clear of snow and ice to facilitate access to essential services and reduce risk of slips and falls. | Throughout | Services maintained |
| **All Services** | | | |
| **Services** | **Action** | **Progress** | **Outcome** |
| **Business Continuity Plans** | Monitor sickness rates and activate Business Continuity Plans if services affected by staff illness or absence. | Hospital and Care services sourcing additional staffing to maintain services. GP services struggling to maintain staffing levels. | Hospital services maintained. Additional support sought to manage basic but essential care in the community for skin ulcer management to prevent admissions. |
| **Supplies** | Review PPE in both NHS and non-NHS services.<br>NHST stocks and fuel supplies secured.<br>Tamiflu supplies secured by previous arrangements. | NHS procurement alert received from supplier.<br>Non-NHS facilities reported reducing stocks of PPE. | National Procurement agreed to send advice to all Health Boards about how to access PPE stocks. NHST checked internal stocks.<br>Non-NHS services advised on PPE requirements.<br>Health Protection Scotland agreed to ask Care Inspectorate to press the use of PPE with licensed care providers. |
| **Communications** | | | |
| **Infection prevention and control advice for professionals** | Advice to NHS and Care Home staff | Emphasis on symptom based approach to respiratory symptoms<br>Creation of a Winter bug toolkit on Staffnet homepage so rapidly visible and accessible. | Aide Memoir for flu and vomiting circulated widely. |
| **Infection prevention and control advice for visitors** | Provision of information to visitors that symptomatic visitors should not visit relatives. | Information in public domain both locally and nationally. | Increased visitor information regarding importance of preventing spread of infection from themselves to others. |

| | | | |
|---|---|---|---|
| **Infection prevention and control advice for carers** | Advice on infection prevention and control for social carers requested. | Generic NHS advice made appropriate for wider audience. | Leaflet circulated via IHSCPs and sent to HPS for wider circulation. World Health Organisation hand hygiene poster circulated. |
| **Infection control prevention and advice for the public** | Request for public information about staying safe. | NHS Inform information and "Know Where to Go" poster published in press and social media on 4/01/2018.<br>Flu posters sought from a number of agencies. | Approximately 30, 000 hits on the NHS inform information and 20, 000 on the "Know Where to Go" poster by 11/01/2018.<br>NHS24 provided generic info-graphic on flu on 15/01/2018.<br>Delay in sourcing national flu advice poster but NHS poster circulated on 18/01/2018. |
| **Immunisation** | Requests for information on eligibility for immunisation, including children. | Children's programme completed and children's vaccine not available to buy.<br>Data on vaccine uptake not available until March. | NHS Health Scotland arranged for vaccination advice to be re-launched to provide further vaccine uptake and community protection |
| **Media requests** | Media requests for information on flu strains. | NHST, other NHS Boards, Health Protection Scotland, Scottish Government responding to press queries. NHS 24 providing advice on symptoms and management. Health Scotland providing advice on flu vaccine. Immunisation Scotland producing advice on vaccinations. No national poster for flu available for circulation. Each agency responding independently to media enquiries. Flu strain enquiries receiving a mix of responses. | Health Protection Scotland (HPS) arranged discussion teleconference on 12/01/2018 with Health Board (HB) Health Protection Teams (HPTs). Agreed that HPS would manage queries about the flu strain and would produce a plain English version of communication lines for HBs. HPS would share material prepared by HBs in response to queries to avoid duplication of effort. |

## 3. Timeline

A very initial review of the data suggested that in the week 4th – 11th December there was an increase in trauma related admissions and this might be attributable to the sub-zero temperature between 10th and 11th December 2017. [1]

From 11th December there was a rapid rise in respiratory related attendances as a proportion of all attendances at the Emergency Departments. The number of cases was well in excess of cases at the same time in previous years and continued at a higher level until the 8th January.

Across Tayside, the number of positive flu diagnoses increased four-fold between the 18th to the 25th December and continued at this level until the first week of January 2018. Flu (A and B) accounted for 60% of laboratory diagnosed respiratory illness and other respiratory viruses accounted for the remaining 40% of diagnoses. The NHS Weekly Trend Information shows that the hospital services absorbed a considerable volume of cases until the critical point was reached to activate the Winter Plan. This, and strict adherence to infection control protocols, ensured that

[1] Weather in December https://www.timeanddate.com/weather/uk/dundee/historic?month=12&year=2017

via the daily huddles bed capacity, discharge management, workload and staffing for critical areas, were secured. (See Appendix 2)

**4. Outcome[2]**

The demand placed on NHS Tayside throughout this period resulted in many of the services provided experiencing significant pressure. Consequently this had a negative impact on standards such as Emergency Department waiting times and the number of operations cancelled. The following sections provide a summary of activity across the system from 1st December 2017 to 14th January 2018.

**4.1 Emergency Department (ED)**

ED attendances at both Ninewells and PRI were high throughout the period, particularly from week ending 7th December to 31st December 2017. Ninewells attendances during week ending 7th December highlight this well; attendances peaked at close to 1,200 during this week which is in excess of 200 additional attendances than the same period last year. The level of activity was driven by two factors in particular: a significant increase in the Trauma during week of 11th December; and a significant increase in respiratory (flu like symptoms) over the Christmas week. This resulted on additional pressure on ED due to the acuity of these patient groups and the level of care they required when presenting.

The level of activity and acuity of patients had a detrimental effect on ED 4 hour wait times. The number of 4 hour breaches increased significantly and performance against the standard deteriorated throughout the period until week ending 31st December 2017, where performance began to recover on both sites.

**4.2 Admissions and Discharges**

The volume of activity experienced within ED over the period is reflected in emergency admission and discharge analysis over the same period. Ninewells Hospital in particular experienced a consistently higher volume of admissions and discharges than the same period last year. For example, throughout the Christmas week, there were 690 emergency medical admissions to Ninewells hospital, 20% higher than the same period last year. PRI did not experience the same consistent level of demand; however did experience weeks where admission and discharges exceeded that of same period last year.

Emergency surgical admissions in Ninewells also experienced a consistently higher demand than last year; however, not to the same extent as medicine. Additionally, increased activity in PRI, when compared to last year, was limited to week of 18 December when the volume of admissions was close to double that of last year.

**4.3 Bed Occupancy**

Bed occupancy in both Ninewells and PRI followed a similar pattern as ED admissions and acute emergency admissions particularity acute medical beds. Occupancy peaked week of 07 January reaching 107% in both Ninewells and PRI and aligns with the prevalence of respiratory flu like presentations at ED. Additionally, boarding increased on both sites during this period which may account for the 100% plus bed occupancy.

Acute surgical beds experienced lower occupancy rates over the period; however did experience increases in line with ED peaks in trauma attendances and pressure on acute medial beds. Occupancy was particularly low over the festive period which will

[2] Data supplied supplied by Kenny Scott and Jenni Woods, NHST Business Unit

have been driven by the step down of elective activity over this period. When compared to the previous year however, occupancy was higher in every week throughout the period. Surgical bed occupancy in PRI was around 25% lower than in Ninewells.

**4.4 Average Length of Stay (ALOS)**

ALOS for emergency medical patients in Ninewells consistently lower than the same period in 2016/2017. PRI showed a similar pattern; however was more variable week on week. Elective medical ALOS in Ninewells tended to remain above that of last year and is reasonably consistent between 1 and 2 days. Elective ALOS in PRI is more variable and experiences significant change week on week e.g. 31st December 0.7 days; 7th January 13 days; 14th January 0.2 days.

Surgical emergency ALOS followed a similar pattern to emergency medical ALOS and was generally lower than 2016/2017 in Ninewells. PRI is considerably more variable changing notably on a week on week basis. Surgical elective ALOS in Ninewells is reasonable consistent, albeit higher than the same period last year. It should be noted there was an increase from 24th December to 7th January. The experience in PRI over the period appears to be similar to Ninewells; however elective ALOS started to rise from 10th December and continued to remain high at 14th January 2018.

**4.5 Patients in Inappropriate Locations – Boarding**

Medical boarding days in both Ninewells and PRI were, on the whole, significantly reduced when compared to the previous year. PRI in particular experienced minimal boarding days until 7th January where there was a small increase. From a Ninewells perspective, there were fewer peaks than the previous year, notably at the beginning of January 2018 where although there was a rise, it was not nearly as significant as the position in January 2017.

Surgical directorate boarding days were minimal on both sites which is a significant improvement on the previous year. There was no surgical boarding over the period where elective activity was stood down on both sites.

**4.6 Patients in Inappropriate Locations – Delayed Discharges**

Delayed discharges are reported to 31st December 2017 and in Ninewells, the volume of medical patients delayed was significantly less than the previous year. This was most apparent over the Christmas week. As would be expected, this had a positive effect on the number of bed days lost to delays over the period. In PRI, the volumes are similar to the previous year throughout December until the Christmas week when, as with the Ninewells position, this improved.

Delays experienced by surgical patients over the period remained lower than the levels experienced last year most notably on the PRI site during the first half of December 2017, when there were far fewer delays.

**4.7 Patients in Inappropriate Locations – Patients Waiting for a Bed**

Predictably, the number of patients experiencing corridor waits on both sites worsens as the pressures increased on ED. Ninewells remained consistently higher than last year throughout December. This peaked during week of 31st December when 185 patients experienced a corridor wait. The numbers in PRI are more variable week on week and improved compared to the same period 2016/2017, until the Christmas week, where the position deteriorated significantly.

### 4.8 Cancelled Operations Due to Bed Pressures

Cancellations due to bed pressures are most prevalent within surgery. Throughout the December 2017 period, there were significantly more cancellations than the 2016 period. These peaked on both sites when the system was under pressure mid-December, then immediately after New Year.

There were no medical elective cancellations on the Perth site; however, Ninewells did experience cancellations during the early part of December 2017.

### 4.9 Bank and Agency Usage

Medical and surgical bank usage in Ninewells was slightly higher when compared to the same period last year, although following a very similar pattern of usage across the period. Agency usage remained very similar to last year.

On the PRI site, medical bank usage was higher than the same period last year; however, agency usage remained fairly consistent. Surgical bank and agency usage increased on the whole over the Christmas period.

### 4.10 Minor Injury Units (MIU)

Across NHS Tayside, attendances at MIUs increased by around 5% in December 2017. This equates to 431 attendances. Attendances at Arbroath Infirmary MIU experienced the largest increase, of nearly 500 attendances over the period. Further analysis undertaken revealed a small decrease in the number of patients who were transferred to an acute hospital over the period.

## 5. Impact from Respiratory Infections

National data on respiratory infections has since been received and the findings relevant to Tayside can be seen below. These demonstrate that the pressure on services were not attributable to respiratory of Influenza infections alone. They also suggest that the impact on the community both in Care Homes and amongst the younger population was significant. *Please note-*

- *these are preliminary results and the observations may change when the data is updated.*
- *these results only represent respiratory infections that were notified to the Health Protection Team. Other illnesses will have contributed to the extreme pressure on hospital and community service but are not necessarily captured through this reporting system.*

1. Data for severe acute respiratory illness (SARI) and admissions to ITU in Tayside in this flu season (2017/18 to date) show:
    a. the number of admissions to ITU for **SARI** was low,
    b. the diagnosis for all the ITU SARI cases was Influenza A,
    c. patients were aged between 15-65+ with 50% aged 45-64 years old,
    d. 75% had not been vaccinated,
    e. 100% received antivirals,
    f. there were no deaths,
    g. no outbreaks were reported in the hospital setting.

2. The data for Acute Respiratory Infections (ARI) for Care Homes show that in the flu season for 2017/18 to date:

a. there were 13 Care Home Outbreaks (3.1 per 100 000 population – average for Scotland was 1.8 per 100 000 but there was a very wide spread of data),
b. the majority of outbreaks were caused by Influenza A,
c. antivirals were prescribed for treatment in 46% of Care Home outbreaks,
d. antivirals were not prescribed for prophylaxis in any incident,
e. 23% of care home cases required hospital admission,
f. Tayside had a Care Home related case fatality rate of 10% (Scottish rate 5.1%).

3. The data for all Influenza cases show that Tayside had the highest number of Influenza B cases and the highest rate of Influenza B infection in Scotland (162 per 100 000 compared with 28 per 100 000 for Scotland).

   A full interpretation of these data will be available at the end of the winter season when information from all areas in Scotland is reviewed and analysed.

## 6. Media analysis[3]

News coverage locally and nationally demonstrated the importance of public sector organisations maintaining a good working relationship with the press. As newspapers reported about winter pressures, they also reported on staff members' hard work and published key messages NHS Tayside wanted the public to receive. In thirty-two winter pressure related articles archived by the Communications department, overall coverage was predominantly neutral. Twenty-six (81%) were neutral, five (16%) were positive, and only one (3%) was negative. The positive coverage focussed squarely on the hard work and dedication of NHS staff, particularly A&E workers for providing excellent care under exceptional pressures. One editorial in the Courier acknowledged the increased number of people needing treatment and went on to praise staff.

*'There is no doubting the outstanding loyalty of NHS staff. Ensuring they have the means to provide the best possible care must be a top priority.'*

An editorial in the Evening Telegraph referred to A&E staff as 'heroes'.

*'Their bosses are rightly proud of the fact they worked extras hours and took on extra duties, and those who sought their help will be grateful for the care and attention they received in their hour of need, even if they had to wait a wee bit longer than expected.'*

In addition to reports of ward closures, more than half of the articles contained key messages from NHS Tayside about safeguarding against slips and falls; not attending A&E departments except with emergency conditions; seeking appropriate treatment elsewhere, such as NHS 24 and local GP surgeries; advice for taking care of flu-like symptoms at home; and not visiting friends and relatives in wards if there was a possibility a person could have the flu. Of the thirty-two articles, eighteen (56%) contained at least one of these messages.

## 7. Conclusion

The demand on health services exceeded that in previous years and delivery was complicated by the Festive holiday commitments. However, the rapid activation of the Winter Plan and the mobilisation of the TWPRG ensured that all services and partners were engaged and participating at an early stage.

The cross-Tayside collaboration through daily meetings ensured that bed capacity was well managed, discharge processes were maintained, mortuary facilities were

[3] Information provided by NHST Communications Department and analysed by Greg Baker PH Department

addressed sensitively and staffing for critical areas was at all times secured. Strict adherence to infection control protocols both in hospital and in the community had a crucial part to play in preventing spread of infection amongst staff, patients and the public. The Tayside response is being considered as a model of good practice at a national level.

**Appendix 1**

## Tayside Winter Pressure Response Group Membership

*The following list includes everyone who received papers. Not everyone on the list attended the meetings/teleconference and not everyone attended every meeting/teleconference – attendance was based on circumstances.*

**Designation / Organisation**

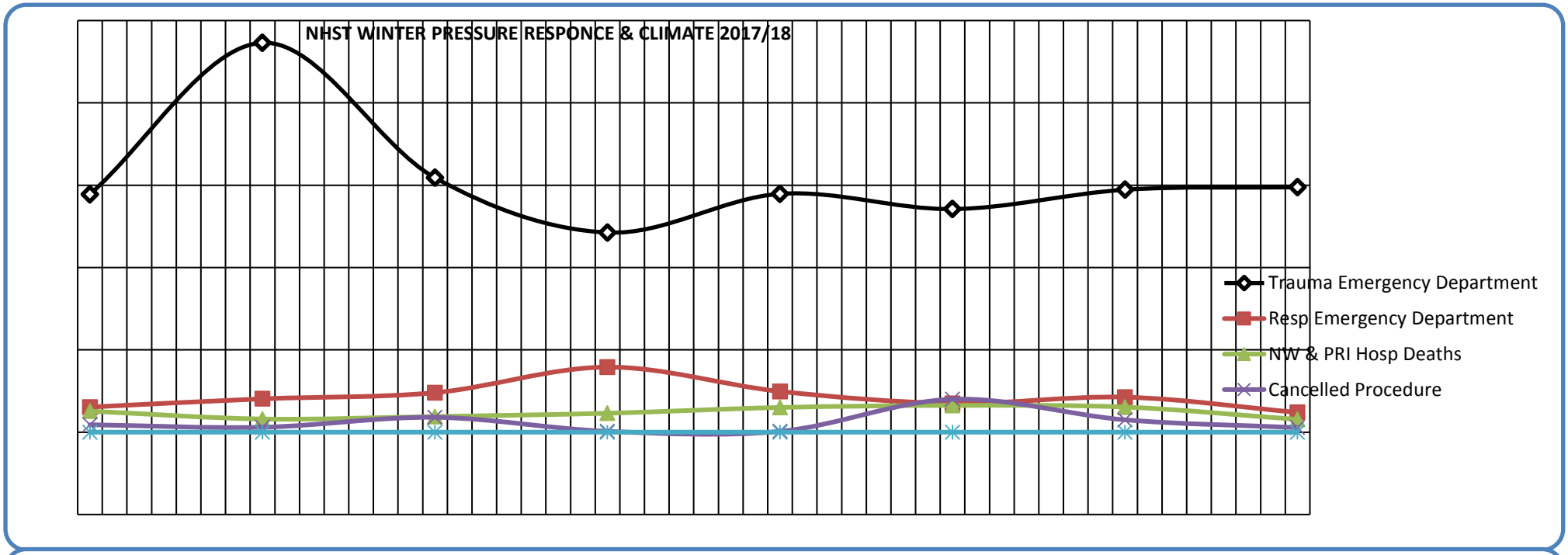
Resilience & Security Manager, Scottish Water
Head of Property, NHST
Public Health Officer, NHST
Joint Clinical Group Director (Diagnostics)
Customer Relationship Manager, Scottish and Southern Energy
Communications Manager, NHST
Learning & Development Coordinator, Tayside LRP
CPHM NHS Fife
Lead Nurse Infection Prevention and Control NHST
Associate Nurse Director NHST
Board Secretary, NHST
Consultant Paediatrician, NHST
Lead Nurse P&K Health & Social Care Partnership
Lead Nurse, Angus HSCP
Head of Ambulance Service, Scottish Ambulance Service
Manager, Community Medicine, PKHSCP
HM Coastguard, Coastal Operations Area Commander (Grampian)
Locality Manager, Dundee Health and Social Care Partnership
Health, Safety and Wellbeing Manager, Perth & Kinross Council
Health Protection Team, NHST
Clinical Laboratory Manager, NHST
Consultant in Public Health Medicine, NHST (Chair)
Consultant Microbiology (Infection Control), NHST
Emergency, Events & Resilience Planning, Operational Support Division, Police Scotland
Acting Head of Safety Services, University of Dundee
Civil Contingencies Officer
Locality Manager Dundee Health & Social Care Partnership
Head of Resilience, NHS Tayside
Consultant, OHS
Resilience Officer, SEPA
Community Safety & Resilience Service Manager, DCC
Consultant Radiologist, NHST/Lead Acute Services Pandemic Flu
Health & Social Care Integration, DCC
Quality & Services Manager, Primary Care NHST
Head of Service, Health and Community Care, Dundee HSCP
Consultant Virologist Medical Microbiology, NHST

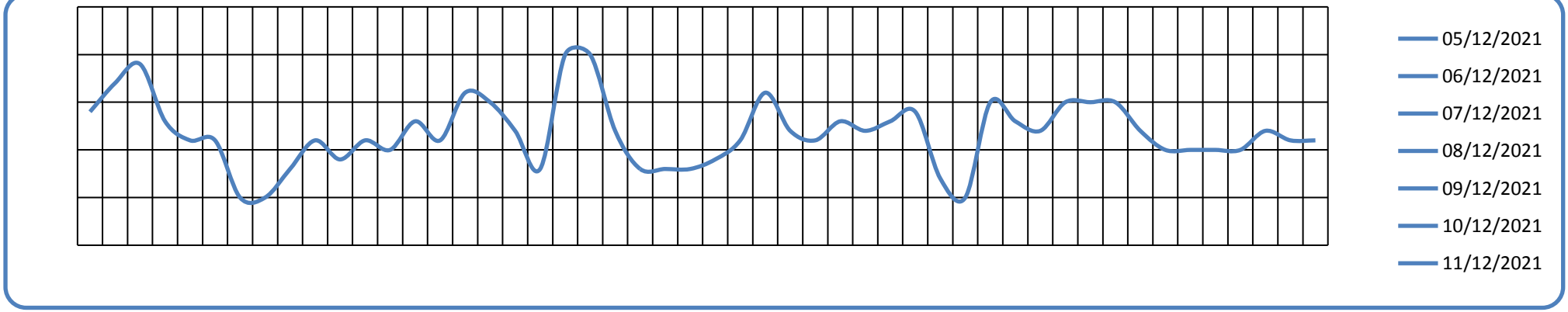
Met Office Advisor
Area Manager, SEPA
Readiness & Resilience Manager Scotland, APHA
Senior Resilience Co-ordinator, North of Scotland
Chief Executive, PKHSCP
Consultant in Microbiology, NHST
Consultant Emergency Medicine, A&E, NHST
Transformational Programme Lead

Consultant in Public Health Pharmacy, NHST
Executive Director, P&KC
Medical Director, NHST
Scottish Government
Resilience Manager, Angus Council
Head of Health Community Care, North Angus
Resilience Planning Advisor, NHST
Resilience Specialist, Scottish Water
Associate Medical Director, NHST
Director of Public Health, NHST
LMC Tayside
Chair NoSRRP
Health & Social Care Integration, PKC
Medical Director, Primary Care, NHST
Chief Operating Officer, NHST
Chief Executive, Angus Council
Director of Strategic Change, Chief Executive, NHST
General Manager, Surgery, NHST

## NHS Weekly Trend Information - as at 22nd January 2018

Source: Business Unit and PH Department NHST



**Appendix 2**

## Social Media Statistics for NHS Tayside Winter Pressure Response 2017/18

**Facebook**

| Type of post | How many times | Reach |
|---|---|---|
| Sunday pharmacy opening times | 7 | 23,041 |
| NHS 24 video – catch it, bin it | 1 | 7758 |
| NHS 24 Know Who To Turn To | 15 | 60,772 |
| Press Release: Looking after flu at home | 3 | 56,452 |
| NHS Inform website | 28 | 69,466 |
| Press Release: Help us prevent the spread of flu | 19 | 69, 466 |

**Twitter**

| Type of post | How many times posted | Reach |
|---|---|---|
| Sunday pharmacy opening times | 5 | 12 |
| NHS 24 video – catch it, bin it | 1 | 37 |
| NHS 24 Know Who To Turn To | 20 | 373 |
| Press Release: Look after flu at home | 1 | |
| Press Release: Help us prevent the spread of flu | 9 | 9 |

**Source: NHS Tayside Communications Department**

# Tayside Winter Pressure Response Group Feedback

The Group were asked for feedback on their experience of the response to the Tayside Winter Pressure Incident 2017/18. The questions posed were:

1. What did you and colleagues do that made an impact?
2. What did others do that you felt made a real difference?
3. Could any of these processes be incorporated into practice on a more routine basis?
4. Any other comments?

The responses have been collated below.

## What made a difference?

### Effective Preparation

- Winter planning sessions were held early in the winter season to raise awareness of winter response arrangements.
- Business Continuity sessions were held with key staff at the start of the winter season to consider staff shortages and the implications on the delivery of critical services.

### Incident Co-ordination

- Hospital "huddles" were held to review secondary care capacity and the Tayside wide Winter Pressures Response Group was established to take action to reduce demand on primary and secondary services.
- A whole system adaptive response was implemented to bring together key players - but alignment of meetings is also essential to support engagement.
- Information was shared on how winter pressures were impacting across the NHS, SAS and NHS24 in order to identify any issues that might have been relevant to the Tayside episode.

#### Service delivery

- In-patient bed management was arranged to prevent cross infection.
- Care Home requests for GP assessments were bundled to make efficient use of time and resources.
- Rapid collation of virology and hospital activity data supported decision-making and forward planning.
- Daily monitoring of mortuary capacity, number of death registrations, throughput at crematoria, throughput through burial, and the lead time from registration of death to cremation/burial ensured availability of services and that timescales did not impact unnecessarily on the grieving process.
- NHS Tayside and Local Authority Partners co-operated to ensure grounds were kept clear of snow and ice to facilitate access to essential services and reduce risk of slips and falls.

- Rapid and pragmatic solutions to issues were identified and implement as they arose – this helped build trust.

**Communication**

- Daily meetings were kept short but enabled information exchange, agreement on actions and supported the rapid dissemination of information.
- Flu information was made available on Staffnet and adapted and circulated for use in the community setting.
- Information was disseminated to ensure heightened awareness of infection control procedures in hospital and community settings.
- Early communication with GP practices meant they were more "in the loop" and were then better able to inform patients.
- The open and honest environment that supported conversations and position statements ensured that everyone contributed and this was essential to a positive outcome.

## Could any of these processes be incorporated into practice on a more routine basis?

The following suggestions were made:

- There was useful learning from the HSCP/primary/secondary care interface which could be incorporated into practice.
- Suitable guidance material for public could be made available at a national level the start of each winter season.
- Confirmation could be sought that winter planning processes are in place at the beginning of each winter season.
- Respiratory infection trends could be reviewed and discussed formally from early December.
- Mortuary information (body storage capacity) could be monitored to ensure early action is taken where storage is approaching capacity.
- Ambulatory Assessment Unit could be open for longer hours and at weekends.
- Continual 'virus' awareness to reduce the burden of respiratory viral infections (any novel respiratory viral pathogen) acquired through healthcare-associated infections should be maintained through a 'symptom-based i.e. transmission based precautions' approach.
- Adequate supplies of PPE in hospital and community (including social care) settings should be maintained throughout the year and plans in place for contingencies.

## Any other comments?

- *Very useful series of meetings which highlighted the fact that NHST/partners are both proactive and well coordinated when it comes to incident response.*

- *The high level of executive team engagement, listening and actions undoubtedly provided an organisational context that enabled a multi-disciplinary whole system approach.*

- *The commitment and flexibility of staff within NHST was clearly evident during this time in particular.*

- *Staff worked extra hours when required to ensure increased demands for tests, advice and actions were met in a necessarily timely manner. This was all achieved efficiently and in a spirit of co-operation.*

- *People felt that they were supporting each other.*

**ITEM No …12……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB49-2018**

## 1.0 PURPOSE OF REPORT

The purpose of the report is to brief the Integration Joint Board on the plans being developed for the use of new monies allocated by Scottish Government as part of the national Mental Health Strategy.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the correspondence sent to Chief Officers confirming the allocation of Action 15 monies across Scotland (attached as appendix 1);

2.2 Notes the response to Scottish Government which outlines plans for the use of Action 15 monies in Dundee (attached as appendix 2);

2.3 Notes that further discussions continue regarding Tayside wide developments, and that the outcome of these discussions may slightly alter the balance of financial commitment to each development;

2.4 Notes that the plans for use of the Action 15 monies are set within a broader context in terms of Mental Health and Wellbeing developments in the city;

2.5 Remits to the Chief Officer to bring forward a report setting out the draft Mental Health and Wellbeing strategic priorities and proposed initial actions for Dundee to the IJB in October 2018.

## 3.0 FINANCIAL IMPLICATIONS

The Scottish Government funding allocation for Action 15 of the Mental Health Strategy for Dundee IJB is £325,907 in 2018/19, rising to £503,674 in 2019/20, £711,069 in 2020/21 and £948,093 in 2021/22. The financial implications of the planned use of this funding is set out within Appendix 2, with funding and developments enhanced through the use of Primary Care Improvement funding.

## 4.0 MAIN TEXT

4.1 Scotland's Mental Health Strategy: 2017-2027, Scottish Government, 2017 sets out vision of 'A Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma.'

4.2 There are 40 Actions committed to within the national Mental Health Strategy. The four themes that underpin the Actions are prevention and early intervention; access to treatment, and joined up accessible services; the physical wellbeing of people with mental health problems and rights, information use and planning.

4.3 Action 15 outlines a commitment to increase the workforce across the country to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons.

4.4 In late May 2018 Scottish Government wrote to Chief Officers of Integration Joint Boards to confirm an additional investment nationally of £35million over the next 4 years, the purpose of the investment being to increase the mental health national workforce by 800 to support the commitment given within Action 15 of the Strategy.

4.5 Initial submissions to Scottish Government outlining broad plans for use of the funding within Dundee, Perth and Kinross and Angus have been made. These initial submissions relate to the use of Action 15 monies for developments that are specific to each area, and there are clear synergies between these.

4.6 Further work is being undertaken to agree plans for cross boundary developments in relation to police custody suites, prisons and Accident and Emergency Departments. Scottish Government colleagues expect to receive notification of the agreed plans by October 2018.

4.7 Dundee's Mental Health and Wellbeing Strategic and Commissioning Group are working within an ambitious set of priorities which are driven by the expressed views of people living in Dundee who have experienced mental health challenges. The themes underpinning the focus of this activity are; the reduction of health inequalities, getting the right support at the right time, prevention/early intervention and recovery based approaches. These are consistent with the national Strategy.

4.8 A draft local Mental Health and Wellbeing Strategy outlining priorities and actions is in the process of being prepared and will be available for the consideration of the IJB later this year.

## 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

| | |
|---|---|
| **Risk 1 Description** | There is a risk that the aims of the strategy and the success of the plan will be adversely impacted upon through the lack of appropriately trained staff |
| **Risk Category** | Workforce |
| **Inherent Risk Level** | Likelihood (3) x Impact (4) = (12) (High) |
| **Mitigating Actions** (including timescales and resources ) | Dundee's priorities consider a diverse approach to meeting the national policy aims rather than focusing on one particular mental health professional model |
| **Residual Risk Level** | Likelihood (3) x Impact (3) = 9 (High) |
| **Planned Risk Level** | Likelihood (2) x Impact (3) = 6 (Moderate) |
| **Approval recommendation** | Given the mitigating actions in place this risk should be accepted |

## 7.0 CONSULTATIONS

The Chief Finance Officer 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 W Lynch
Chief Officer

DATE: 17 August 2018

Arlene Mitchell
Locality Manager
Health and Social Care Partnership

Population Health Directorate
Mental Health and Protection of Rights Division

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Chief Officers, Integration Authorities

cc: Chief Executives, NHS Boards
Directors of Finance, NHS Boards
Chief Executives, Local Authorities
Angiolina Foster, Chief Executive, NHS24
Caroline Lamb**,** Chief Executive, NES
Colin McKay, Chief Executive, MWC
Health & Justice Collaboration Improvement Board

Your ref:
Our ref:

23 May 2018

Dear Colleague

**ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19**

As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons. The detail is set out in Action 15 of the Mental Health Strategy. The funding will be available from this year (£12 million, of which £11 million is the subject of this letter) and will rise to £35 million in 2021-22.

**Background**

You will know that last year, Ministers established the *Health & Justice Collaboration Improvement Board* (HJCIB). The Board draws together some of the most senior leaders from Health, Justice and Local Government. Its purpose is to lead the creation of a much more integrated service response to people whose needs draw upon the work of our Health and Justice services. As you might expect, our mutual response to people who suffer mental illness and distress is a significant theme in the Board's interests. Membership of the Board is set out an Annex A.

Ministers asked the Board to consider how our commitment to additional mental health workers might best be delivered.

**National test of change**

The Board has subsequently set out an approach that will test improvements in national arrangements for service delivery. This involves the Ambulance Service, NHS24 and Police Scotland, and £1 million has been set aside for this initiative. The current thinking on these ideas is set out at Annex B.

**Local improvements**

The Board has also adopted some broad principles (helpfully informed by a Short Life Working Group with membership from Integration Authorities, Health Boards, justice and local government) that it believes are likely to inform credible local improvements. These include recognition that:

- the application of additional resources should result in additional services commensurate with the commitment in the Mental Health Strategy to provide 800 additional mental health workers by 2021-22;

- the nature of the additional capacity will be very broad ranging – including roles such as peer and support workers;

- prospective improvements may include the provision of services through digital platforms or telephone support;

- improvement may include development for staff who are not currently working in the field of mental health.

**Links to the Primary Care Improvement Fund**

Richard Foggo has written to Integration Authority Chief Officers and NHS Chief Executives today regarding the Primary Care Improvement Fund (PCIF) allocation for 2018-19. His correspondence should be read in conjunction with this letter.

As outlined in Richard's letter, nearly £10 million was invested during 2016-18 via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, the Primary Care Improvement Fund (£45.750 million) is a single allocation to provide maximum flexibility to local systems to deliver key outcomes.

The PCIF includes recurring funding for mental health services, building on the funding for primary care mental health previously provided. Although it is separate to this funding line, there is likely to be close cross-over between the services, particularly in general practice settings, and in some cases the staff may be the same individuals.

As set out in the letter, Primary Care Improvement Plans should demonstrate how this funding is being used to re-design primary care services through a multi-disciplinary approach, including mental health services.

PCIPs should also show how wider services, including the mental health services which are the subject of this letter, integrate with those new primary care services.

**Planning and Partnerships for Delivery of 800 Mental Health Workers**

We want to ensure that IAs are able to utilise the additional resources for 800 mental health workers and the PCIF flexibly to support sustainable mental health and primary care service redesign. As far as possible we want to ensure that the planning processes, governance and evaluation processes are aligned.

**Planning: by 31 July**

We are asking that Integration Authorities each develop a plan by 31 July that sets out goals for improving capacity in the settings outlined in Action 15 of the Mental Health Strategy. We would like the plan from each Authority to set out:

- How it contributes to the broad principles set out under *Local Improvements* on page 2;
- How it takes account of the views of local Justice and other Health partners in the area about what improvements should be introduced
- How it fits with other local plans currently in development.
- Initial scoping of potential staffing changes over the next four years as a result of this additional funding, towards the committed 800.

Our reason for asking you to do this is that it will help the H&JCIB to shape discussions around future collaboration – including further consideration of national proposals. We will let you know about our thinking as consequence of these discussions over the summer.

This should include demonstrating additionality of the new workforce, such as information about the numbers of additional staff being recruited, existing staff being up-skilled (who are currently not working within mental health services) and the settings which will allow the Scottish Government to demonstrate progress against the national commitment. If it is possible, this could be through a supplementary to your Primary Care Improvement Plans or it could be through a linked document

In the longer term, we anticipate that Primary Care Improvement Plans might start to allow an increasingly integrated approach to mental health planning and delivery of the 800 mental health worker commitment. As set out in Richard Foggo's letter, it is important that the PCIPs from the outset show links with broader community developments, and the 800 mental health worker commitment. Over time, we anticipate that this may develop into a single statement of the approaches being developed.

**Consultation and Engagement**

The H&JCIB recognises that redesigning services to meet people's needs across health and justice settings is complex and that it will require collaborative partnership working across organisational boundaries.

We recognise that this is a complex area that involves many partners, but it will be essential that your emerging plans demonstrate how Justice and Health partners (both Health Boards and GPs) have been consulted and included in preparation of the plan. If that is not possible to deliver fully in the timescales, an indication of consultation and engagement plans would be very helpful.

**Governance**

Giving primacy to Integration Authorities to deliver the national commitment for 800 mental health workers in the Primary Care Improvement Plans simplifies local governance arrangements. At local level, Integration Authorities will hold NHS Boards and councils to account for delivery of the milestones set out in their plans, in line with the directions provided to the NHS Board and Council by the Integration Authority for the delivery of Strategic Plans.

At national level, we will consider how we can ensure that Ministers have the necessary assurances about delivery of the overall 800 staff over four years.

**Monitoring and Evaluation**

You will need to plan for and demonstrate a clear trajectory towards 800 additional mental health workers under the funding for this commitment over the next four years, and we will consider what national oversight arrangements should be in place to offer assurance on that point.

The plans should also include consideration of how the changes will be evaluated locally.

**Allocation methodology and future funding**

IAs have delegated responsibilities for adult Mental Health services therefore we are asking you to work with Health and Justice partners to deliver a holistic perspective on the additional mental health requirements in key settings (including but not restricted to A&E, GP practices, prisons and police custody suites).

The Scottish Government therefore plans to allocate funding for local improvements to Integration Authorities (via their associated NHS Health Board). National tests of change will continue to be funded centrally.

The expected allocation of additional funds over the next period in total and to each Integration Authority is set out at Annex C. The funding should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements of the commitment. We will engage with IAs and others on any plans to baseline these funds beyond 2021/22 subject to Parliamentary approval of the budget.

This is intended to guide your thinking about the future in terms of the funding over the next four years under this commitment. In broad terms, the distribution presumes a local share of the funding based on National Resource Allocation Committee (NRAC)

principles and we would encourage partnership working across IA boundaries, as per the statutory duty on IAs to work together particularly within Health Board areas[1].

In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex D. A final template will be issued before September.

We understand that the detail of these plans will take some time to develop and that your ideas about what is necessary will change as the extent and depth of understanding and service response improve over time. We also know that tackling these issues in a more effective way over time will do a lot to improve the help that we provide to communities. We are grateful to Chief Officers and to partners for your commitment to prioritising delivery of this commitment in keeping with the ambition in the Mental Health Strategy.

Please share your plans with Pat.McAuley@gov.scot If you have questions about the process or require further information, please contact Pat on 0131 244 0719.

Penny Curtis
Head of Mental Health and Protection of Rights Division

[1] Given Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

**ANNEX A**

**Membership of the Health and Justice Collaboration Improvement Board**

| | |
|---|---|
| Paul Johnston (co-chair) | DG Education, Communities & Justice |
| Paul Gray (co-chair) | DG Health and Social Care |
| Iain Livingstone | Police Scotland |
| Alasdair Hay | Scottish Fire and Rescue Service |
| Pauline Howe | Scottish Ambulance Service |
| Colin McConnell | Scottish Prison Service |
| Karyn McCluskey | Community Justice Scotland |
| David Harvie | Crown Office and Procurator Fiscal Service |
| Robbie Pearson | Healthcare Improvement Scotland |
| Jane Grant | NHS GG&C |
| Cathie Curran | NHS Forth Valley |
| David Williams | IA Chief Officers Group |
| Shiona Strachan | Clackmannanshire & Stirling IJB |
| Sally Louden | COSLA |
| Joyce White | SOLACE |
| | |
| Andrew Scott | Scottish Government |
| Neil Rennick | Scottish Government |
| Gillian Russell | Scottish Government |

**ANNEX B**

**NHS24 / Police Scotland / Scottish Ambulance Service Collaboration Project**

**IMPROVING THE MANAGEMENT OF, AND RESPONSE TO, MENTAL HEALTH CRISIS AND DISTRESS FOR THOSE PRESENTING TO SCOTTISH AMBULANCE SERVICE & POLICE SCOTLAND**

**What are we trying to accomplish?**

To support the realisation of Action 15 – Mental Health Strategy (Scotland) 2017-2027, this project (test of change) will improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being who are being supported by Police Scotland and/or the Scottish Ambulance Service.

This initial (draft) proposal has been shared with senior colleagues across all three partner agencies. To date we have received a positive response to the overarching principles of the First Response Test of Change concept, which is aligned to:

Integration with strategic priorities across all service providers.
Integration and facilitation of a joint co-productive / collaborative approach to future service development and delivery.

The project will initially be implemented across a specified geographical area, and delivered within a "test and learn" environment.

**The project aim is:**

**To improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being presenting to Police Scotland and / or Scottish Ambulance Service. By increasing access for Police Scotland and Scottish Ambulance Control Room and Frontline Staff to designated mental health professionals within NHS 24, working closely with locality based care and support services, to provide an appropriate and enhanced mental health triage and assessment of need service.**

**The project will also aim to (1) Reduce deployment of frontline Police Scotland and Scottish Ambulance Service staff to manage patients in mental distress/ suffering from poor mental health or mental well-being, and (2) Reduce demand placed on locality based Emergency services to manage individuals in mental health crisis / mental distress.**

The current service provision for patients who contact Police Scotland / Scottish Ambulance Service requiring mental health care and support is described in Appendix 1.

Significant analysis of the demand placed on NHS 24, Scottish Ambulance Service, Police Scotland and NHS Emergency Departments to manage the mental health and

well-being of the population has been gathered and this will be used to determine outcome measures and key performance indicators for the test of change. Key findings from this work have identified:

People with a Mental Health Problem are three times more likely than the general population to attend the Emergency Department.
The peak presentation time to the Emergency Department is after 11pm, and this patient group are five times more likely to be admitted in the out of hours period.
Frequent callers to emergency services are more likely to be already known and supported by locality based mental health services.

The benefits of an improved care pathway (Appendix 2) for individuals contacting in mental distress / with poor mental health are:

The ability to provide the level of support required to reduce distress and safely manage the needs of the individual effectively either via telephone support or ongoing referral to appropriate locality based services.
Reduction in the need for people to be transferred by / to emergency services.
Reduction in unnecessary demand being placed on Emergency Departments

Project (service) outcomes will be reviewed and reported on monthly, and project activities will be coordinated to ensure that changes tested and implemented successfully within the "test and learn" environment are, if appropriate and feasible, spread across the wider service.

**How will we know that a change is an improvement?**

A framework of evaluation will be developed in consultation with all partners, including the locality based integrated joint board supporting the "test and learn" phase. This framework will include both quantitative and qualitative measures. Qualitative data will also be used, to gain insights and feedback from individuals utilising the service, staff, partners and wider stakeholders.

**Qualitative Outcome measures – across the triumvirate model**

Individual experience in relation to outcomes, satisfaction levels, and any follow up action
Partner experience in relation to appropriateness of contacts received, and any follow up/re-triage required at a local level
Staff experience – NHS 24 / Police Scotland / Scottish Ambulance Service

**Quantitative Outcome measures – across the triumvirate model**

Number of mental health calls managed within the test & learn environment.
Number of mental health calls resulting in a final disposition of self care and our web based content
Numbers of mental health calls across the range of possible outcomes
Reduction in demand to emergency services including ED attendance
Number of contacts signposted to community based services

The project team have had the opportunity to liaise with other service providers who have implemented a first response service to manage the mental health needs of the population they serve. This service model incorporates mental health professionals working across a number of service areas, including Police Control Centres.

Data from Cambridgeshire and Peterborough Crisis Care Concordant (comparing 6 months pre intervention, 8 months post intervention) showed:

ED attendance for any "mental health" need – down 25%
Admission to Acute Trust for MH patients from ED – down 19%
Mental Health Ambulance Conveyances – down 26%
111 Calls and OOH GP appointments – down 45% and 39%

**What changes can we make that will result in improvement?**

The timetable below highlights the key milestones of the initial test of change proposal:

| TIMESCALE | OUTCOME |
|---|---|
| To Month 3 | Briefing Paper re ToC to sponsor<br>Identification of ToC Geographical Area<br>Establish Programme Board / Governance and Assurance Structure.<br>Recruitment of Frontline Mental Health Professionals<br>Recruitment of project staff<br>Establish Shared Outcome Measures across all partner agencies.<br>Planning and preparation; Process, Operations, Technology and Information |
| Month 3 – Month 6 | Training and Locality Pathway Development.<br>Phase One of Implementation of TOC. |
| Month 6 – Month 9 | Evaluation of Phase One Implementation.<br>Phase 2 / Whole System Implementation. |
| Month 9 – Month 12 | Project Evaluation.<br>Development Proposal for further / future upscaling of model – national learning and implementation plan |

**Project Team**

The Project Team will compromise of three distinct groupings, all of which will be aligned to the current Service Transformation Plans in place across NHS 24 / Police Scotland and the Scottish Ambulance Service:

**Programme Board (Quarterly Meetings)**

Programme Lead(s) – PS / SAS / NHS24
Communication and Engagement Lead
Evaluation Lead
Locality Representative(s)
Project Manager (NHS 24)
Executive Leadership Representation from PS / NHS24 / SAS
Executive Sponsor : Scottish Government Mental Health Division

**Implementation Group (Monthly Meetings)**

Programme Leads
Project Manager
Data Analyst
Locality Representatives – including service users.
Frontline Police Scotland & Scottish Ambulance Service Representatives
Communication and Engagement Lead

**Project (Service) Delivery Team (Daily / Weekly Meetings)**

Project Manager
Communication & Engagement
Team Leader(s)
Mental Health Support Workers
Mental Health Advisors
Mental Health Specialist Practitioners
Learning & Development Advisor

**Financial Implications**

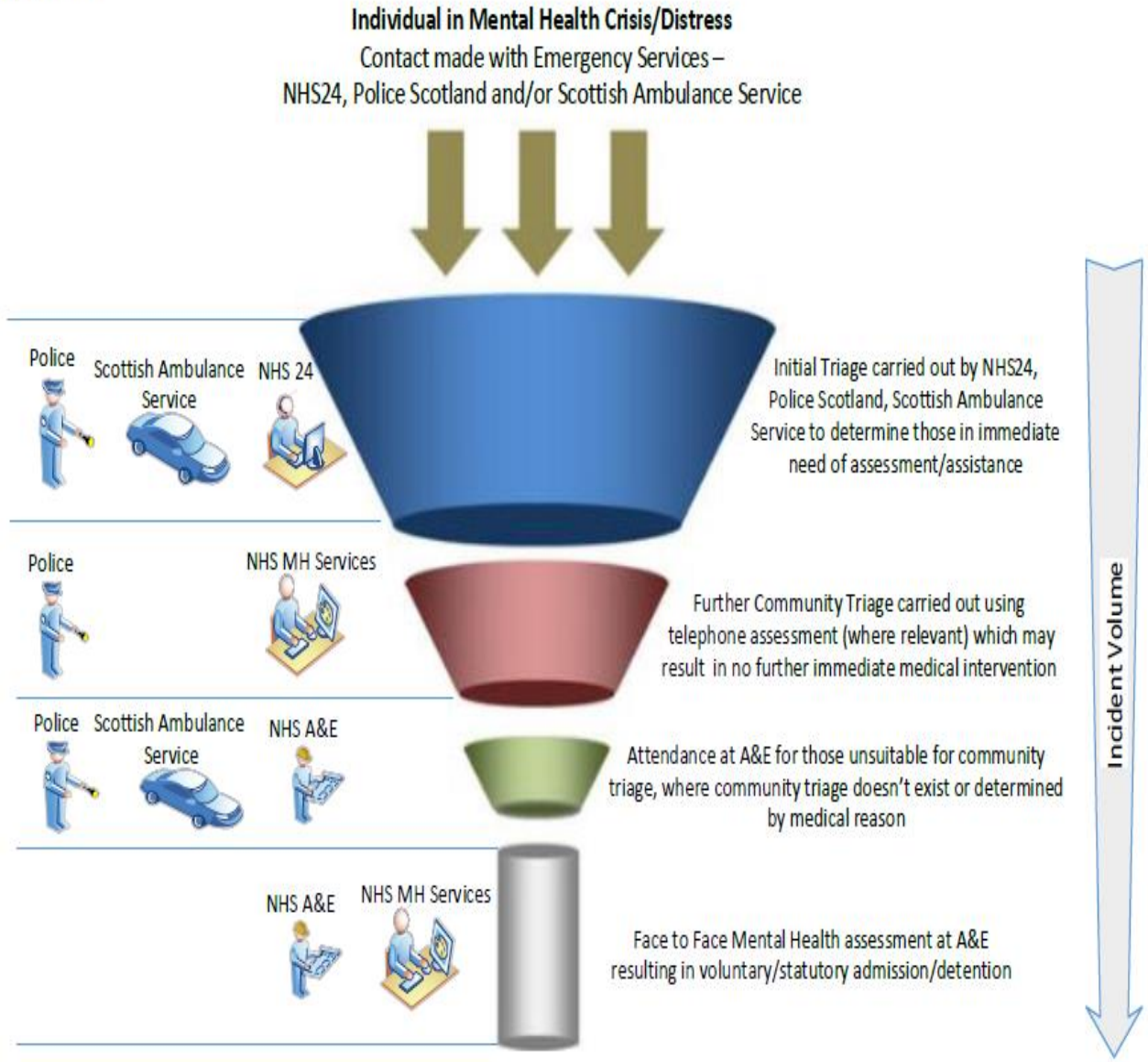
The final budget required to deliver this proposed test of change model is dependant on the needs and demand of the agreed geographical area where the pilot will be implemented. The table below details a workable draft budget, with reference given to particular roles and responsibilities required to ensure a smooth delivery of the project across all three partner areas. Several of these roles will straddle across all three components of the project.

| Details | Amount |
|---|---|
| Infrastructure, Development & Implementation of Model<br><br>- Senior Programme Leadership<br>- Communication and Engagement<br>- Learning & Education<br>- Technology / Systems Upgrade | £117,144 |
| Service Delivery Staffing<br><br>- Mental Health Clinical Service Manager (1xWTE Band 8a)<br>- Mental Health Team Leaders (2x WTE Band 7)<br>- Mental Health Call Operators (5x WTE Band 3)<br>- Mental Health and Well-being Advisors (4x WTE Band 4)<br>- Mental Health Specialist Practitioner (4x WTE Band 6)<br><br>*** This would ensure at least 16 new Mental Health Professionals being recruited to support direct patient care*** | £669,288 |
| Evaluation and Programme Management<br><br>Project Administrator<br>Data Analyst / Researcher | £81,582 |

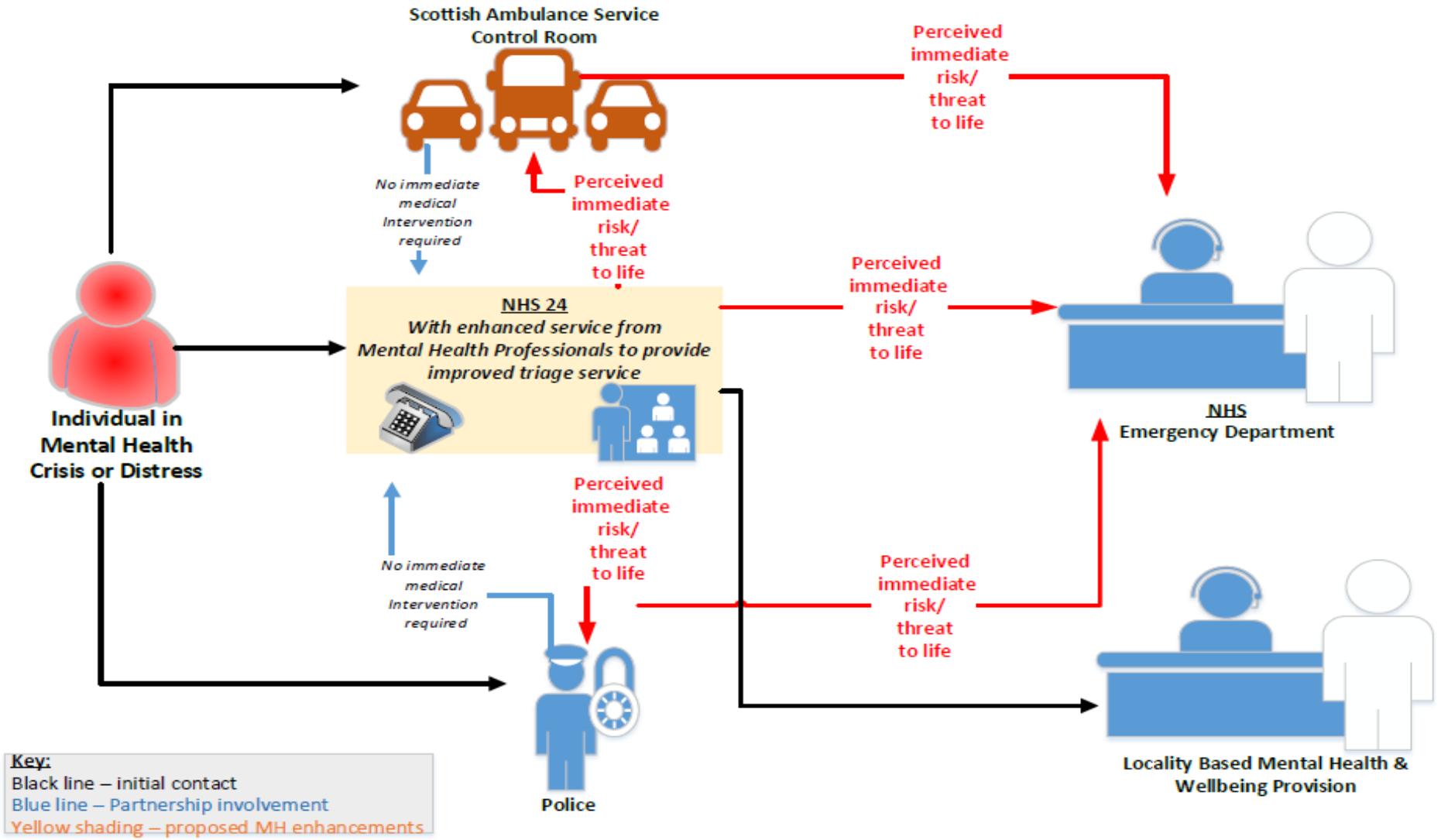
The proposed draft budget for year 1 would be **£868,014.**

## Appendix 1: Current Service provision

Appendix 1



## Appendix 2 – Proposed Enhanced Mental Health Pathways First Response



**ANNEX C**

**Breakdown of funding**

**Please note** - these figures are only provided as a guide using the NRAC formula calculator for 2018/19. [2] The formula changes only very slightly each year therefore it is not possible to provide an exact figure over the next 4 years.

| Allocations by Territorial Board – 2018/2019<br>£11 Million | | |
|---|---|---|
| **NHS Board** | **Target Share** | **NRAC Share** |
| NHS Ayrshire and Arran | 7.409% | £815,006 |
| NHS Borders | 2.104% | £231,456 |
| NHS Dumfries and Galloway | 2.979% | £327,738 |
| NHS Fife | 6.806% | £748,636 |
| NHS Forth Valley | 5.419% | £596,129 |
| NHS Grampian | 9.873% | £1,085,983 |
| NHS Greater Glasgow & Clyde | 22.337% | £2,457,118 |
| NHS Highland | 6.442% | £708,660 |
| NHS Lanarkshire | 12.348% | £1,358,226 |
| NHS Lothian | 14.80 4% | £1,628,474 |
| NHS Orkney | 0.483% | £53,077 |
| NHS Shetland | 0.490% | £53,907 |
| NHS Tayside | 7.848% | £863,306 |
| NHS Western Isles | 0.657% | £72,285 |

| Breakdown of estimated allocation per IJB - 2018/2019<br>£11 Million | | | | | |
|---|---|---|---|---|---|
| **NHS Board** | **NRAC Share %** | **NRAC Share £** | **HSCP Name** | **HSCP NRAC Share %** | **NRAC Share £** |
| Ayrshire & Arran | 7.41% | 815,006 | East Ayrshire | 2.43% | £267,351 |
| | | | North Ayrshire | 2.72% | £299,538 |
| | | | South Ayrshire | 2.26% | £248,118 |
| Borders | 2.10% | 231,456 | Scottish Borders | 2.10% | £231,456 |
| Dumfries & Galloway | 2.98% | 327,738 | Dumfries and Galloway | 2.98% | £327,738 |
| Fife | 6.81% | 748,636 | Fife | 6.81% | £748,636 |
| Forth Valley | 5.42% | 596,129 | Clackmannanshire and Stirling | 2.55% | £280,549 |
| | | | Falkirk | 2.87% | £315,580 |
| Grampian | 9.87% | 1,085,983 | Aberdeen City | 3.92% | £431,203 |

[2] As per the footnote on page 5, Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

| | | | | | |
|---|---|---|---|---|---|
| | | | Aberdeenshire | 4.23% | £465,384 |
| | | | Moray | 1.72% | £189,396 |
| Greater Glasgow & Clyde | 22.34% | 2,457,118 | East Dunbartonshire | 1.82% | £199,776 |
| | | | East Renfrewshire | 1.56% | £171,667 |
| | | | Glasgow City | 12.09% | £1,329,497 |
| | | | Inverclyde | 1.65% | £181,485 |
| | | | Renfrewshire | 3.40% | £373,503 |
| | | | West Dunbartonshire | 1.83% | £201,190 |
| Highland | 6.44% | 708,660 | Argyll and Bute | 1.85% | £203,883 |
| | | | Highland | 4.59% | £504,777 |
| Lanarkshire | 12.35% | 1,358,226 | North Lanarkshire | 6.43% | £706,750 |
| | | | South Lanarkshire | 5.92% | £651,476 |
| Lothian | 14.80% | 1,628,474 | East Lothian | 1.83% | £201,801 |
| | | | Edinburgh | 8.32% | £915,205 |
| | | | Midlothian | 1.57% | £173,170 |
| | | | West Lothian | 3.08% | £338,298 |
| Orkney | 0.48% | 53,077 | Orkney Islands | 0.48% | £53,077 |
| Shetland | 0.49% | 53,907 | Shetland Islands | 0.49% | £53,907 |
| Tayside | 7.85% | 863,306 | Angus | 2.15% | £237,042 |
| | | | Dundee City | 2.96% | £325,907 |
| | | | Perth and Kinross | 2.73% | £300,357 |
| Western Isles | 0.66% | 72,285 | Eilean Siar (Western Isles) | 0.66% | £72,285 |

| **Allocations by Territorial Board – 2019/2020<br>£17 million** | | |
|---|---|---|
| **NHS Board** | **Target Share** | **NRAC Share** |
| NHS Ayrshire and Arran | 7.409% | £1,259,555 |
| NHS Borders | 2.104% | £357,705 |
| NHS Dumfries and Galloway | 2.979% | £506,503 |
| NHS Fife | 6.806% | £1,156,983 |
| NHS Forth Valley | 5.419% | £921,290 |
| NHS Grampian | 9.873% | £1,678,337 |
| NHS Greater Glasgow & Clyde | 22.337% | £3,797,365 |
| NHS Highland | 6.442% | £1,095,201 |
| NHS Lanarkshire | 12.348% | £2,099,076 |
| NHS Lothian | 14.804% | £2,516,732 |
| NHS Orkney | 0.483% | £82,029 |
| NHS Shetland | 0.490% | £83,311 |
| NHS Tayside | 7.848% | £1,334,200 |
| NHS Western Isles | 0.657% | £111,713 |

| Breakdown of estimated allocation per IJB - 2019/2020<br>17 Million | | | | | |
|---|---|---|---|---|---|
| **NHS Board** | **NRAC Share %** | **NRAC Share £** | **HSCP Name** | **HSCP NRAC Share %** | **NRAC Share £** |
| Ayrshire & Arran | 7.41% | 1,259,555 | East Ayrshire | 2.43% | £413,178 |
| | | | North Ayrshire | 2.72% | £462,922 |
| | | | South Ayrshire | 2.26% | £383,455 |
| Borders | 2.10% | 357,705 | Scottish Borders | 2.10% | £357,705 |
| Dumfries & Galloway | 2.98% | 506,503 | Dumfries and Galloway | 2.98% | £506,503 |
| Fife | 6.81% | 1,156,983 | Fife | 6.81% | £1,156,983 |
| Forth Valley | 5.42% | 921,290 | Clackmannanshire and Stirling | 2.55% | £433,575 |
| | | | Falkirk | 2.87% | £487,715 |
| Grampian | 9.87% | 1,678,337 | Aberdeen City | 3.92% | £666,404 |
| | | | Aberdeenshire | 4.23% | £719,229 |
| | | | Moray | 1.72% | £292,703 |
| Greater Glasgow & Clyde | 22.34% | 3,797,365 | East Dunbartonshire | 1.82% | £308,745 |
| | | | East Renfrewshire | 1.56% | £265,303 |
| | | | Glasgow City | 12.09% | £2,054,677 |
| | | | Inverclyde | 1.65% | £280,477 |
| | | | Renfrewshire | 3.40% | £577,233 |
| | | | West Dunbartonshire | 1.83% | £310,930 |
| Highland | 6.44% | 1,095,201 | Argyll and Bute | 1.85% | £315,091 |
| | | | Highland | 4.59% | £780,110 |
| Lanarkshire | 12.35% | 2,099,076 | North Lanarkshire | 6.43% | £1,092,250 |
| | | | South Lanarkshire | 5.92% | £1,006,826 |
| Lothian | 14.80% | 2,516,732 | East Lothian | 1.83% | £311,875 |
| | | | Edinburgh | 8.32% | £1,414,407 |
| | | | Midlothian | 1.57% | £267,626 |
| | | | West Lothian | 3.08% | £522,823 |
| Orkney | 0.48% | 82,029 | Orkney Islands | 0.48% | £82,029 |
| Shetland | 0.49% | 83,311 | Shetland Islands | 0.49% | £83,311 |
| Tayside | 7.85% | 1,334,200 | Angus | 2.15% | £366,337 |
| | | | Dundee City | 2.96% | £503,674 |
| | | | Perth and Kinross | 2.73% | £464,188 |
| Western Isles | 0.66% | 111,713 | Eilean Siar (Western Isles) | 0.66% | £111,713 |

| Allocations by Territorial Board – 2020/2021<br>£24 million | | |
|---|---|---|
| **NHS Board** | **Target Share** | **NRAC Share** |
| NHS Ayrshire and Arran | 7.409% | £1,778,196 |
| NHS Borders | 2.104% | £504,995 |

| | | |
|---|---|---|
| NHS Dumfries and Galloway | 2.979% | £715,064 |
| NHS Fife | 6.806% | £1,633,388 |
| NHS Forth Valley | 5.419% | £1,300,645 |
| NHS Grampian | 9.873% | £2,369,417 |
| NHS Greater Glasgow & Clyde | 22.337% | £5,360,986 |
| NHS Highland | 6.442% | £1,546,166 |
| NHS Lanarkshire | 12.348% | £2,963,402 |
| NHS Lothian | 14.804% | £3,553,033 |
| NHS Orkney | 0.483% | £115,805 |
| NHS Shetland | 0.490% | £117,615 |
| NHS Tayside | 7.848% | £1,883,576 |
| NHS Western Isles | 0.657% | £157,712 |

**Breakdown of estimated allocation per IJB - 2020/2021**
**24 Million**

| NHS Board | NRAC Share % | NRAC Share £ | HSCP Name | HSCP NRAC Share % | NRAC Share £ |
|---|---|---|---|---|---|
| Ayrshire & Arran | 7.41% | 1,778,196 | East Ayrshire | 2.43% | £583,310 |
| | | | North Ayrshire | 2.72% | £653,537 |
| | | | South Ayrshire | 2.26% | £541,348 |
| Borders | 2.10% | 504,995 | Scottish Borders | 2.10% | £504,995 |
| Dumfries & Galloway | 2.98% | 715,064 | Dumfries and Galloway | 2.98% | £715,064 |
| Fife | 6.81% | 1,633,388 | Fife | 6.81% | £1,633,388 |
| Forth Valley | 5.42% | 1,300,645 | Clackmannanshire and Stirling | 2.55% | £612,106 |
| | | | Falkirk | 2.87% | £688,539 |
| Grampian | 9.87% | 2,369,417 | Aberdeen City | 3.92% | £940,806 |
| | | | Aberdeenshire | 4.23% | £1,015,383 |
| | | | Moray | 1.72% | £413,228 |
| Greater Glasgow & Clyde | 22.34% | 5,360,986 | East Dunbartonshire | 1.82% | £435,875 |
| | | | East Renfrewshire | 1.56% | £374,545 |
| | | | Glasgow City | 12.09% | £2,900,720 |
| | | | Inverclyde | 1.65% | £395,968 |
| | | | Renfrewshire | 3.40% | £814,917 |
| | | | West Dunbartonshire | 1.83% | £438,960 |
| Highland | 6.44% | 1,546,166 | Argyll and Bute | 1.85% | £444,835 |
| | | | Highland | 4.59% | £1,101,332 |
| Lanarkshire | 12.35% | 2,963,402 | North Lanarkshire | 6.43% | £1,542,000 |
| | | | South Lanarkshire | 5.92% | £1,421,401 |
| Lothian | 14.80% | 3,553,033 | East Lothian | 1.83% | £440,294 |
| | | | Edinburgh | 8.32% | £1,996,810 |
| | | | Midlothian | 1.57% | £377,825 |
| | | | West Lothian | 3.08% | £738,104 |

| | | | | | |
|---|---|---|---|---|---|
| Orkney | 0.48% | 115,805 | Orkney Islands | 0.48% | £115,805 |
| Shetland | 0.49% | 117,615 | Shetland Islands | 0.49% | £117,615 |
| Tayside | 7.85% | 1,883,576 | Angus | 2.15% | £517,182 |
| | | | Dundee City | 2.96% | £711,069 |
| | | | Perth and Kinross | 2.73% | £655,325 |
| Western Isles | 0.66% | 157,712 | Eilean Siar (Western Isles) | 0.66% | £157,712 |

| **Allocations by Territorial Board – 2021/2022<br>£32 million** | | |
|---|---|---|
| **NHS Board** | **Target Share** | **NRAC Share** |
| NHS Ayrshire and Arran | 7.409% | £2,370,927 |
| NHS Borders | 2.104% | £673,327 |
| NHS Dumfries and Galloway | 2.979% | £953,418 |
| NHS Fife | 6.806% | £2,177,851 |
| NHS Forth Valley | 5.419% | £1,734,193 |
| NHS Grampian | 9.873% | £3,159,222 |
| NHS Greater Glasgow & Clyde | 22.337% | £7,147,981 |
| NHS Highland | 6.442% | £2,061,555 |
| NHS Lanarkshire | 12.348% | £3,951,202 |
| NHS Lothian | 14.804% | £4,737,378 |
| NHS Orkney | 0.483% | £154,407 |
| NHS Shetland | 0.490% | £156,821 |
| NHS Tayside | 7.848% | £2,511,435 |
| NHS Western Isles | 0.657% | £210,283 |

| **Breakdown of estimated allocation per IJB - 2021/2022<br>£32 Million** | | | | | |
|---|---|---|---|---|---|
| **NHS Board** | **NRAC Share %** | **NRAC Share £** | **HSCP Name** | **HSCP NRAC Share %** | **NRAC Share £** |
| Ayrshire & Arran | 7.41% | 2,370,927 | East Ayrshire | 2.43% | £777,747 |
| | | | North Ayrshire | 2.72% | £871,383 |
| | | | South Ayrshire | 2.26% | £721,797 |
| Borders | 2.10% | 673,327 | Scottish Borders | 2.10% | £673,327 |
| Dumfries & Galloway | 2.98% | 953,418 | Dumfries and Galloway | 2.98% | £953,418 |
| Fife | 6.81% | 2,177,851 | Fife | 6.81% | £2,177,851 |
| Forth Valley | 5.42% | 1,734,193 | Clackmannanshire and Stirling | 2.55% | £816,141 |
| | | | Falkirk | 2.87% | £918,051 |
| Grampian | 9.87% | 3,159,222 | Aberdeen City | 3.92% | £1,254,408 |
| | | | Aberdeenshire | 4.23% | £1,353,844 |
| | | | Moray | 1.72% | £550,970 |

| | | | | | |
|---|---|---|---|---|---|
| Greater Glasgow & Clyde | 22.34% | 7,147,981 | East Dunbartonshire | 1.82% | £581,167 |
| | | | East Renfrewshire | 1.56% | £499,394 |
| | | | Glasgow City | 12.09% | £3,867,627 |
| | | | Inverclyde | 1.65% | £527,957 |
| | | | Renfrewshire | 3.40% | £1,086,555 |
| | | | West Dunbartonshire | 1.83% | £585,280 |
| Highland | 6.44% | 2,061,555 | Argyll and Bute | 1.85% | £593,113 |
| | | | Highland | 4.59% | £1,468,442 |
| Lanarkshire | 12.35% | 3,951,202 | North Lanarkshire | 6.43% | £2,056,001 |
| | | | South Lanarkshire | 5.92% | £1,895,202 |
| Lothian | 14.80% | 4,737,378 | East Lothian | 1.83% | £587,059 |
| | | | Edinburgh | 8.32% | £2,662,414 |
| | | | Midlothian | 1.57% | £503,767 |
| | | | West Lothian | 3.08% | £984,138 |
| Orkney | 0.48% | 154,407 | Orkney Islands | 0.48% | £154,407 |
| Shetland | 0.49% | 156,821 | Shetland Islands | 0.49% | £156,821 |
| Tayside | 7.85% | 2,511,435 | Angus | 2.15% | £689,576 |
| | | | Dundee City | 2.96% | £948,093 |
| | | | Perth and Kinross | 2.73% | £873,766 |
| Western Isles | 0.66% | 210,283 | Eilean Siar (Western Isles) | 0.63% | £210,283 |

**ANNEX D**

**ACTION 15 - OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018**

**IA area**

**Summary of agreed spending breakdown for 2018-19 with anticipated monthly phasing**

**Actual spending to date against profile, by month**

**Remaining spend to end 2018-19, by month**

**Projected under/ over spend by end 2018-19**

**Is it expected that the full second tranche will be required in 2018-19?**

Please return to:

Pat McAuley
3ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Pat.McAuley@gov.scot

Appendix 2

David W Lynch
Chief Officer
Dundee Health & Social Care Partnership
Claverhouse Office
Jack Martin Way
Dundee DD4 9FF

If calling, please ask for
**Arlene Mitchell, 01382 438338**
Email: arlene.mitchell@dundeecity.gov.uk

Mr Pat McAuley
Email: Pat.McAuley@gov.scot

Our Ref **AM/PC**
Your Ref
Date **03 August 2018**

Dear Mr McAuley

**ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19**

Please find attached Dundee Health and Social Care Partnership's commissioning intentions in relation to the above funding allocation. The figures provided are intended to demonstrate broadly how we intend to use the investment and will be subject to minor change once Tayside wide developments are confirmed. Dundee Integration Joint Board will consider these later in August.

The actions prioritised are driven by the expressed views of people living in Dundee who have experienced mental health challenges and who contribute significantly to developments within the city. The main themes that underpin our priorities are; the reduction of health inequalities, getting the right support at the right time, prevention/early intervention and recovery based approaches.

In relation to our collaborative work with partners within Angus and Perth and Kinross, the following priorities are being considered on a regional basis and resulting plans will be shared with you in September 2018:

- Forensic and Custody Healthcare: Trauma Informed Practice.
- Prison Healthcare: Trauma Informed Practice.
- Accident and Emergency responses.

Please do not hesitate to contact me should you require further information about any of our plans.

Yours sincerely

Arlene N. Mitchell

Arlene Mitchell, Locality Manager
Dundee Health and Social Care Partnership

**ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19**

The following areas have been prioritised by Dundee's Mental Health and Wellbeing Strategic and Commissioning group and will contribute to the national commitment to invest in 800 additional mental health workers across the country. The primary aim will be to increase access to dedicated mental health professionals within Accident and Emergency Departments, GP practices, every police station custody suite and to prisons.

Areas Prioritised:-

1. Patient Assessment and Liaison Mental Health Service
2. Social Prescribing
3. Do You Need to Talk? Listening Service
4. Supporting People in Distress Framework

At the core of all local developments is the principle of planning for and with people, taking a locality approach. People living in Dundee have also expressed a strong view that future improvements should lead to the delivery of support in a more whole system way, for example whether this be for families (as opposed to for children and adults separately with the same family), or for people for whom both mental health and substance misuse are challenges. Opportunities to test out more holistic approaches to delivery and planning are already being progressed.

## 1. Patient Assessment and Liaison Mental Health Service (PALMS)

A large number of GP consultations are for mental health problems. It is also known, however, that stigma and other factors prevent people accessing help. The mental health services and resources available to GP's are significant and range from community based resources, through to adult psychological services to community mental health services and in-patient care. This makes it difficult to successfully ensure that an individual is referred to the service best placed to meet their mental health needs. Where an individual is referred to a service that cannot meet their needs, it is likely that they will have had a considerable wait for this to be determined. Transitions to other services, however are not always smooth.

A number of regions across the United Kingdom have well established primary mental health care services. These largely provide triage to other existing mental health services, signposting to community resources and, in some cases, brief intervention. Most services still required GP referral. As such, the services are not intended to impact directly on GP workload and add an extra step in an individual finding their way to the most appropriate service.

The introduction of a mental health specialist within practices/GP clusters within the city will be incrementally introduced and fully functioning within all areas by 2021/2022.

The first stage of this will involve an experienced clinical psychologist becoming embedded within 2 practices working in parallel with GPs to function as the "mental health specialist" and attract initial assessment of new mental health presentations away from GP clinics. This service will be known as PALMS (the **P**atient **A**ssessment and **L**iaison **M**ental **H**ealth **S**ervice). The service will only be for adult patients.

Posters and leaflets within the practice will encourage patients to self-refer (booking appointments through Reception) for assessment. Patients seeking GP appointments will be triaged by Reception and offered diversion to the service where the primary issue is mental health.

GPs will continue to monitor, support and prescribe medication to patients where appropriate. GPs will also continue to make onward referrals to Adult Psychological Therapies Services, Community Mental Health Teams and other services where they are confident that the person is being referred to the correct service. Where this is in doubt, GPs will have the option of directing the individual to the PALMS service.

PALMS will operate three directly booked primary care triage clinics each week within each practice. A further two clinics will be used for conducting more comprehensive assessments and liaison work where specialist onward referral is indicated. All clinics will be based within practices. This will also allow for direct clinical advice and liaison between GPs and PALMS. Professional support from the mental health specialist will also be available to GPs as part of the development, this will allow for discussion about complex cases the GP may be managing. The initial test of change will operate for a period of twelve months. PALMS will be hosted by the Dundee Adult Psychological Therapies Service (which is part of Dundee Health and Social Care Partnership). This will allow for good staff and clinical governance.

Two GP practices will be identified to participate. Each practice will need to have space to host a clinical psychologist five sessions per week in a suitable consulting room with access to IT systems.

An examination of referral patterns to mental health services in Dundee has been undertaken and has been presented to the GP Cluster Lead group to assist in determining which practices may be better placed to participate

<u>Anticipated Outcomes</u>

- Service uptake will be monitored and reported
- 80% of referrals will be seen within 5 working days
- Referral rates and patterns to specialist services will be contrasted with a practice of similar size and demography with an expectation that the number of declined referrals will decrease (a measure of “right place”)
- “Did Not Attend” rates for first appointments in PALMS will be lower than those of Dundee Adult Psychological Therapies Service. (as a best current equivalent) as a proxy measure of “right time”
- There will be an increase in the quality of referrals to specialist services. This will be determined by contrasting PALMS referrals with ‘traditional’ GP referrals to specialist services
- Patient journeys subsequent to PALMS for those referred on the specialist mental health service will be examined (will require Caldicott approval) to determine whether an episode of care was delivered and what clinical interventions were delivered (a measure of “right place”)
- Patients triaged/assessed by PALMS will make fewer mental health consultations with GPs in the three months following assessment than the three month period before
- Patient satisfaction measures will indicate positive views of the service

Extending the Model

There are 4 GP clusters within the City and 24 practices at this time. Each cluster incorporates between 4 – 7 practices and it is anticipated that future roll out of the model will be by cluster as opposed to each individual practice. This will allow for a flexible (adaptable model that will be able to respond to capacity and demand via a 'cluster' team. Early learning from the initial model test will inform the skill level required for the 'mental health specialist' the model is introduced more widely, there may therefore be an opportunity to reduce fte costs based on initial learning gained.

It is anticipated that approximately 10 mental health specialists will be appointed between 2018 and 2021 to support this development.

**Patient Assessment and Liaison Mental Health Service (PALMS) Pathway**

CRISIS RESPONSE & RESOLUTION TEAM

CMHT

APTS

FURTHER COMPREHENSIVE ASSESSMENT IF SPECIALIST MENTAL HEALTH REFERRAL REQUIRED

GP ASSESSMENT (MISSED FOR TRIAGE)

REDIRECT TO RANGE OF COMMUNITY BASED SERVICES

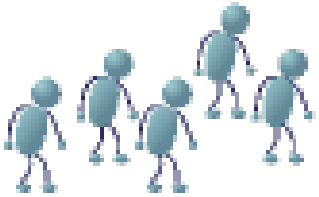
BRIEF ASSESSMENT APPOINTMENT (30 m max )

DIRECT PATIENT TO SOCIAL PRESCRIBER

BOOKING COMPLETED BY GP RECEPTION – MAX WAIT 10 DAYS; AIM FOR WITHIN 5 DAYS

SELF-REFERRAL RECRUITED BY POSTERS WITHIN PRACTICE

RECEPTIONIST TRIAGE WHEN LOOKING FOR GP APPOINTMENT



## 2. Social Prescribing

In 2011, the Sources of Support social prescribing scheme was piloted in one GP practice as part of the Scottish Government Equally Well test site in Dundee and scaled up to a further 3 GP practices through a combination of local and national funding in 2013. The SOS scheme sits within Dundee's integrated Health Inequalities Service.

An external evaluation demonstrated that the service had positive impacts on both clients and GPs themselves. Data shows that over 70% of referred patients engaged with the scheme in some way, there is a fairly even split between males and females, 76% of clients were aged between 20 and 59 years, and over half (56%) were single. 92% of clients had some sort of mental health and issue and ¼ had a physical health issue. The majority were unemployed and/or unfit to work and 84% of males and 76% of females are in receipt of welfare benefits. 61% of clients lived in SIMD quintile 1, which is higher that the deprivation profile of participating practices. 59% of patients required assisted visits to support them to access services; reasons included chronic anxiety, mobility issues, financial constraints and lack of social skills. Evidence shows that 65% of patient goals were met and 84% had some positive outcome. Outcomes include increased access to service and activities, decreased social isolation, improved or new housing, financial and benefits issues being addressed, new meaning and purpose, and increased confidence, awareness and self-esteem. Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. The role of the link worker has been shown to be sophisticated and complex, and includes skills such as negotiation, facilitation, research, networking and advocacy.

In 2016, as a result of the Scottish Government manifesto commitment to fund 250 link workers by the end of this political term, Dundee HSCP agreed to be an "early adopter" for the national Community Link Worker Programme and discussions took place to agree how the HSCP could help the Scottish Government achieve its initial target of 40 link workers in post across Scotland by the end of September 2017. This resulted in Dundee submitting a proposal for 5 new link workers. Subsequently, the national programme implementation team advised that further link workers be proposed, which resulted in 9 new link workers being funded bringing the total number of link workers in Dundee funded through the national programme to twelve. This added investment has enabled the Sources of Support scheme to be offered on a city-wide basis within practices that have above average levels of deprived patients in their practice populations.

Dundee HSCP received confirmation of three year funding from senior civil servants prior to undertaking a large scale recruitment drive for new link workers. Contracts were offered on a permanent basis with the understanding the IJB would build in longer term sustainability if required after that.

Social prescribing as a service and an approach sits within a range of plans at a local level including the Fairness Commission action plan, the City Plan, and the HSCP strategic and implementation plans demonstrating its contribution to a number of priority strategic outcomes. The majority of actions reflect the work of the Sources of Support scheme and efforts to build the capacity of frontline staff to act as social prescribers. The Equally Well Co-ordinator leads on capacity building activity and developed the Health Inequalities and Prevention training as a response to the recommendations in the Dundee Partnership Report on Prevention, and to complement the existing Community Health Team training programme which includes Poverty Sensitive Practice, Mind Yer Heid, and Substance Misuse and Recovery. The Health Inequalities and Prevention training promotes a toolkit reflecting social prescribing methodology and since January 2017 the Equally Well Co-ordinator has delivered 76 sessions to over 1000 frontline staff, almost half of whom sit within the Health and Social Care Partnership. Post session evaluation and follow up surveys demonstrate that between 82 and 99% of participants think that the session has raised their awareness of health inequalities and

social prescribing and built their capacity to adopt social prescribing approaches with vulnerable and at-risk individuals.

Whilst social prescribing activity is reflected in relevant strategic plans, the external evaluation for the Sources of Support scheme recommended that there required to be a specific framework for social prescribing. Specifically, it stated that there needs to be a clearer formulation of what is meant by social prescribing in terms of detail, not just broad brush statements…to prevent fragmentation and duplication of effort across existing policies. The evaluation suggests the need for a pragmatic approach based less on parity and uniformity and more on tailoring social prescribing approaches be that individual, client group, or locality…The lack of an overarching Social Prescribing Framework (linked to the Integrated Care agenda) within which to develop, leaves the service having to pick a development pathway among a range of other policies.

To this end, a Social Prescribing Framework group was established in May 2018 aiming to; define what is meant by social prescribing as a service and approach; map out existing activity across the spectrum of approaches; look at gaps, duplication, opportunities for expansion, onward referral pathways and processes, data collection and evidence; link to national strategies and local plans. The mapping questionnaire will be produced by June and piloted with a view to circulating more widely in September. Findings will be used to develop the framework, which will be shared across the wider partnership.

The allocation of funding will support the mainstreaming of the sources of support service within the city and support a far greater workforce to better understand, and therefore adopt, a social prescribing approach.

### 3. Do You Need to Talk? Listening Service (DYNTT)

Over recent years NHS Tayside Spiritual Care Department has been incrementally developing a listening service in GP practices and other healthcare facilities. Integrated Care Funding was used to help embed and expand the service. Led by the Senior Chaplain, a team of volunteers have been trained and supported to enable them to deliver 50 minute sessions to patients to talk through anxieties and concerns relating to life. Most patients return for further appointments until they become more confident in their own coping mechanisms and more resilient. The service is provided in the main by carefully selected, trained and supervised volunteers, supported by experienced chaplains.

Most GP practices now have access to this service however the current priority is to ensure this is available within all practices and that the service can continue to build an expert volunteer workforce that is well supported. The service has extended to support young people over age 13, in some practices, this has been an unexpected but very welcome outcome. The service works in conjunction with Dundee Volunteer Centre to promote volunteering opportunities.

Outcomes being achieved:

- Because of the assets/strengths process as part of the listening, DYNTT supports the development of positive health behaviours and promotes wellbeing.

- Spiritual Wellbeing at its core is Person Centred ‘helping people discover hope, meaning and purpose in times of loss, illness and transition.’

- By offering carers DYNTT they are able to build their own resilience and this therefore benefits both themselves and the person/people they care for.

- Because of the well established use of the particular gifts of volunteers in the DYNTT listening service this is a good model of capacity building without high levels of expenditure.

- DYNTT provides a complimentary form of support and is essential as part of the pathway of care providing physical, emotional, spiritual and mental wellbeing. GP's are already reporting a drop in the prescribing of some medications and it is thought this can be attributed to patients having access to DYNTT.

- DYNTT trains and supports volunteers, supported by skilled and experienced chaplains. This service reflects an efficient and effective use of health and social care resources.

The funding allocation will enable the DYNTT listening service to be available within all GP practices and will provide an infrastructure within which further volunteers can be recruited, trained and supported by chaplains. Further opportunities to provide support within locality hubs can also be explored.

## 4. Responding to Distress Framework

Dundee Mental Health and Wellbeing Strategic Planning Group has identified as one of its top priorities the need to create a framework of linked responses and clearer pathways for people who are experiencing overwhelming distress and who may be suicidal.

We see this as a range of services, which are open to anyone who is in extreme distress. End users may or may not have diagnosed mental health challenges, and may or may not be intoxicated.

We seek to provide the right support at the right time for people in distress, and simultaneously, to relieve pressures on our emergency services. In Dundee, often the only "safe" place for someone in distress is in the care of the police or hospital services, with neither being appropriate at times.

The distress framework should be available, 24 hours/day, 7 day/week, and 365 days/year and provide:

- Information about where to find help
- Support through the immediate distress
- Help to create a safe plan
- Follow-up contact if required

Our vision is of a framework consisting of a range of practical elements, which are:

- Accessible information about sources of support
- A 24/7 phone line manned by someone with mental health expertise
- A small number of beds for very short stay emergency accommodation
- A network of drop-in facilities for first contact and follow-up support

We intend to create the framework by building on existing or already planned developments, including:

- Use of social media and technology enabled care
- New Safety and Alarm Centre opening December 2018
- Availability of community based mental health expertise 24/7
- Build on existing triage arrangements to strengthen community based first responses

- Availability of accommodation units, created through existing current Strategic House Investment Plan partnership arrangements
- Existence of potential contact points such as Lochee Hub, Cairn Centre, Alberth Street Pharmacy, Community Centres and Church hall cafes in local neighbourhood across the city
- Peer Support developments
- Access to Advocacy where required

The funding allocation will contribute to the overall cost of developing the framework. It is envisaged that a mix of additional health professionals, voluntary sector staff, peer support workers and volunteers will be involved in developments. The outcomes that will be achieved by developing a supporting people in distress framework will also contribute to improved access to mental health support within Accident and Emergency service at Ninewells Hospital.

# Responding to distress 'pathway'

**Referrals/enquiries received from**: Emergency services (Police & ambulance), A & E, Social Work out of hours, NHS 24, Carseview, Safe Zone bus, GPs, Statutory and voluntary support services, members of the public

## 24/7 accessible support

**1. Initial screening questions 2. Clinical assessment**
OUTCOME INFORMS RISK ASSESSMENT: Is there a need for immediate intervention to ensure personal safety?

Establish if substance use involved

(If repeat callers, info sharing between teams/services essential to establish a management plan where required)

**YES**

**Carseview**
Assessment

**Responders Service**
Home visit

Risk assessment

**Safe Place beds**

location dependent on whether substance use assessed

**Follow up:**

Referrals so longer term services and supports can put in place if necessary

**NO**

**Brief intervention at point of contact:**

Listening ear: emotional support (over phone or by pre-arranged appointment). Establish if currently in contact with services/supports

**Peer Link worker service:**
short term, focused support,

**Referral/sign-posting to other MH services:**
Peer Link Service, Social Prescribing, Statutory services, Voluntary services, Counselling etc.

**Referral/sign-posting for practical issues:**
Housing, finances/benefits, food banks etc.

**Sign-posting to self help and community based resources (info pack?):** Moodjuice, Living Life to the Full, Steps for stress, Mobile Apps (e.g. Suicide?Help!), WRAP, MyLife website for community groups/resources

Appendix 2

## Proposed Investment Against Priorities

| Year | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|
| | £ | £ | £ | £ |
| Action 15 Allocation (Dundee) | 325,907 | 503,674 | 711,069 | 948,093 |
| Primary Care Improvement Fund | 36,000 | 73,000 | 124,000 | 227,000 |
| Total | 361,907 | 576,674 | 835,069 | 1,175,093 |
| **Patient Assessment and Liaison Mental Health Service** | 36,000 | 73,000 | 312,000 | 568,000 |
| **Social Prescribing** | 45,000 | 135,000 | 135,000 | 135,000 |
| **Do You Need to Talk? Listening Service** | 0 | 30,000 | 30,000 | 30,000 |
| **Supporting People in Distress** | 180,000 | 188,000 | 208,000 | 291,000 |
| Total | 261,000 | 426,000 | 685,000 | 1,024,000 |
| Tayside projects tbc/inflation etc | 100,000 | 150,000 | 150,000 | 150,000 |
| **Total Investment** | **361,000** | **576,000** | **835,000** | **1,174,000** |

**ITEM No …13……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **DUNDEE INTEGRATION JOINT BOARD 2018/19 BUDGET**

**REPORT BY:** **CHIEF FINANCE OFFICER**

**REPORT NO:** **DIJB30-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to present NHS Tayside's formal budget offer to Dundee Integration Joint Board in relation to the delegated budget 2018/19.

## 2.0 RECOMMENDATIONS

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

2.1 Notes and adopts the formal delegated budget offer to Dundee Health and Social Care Partnership from NHS Tayside subject to the caveats noted in sections 4.3.1 – 4.3.4

2.2 Notes the Dundee share of additional Scottish Government funding for Mental Health and Primary Care Transformation Funding as set out in section 4.6;

2.3 Notes the total value of Dundee Integration Joint Board's delegated budget for 2018/19 as set out in Table 3 of this report.

## 3.0 FINANCIAL IMPLICATIONS

The proposals outlined in this report set out an overall budget for 2018/19 for Dundee Health and Social Care Partnership of £227.5m as noted in Table 4 of this report.

## 4.0 MAIN TEXT

### 4.1 Background

4.1.1 Dundee IJB considered report number DIJB17-2018 (Dundee Integration Joint Board Budget 2018/19) at a special meeting of Dundee IJB held on 30th March 2018. This report set out to the IJB the formal budget offer from Dundee City Council and indicative budget from NHS Tayside given the NHS Tayside budget process was at that time still ongoing. The IJB subsequently approved a list of interventions in order to balance the various cost pressures and financial challenges based on the level of resources anticipated as a result of these budget considerations.

4.1.2 A significant issue to note for the delegated budget for 2018/19 is a change in the risk sharing agreement as outlined in the Integration Scheme whereby at the end of the first two years of the integrated budget, any residual financial risks are shared proportionately between Dundee City Council and NHS Tayside rather than these being picked up by the party from which the overspend is generated.

### 4.2 Proposed NHS Tayside Delegated Budget

4.2.1 NHS Tayside's Financial Plan 2018/19 was considered and approved by Tayside NHS Board at its meeting on 28th June 2018. NHS Tayside continues to be faced with unprecedented financial challenges with significant cost pressures and the need to identify substantial

financial savings. A range of savings to the value of £29.4m have been identified to close the projected gap of £48.1m however, a balance of £18.7m is still required to be found. These figures include savings required within each of the Integration Joint Boards, with financial risks remaining within prescribing and Mental Health and Learning Disability Services. One of the key assumptions made in relation to NHS Tayside's Financial Plan is that the IJBs manage any further cost pressures within available resources, particularly given the changes to the risk sharing arrangement effective from 2018/19.

4.2.2 In relation to the delegated budget, funding to support pay increases will be provided from a general inflationary uplift of 1.5% with further funding from the Scottish Government for pay awards above 1% for Agenda for Change staff (now confirmed as a 3% uplift for staff), and a 1.5% uplift applied to other costs including an uplift to the prescribing budget. Therefore it is anticipated that these uplifts will fully fund general increases in expenditure in 2018/19 with the exception of prescribing. The formal budget offer is consistent with the indicative budget presented to the IJB in March 2018. The interventions agreed by the IJB in March 2018 are required to address a range of legacy funding issues within the delegated budget and through the impact of hosted services, particularly the need to shift historical savings from a non-recurring to a recurring basis and the prescribing budget shortfall.

4.2.3 As part of the NHS Tayside Financial Plan 2018/19, the NHS Board has agreed to devolve all pre 2018/19 reserves relating to primary and community care to the IJBs to the total value of £6.1m. This funding is largely due to unspent, but forward committed resources from a range of historical change funds, including primary care, mental health and reshaping care for older people. The Dundee share of this is £1.971m. The balance will be set within the IJB's reserves for future consideration by the IJB.

**4.3 Prescribing**

4.3.1 The current year's projected financial position in relation to the prescribing budget was presented to the IJB at its meeting on 27th June 2018 (Report DIJB41-2018 – Dundee Prescribing Management Position). This report set out the anticipated factors likely to impact on the prescribing expenditure position and the corresponding Prescribing Management Group's savings plan developed to mitigate where possible the financial shortfalls and risks within the prescribing budget. The financial position shows a projected shortfall of just over £400k assuming all factors impact as anticipated however this rises to over £700k following a risk assessment of the scale and pace of the interventions. The updated position remains the same.

4.3.2 The IJB previously accepted the indicative level of prescribing budget from NHS Tayside with a range of caveats

- the final GP prescribing budget delegated by NHS Tayside is set at a minimum budget level which includes an additional £800k to reflect NHS Tayside's benefit of additional funding through the NHS Scotland Resource Allocation Committee (NRAC) funding formula (giving a total prescribing budget of £34,117k);
- the IJB will not be held responsible for any overspends incurred on account of the Prescribing Management Group (PMG) actions not being delivered at the scale and pace set out in the associated cost reduction plan;
- the IJB will not be responsible for significant changes in price increases (drug tariffs) against those estimated in the prescribing plan.

4.3.3 The IJB would take responsibility for the level of volume growth and the impact of the local interventions as part of the Dundee Medicines Management Plan.

4.3.4 It is proposed that the IJB maintains this position and that any significant variances as a result of the above being incurred will be brought to the attention of the IJB once known.

**4.4 Impact of Hosted Services – Mental Health Inpatient Services**

4.4.1 Perth & Kinross IJB continues to work in partnership with Dundee, Angus and NHS Tayside, to reduce the cost pressures associated with the Mental Health Inpatient Service and General Adult Psychiatry which has had a considerable funding gap over the last two years, partly met through non-recurring funding from NHS Tayside. Reducing this gap is associated with the major service redesign programme which the IJB supported in December 2017

(Report DIJB49-2017, Mental Health & Learning Disability Redesign Transformation Programme – Consultation Feedback Report) however this will take time to implement.

4.4.2 There are a range of further operational interventions identified to address these cost pressures however a projected deficit of around £1.3m overall remains projected for 2018/19.

4.4.3 The impact to Dundee of any residual overspend for these services is around 40% of the total Tayside figure, resulting in an unbudgeted financial pressure of approximately £520k. This presents a significant risk to the IJB in being able to achieve a balanced budget in 2018/19 and this position will be monitored closely throughout the remainder of the financial year with mitigating actions identified and reported back to the IJB within future revenue monitoring reports.

**4.5 Large Hospital Set Aside**

4.5.1 An indicative figure for the Large Hospital Set Aside provided by NHS Tayside was included within the IJB's 2017/18 annual accounts based on a combination of activity information and direct costs of the specialties included within the large hospital set aside following Scottish Government correspondence. It was acknowledged that the methodology used for 2017/18 needs to be developed further during 2018/19 in order to provide a better insight into the local populations' consumption of the specialties within the Large Hospital Set Aside. This work continues to be taken forward at both a local and national level.

**4.6 Impact of Additional National Funding**

4.6.1 The local allocation of additional funding being provided nationally in Primary Care and Mental Health Services is noted below. The local figures for Alcohol and Drug Partnerships is yet to be determined by the Scottish Government and the impact of this on the delegated budget will be highlighted to the IJB once known. Proposals for the investment of this funding through the various governance groups and in line with the Scottish Government's policy aims will be placed before the IJB once developed. The high level Primary Care Improvement Plan has already been approved by the IJB at its meeting of 27th June 2018 (Report No DIJB26-2018 – Tayside Primary Care Improvement Plan). The additional national and local resources are shown below for information:

**Table 1**

| Fund | Dundee Share £m |
|---|---|
| Primary Care Transformation | 1.356 |
| Mental Health | 0.326 |
| Alcohol and Drug Partnerships (additional £20m nationally) | Tbc |

**4.7 Reserves Position**

4.7.1 As reported in the budget paper (Report No DIJB17-2018 – Dundee Integration Joint Board Budget 2018-2019) presented to the IJB in March 2018, at the end of the IJB's first year of operation (2016/17), the IJB created a reserve of approximately £5m, primarily as a result of a carry forward of historical Change Funding (£4m) to support transformational change and an underspend of around £1m in its social care budget. It was acknowledged that a further £1m of resources sat within NHS Tayside as historical legacy funding, which with further underspends in specific funds at the end of 2017/18, is now identified as £1.9m in total as set out in 4.2.3. The IJB's draft unaudited accounts for 2017/18 indicates a net reserves position of £4.560m (excluding the additional NHS transfer to the IJB during 2018/19 as noted above) and this position will be confirmed once the audited accounts are available at the end of September 2018. The IJB committed a further use of reserves in order to support the overall budget position at its meeting in March 2018 in addition to the reserves already committed to support transformational change. The flexibility available to the IJB during

2018/19 to meet unexpected pressures or further transformational change is provisionally as follows:

**Table 2 – Provisional IJB Reserves Position (as at 31 March 2018)**

| | £000 |
|---|---|
| Value of Reserves per unaudited accounts | 4,560 |
| Legacy Resources from NHS Tayside | 1,971 |
| Less: Already Committed | (5,705) |
| Balance Remaining | 826 |

**4.8 Proposed Dundee IJB Delegated Budget 2018/19**

Factoring all of the above against the delegated budget results in a proposed position for 2018/19 as noted in Table 3 below:

**Table 3 – Dundee Health & Social Care Partnership Proposed Delegated Budget 2018/19**

| | Dundee City Council | NHS Tayside | Total Proposed Budget 2018/19 |
|---|---|---|---|
| | £m | £m | £m |
| **2018/19 Budget** | | | |
| Hospital & Community Based Services | 73.5 | 77.3 | 150.8 |
| Family Health Services Prescribing | | 34.1 | 34.1 |
| General Medical Services | | 40.9 | 40.9 |
| Large Hospital Set Aside (value tbc) | | tbc | tbc |
| Total Baseline Budget | **73.5** | **152.3** | **225.8** |
| Primary Care/ Mental Health Innovation Funding | | 1.7 | 1.7 |
| ADP Additional Funding | | tbc | tbc |
| **Total Proposed Budget 2018/19** | **73.5** | **154** | **227.5** |
| | | | |
| Note:* | | | |
| Net Effect of Hosted Services | | 4.8 | 4.8 |
| | | | |
| | | | |

**5.0 POLICY IMPLICATIONS**

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues at this stage however, the financial position will continue to be monitored throughout the financial year.

## 6.0 RISK ASSESSMENT

| | |
|---|---|
| **Risk 1 Description** | There is a risk that the IJB will not be able to balance its resources and achieve its strategic objectives should the combination of the level of funding provided through the delegated budget and the impact of the IJB's Transformation Efficiency Programme be insufficient. |
| **Risk Category** | Financial |
| **Inherent Risk Level** | Likelihood 4 x Impact 4 = 16 (Extreme) |
| **Mitigating Actions** (including timescales and resources ) | Developing a robust and deliverable Transformation Programme. Negotiations with Dundee City Council and NHS Tayside to agree the most advantageous funding package as part of the development of the IJB's delegated budget. |
| **Residual Risk Level** | Likelihood 3 x Impact 4 = 12 (High) |
| **Planned Risk Level** | Likelihood 3 x Impact 4 = 12 (High) |
| **Approval recommendation** | Although the risk levels remain high, the range of interventions identified generally have a medium to low risk of delivery in 2018/19 therefore the risks should be accepted. Risks around the Prescribing budget will be continually monitored and reported to the IJB throughout the year. |

## 7.0 CONSULTATIONS

The Chief Officer, Executive Director of Corporate Services - Dundee City Council, Deputy Director of Finance - NHS Tayside 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 | |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | ✓ |

## 9.0 BACKGROUND PAPERS

None.

Dave Berry
**Chief Finance Officer**

**DATE:** 31st July 2018

# DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

| | | |
|---|---|---|
| 1 | Reference | DIJB30-2018 |
| 2 | Date Direction issued by Integration Joint Board | 28th August 2018 |
| 3 | Date from which direction takes effect | 28th August 2018 |
| 4 | Direction to: | NHS Tayside & Dundee City Council |
| 5 | Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s) | Yes |
| 6 | Functions covered by direction | All delegated services. |
| 7 | Full text of direction | Dundee Integration Joint Board directs Dundee City Council and NHS Tayside to provide health and social care services as commissioned by Dundee Integration Joint Board within the resources allocated as set out in this report, subject to formal notification from NHS Tayside as to the level of budget offer. Further Directions will be issued by Dundee Integration Joint Board during 2018/19 as to the future provision of these services. |
| 8 | Budget allocated by Integration Joint Board to carry out direction | Dundee City Council – £73.5m<br>NHS Tayside - £154m |
| 9 | Performance monitoring arrangements | Through regular financial monitoring reports to Dundee Integration Joint Board. |
| 10 | Date direction will be reviewed | N/A |

**ITEM No …14……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **FINANCIAL MONITORING POSITION AS AT JUNE 2018**

**REPORT BY:** **CHIEF FINANCE OFFICER**

**REPORT NO:** **DIJB47-2018**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2018/19.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report including the overall projected financial position for delegated services to the 2018/19 financial year end as at 30 June 2018.

## 3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 30th June 2018 shows a net projected overspend position of £1,064k. This is the first projection made for the financial year. The overspend is primarily as a result of overspends in GP prescribing of £415k, General Medical Services of £175k and the net impact of hosted services of £473k.

3.2 The budgets against which the financial projections are monitored against are subject to final approval by the IJB as noted in item 13 of this agenda.

## 4.0 MAIN TEXT

### 4.1 Background

4.1.1 As part of the IJB's financial governance arrangements, the Integration Scheme outlines that "The Chief Finance Officer will ensure routine financial reports are available to the Chief Officer and the Integration Joint Board on a timely basis and include, as a minimum, annual budget, full year outturn projection and commentary on material variances."

4.1.2 The IJB considered the overall budgeted resources for delegated services at its meeting in March 2018 following receipt of confirmation of Dundee City Council's budget. The NHS budget was noted as being indicative at this time with the NHS budget proposal to be considered by the IJB as a separate item on this meeting agenda. Members of the IJB will recall that risks around the prescribing budget were noted within the paper presented in March in addition to Report DIJB41-2018 (Dundee Prescribing Management Position) considered by the IJB at its meeting held on 27th June 2018.

4.1.3 The financial information presented has been provided by the finance functions of NHS Tayside and Dundee City Council as set out within the Integration Scheme.

4.1.4 IJB members will note that as we move into year 3 of the IJB formally taking over responsibility for the strategic planning and operational management of delegated services, the risk sharing arrangements as outlined in the Integration Scheme change with any residual overspends incurred by the end of the financial year to be met proportionately by the Council and NHS Tayside following a number of actions to be taken by the IJB. Discussions will be ongoing throughout the financial year with both parties to consider the implications of this should this situation arise. Officers within the partnership will however continue to explore areas to control expenditure and to mitigate overspends.

**4.2 Projected Outturn Position – Key Areas**

4.2.1 The following sets out the main areas of note from the financial information contained within Appendices 1 (Summary Position) and 2 (More Detailed Position) and provides commentary on the reasons for significant variances, actions being taken to manage these and outlines the key elements of risk which may remain.

**4.3 Services Delegated from NHS Tayside**

4.3.1 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £1,064k by the end of the financial year.

4.3.2 A number of service underspends are noted within the development of Enhanced Community Services due to timing delays in recruiting to new posts, Allied Health Professionals (AHP) primarily as a result of staff vacancies and Community Based Psychiatry of Old Age. This is additional to the staff efficiency savings incorporated into the base budget for these services and therefore provides a further contribution to achieving the overall savings target.

4.3.3 Staff cost pressures exist in a number of other services such as the Medicine for the Elderly budget, Palliative Care and Nursing Services. Additional staffing pressures have contributed to the adverse position within these services. Overall, directly managed operational services are anticipated to be in financial balance by the end of the financial year.

4.3.4 The Family Health Services prescribing budget currently projects a shortfall totalling £415k based on the expenditure trends to date and the impact of a range of interventions as part of the Tayside wide Prescribing Management Group's action plan as noted in the Dundee Prescribing Management Position report presented to the June 2018 IJB meeting (Report DIJB41-2018). These figures do not however at this stage reflect the risk assessed intervention plan as outlined in the June report which noted that the prescribing overspend could increase to around £700k. This will continue to be monitored closely throughout the financial year.

4.3.5 Members of the IJB will also be aware that Angus and Perth & Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. More detail of the recharges from Angus and Perth & Kinross IJBs to Dundee IJB are noted in Appendix 3. This shows net overspends to the value of £659k being recharged with the net impact of hosted services to Dundee being an overspend of £473k.

4.3.6 As with 2017/18, the financial position of Dundee City IJB continues to be impacted upon by the significant overspend in the Mental Health Inpatient service which is hosted by Perth & Kinross IJB. Notably Perth & Kinross IJB has continued to utilise cost pressure funding and apply other interventions to reduce the overspend position in respect of this service provision. This has resulted in Dundee City IJB reducing its share of the estimated overspend to £384k (previously reported £500k). Other hosted services previously highlighted as areas of financial risk such as the Out of Hours & Forensic services hosted by Angus have also seen reductions in the projected overspend for the year through a range of interventions. These will continue to be monitored closely over the remainder of the financial year.

### 4.4 Services Delegated from Dundee City Council

4.4.1 The financial projection for services delegated from Dundee City Council to the IJB shows a balanced financial position at this stage of the financial year. Within this however there are a number of budget pressures which reflect a continuation of recent demographic trends, particularly within Older People's Services and Learning Disability Services. Continued increasing demand for home care packages to support people in their own homes and reduce delays in hospital is the main contributing factor to the projected overspend in Older People's Services. Similarly, the demand for accommodation with support for people with a Learning Disability continues to grow.

4.4.2 A range of underspends within Mental Health Services, Physical Disabilities and Management and Support functions mainly arising from staff turnover are currently projected to balance the budget pressure areas.

## 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

| | |
|---|---|
| **Risk 1 Description** | There is a significant risk that the IJB is unable to deliver a balanced budget over the financial year. |
| **Risk Category** | Financial |
| **Inherent Risk Level** | Likelihood 4 x Impact 5 = Risk Scoring 20 (which is Extreme Risk Level) |
| **Mitigating Actions** (including timescales and resources ) | The IJB has agreed a range of efficiency savings and other interventions including the use of reserves to balance expenditure.<br>A range of service redesign options through the Transformation Programme will offer opportunities to further control expenditure.<br>Regular financial monitoring reports to the IJB will highlight issues raised. |
| **Residual Risk Level** | Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level) |
| **Planned Risk Level** | Likelihood 3 x Impact 4 = Risk Scoring 12 (which is a High Risk Level) |
| **Approval recommendation** | While the inherent risk levels are extreme, the impact of the planned actions reduce the risk and therefore the risk should be accepted. |

## 7.0 CONSULTATIONS

The Chief Officer, Executive Director of Corporate Services (Dundee City Council), Director of Finance of NHS Tayside 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

**9.0 BACKGROUND PAPERS**

None.

Dave Berry
Chief Finance Officer

**DATE**: 27 July 2018

Appendix 1

**DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2018/19 AS AT June 2018**

| | Dundee City Council Delegated Services | | NHST Dundee Delegated Services | | Partnership Total | |
|---|---|---|---|---|---|---|
| | Net Budget | Projected Overspend / (Underspend) | Net Budget | Projected Overspend / (Underspend) | Net Budget | Projected Overspend / (Underspend) |
| | £,000 | £,000 | £,000 | £,000 | £,000 | £,000 |
| **Older Peoples Services** | 37,155 | 215 | 15,483 | 3 | 52,638 | 218 |
| **Mental Health** | 4,140 | -120 | 3,260 | 50 | 7,400 | -70 |
| **Learning Disability** | 22,003 | 370 | 1,244 | -30 | 23,247 | 340 |
| **Physical Disabilities** | 8,777 | -335 | 0 | 0 | 8,777 | -335 |
| **Substance Misuse** | 836 | 0 | 2,614 | -20 | 3,450 | -20 |
| **Community Nurse Services / AHP / Other Adult** | 395 | 0 | 10,898 | -42 | 11,294 | -42 |
| **Hosted Services** | 0 | 0 | 18,092 | -291 | 18,092 | -291 |
| **Other Dundee Services / Support / Mgmt** | 333 | -130 | 25,982 | -203 | 26,315 | -333 |
| **Centrally Managed Budgets** | | | 1,767 | 532 | 1,767 | 532 |
| **Total Health and Community Care Services** | **73,638** | **0** | **79,341** | **0** | **152,979** | **0** |
| Prescribing (FHS) | 0 | 0 | 32,423 | 415 | 32,423 | 415 |
| Other FHS Prescribing | 0 | 0 | 894 | 0 | 894 | 0 |
| General Medical Services | 0 | 0 | 23,758 | 175 | 23,758 | 175 |
| FHS - Cash Limited & Non Cash Limited | 0 | 0 | 17,161 | 1 | 17,161 | 1 |
| **Grand Total** | **73,638** | **0** | **153,577** | **591** | **227,215** | **591** |
| Hosted Services* | | | 4,853 | 473 | 4,853 | 473 |
| **Grand Total** | **73,638** | **0** | **158,430** | **1,064** | **232,068** | **1,064** |
| ***Hosted Services - Net Impact of Risk Sharing Adjustment** | | | | | | |

**Appendix 2**

**Dundee City Integration Joint Board – Health & Social Care Partnership – Finance Report June 2018**

| | Dundee City Council Delegated Services | | NHST Dundee Delegated Services | | Partnership Total | |
|---|---|---|---|---|---|---|
| | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 |
| Psychiatry Of Old Age (POA) (In Patient) | | | 4,417 | 88 | 4,417 | 88 |
| Older People Serv. – Ecs | | | 0 | (500) | 0 | (500) |
| Older Peoples Services -Community | | | 501 | 25 | 501 | 25 |
| Continuing Care | | | 1,338 | 0 | 1,338 | 0 |
| Medicine for the Elderly | | | 5,732 | 525 | 5,732 | 525 |
| Medical ( POA) | | | 643 | (20) | 643 | (20) |
| Psychiatry Of Old Age (POA) - Community | | | 1908 | (175) | 1,908 | (175) |
| Intermediate Care | | | 944 | 61 | 944 | 61 |
| Dundee- Supp People At Home | | | 0 | 0 | 0 | 0 |
| Older People Services | 37,155 | 215 | | | 37,155 | 215 |
| **Older Peoples Services** | 37,155 | 215 | 15,483 | 3 | 52,638 | 218 |
| General Adult Psychiatry | | | 3,260 | 50 | 3,260 | 50 |
| Mental Health Services | 4,140 | (120) | | | 4,140 | (120) |
| **Mental Health** | 4,140 | (120) | 3,260 | 50 | 7,400 | (70) |
| Learning Disability (Dundee) | 22,003 | 370 | 1,244 | (30) | 23,247 | 340 |
| **Learning Disability** | 22,003 | 370 | 1,244 | (30) | 23,247 | 340 |

| | Dundee City Council Delegated Services | | NHST Dundee Delegated Services | | Partnership Total | |
|---|---|---|---|---|---|---|
| | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 |
| Physical Disabilities | 8,777 | (335) | | | 8,777 | (335) |
| **Physical Disabilities** | 8,777 | (335) | 0 | 0 | 8,777 | (335) |
| Alcohol Problems Services | | | 690 | (60) | 690 | (60) |
| Drug Problems Services | | | 1,924 | 40 | 1,924 | 40 |
| Substance Misuse | 836 | 0 | | | 836 | 0 |
| **Substance Misuse** | 836 | 0 | 2,614 | (20) | 3,450 | (20) |
| A.H.P. Admin | | | 363 | 0 | 363 | 0 |
| Physiotherapy | | | 3,262 | (75) | 3,262 | (75) |
| Occupational Therapy | | | 1,302 | (73) | 1,302 | (73) |
| Nursing Services (Adult) | | | 5,450 | 150 | 5,450 | 150 |
| Community Supplies - Adult | | | 155 | (20) | 155 | (20) |
| Anticoagulation | | | 366 | (24) | 366 | (24) |
| Joint Community Loan Store | | | 0 | 0 | 0 | 0 |
| Intake/Other Adult Services | 395 | 0 | | | 395 | 0 |
| **Community Nurse Services / AHP / Intake / Other Adult Services** | 395 | 0 | 10,898 | (42) | 11,294 | (42) |

| | Dundee City Council Delegated Services | | NHST Dundee Delegated Services | | Partnership Total | |
|---|---|---|---|---|---|---|
| | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 |
| Palliative Care – Dundee | | | 2,481 | 83 | 2,481 | 83 |
| Palliative Care – Medical | | | 1,085 | 0 | 1,085 | 0 |
| Palliative Care – Angus | | | 315 | 9 | 315 | 9 |
| Palliative Care – Perth | | | 1,567 | 149 | 1,567 | 149 |
| Brain Injury | | | 1,552 | 90 | 1,552 | 90 |
| Dietetics (Tayside) | | | 2,684 | (245) | 2,684 | (245) |
| Sexual & Reproductive Health | | | 1,991 | (25) | 1,991 | (25) |
| Medical Advisory Service | | | 151 | (48) | 151 | (48) |
| Homeopathy | | | 26 | 3 | 26 | 3 |
| Tayside Health Arts Trust | | | 57 | 0 | 57 | 0 |
| Psychology | | | 4,641 | (417) | 4,641 | (417) |
| Eating Disorders | | | 0 | 0 | 0 | 0 |
| Psychotherapy (Tayside) | | | 794 | 140 | 794 | 140 |
| Learning Disability (Tayside AHP) | | | 749 | (30) | 749 | (30) |
| **Hosted Services** | 0 | 0 | 18,092 | (291) | 18,092 | (291) |
| Working Health Services | | | 0 | 0 | 0 | 0 |
| The Corner | | | 394 | 25 | 394 | 25 |
| Resource Transfer | | | 0 | 0 | 0 | 0 |
| Grants Voluntary Bodies Dundee | | | 46 | 0 | 46 | 0 |
| IJB Management | | | 734 | (35) | 734 | (35) |
| Partnership Funding | | | 23,233 | 0 | 23,233 | 0 |
| Carers Strategy | | | 0 | 0 | 0 | 0 |
| Public Health | | | 473 | 0 | 473 | 0 |
| Keep Well | | | 576 | (120) | 576 | (120) |
| Primary Care | | | 526 | (73) | 526 | (73) |
| Support Services/Management Costs | 333 | (130) | | | 333 | (130) |
| **Other Dundee Services / Support / Mgmt** | 333 | (130) | 25,982 | (203) | 26,315 | (333) |

| | | | | | | |
|---|---|---|---|---|---|---|
| Centrally Managed Budgets | | | 1,767 | 532 | 1,767 | 532 |

| | Dundee City Council Delegated Services | | NHST Dundee Delegated Services | | Partnership Total | |
|---|---|---|---|---|---|---|
| | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 | Annual Budget £,000 | Projected Over / (Under) £,000 |
| **Total Health and Community Care Services** | **73,638** | **0** | **79,341** | **0** | **152,979** | **0** |
| **Other Contractors** | | | | | | |
| Prescribing (FHS) | | | 32,423 | 415 | 32,423 | 415 |
| Other FHS Prescribing | | | 894 | 0 | 894 | 0 |
| General Medical Services | | | 23,758 | 175 | 23,758 | 175 |
| FHS - Cash Limited & Non Cash Limited | | | 17,161 | 1 | 17,161 | 1 |
| **Grand Total H&SCP** | **73,638** | **0** | **153,577** | **591** | **227,215** | **591** |
| Hosted Recharges Out | | | (10,601) | (186) | (10,601) | (186) |
| Hosted Recharges In | | | 15,454 | 659 | 15,454 | 659 |
| **Hosted Services - Net Impact of Risk Sharing Adjustment** | | | **4,853** | **473** | **4,853** | **473** |
| **TOTAL** | | | **158,430** | **1,064** | **232,068** | **1,064** |
| **Large Hospital Set Aside** | | | **tbc** | **tbc** | **tbc** | **tbc** |

**NHS Tayside - Services Hosted by Integrated Joint Boards - Charge to Dundee IJB**
**Risk Sharing Agreement - June 2018**

**Appendix 3**

**Services Hosted in Angus**

| | Annual Budget | Forecast Over/ (Underspend) | Dundee Allocation |
|---|---|---|---|
| Forensic Service | 907,129 | (15,000) | (5,910) |
| Out of Hours | 6,868,549 | 300,000 | 118,200 |
| Tayside Continence Service | 1,419,195 | (126,702) | (49,921) |
| Ang-loc Pharmacy | 0 | 0 | 0 |
| Speech Therapy (Tayside) | 955,397 | (2,304) | (908) |
| **Hosted Services** | **10,150,270** | **155,994** | **61,462** |
| 2018/19 Efficiency Target | -148,425 | 148,425 | 58,479 |
| **Grand Total Hosted Services** | **10,001,845** | **304,419** | **119,941** |

**Services Hosted in Perth**

| | | | |
|---|---|---|---|
| Angus Gap Inpatients | 2,149,731 | 275,000 | 108,350 |
| Dundee Gap Inpatients | 5,182,051 | 500,000 | 197,000 |
| Dundee Gap Snr Medical | 1,916,270 | 175,000 | 68,950 |
| P+K Gap Inpatients | 5,450,389 | 125,000 | 49,250 |
| Learning Disability (Tayside) | 5,841,019 | (100,000) | (39,400) |
| T.A.P.S. | 635,189 | (27,500) | (10,835) |
| Tayside Drug Problem Services | 810,156 | (135,000) | (53,190) |
| Prison Health Services | 3,004,536 | 95,000 | 37,430 |
| Public Dental Service | 1,954,173 | (5,000) | (1,970) |
| Podiatry (Tayside) | 2,774,310 | (31,500) | (12,411) |
| **Hosted Services** | **29,717,824** | **871,000** | **343,174** |
| 2018/19 Efficiency Target | -497,117 | 497,117 | 195,864 |
| **Grand Total Hosted Services** | **29,220,707** | **1,368,117** | **539,038** |

| | | | |
|---|---|---|---|
| **Total Hosted Services** | **39,222,552** | **1,672,536** | **658,979** |

**ITEM No …15(b)……..**

**DIJB52-2018** **Appendix 1**

**DUNDEE INTEGRATION JOINT BOARD DRAFT ACCOUNTS 2017/18**

**Final Accounts – Funding Variations (and Adoption of Specific Presentation)**
*Extract - Note to Dundee Joint Integration Board regarding variations to the existing Scheme of Integration and the adoption of specific presentation of information within the framework of the International Financial Reporting Standards (IFRS).*

Background
The following note provides details of variations to the delegated budget for which approval is sought by the Dundee Integration Joint Board. The adjustments and explanations for these adjustments are outlined below section 1.

In addition information has been presented within the requirements of the International Financial Reporting Standards (IFRS) and attributable supplementary Local Authority (Scotland) Accounts Advisory Committee (LASAAC). Specific applications of the guidance are outlined in section 2.

Section 1 – Variations to Delegated Budget

**Local Authority Variations** – The agreed delegated budget 2017/18 provided for a budgeted payment of £74,694m from Dundee City Council to the Dundee Integration Joint Board to fund the commissioning of services. It is recognised that a number of technical year-end adjustments will result in variations in costs outwith the control of the IJB (e.g. adjustments to pension costs, inclusion of central support.). To compensate for this the Dundee Integration Joint board was provided with a corresponding increase in funding. This meant that the total funding provided to the IJB was £85,314m, an increase of £10,620m.

These year-end adjustments will be a feature of each year end accounts process. Notably they are difficult to quantify at the commencement of the financial year (e.g. pension costs adjustments can vary significantly within a single financial year, central support costs) and cognisance of these variations requires to be taken of these variations in the Dundee Integration Joint Boards accounts.

The Dundee City Council adjusted funding is outlined below:-

| **DCC Funding to Dundee Integration Joint Board (DIJB)** | **£000** |
|---|---|
| **Initial Dundee City Council contribution to DIJB** | **74,694** |
| Additional Funding from Dundee City Council | 10,620 |
| **Total Funds provided by Dundee City Council** | **85,314** |

**NHS Tayside Variations** – The financial reporting process throughout the year highlighted significant pressures on NHS Tayside related services leading to an overspend which as part of the risk sharing arrangement was to be funded from NHS Tayside. This means that the funding provided by NHS Tayside is in excess of that outlined in the integration agreement.

The NHS Tayside contribution also includes specific Integration funding which was provided by the Scottish Government with NHS Tayside acting as an agent. These monies have been provided to the Dundee Integration Joint Board and those not expended currently sit in the Board's reserves.

The NHS Tayside adjusted funding is outlined below:-

| **NHS Funding to Dundee Integration Joint Board (DIJB)** | **£000** |
|---|---|
| **Initial NHS Contribution to DIJB (incl Large Hospital Set Aside)** | **174,752** |
| Less: Supplementary Budget Adjustments | (736) |
| Add: Additional Funding to Cover Overspends | 2,407 |
| Add: Net Effect of Hosted Services Budget | 448 |

| | |
|---|---|
| **Final NHS contribution to DIJB** | **176,871** |

Section 2 – Specific application of International Financial Reporting Standards (IFRS)

**Netting of Income** – The Dundee Integrated Joint Board annual accounts have been prepared on the basis that all operational expenditure is shown net of income as it is reflects the actual environment the board is working under. In particular the Dundee Integration Joint Board does not have the legal power to set charges for services provided by either the Council or NHS Tayside. In addition the IJB cannot pursue an action to recover income from a service recipient. More specifically it reflects the role of the Dundee Integration Joint Board as a net funding vehicle. Audit Scotland has indicated that this is the preferred approach.

To support this position the following text is included on the face of the 2017/18 Annual Accounts

"The Dundee Integration Joint Board's Comprehensive Income and Expenditure Statement shows the net commissioning expenditure provided to partners to support services. It does not detail income received from service users as this remains the statutory responsibility of the partners."

**Offsetting of Debtors & Creditors** – The Dundee Integration Joint Board accounts have been prepared on the basis that the net expenditure from Dundee City Council and NHS Tayside recognises that debtors and creditors in respect of NHS Tayside and Dundee City Council with third parties (other than the Dundee Integration Board) but not yet settled in cash terms are offset against the funds they are holding on behalf of the IJB. This essentially requires that when consolidating its accounts the Dundee Integration Joints Board have consolidated the accrued net expenditure. Therefore only debtors and creditors between Dundee Integration Joint Board and its two constituent body are detailed in the IJB's final accounts. The only exception to this is Audit Scotland audit fees.

**ITEM No …16……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 28 AUGUST 2018**

**REPORT ON:** **CARSEVIEW REPORT**

**REPORT BY:** **DIRECTOR OF STRATEGIC CHANGE, NHS TAYSIDE**

**REPORT NO:** **DIJB50-2018**

## 1.0 PURPOSE OF REPORT

This report provides members of the Integration Joint Board with an update on the actions taken by NHS Tayside and Perth and Kinross Health and Social Care Partnership, following a BBC Investigates documentary on Carseview Hospital which was aired on BBC Scotland on 9th July 2018. The report also provides information as to the progress made to implement the investigation into Carseview Hospital.

## 2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report and remits the Chief Officer to provide a further update on the progress of the Carseview investigation to a future IJB.

## 3.0 FINANCIAL IMPLICATIONS

There are no financial implications arising from this report.

## 4.0 MAIN TEXT

### 4.1 Background

4.1.1 On Monday, 9 July 2018, a BBC Scotland Investigates documentary was broadcast, featuring patients sharing their experiences of the Carseview Centre in Dundee, which included a number of serious allegations about care and treatment.

4.1.2 The BBC investigative team spoke to 23 patients and family members who have shared their experiences about their contacts with services in the Carseview Centre. The programme made allegations about bullying, inappropriate use of restraint and widespread use and sale of illegal drugs.

4.1.3 In response, NHS Tayside was very concerned about the nature of the allegations in the programme and therefore has taken a number of actions in response to the issues raised in the programme.

### 4.2 Action Taken in Response

4.2.1 The NHS Tayside Chairman provided a full statement on behalf of the NHS Board to the BBC, acknowledging the Board's serious concerns about the allegations, giving a commitment to investigate any claims brought to NHS Tayside and asking for the patient testimonies to be

shared. The Board also stated that all testimonies received would be considered in the body of evidence gathered by the Independent Inquiry.

4.2.2 After the programme, and having seen the allegations in full, the Chairman gave interviews to STV and the BBC, as well as issuing further staff communications and media statements.

4.2.3 NHS Tayside took a number of actions to urgently address the concerns raised.

1. A meeting with Police Scotland to discuss the concerns relating to people bringing drugs into Carseview Centre and a new partnership initiative to further tackle the issue. Further discussions have been held with Police Scotland looking at police activity relating to Carseview Centre over recent years.
2. The announcement of the appointment of an Associate Medical Director for Mental Health Services, Professor Keith Matthews, to strengthen the leadership team and work with frontline teams to improve services.
3. The subsequent announcement of the appointment of an Associate Director for Mental Health Transformation, Arlene Wood, to complete the new strengthened leadership team with the Associate Medical Director and Associate Nurse Director.
4. A dedicated point of contact through a confidential email address and telephone number for people to get in touch with NHS Tayside to share their concerns and experiences following the BBC documentary, with a commitment to investigate. To date there have been 20 contacts through this route (this is separate from the Independent Inquiry into Mental Health Services in Tayside).
5. An agreement with the BBC to contact all those they had spoken with, give them the named contact in NHS Tayside and encourage them to get in touch, even if they had had their complaints investigated before.
6. A lead Director, Mr Bill Nicoll, Director of Strategic Change, was asked to coordinate NHS Tayside's ongoing response and to take forward a review to assess the available data and information, including:
    a. Review of police activity, including offences relating to supply, possession or use of illicit or illegal substances and any other offences.
    b. Review of the data on restraint used across mental health services and training status, including in the Carseview Centre.
    c. Review of complaints relating to Carseview over the last five years.
    d. Review of staff disciplinary processes.
    e. Review of Resources.

4.2.4 For those who made contact to offer comment through the email address, options were provided to have their experience fed directly into the Independent Inquiry, to have their experience regarded as a significant concern or to initiate a complaint or feedback. In each case an offer was also made to meet to expand further on their feedback. Where more immediate follow up action was required, action has been taken.

**4.3 Next Steps**

4.3.1 The analysis and findings from the reviews will be considered by the NHS Tayside Chief Executive and Chief Officer (Perth and Kinross).

**5.0 POLICY IMPLICATIONS**

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

## 6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as the information provided is to provide the members with an up to date position statement.

## 7.0 CONSULTATIONS

The Chief Officer 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 | ✓ |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

None.

Bill Nicoll
Director of Strategic Change
NHS Tayside

DATE: 21 August 2018

**ITEM No …17……..…..**

**DIJB 48-2018**

**DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD - ATTENDANCES - JANUARY 2018 TO DECEMBER 2018**

| Organisation | Member | Meeting Dates January 2018 to December 2018 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 24/1 | 27/2 | 30/3 | 24/4 | 27/6 | 28/8 | 30/10 | 18/12 |
| NHS Tayside (Non Executive Member) | Doug Cross | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Dundee City Council (Elected Member) | Cllr Ken Lynn | ✓ | ✓ | ✓ | √ | ✓ | | | |
| Dundee City Council (Elected Member) | Roisin Smith | ✓ | A | ✓ | A | ✓ | | | |
| Dundee City Council (Elected Member) | Helen Wright | ✓ | A | ✓ | ✓ | ✓ | | | |
| NHS Tayside (Non Executive Member) | Judith Golden | ✓ | ✓ | ✓ | A | | | | |
| NHS Tayside (Non Executive Member) | Munwar Hussain | ✓ | ✓ | ✓ | A | A | | | |
| Chief Officer | David W Lynch | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| Chief Finance Officer | Dave Berry | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| NHS Tayside (Registered Medical Practitioner (whose name is included in the list of primary medical performers) | Frank Weber | A | ✓ | A | ✓ | ✓ | | | |
| NHS Tayside (Registered Medical Practitioner (not providing primary medical services) | Cesar Rodriguez | A | √ | A | √ | ✓ | | | |
| NHS Tayside (Registered Nurse) | Sarah Dickie | ✓ | ✓ | ✓ | A | A | | | |
| Dundee City Council (Chief Social Work Officer) | Jane Martin | ✓ | √ | √ | ✓ | A | | | |
| Voluntary Sector Representative | Christine Lowden | ✓ | A | √ | ✓ | ✓ | | | |
| NHS Tayside (Staff Partnership Representative) | Raymond Marshall | ✓ | A | A | ✓ | A | | | |
| Trade Union Representative | Jim McFarlane | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| NHS Tayside (Director of Public Health) | Drew Walker | ✓ | A/S | A | ✓ | ✓ | | | |
| Carer Representative | Martyn Sloan | ✓ | ✓ | A | ✓ | ✓ | | | |
| Service User Representative | Andrew Jack | A | ✓ | ✓ | ✓ | ✓ | | | |

✓ Attended

A Submitted Apologies

A/S Submitted Apologies and was Substituted

No Longer a Member and has been replaced / Was not a Member at the Time