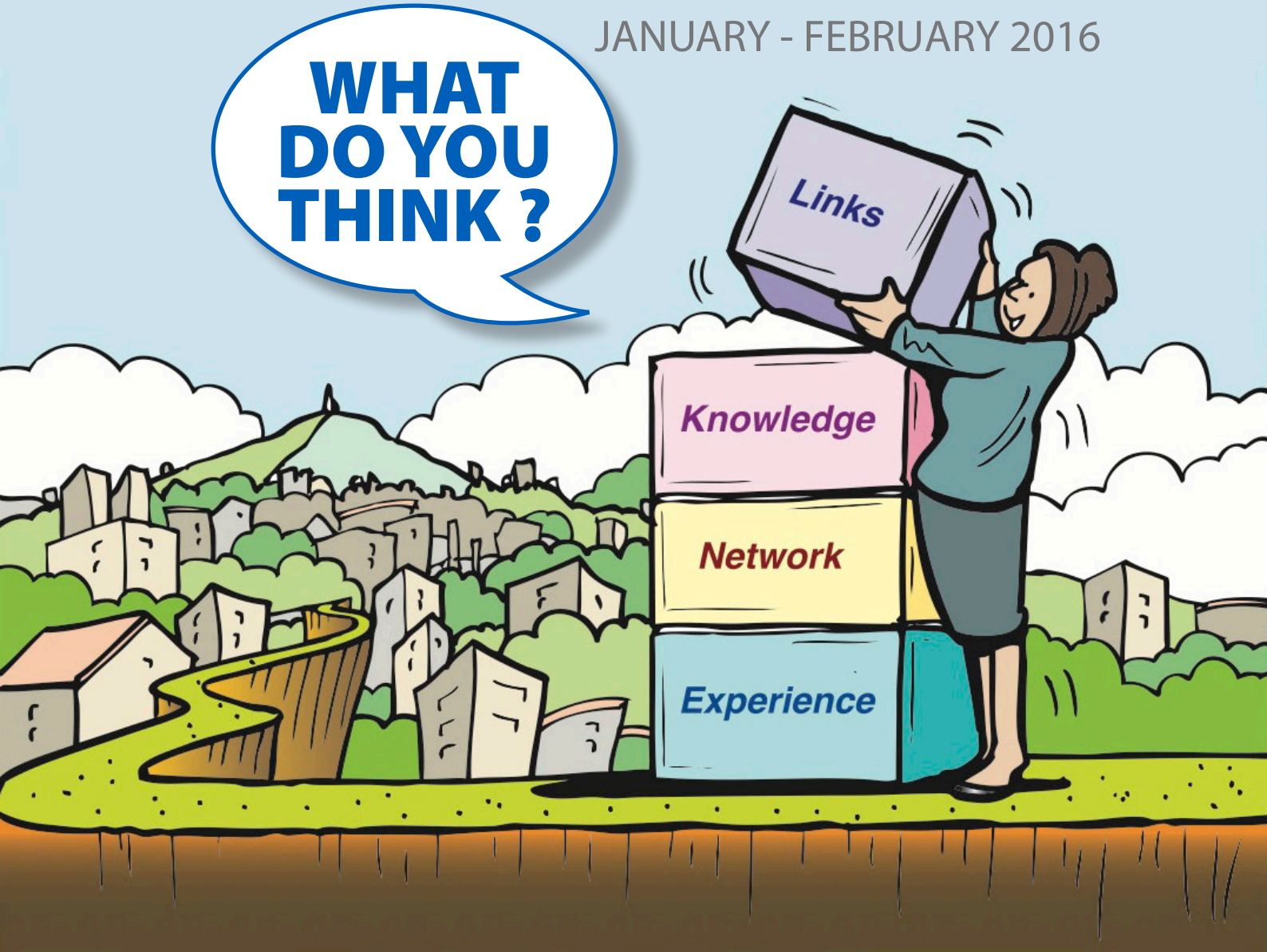
Dundee
Health & Social Care
Partnership

CONSULTATION ON DRAFT HEALTH AND SOCIAL CARE STRATEGIC AND COMMISSIONING PLAN 2016 - 2021

JANUARY - FEBRUARY 2016



CONTENTS

FOREWARD

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. The main purpose of integration is to use the available resources to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex and who require support from health and social care at the same time.

We recognise the important role communication has to play in this process and the benefits of engaging with those who use services, their families, carers and the public, to involve them in the planning, development, delivery and continuous improvement of services. In order to support the Dundee Health and Social Care Partnership (the Partnership) we are developing this five year Strategic and Commissioning Plan (the Plan) to help us plan and deliver services for both current need and the needs of people in the future. We want to know what you think services should be like in the future so that we can make them more personalised and responsive to your needs. This is an opportunity for you to comment and share your ideas on our proposals.

Rather than doing things 'to' or 'for' people we will work 'with' people to support them to regain and retain the skills and motivation needed to achieve independent lives and to help them to direct the support that they may need to achieve this. The provision of health and social care services to the citizens of Dundee is a complex task involving enquiries and referrals, visits and assessments, care planning, service delivery and reviews. This is set within a challenging financial and resource agenda that will affect areas such as funding and the ability to recruit staff.

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. We want to hear as many views as possible and would encourage you to provide us with your thoughts.

Doug Cross
Chair, Dundee Integration Joint Board

Ken Lynn
Vice Chair, Dundee Integration Joint Board

1.0 INTRODUCTION AND BACKGROUND INFORMATION

This Plan describes how the Partnership will develop health and social care services for adults over the next five years.

Health, social care and wellbeing are key factors which impact on our communities and our citizens. Dundee City Council and NHS Tayside have a long and successful history of working in partnership. This Plan builds on that history by emphasising the importance of integrating our care services further. Ill, vulnerable or disabled people often need support from more than one service. For their care to be effective it needs to be personalised and well coordinated. Integrated care is essential to ensure that gaps or weaknesses in one part of the service do not affect services elsewhere. By working in this way we hope to reduce hospital admissions and keep our citizens in their own communities for longer.

In a time of rising demand for services, growing public expectation and increasing financial constraint, it is essential that we make sure social care, primary care, community health and acute hospital services work well together and with other partners in a truly integrated way.

Making the Case for Change is at the heart of this Plan. It is not a critique of current provision but it is a recognition that the existing model of care in Dundee needs to change in order to meet both current and future challenges. There are no choices in this regard. If we do nothing the current health and social care system will not be able to continue to deliver the high quality services we expect to meet the needs of the Dundee population.

We recognise that our health and social care system is challenged and we need strong planning and commissioning in order to drive forward improvements in performance and deliver the efficiencies required for the future.

This Plan is the second phase of our consultation with you and will lead to the development of our final Plan and relevant action plans. The Plan is being developed with and through our localities, clinicians, professionals, the wider workforce and the population of Dundee. We know that any Plan that is not fully grounded in its local context is more likely to fail and we will ensure this is recognised through planning for localities.

This Plan needs to reflect the context within which we operate and is shaped around our vision.

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

Our draft key priorities have already received very positive feedback from our first phase of consultation with agreement that, addressing unplanned admissions and delayed discharges from hospital, tackling variations in the use and delivery of health and social care services and developing a strong focus on prevention to ensure best value for the public purse, are central to the way forward in Dundee.

To be successful as a Partnership we also need a strong, committed and sustainable workforce. Their development is a key element of this Plan.

We face some challenges and being open, honest and transparent will characterise how we work in responding to these challenges and making the difficult decisions that this demands.

Our values - professional and honest, listening and learning, being open and transparent and respecting and caring - sum up how we will approach this Plan. We know that while integrated care is often talked about it is not always delivered. The integration of health and social care across Scotland offers an unprecedented opportunity for us to develop and implement different ways of working at a local level to achieve shared goals, better experiences and better outcomes for the citizens of Dundee.

1.1 Policy Context

The Act came into effect on 2 April 2014. The purpose of the Act is to provide a framework that supports improvements in the quality, efficiency and consistency of health and social care services, through the integration of NHS and local authority based services in Scotland.

This is in line with the Scottish Government's key goal "to focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth" - Scottish Government, December 2015.

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and require support from both health and social

care. Additionally the integration of health and social care services aims to:

- Improve the quality and consistency of services for patients, carers, service users and their families
- Provide seamless, joined up, high quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so
- Ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex needs

As specified in the Regulations made under the terms of the Legislation, NHS Tayside and Dundee City Council have delegated community health and social care functions for adult and older people to the Integration Joint Board (IJB). IJBs with similar functions have been established in Angus and Perth and Kinross. Legislation requires that as the NHS Tayside area is common to all three, all of the Partnerships must take cognisance of each other's priorities, particular the implications these may have for NHS Tayside.

1.2 Strategic Commissioning

"Strategic Commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to all agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place." – Strategic Commissioning Steering Group 2012.

1.3 Dundee Strategic and Commissioning Plan

The Plan describes how the Partnership will make changes and improvements to develop health and social care for adults over the next five years. It explains what our priorities are, why and how we decided them and how we intend to make a difference by working closely with partners in and beyond Dundee.

The Plan is underpinned by a number of national and local policies, strategies and action plans. It will provide the strategic direction for how health and social care services will be shaped in Dundee in the coming years and describes the transformation that will be required to achieve our vision.

1.4 Services the Strategic and Commissioning Plan Covers

The Act establishes the legal framework for integrating health and social care in Scotland. It requires each Health Board and local authority to delegate some of its functions to the new IJBs. By delegating responsibility for health and social care functions the objective is to create a single system for local joint planning and delivery of health and social care services. This is built around the needs of people who may need/use these services and supports service redesign which focuses on preventative and anticipatory care in communities.

The Regulations, which underpin the Act, set which health and social care functions and services must be delegated to the IJB. The Act limits the functions that can be included in the 'must be delegated' list to services provided to people over the age of 18. The effect of this is that no children's health and social care services will require to be delegated to the IJB. In Dundee we have agreed that our initial focus for service integration, and therefore for this Plan, is for adult services only.

A key feature of the legislation is that integration must include adult social care, adult primary and community health care services and elements of adult hospital care that offer the best opportunities for service redesign.

The social care services relating to adults which must be delegated to the IJB are:

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Alcohol and drug services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area coordination
- Respite provision
- Occupational therapy services

- Re-ablement services, equipment and Telecare

Each Health Board must also delegate all adult primary and community health services, along with a proportion of hospital sector provision. Health services which must be delegated to the IJB are:

- District nursing services
- Substance misuse services
- Services provided by Allied Health Professionals in an outpatient department, clinic or outwith a hospital
- Public dental services
- Primary medical services
- General dental services
- Community geriatric medicine services
- Community palliative care services
- Community learning disability services
- Community mental health services
- Community continence services
- Kidney dialysis services provided outwith a hospital
- Services provided by health professionals that promote public health

In Regulations, the Scottish Government has also identified which aspects of acute hospital care offer the best opportunity for improvement under health and social care integration. These are:

- Accident and emergency services provided in a hospital
- Inpatient hospital services relating to:
    - General medicine
    - Geriatric medicine
    - Rehabilitation medicine
    - Respiratory medicine
    - Psychiatry of learning disability
- Palliative care services provided in a hospital
- Inpatient hospital services provide by G.P.'s
- Services provided in a hospital in relation to addiction or substance dependence
- Mental health services provided in a hospital except secure forensic mental health services

The IJB will be responsible for the strategic planning of these services which are the ones most commonly associated with unplanned or avoidable hospital bed day use for adults.

1.4.1 Housing Contribution Statement

The interface with housing services will be crucial to the success of integration. Only certain limited aspects relating to housing are included in the scope of the current delegated services. Historically, the housing sector has made a significant contribution to successive Scottish Government`s health and social care polices through the provision of housing, housing support, and housing management services; thereby meeting the needs, demand, and aspirations of a significant number of the Scottish population.

The requirement to develop a local Housing Contribution Statement (HCS) is a statutory requirement under Section 53 of the Public Bodies (Joint Working) (Scotland) Act, 2014. The Statement was implemented in 2015 through the introduction of the Scottish Government`s HCS statutory Housing Advice Note (2015), which applies to Integration Authorities, Health Boards, and Local Authorities. The Advice Note outlines the significant contribution of the Housing Sector to the national Health and Social Care Integration agenda.

Dundee`s HCS outlines the contribution of the local Housing Sector in achieving the identified outcomes of Dundee`s Health and Social Care Partnership`s Strategic Commissioning Plan. The Local Housing Strategy is the primary strategic document for the provision of housing, housing support, and homelessness services in the city, and is embedded in the city`s Community Partnership Planning Framework. Dundee`s HCS, therefore, will primarily reflect the Health and Social Care housing related priorities that are outlined in the city`s current Local Housing Strategy; and its associated strategic housing documents.

1.4.2 Hosting Arrangements

In appropriate cases, the IJB can agree that another IJB will be responsible for delivering an integrated function on its behalf. This is called hosting.

Hosting may be considered an appropriate arrangement for the delivery of integrated functions for a range of reasons, if the services involved are:

- Highly specialised or complex health services requiring specialist knowledge and expertise to provide quality of care
- Area wide services which are delivered from within a single site or location and are managed by a dedicated team of staff

- Small discrete services that would be very difficult to disaggregate out to be managed at a single IJB level
- Functions or services undergoing major change or transition where the delegation to a number of IJBs may disrupt the transformational change programme

The Integration Scheme for Dundee sets out a range of services which are considered to be most appropriately delivered through hosting arrangements.

The following services are currently planned and delivered on a pan-Tayside basis and will be hosted by Dundee IJB on behalf of other Tayside IJBs;

- Tayside Sexual and Reproductive Health Services
- Tayside Specialist Palliative Care Services
- Homeopathy
- The Centre for Brian Injury Rehabilitation (CBIR)
- Eating disorders
- Nutrition and Dietetics
- The Medical Advisory Service
- Tayside Health Arts Trust
- Keep Well
- Psychology
- Psychotherapy

2.0 WHO WE ARE

2.1 Integration Joint Board

NHS Tayside and Dundee City Council agreed an Integration Scheme for Dundee which was approved by Scottish Ministers in September 2015. This then enabled the Order to come into force which established an IJB in October 2015. The Integration Scheme sets out the functions which are delegated by NHS Tayside and Dundee City Council to the IJB. The IJB is responsible for the planning, oversight and delivery of integrated functions.

The IJB operates as a Body Corporate (a separate legal entity), acting independently of NHS Tayside and Dundee City Council. The IJB consists of six voting members appointed in equal number by NHS Tayside and Dundee City Council, with a number of representative members who are drawn from the third sector, independent sector, staff, carers and service users. The IJB is advised by a number of professionals including the Chief Officer, Medical Director, Nurse Director and Chief Social Work Officer.

2.1.1 Key Functions of the IJB

The key functions of the IJB are to:

- Prepare a Plan for integrated functions that is in accordance with national and local outcomes and integration principles
- Allocate the integrated budget in accordance with the Plan
- Oversee the delivery of services that are within the scope of the Partnership.

This Plan is the first to be produced by the Partnership.

2.2 Dundee Health and Social Care Partnership

The Partnership consists of Dundee City Council, NHS Tayside, and partners from across the third sector and independent providers of health and care services. These organisations and agencies are working closely together to put in place formal joint working and planning arrangements with the aim of providing better, more integrated, adult health and social care services.

The Partnership will promote transparent and inclusive partnership working. Features of this partnership will be positive relationships and clear accountability and governance arrangements. These, along with the formulation and implementation of this Plan, will improve outcomes for the population of Dundee.

2.3 Links to Other Partnerships

There are well established partnership mechanisms currently in place in Dundee which involves the Council, NHS Tayside, Police Scotland, and a range of other key partners, in the planning, co-ordination and delivery of services.

2.3.1 Community Planning Partnership

Central to these strategic partnership arrangements is the Community Planning Partnership (known locally as the Dundee Partnership or CPP) which provides strategic oversight and a vehicle for co-ordinated interagency working.

The CPP holds the lead responsibility for the development and delivery of Dundee's Single Outcome Agreement (SOA) 2013-2017. Through the SOA, the local authority and partners are delivering against the range of agreed national outcomes in a way which reflects local needs and priorities. Dundee's SOA is linked here for information:

http://www.dundeepartnership.co.uk/sites/default/files/SOA%202013-2017%20(final).pdf

The link to the Dundee Partnership website is also included.

http://www.dundeepartnership.co.uk

Central to the Community Planning structure are seven Partnership Theme Groups, which are made up of senior representatives from the Council, partner agencies and organisations. There are also five cross cutting theme groups, one of which is Dundee's Alcohol and Drug Partnership (ADP). These Theme Groups include the chairs of the Strategic Planning Groups (SPGs) which are responsible for taking forward the agreed work streams that link to the strategic priorities of each of the identified Theme Groups. Each of the SPGs has a lead responsibility for one of the priority themes expressed in the SOA.

In Dundee there are eight Local Community Planning Partnership Groups (LCPPs) which are well established in each of the eight multi-member wards, bringing together elected members, Council officers,

partners in Health, Police and Fire and Rescue Services, and community representatives.

The LCPPs build on Dundee's decentralisation strategy and promote local co-ordination of service planning and delivery within the strategic priorities for the city. There is officer representation from Social Work and Dundee's CHP on each of the city's eight LCPPs, and staff have been heavily involved in the work of the SPGs. Information is contained in this Plan regarding the future links to be developed between the Partnership and Dundee's eight LCPPs in the future.

2.3.2 Children and Families Partnership

With the creation of Dundee's new Health and Social Care Integration Authority, and the review of the Council's service and management structure, new governance and organisational arrangements for the delivery of social work and social care services are being introduced. This includes the integration of Children's and Criminal Justice Social Work Services with the Education Department to create a new Children and Families Service in Dundee.

As with the establishment of Dundee's Health and Social Care Partnership, the arrangements for the new Children and Families Service will be in place from 1 April 2016. From that date social work services for children, their parents and carers will be delivered through separate organisational arrangements from those in Adult Services.

We recognise the need for there to be strong links between both of these Partnerships to ensure that services for children and adults are appropriately integrated at the point of delivery for individual families. This is particularly important for young people with long term health conditions or disabilities, for whom appropriate care and support plans need to be put in place, during their transition into adult services. We are committed to working in close partnership with the Children and Families Service to achieve the delivery of integrated services for the people of all ages in Dundee who require health, social work and social care services.

3.0 CONVERSATIONS WITH YOU

The writing of this Plan has been shaped and informed by a range of work and contributions, which include:

- The views and contributions from representative care groups and individuals, including specific care groups
- The analysis of information about health and social care needs across the population of Dundee
- Listening to and consideration of issues and concerns raised by local people about current models of service delivery
- Consultation and engagement throughout the development of both our Integration Scheme and our draft Vision and Priorities

This information has been overseen by our Integrated Strategic Planning Group.

We want to ensure that we continue to actively engage with as many people as possible, not just in the preparation of this Plan, but throughout its implementation, so that we are confident that our participation and engagement processes encourage dialogue and partnership.

A key feature to ensuring the success of this approach in the future will be the implementation of our Participation and Engagement Strategy.

3.1 Equality, Diversity and Human Rights

We are committed to embedding the principles of equal opportunities and human rights in the planning and delivery of good quality health, social care and housing services, as well as the appropriate information, advice and support services, in Dundee.

All our partners will strive to encourage equal opportunities, responding to the different needs and service requirements of all people, including those with protected characteristics outlined in the Equality Act (2010). In addition to this, the IJB will ensure that the principles of human rights are built into their governance arrangements, in line with the spirit of this legislation.

This Plan has been subject to an Integrated Equality Impact Assessment (IEIA). The IJB seeks to improve the way that decisions taken are assessed in relation to the following:

- Equality and Diversity
- Fairness and Poverty
- Environment
- Corporate Risk

The IEIA seeks to demonstrate that the IJB have considered all the likely impacts of the Plan, and have identified the mitigation required to overcome any negative impacts. This should ensure that the content of the Plan, and more importantly, its impact, does not worsen existing inequalities in Dundee.

In addition to this, the IJB have developed a set of Interim Draft Equality Outcomes which fulfil the general duty of Scottish public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

3.2 Participation and Engagement

Participation and engagement has been central to the development of this Plan. To achieve this, a range of engagement methods have been used to ensure that there were many opportunities for a wide range of stakeholders to contribute to the emerging Plan.

Our engagement journey started well before the design of this document. Some examples of the methods and opportunities used include the following:

- We held three large scale stakeholder events with up to 120 participants at each event, representing our local authority, health, third sector, community planning and independent partners across the city. ***In total, over 300 people attended these events.***

- We supported ongoing engagement activity led by our Care Group Strategic Planning Groups. ***These groups are represented by around 200 people.***

- We undertook specific consultation around the development of our Integration Scheme and the vision and priorities contained within this Plan. In particular, we took our consultation out into our local communities, through our network of community centres and libraries, to create opportunities for the voices of local people to be heard. ***We spoke to in excess of 50 people.***

- We created opportunities for consultation via our web based communication channels within the local authority and NHS

Tayside, which were open to the general public and others. ***We had 27 electronic responses, with an additional 14 people responding via email or other methods.***

- We supported the development of a Public Reference Group, membership of which includes service users representative of our Care Groups. ***This group has a membership of around 10 people.***

- We held focus groups with staff and other stakeholders, listening to their views and contributions and used this information to develop the content of the Plan. ***We had 14 focus groups with over 65 people in total (including staff) choosing to attend one of the meetings.***

The result has been a Plan which we believe reflects this participation and engagement journey. Our hope is that those who have supported this process will be able to recognise where their contribution has made a difference to the content of the Plan.

Our participant and engagement work does not stop here. The Partnership is committed to continuing with this process, and to creating opportunities for involvement that build on the excellent work already carried out to date.

The IJB have adopted a Participation and Engagement Strategy that sets out the principles which will ensure that, beyond the work undertaken to develop this Plan, the voices of our service users, carers, staff and communities are heard, recognised and valued.

Co-production will be at the heart of integration. This means that the strengths and assets of local communities will be utilised to improve the health and wellbeing of local people.

3.3 Transparency and Accountability

The IJB is an accountable body. In addition to our continuing engagement activity, we will regularly publish information on how we are progressing in the delivery of this Plan, and continue to consult on how we best implement change. The principles of transparency and accountability will also be the foundations on which we build our performance framework and our governance arrangements for the Partnership.

4.0 NATIONAL OUTCOMES AND INDICATORS

4.1 National Outcomes

There are nine National Outcomes agreed by the Scottish Government that the Partnership will deliver against. Our vision for the people of Dundee will help us to deliver on these outcomes and our local priorities.

Table 1 National 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, including 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	To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.

4.2 National Indicators

The nine National Outcomes will be measured using a suite of 23 National Indicators.

Table 2 National Indicators

1.	Percentage of adults able to look after their health very well or quite well.
2.	Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3.	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4.	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5.	Percentage of adults receiving any care or support who rate it as excellent or good.
6.	Percentage of people with positive experience of care at their G.P. practice.
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.
8.	Percentage of carers who feel supported to continue in their caring role.
9.	Percentage of adults supported at home who agree they felt safe.
10.	Percentage of staff who say they would recommend their workplace as a good place to work.
11.	Premature mortality rate.
12.	Rate of emergency admissions for adults.
13.	Rate of emergency bed days for adults.
14.	Readmissions to hospital within 28 days of discharge.
15.	Proportion of last 6 months of life spent at home or in community setting.
16.	Falls rate per 1,000 population in over 65s.
17.	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
18.	Percentage of adults with intensive needs receiving care at home.
19.	Number of days people spend in hospital when they are ready to be discharged.
20.	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21.	Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
22.	Percentage of people who are discharged from hospital within 72 hours of being ready.
23.	Expenditure on end of life care.

4.3 Local Outcomes and Indicators

The National Outcomes and Indicators will be incorporated, with Dundee's local outcomes, into an Outcomes and Performance Framework being developed for the Partnership. The Framework will include measures to allow us to monitor our progress in achieving the strategic priorities and shifts identified in this Plan, as well as our improvement against the National Outcomes.

There are 10 local outcomes laid out in Dundee's SOA. These are the local outcomes against which the delivery of outcomes by adult health and social work services are currently being measured. Of these 10 local outcomes the following are those which are most relevant for adult health and social care services in Dundee.

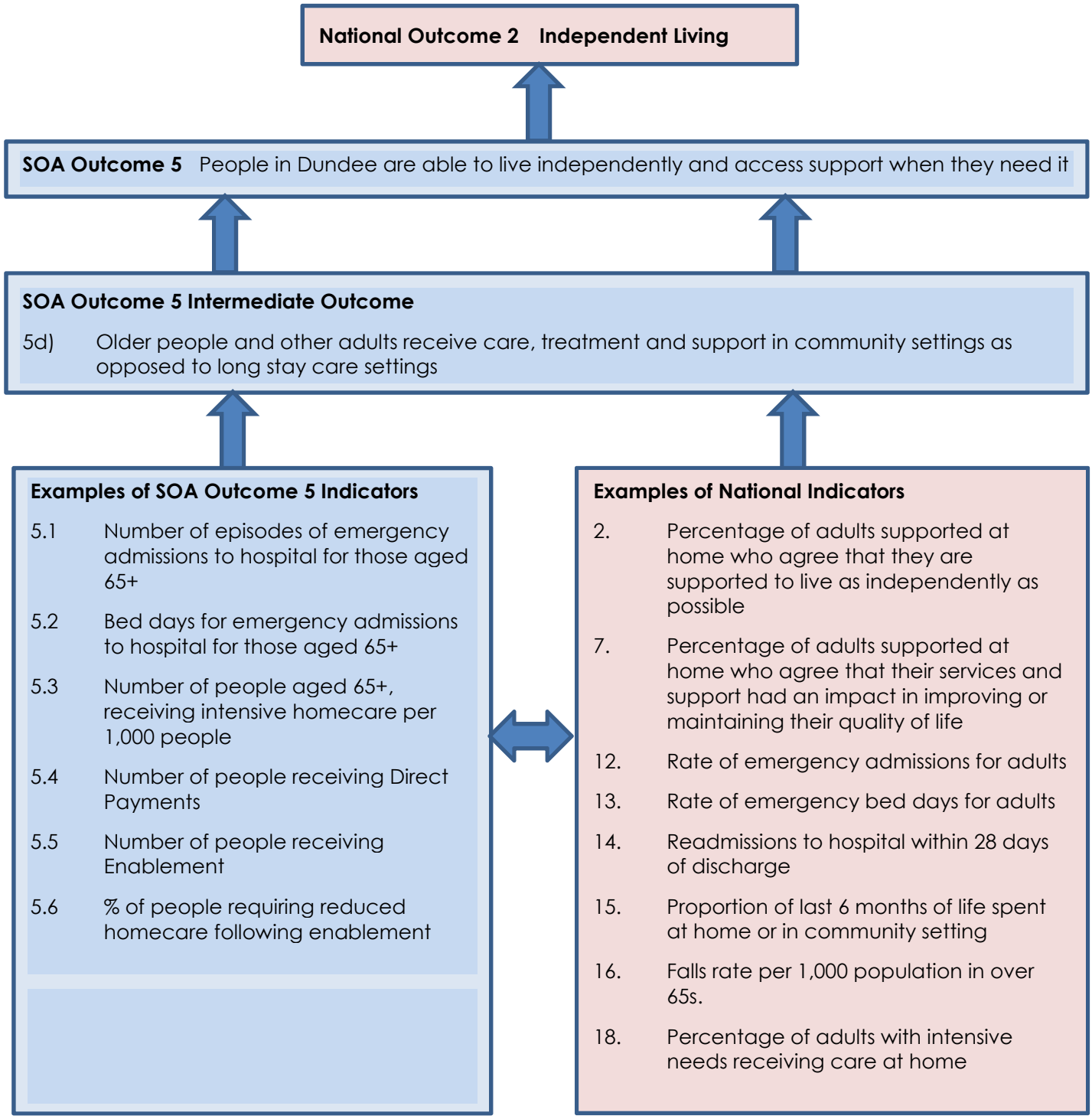
Table 3 Dundee Outcomes

Dundee Outcome 4	People in Dundee will have improved physical health and mental wellbeing and will experience fewer health inequalities
Dundee Outcome 5	People in Dundee are able to live independently and access support when they need it
Dundee Outcome 6	Our communities will be safe and feel safe
Dundee Outcome 7	Dundee will be a fair and socially inclusive city
Dundee Outcome 8	Our people will live in strong, popular and attractive communities
Dundee Outcome 9	Our communities will have a high quality and accessible local services and facilities

There is a complex matrix of relationships which exist between these separate, but inter-related sets of national and local outcomes and indicators. For this reason we have chosen to illustrate the connections between these (the golden thread, as it is sometimes referred to) through focusing on those which relate directly to our SOA Outcome 5.

Figure 1 below shows the relationship between Outcome 5, those of Outcome 5's Intermediate Indicators which are most relevant, and the National Outcome and Indicators to which they most strongly link.

Figure 1: Relationship between local and national outcomes and indicators



4.4 Tom's Story

Tom's story is an innovative communications project which shows how integration will change the way care and support services in Dundee are delivered. Tom's story has relevance for many people living in Dundee and depicts Tom's journey, with his chronic health problems as he gets older, before and after the joining up of services and highlights a range of issues. We see Tom going from a position where he is struggling to manage his health conditions with frequent visits to hospital, to a place in his life where he is able to cope better, regain his independence and enjoy the things in life he likes to do.

The purpose of the short video is to give a simple message that health and social care integration will ensure services work better together to provide people choices that meet their needs and not the needs of the service. We aim to make Tom's story a reality in Dundee and our proposed service models and how we will use our combined resources

Link to Tom's Story:

http://www.dundeecity.gov.uk/integration#

5.0 THE CASE FOR CHANGE

In this section of the Plan we describe the drivers for change, the strategic shifts which will have to take place to address the changes required and the locality framework which will be developed in Dundee to implement these strategic shifts.

5.1 Drivers for Change

Our Case for Change is informed by the current demographic and socio-economic situation in Dundee and is built on a number of key drivers that are articulated throughout this Plan. These drivers have been grouped up into three driver themes which directly link to the strategic priorities.

Population's health and wellbeing

- Demographic changes
- Deprivation and inequalities
- Prevalence of multi-morbidities
- Incidence of multi-morbidity experienced at a younger age
- Variation within and between localities

Delivery of right support at the right time

- Centralised development and decision making
- Services are not tailored to address community/locality differences
- Reliance on unpaid carers
- Support is not sufficiently individualised
- People report variable experiences of care and health

Fiscal constraints

- Increasing demand/reducing resources
- High costs/reduced budgets
- Sustainability of current models
- Balance of care
- Effectiveness of current models

5.1.1 Analysis for Change: Population's Health and Wellbeing

To inform our thinking and planning a full strategic assessment of needs has been undertaken in Dundee. This has included detailed individual care group Strategic Needs Assessments, each of which has then fed up to an overarching Strategic Needs Assessment.

The demographic information and other data about need in the city that is provided in this section and other sections in this Plan has emerged from the needs assessment work undertaken to date. This analysis uses descriptive statistical techniques in order to describe populations, and this has led to a number of hypotheses which may be further explored using inferential statistical techniques in later versions of the needs assessment.

The very detailed work taking place to fully complete the needs assessment process is continuing. A copy of the overarching Strategic Needs Assessment reflecting the picture to date is linked to this Plan.

A Demographic Changes

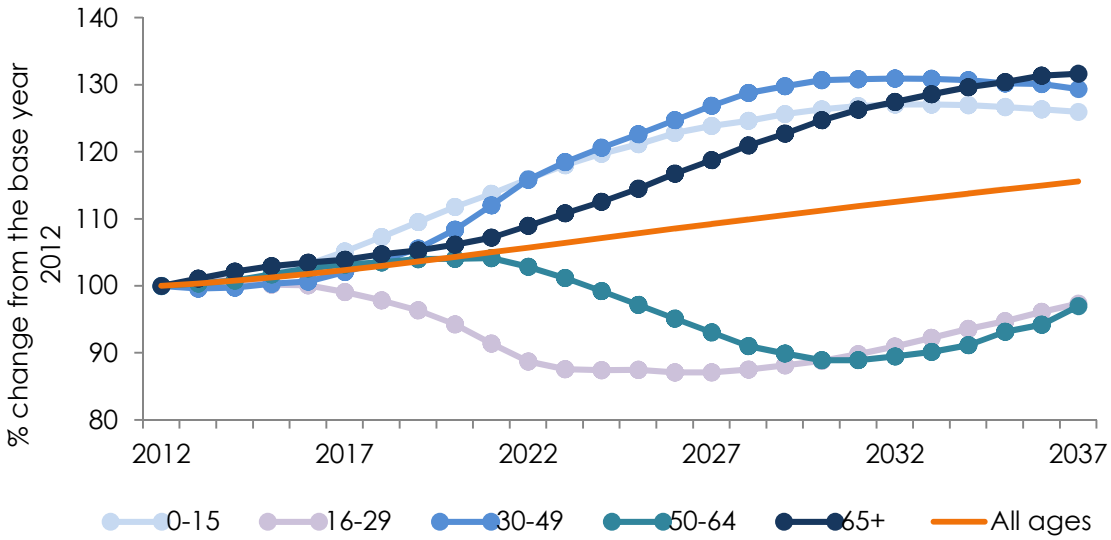
The population of Dundee in 2014 was 148,260 which is an increase of 0.1% from 148,170 in 2013. The population of Dundee accounts for 2.8% of the total population of Scotland.

In Dundee 24.5% of the population are aged 16 to 29 years. This is larger than Scotland as a whole where 18.3% are aged 16 to 29 years. It is relevant to note that Dundee has a high proportion of students, and this increases the number of young people in the 18 to 29 age group. However many students do not remain in the city beyond the end of their course of study.

At the same time people aged 60 and over make up 22.5% of the Dundee population. This is smaller than Scotland as a whole, where 24.0% are aged 60 and over. By 2037 the population of Dundee is projected to be 170,811. This is an increase of 15% when compared to the estimated population in 2014. This growth can be attributed to a combination of in-migration and increased life expectancy.

Currently, the 16-64 population accounts for two thirds of the Dundee population with an estimated 98,706 people. However, as shown in Chart 1, this age group is projected to grow at a slower rate (9% to 107,815) than the older population. In fact, the 16-29 and the 50-64 age groups are projected to fall in the next 10 years, and this may have some impact on the size of the working population and the economy of the city in the medium term.

Chart 1: Dundee projected population by age groups, 2012 - 2037



Source: 2012-based principal population projections for Council areas 2012-2037 National Records of Scotland

Chart 1 shows the level of projected increase in the older people population in Dundee. Whilst we may not be anticipating the very large increases in the 65+ age group that will affect some other parts of Scotland, we still expect to see an increase of 45% in the population aged over 75 by 2037. The 75+ and 90+ age groups, who will see the largest increase in numbers, are those who increasingly rely on unpaid family care, and health and social care services, as they become more frail.

Information extracted from Scotland's 2011 Census shows that 13,072 people in Dundee identified themselves as being a carer, with 59% of carers being female. Given that people aged 50-64 are in the age group which contains the highest rate of carers in Dundee, the projected fall in the number of people in this age group is likely to reduce the level of unpaid care available to the rising number of older people in Dundee who will need it in future years.

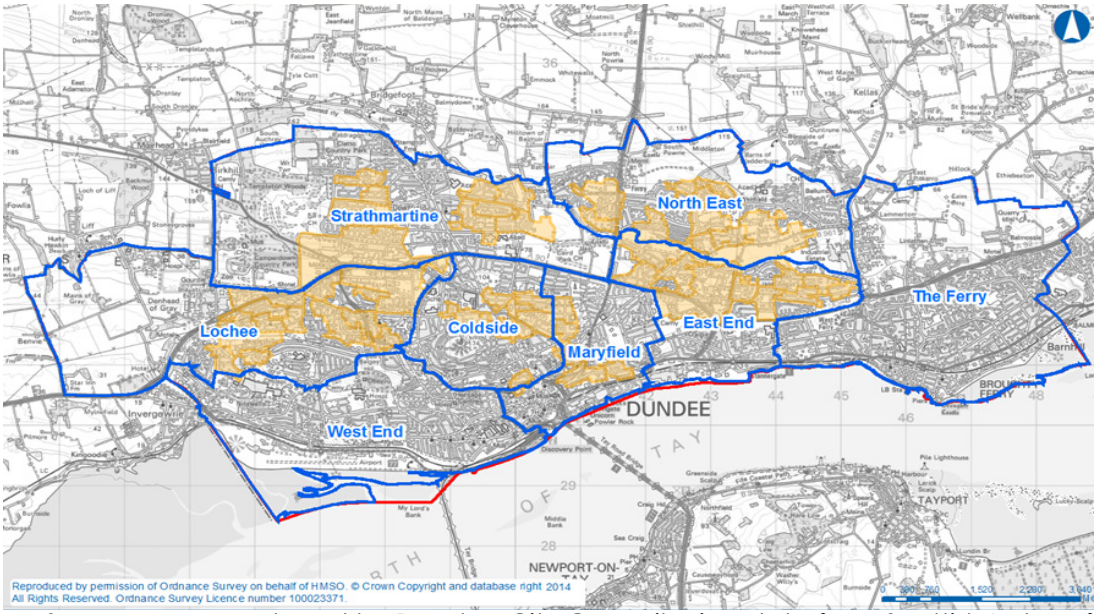
B Deprivation and Inequalities

Deprivation in Dundee is high. Just over 29% of the population lives in the 15% most deprived areas of Scotland. Overall Dundee is the third most deprived local authority in Scotland, with only Glasgow and Inverclyde having higher deprivation.

The following map shows those areas in Dundee which are within the 15% most deprived areas in Scotland. Six out of eight of the Dundee Local Community Planning Partnership (LCPP) areas delineated on the

map have deprivation levels which are above the Scottish average of 15%, and five have deprivation levels which are above Dundee's average of 29%.

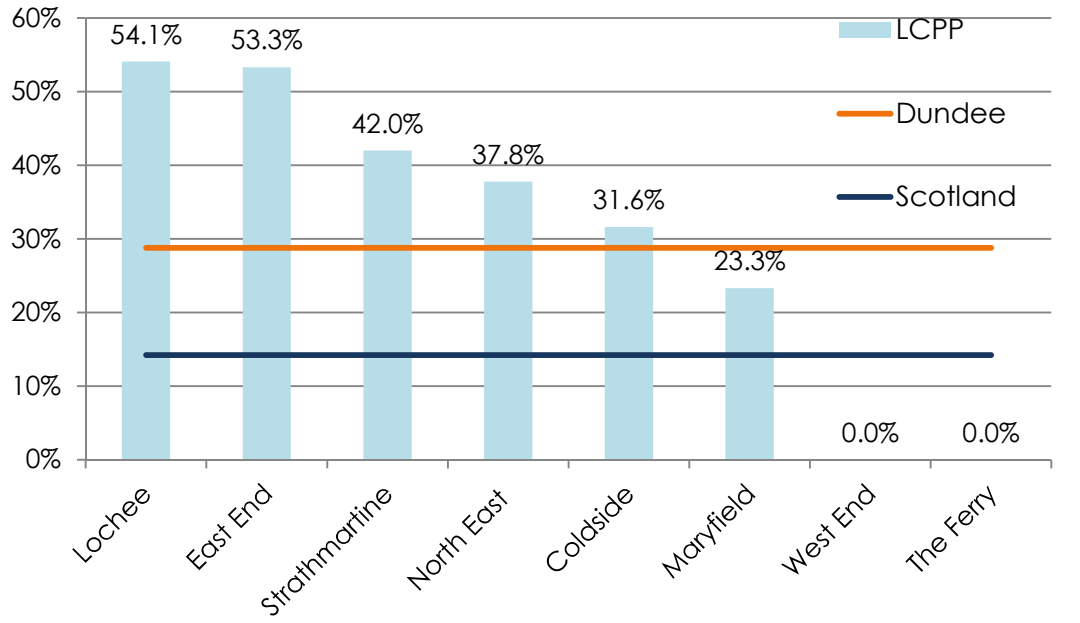
Chart 2: Location in Dundee of datazones within 15% most deprived in Scotland



Source: Map produced by Dundee City Council using data from Scottish Index of Multiple Deprivation 2012, Scottish Government

Chart 3 below shows in more detail the variation in levels of deprivation between LCPP areas. It is clear that the Lochee and East End LCPPs are the most deprived in the city, with over half of their local populations living in 15% of the most deprived areas in Scotland.

Chart 3: Percentage of LCPP populations in 15% most deprived datazones in Scotland



Source: Scottish Index of Multiple Deprivation 2012, Scottish Government

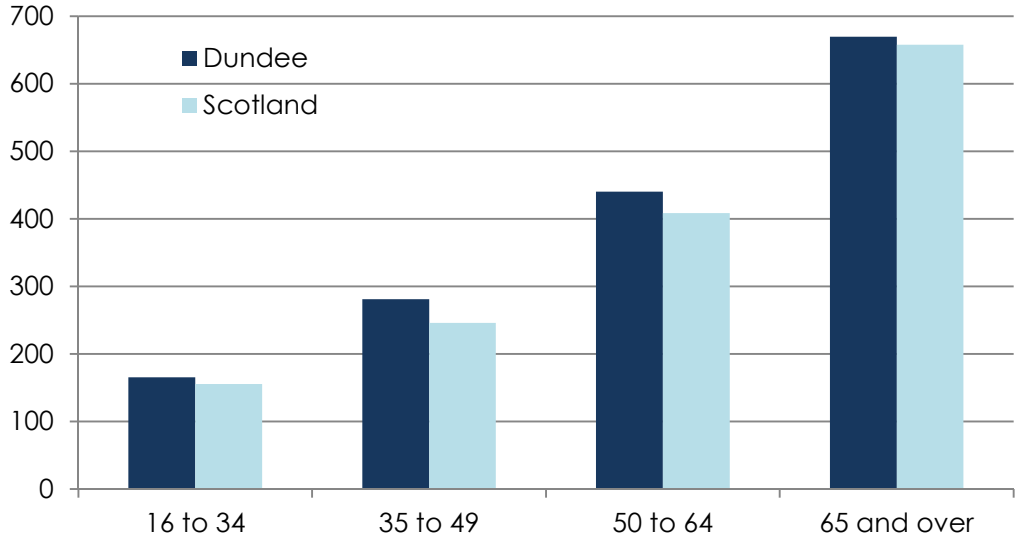
Dundee has the second lowest life expectancy in Scotland. Although this has increased over the last ten years, it remains low in comparison to the rest of Scotland. In Dundee life expectancy is 76.8 years, whereas it is 78.7 years in Scotland as a whole. Life expectancy varies substantially by deprivation level and the occurrence of morbidity (health conditions) and disability. The life expectancy of a female who lives in one of the least deprived LCPP areas in Dundee is over ten years more than a male who lives in one of the most deprived LCPP areas in the city.

C Prevalence of Multi-Morbidities Experienced at a Younger Age

While we expect the number of older people to rise over the next 22 years (and therefore the number of people with one or more health conditions) we also know that the effects of deprivation and health inequalities lead to more people in Dundee experiencing age associated morbidities and multi-morbidities (more than one health condition) at a younger age than many people living elsewhere in Scotland. This means that more people enter older age with pre-existing health conditions, and they have a need for higher levels of health and social care at an earlier stage than people of the same age in other parts of the city, or in other areas of Scotland.

Chart 4 shows the rate of people living in Dundee and Scotland who have one or more health condition. This chart shows that across all age groups the rate of people in Dundee is higher than in Scotland as a whole.

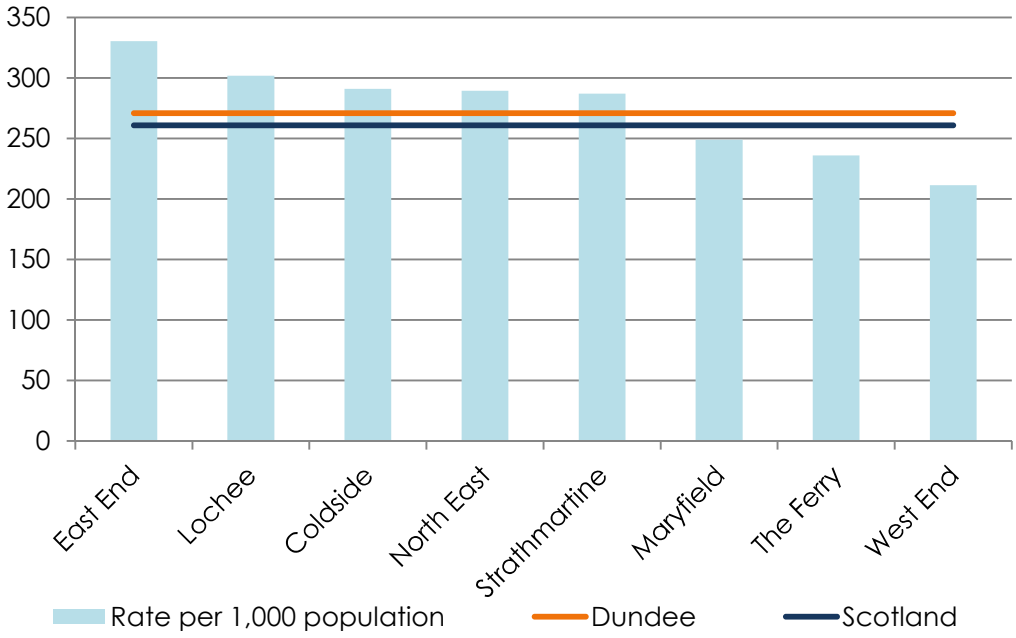
Chart 4: One or more health condition: rate per 1,000 of population (aged 16 and over) in Dundee and Scotland



Source: Scotland Census 2011

There is considerable variation in multi-morbidity rates between LCPPs across the city and not all LCPPs contribute to this trend. Charts 5 and 6 to follow show the rate of people (aged 16-64, and those over 65) with one more or health condition in each LCPP area, as compared with the Dundee and Scotland average rates.

Chart 5: Number of people per 1,000 of population (aged 16 to 64) with one or more health condition by LCPP area, Dundee and Scotland

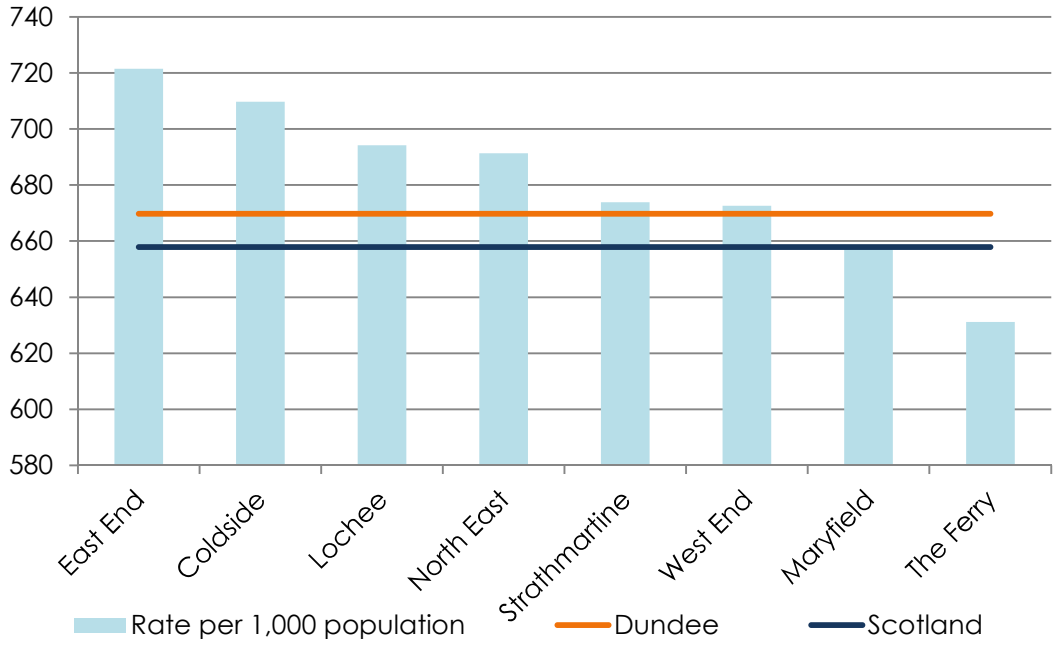


Source: Scotland Census 2011

It has already been noted that the East End and Lochee are the LCPPs with the highest levels of deprivation, and these figures indicate that they also have the highest rate of people experiencing multiple health conditions compared with the more affluent parts of Dundee and Scotland.

There is extensive research evidence of the relationship which exists between deprivation and health conditions. These figures demonstrate the level of impact deprivation is having on the health of people aged 16-64 living in LCPP areas across the city.

Chart 6: Number of people per 1,000 of population (aged 65 and over) with one or more health condition by LCPP area, Dundee and Scotland



Source: Scotland Census 2011

As with the analysis of the 16-64 age group in Chart 5, Chart 6 above shows the level of morbidity and multi-morbidity for people aged 65 and over in each LCPP in Dundee, as compared with the average rates in Dundee and Scotland. Chart 5 identifies the East End and Lochee, as the two LCPPs with the highest levels of deprivation in the city, and Chart 6 illustrates the correspondingly high levels of associated morbidity and multi-morbidity for the over 65 age group also.

However, it is relevant to note that the same correlation is not in evidence for the Coldside LCPP which has the second highest rate of people aged 65+ with one or more health condition, but only the 5th highest deprivation in the city. This is because of the high number of people over the age of 65 who live in the cluster of very sheltered housing and housing with care located within this LCPP.

This population of people aged 65+ have frequently relocated from other LCPP areas, including those that have the highest levels of deprivation, to live in the accommodation with support that is provided in Coldside. Therefore the higher rate of multi-morbidities for the Coldside LCPP will at least in part reflect the impact of deprivation experienced by those who have previously lived in the more deprived parts of the city.

D Prevalence of Key Morbidities and Multi-Morbidities

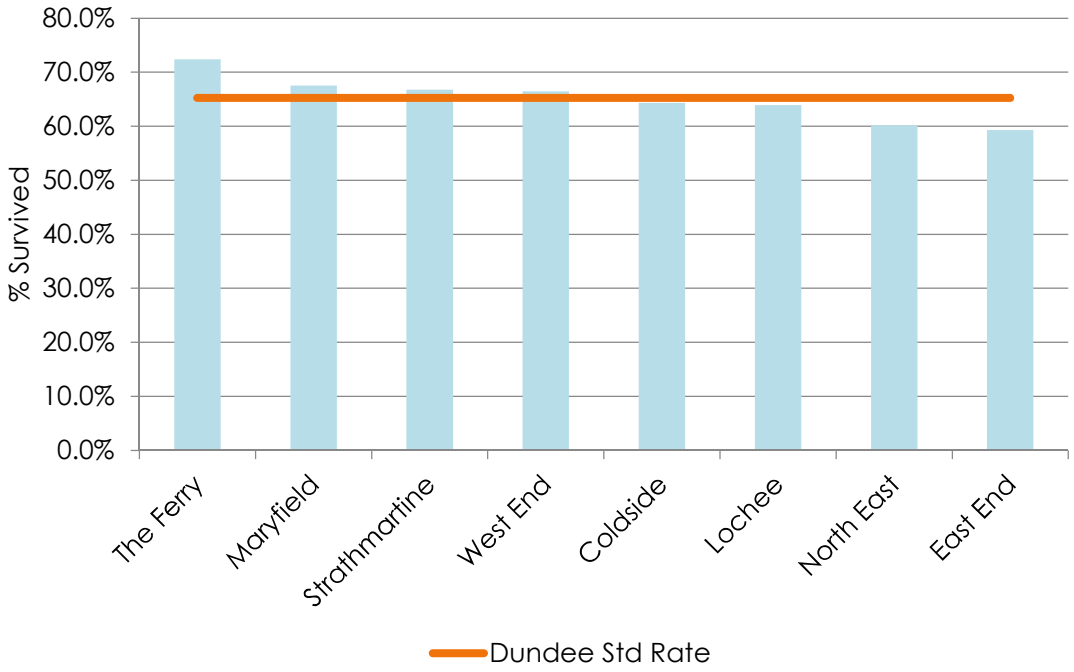
As described, there is a direct correlation between deprivation and a range of health conditions and health and social inequalities. Dundee's population ranks in the top five local authorities in Scotland for the prevalence of learning disabilities, physical disabilities, mental health issues and substance misuse. Detailed data and analysis is to be provided for all care groups in the overarching and individual care group Strategic Needs Assessments, which will be made available for reference. The following are two examples of the impact of deprivation on the prevalence of key morbidities and health inequalities in Dundee.

Cancer

At any given point there are over 5,000 people living in Dundee who are or have been treated for cancer. Cancer is a condition that one in two people will develop during their lifetime and the risk increases with age and lifestyle.

Approximately 450 people die as a result of cancer each year in Dundee and there is a higher risk of dying of cancer, for those who live in the most deprived areas of the city. The (age and gender standardised cancer) mortality rate for the East End is around one and a half times greater than for The Ferry. For every 10 people in The Ferry who died from cancer between 2009 and 2014, there were on average about 15 people in the East End who died from cancer.

Chart 7: Percentage of People with Cancer who Survived more than 1 year after Diagnosis between 2009 and 2013



Source: NSS ISD 2015

Chart 7 shows clear links between deprivation and cancer survival of more than one year after diagnosis. The Ferry is the LCPP area which has the lowest deprivation and it has the highest rate of people who survived cancer for one or more years following diagnosis. The East End is one of the most deprived areas and has the lowest rate of people who survived cancer for one or more years following diagnosis.

Further analysis may involve looking in more detail at cancer types, as different types of cancer have different rates of survival, and there could be differences in the types of cancer that are prevalent in each of these LCPP areas.

Cancer mortality can be reduced with earlier diagnosis, through improved screening techniques, and education and cancer awareness in the community. Improved treatment and aftercare services and a healthier lifestyle are also likely to improve the likelihood of long term survival after cancer has been diagnosed. Further analysis is required at LCPP and neighbourhood level of the differences there may be between communities in terms of levels of cancer awareness and access to services, along with lifestyle and availability of family and community supports.

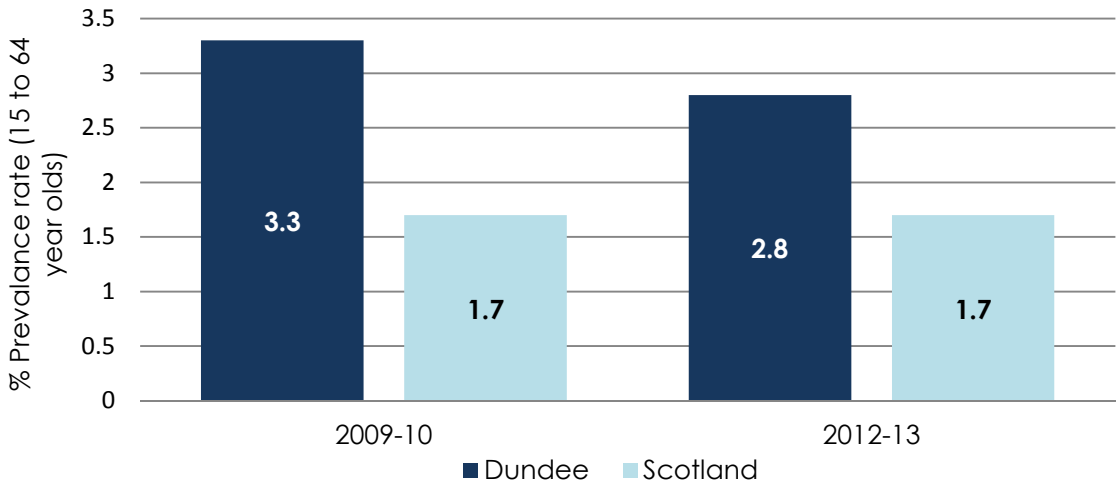
Substance Misuse

Substance misuse in Dundee has been identified as one of the key priorities to be addressed by the Partnership, 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. The following substance misuse statistics have been included to provide more detailed information regarding the scale of the challenge presenting, and the links with deprivation in Dundee.

Drug Related Harm

Chart 8 shows the estimated prevalence of problem drug use for those aged 15 to 64 in Dundee, compared with Scotland as a whole. According to estimates Dundee City had the second highest prevalence rate in Scotland in 2012/13, with only Inverclyde having a higher prevalence rate.

Chart 8: Prevalence of problem drug use in Dundee and Scotland



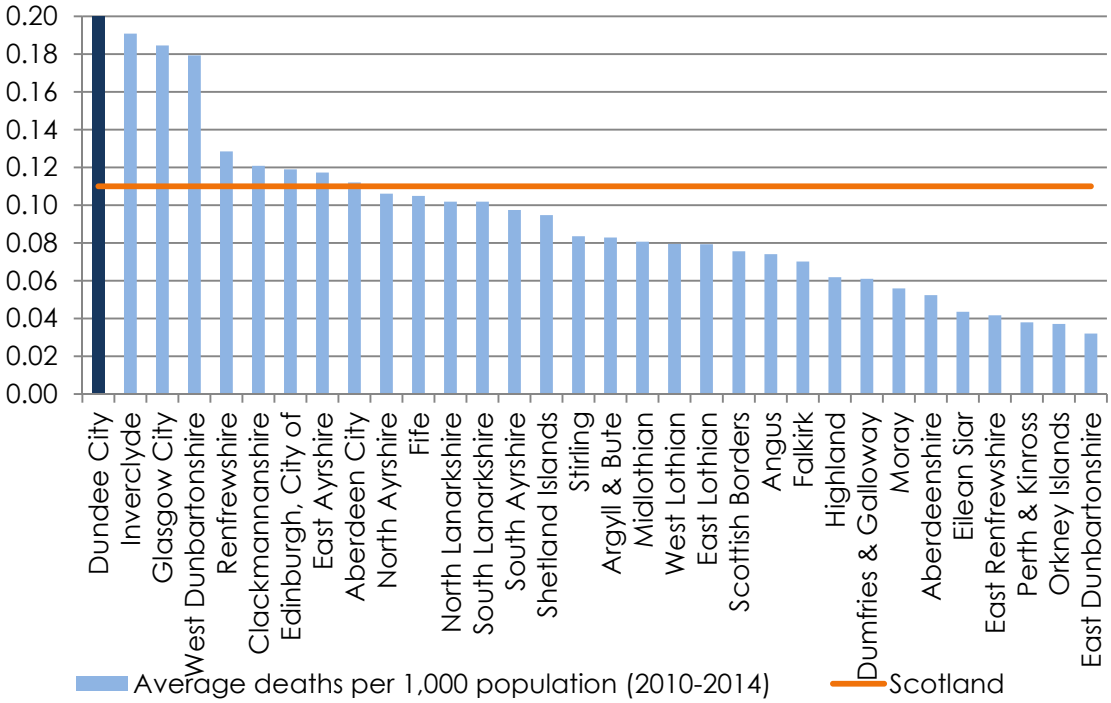
Source: Estimating the prevalence of drug misuse in Scotland 2012/13 ISD Scotland

In 2014, 613 drug related deaths were registered in Scotland of which 31 were in Dundee. This data has been compared with a four year average which covers the period 2010-14. Using a four year average mitigates any annual fluctuations, and shows that:

- For Scotland as whole, the average of 558 drug related deaths per year represented a death rate of 0.11 per 1,000 of population
- Dundee had an average of 30 drug related deaths per year, representing a death rate of 0.2 per 1,000 of population, and the highest rate of all local authorities in Scotland

Chart 9 below shows Dundee's figures for average drug related deaths, compared with those for all local authorities in Scotland.

Chart 9: Average drug related deaths per 1,000 population (2010 - 14)



Source: Drug related deaths in Scotland 2014, National Records of Scotland

It is significant to note that Glasgow and Inverclyde (as the only two local authorities in Scotland with higher levels of deprivation than Dundee) follow Dundee with the next highest levels of drug related deaths. This demonstrates the significant impact that drug misuse has on Dundee and helps to illustrate the additional impact that deprivation has on outcomes for people who do misuse drugs.

Alcohol Related Harm

There are no national measures for the prevalence of alcohol related health harm. However, data from the Scottish Health Survey 2008-11 showed that in Tayside, of those who did report drinking, 48% of men and 36% of women were drinking outwith government guidelines.

The latest annual figures from the National records of Scotland showed that the number of alcohol related deaths had increased from 29 in 2013 to 42. This was the first time the number had increased since 2008.

Chart 10: Alcohol related hospital discharges in Dundee 2014/15 by highest and lowest deprivation

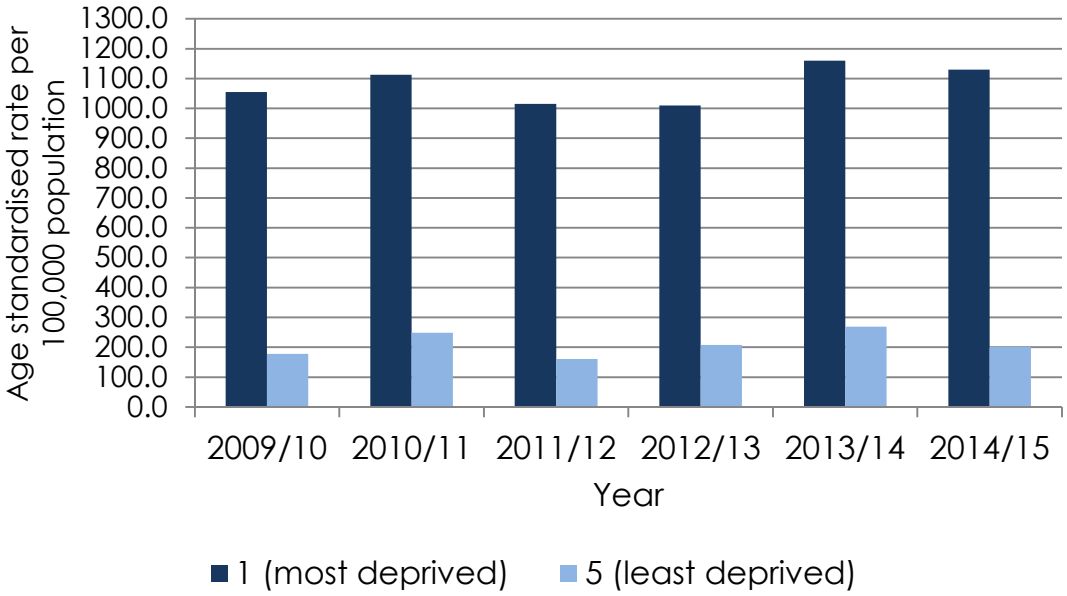


Chart 10 shows the number of alcohol related hospital discharges in Dundee. There is considerable inequality between the number of alcohol related discharges from the most deprived and the least deprived areas.

E Variation in Deprivation and Multi-Morbidity Levels within LCPP areas

It is important to note that as well as the variation that exists **between** Dundee's eight LCPPs, there is also variation in levels of deprivation and health conditions **within** each of these LCPP areas. More detailed analysis shows that there are in fact neighbourhoods experiencing deprivation and one or more health condition at an even greater rate than that presented at LCPP level. Conversely, there are neighbourhoods in some LCPPs with lower rates of deprivation and health conditions than that shown at LCPP level. This level of variation is evident for example within the Lochee LCPP area, when comparing the Whorterbank and Clement Park/Foggyley neighbourhoods with the Sutherland and Gowrie Park neighbourhoods, all in the same LCPP.

More detailed information regarding the variation within LCPP areas at neighbourhood level is provided below.

F Prevalence of Morbidities and Impact on Use of Health and Social Care Services

There is a strong correlation between the levels of deprivation in each of the eight LCPP areas, the prevalence of health and social inequalities and the impact on the use of health and social care services in Dundee. Such variation can be measured by comparing the rate of 'unscheduled care' provided by NHS Tayside for people in Dundee.

Rate of Unscheduled Care in Dundee

The term 'unscheduled care' is defined as referring to:

"NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional…..or is outwith the core working period of NHS Scotland.

Scottish Government, Building a Health Service Fit for the Future Volume 2: A guide for the NHS 2005

Unscheduled care includes emergency admissions to hospital and the length of stay in hospital required by those admitted on an emergency basis. By definition the demand for unscheduled care can occur at any time, and services must be available to respond to the need for care 24 hours a day, 7 days a week.

The task of allocating the necessary resources to ensure that such demand can be appropriately met when required, presents a continuing challenge, particularly in the context of the current and future financial constraints being faced by health and social care services in Dundee.

As in other parts of Scotland, the rise in the level of unscheduled care has been one of the biggest pressures on services in Dundee in the last 20 years. However there is a significant difference in the level of unscheduled care in Dundee, compared with other areas in Scotland. This is shown in the 'bed day rate', which refers to the rate of occupation of hospital beds per 100,000 people in Dundee.

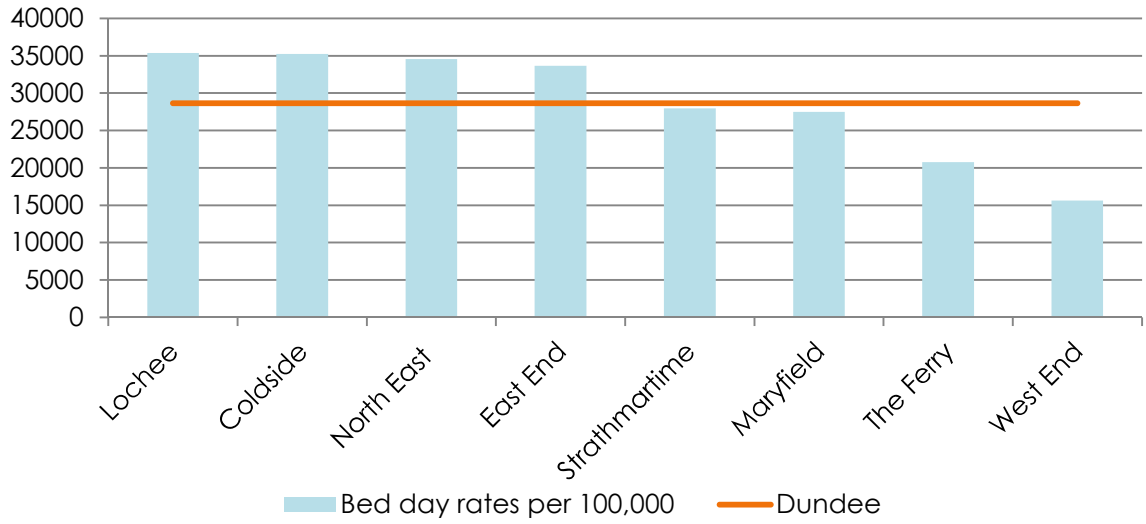
In 2014/15 the bed day rate in Dundee for people admitted to hospital as an emergency totalled 81,465 bed days, against the Scotland average of 73,597 bed days, per 100,000 of the population. This rise in the use of unscheduled care has brought about an incremental and significant shift in the balance between the rate of planned and unplanned admissions to hospital in Dundee. It is a significant challenge to plan and manage effectively the allocation of health

and social care resources with the current demand for such a high level of unscheduled care in Dundee.

Variation in Unscheduled Care Rates between LCPP Areas

When comparing the rates of unscheduled care at LCPP level for people **aged 16-64**, the most deprived areas are shown to have higher bed day rates for emergency admissions than the least deprived LCPP areas. This is illustrated in Chart 11.

Chart 11: Bed Day Rate per 100,000 of Population for Emergency Admissions (people aged 16-64)



Source NSS ISD 2015

Chart 11 also shows a correlation between bed day rates, the rates of people living in deprivation, and the rates of people with one or more health conditions, when comparing for these three variables across LCPPs.

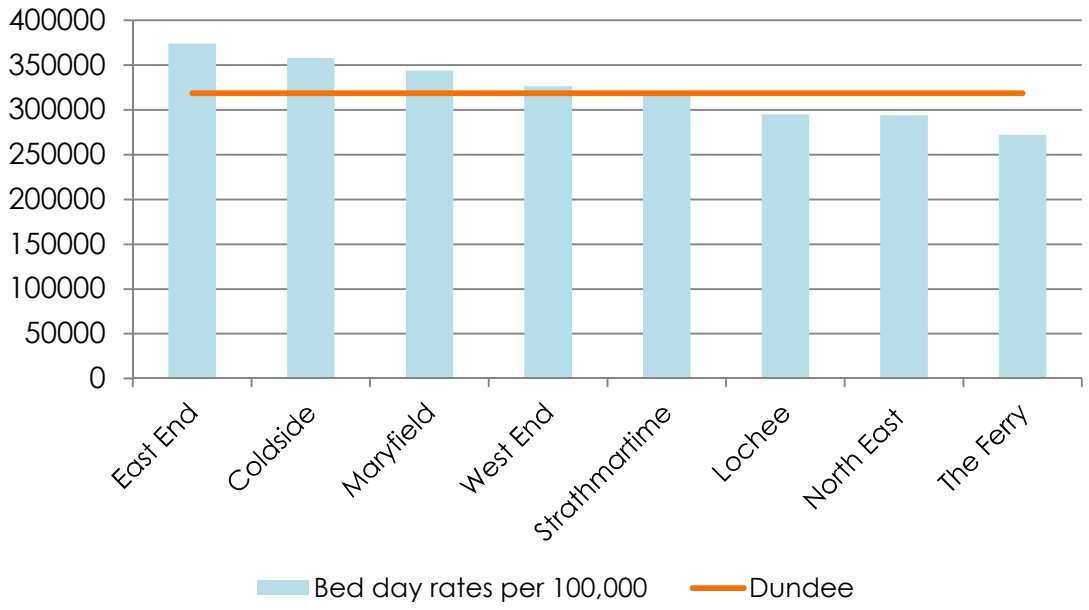
All eight LCPPs do not present in exactly the same order for bed day rate and for deprivation. However, when only considering the most deprived and least deprived LCPP areas, there is a stronger correlation in evidence between these two variables. Lochee, as the LCPP area with highest levels of deprivation, is also the highest in Dundee for problem drug misuse and mental illness. This may help explain the high bed day rate for this LCPP area for the 16-64 age group.

When comparing the bed day rates and the rate of people with one or more health conditions, the order for LCPP areas is the same, with the exception of the East End LCPP area. East End has the highest rate of people with one or more health condition, but only the 4th highest bed

day rate.

Chart 12 shows the bed day rates by LCPP area for people **aged 65 and over** admitted to hospital on an emergency basis. As can be seen, there is significantly less variation overall in bed day rates between LCPPs when compared to the same data for people aged 16-64.

Chart 12: Bed Day Rate per 100,000 of Population for Emergency Admissions (people aged 65+)



Source NSS ISD 2015

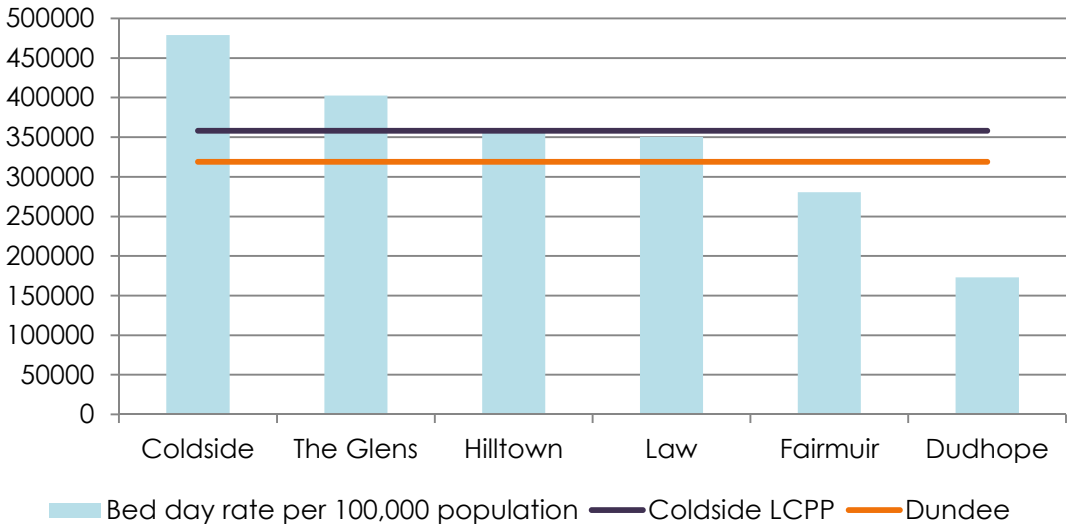
There is a strong correlation between bed day rates and the rate of people aged 65 and over with one or more health conditions for some LCPP areas. East End, Coldside, Strathmartine and The Ferry are LCPP areas that are ranked in the same order for both of these variables. This is a correlation which is not unexpected, as both of these variables relate to health needs, and those with one or more health conditions are at higher risk of emergency admission to hospital. East End and Strathmartine are two of the most deprived LCPP areas and Coldside and The Ferry have the highest rate of older people. Long term conditions associated with deprivation and also old age are likely to increase bed day rates in these areas.

However the correlation between deprivation and bed day rates for people aged 65 and over is not as strong as that for the 16-64 age group. For example, the bed day rate for Lochee (which is the LCPP with the highest rate for deprivation) is the third lowest for bed day rates in Dundee. Similarly the West End (as very low for deprivation) is the fourth for bed day rate.

Variation in Unscheduled Care Rates within LCPP Areas

There is similar variation **within** each of Dundee's LCPP areas in the use of unscheduled care. The LCPP area with the highest variation in unscheduled care **for over 65's** is Coldside. As shown in Chart 13, there is a neighbourhood within the Coldside LCPP, which is also called Coldside. This neighbourhood has the highest bed day rate per 100,000 of the population for people aged 65+ (479,122 bed days). The neighbourhood in the Coldside LCPP with the lowest bed day rate for those aged 65+ is Dudhope (173,200 bed days).

Chart 13: Coldside LCPP area by neighbourhood/bed day rate per 100,000 of population for emergency admissions (people aged 65+)

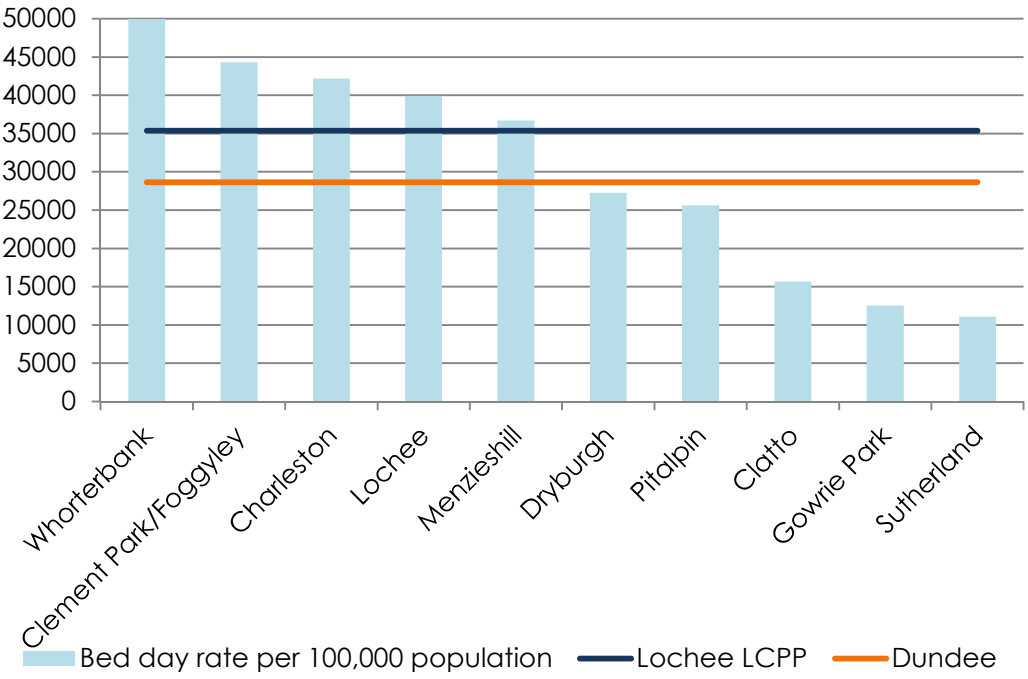


Source: ISD Scotland, unpublished data: emergency admissions and bed days

As previously described, the high bed day rate in the Coldside neighbourhood can be related, at least in part, to the cluster of very sheltered housing and housing with care, and the high rate of multi-morbidities in the frail older people population living there.

The LCPP area with the highest variation in bed day rates for people **aged 65 and under** is Lochee. Within Lochee the neighbourhood with the highest bed day rate for this age group per 100,000 of the population is Whorterbank (49,928 bed days) and the neighbourhood with the lowest bed day rate is Sutherland (11,092 bed days). It should be noted that there is a neighbourhood in the Lochee LCPP also called Lochee.

Chart 14: Lochee LCPP area by neighbourhood/bed day rate per 100,000 population for emergency admissions (people under age 65)



Source: ISD Scotland, unpublished data: emergency admissions and bed days

Whorterbank, Clement Park/Foggyley, Charleston and Lochee are amongst the most deprived areas in the city, whilst Gowrie Park and Sutherland are amongst the least. Chart 14 shows, therefore, that the least deprived neighbourhood areas in the Lochee LCPP have significantly lower levels of unscheduled care usage. It also shows by comparison the high usage of unscheduled care in the less than 65 age group living in five of the 10 neighbourhood areas in the Lochee LCPP.

This significant variation can be attributed to the high level of deprivation and substance misuse, mental illness and multiple long term health conditions, which are known to be prevalent in these deprived neighbourhoods in the Lochee LCPP area.

Analysis shows therefore that not only does the need for unscheduled care differ from one LCPP area to the next, but also that within some LCPPs there can be very significant differences in the level of need between neighbourhoods. This further increases the challenge of ensuring that the health and social care resources available are distributed in the most fair and effective way for the people of Dundee who live in local neighbourhoods across the city.

G Population Health and Wellbeing Summary

In conclusion the main drivers for change associated with population health and wellbeing in Dundee are:

- the current and projected demographic changes taking place, which may have an impact on the size of the working population and the economy of the city over the next 10 years
- the increase in life expectancy and significant increase in the older people population, in particular the 75+ and 90+ age groups
- the decrease in the number of people aged 50-64, who are the main providers of unpaid care for older family members
- the level of deprivation and the health and social inequalities across Dundee, affecting people of all ages who live in deprived neighbourhoods
- the prevalence of health conditions and multi-morbidities in the older people population, as they live longer, but rely increasingly on health and social care services for care and support
- the higher level of morbidity and multi-morbidities experienced at a younger age by people affected by deprivation and health and social inequalities
- the impact of earlier morbidity and multi-morbidities on people in the 50-64 age group, both in terms of their own care needs, and their capacity to provide unpaid care for older family members
- the variation in the levels of need between LCPP areas, and within LCPPs at a neighbourhood level
- the high level of unscheduled care in the city

All of these factors collectively lead to a strong Case for Change. We know that if we are to improve the health and wellbeing of Dundee's adult population into the future, we have to take account of, and plan for, these demographic changes in the years ahead, and at the same time reduce the significant impact of deprivation on the health and wellbeing of people of all ages.

We have concluded that this will require an approach to the use of health and social care resources that is much more targeted than that only at a Dundee or LCPP level. We have also recognised that there is an imperative to reduce the reliance on unscheduled care, with its negative impact on the resourcing and delivery of planned health and social care services for the people of Dundee.

More detailed information regarding this 'direction of travel' for change in the use of health and social care resources will be provided in the 'What Needs to Change' and other sections of this report to follow.

5.1.2 Analysis for Change: Delivery of Right Support at Right Time

Through the implementation of models of change, more emphasis is now being placed in Dundee on the development of preventative services and early interventions to support people with needs to live more independently in the community. Significant investment has been made in the move from institutional forms of support to community supports, through the development of additional supported accommodation, the promotion of employment and college opportunities, and the development of enablement and enabler supports.

Professionals from different agencies are now working together to develop more integrated services and improve health outcomes for people who need support. The work undertaken to date has led to the development of a range of new initiatives and revised models of working and has demonstrated improved outcomes for service users. Consultation and engagement processes with people in Dundee have been used to contribute to a number of these service improvements which have been designed with a focus on improving flexibility and choice.

As described above however, demographic changes, levels of deprivation, health and social inequalities, and variation in levels of need across the city, require action to be taken to improve the effectiveness of health and social care services. Overall, when comparing our performance against the nine National Outcomes we recognise that there is still significant work to do to more fully realise our vision for the people of Dundee.

At the same time we recognise that the current organisational arrangements for the planning and delivery of services is no longer fit for purpose and we have undertaken a review of the way in which our health and social care resources in Dundee are organised and delivered.

The following are the further drivers for change which have been identified as part of our self-evaluation process.

A Centralised Development and Decision Making

To date the resources allocated for social work services by the Council, and those allocated to the Dundee CHP from NHS Tayside, have been separately organised and managed within traditional, hierarchical, line

management structures within each agency.

Within social work the delivery of services has been organised around adult care groups, which have included people with physical disabilities, learning disabilities, mental health and substance misuse issues. We have described these care groups as 'communities of interest' and services have been planned, organised and delivered to them at a city wide level. Whilst these organisational arrangements have allowed for services to be developed and delivered to better meet the specific needs of people with different disabilities, this has meant that decision making regarding the use of the resources available for each care group has been very high level and centralised.

Within older people's services the responsibility for the delivery of services has been assigned to two service managers who have managed the allocation of resources for older people along the lines of an east and west organisational division of the city. This arrangement has been partly driven by the size of the resource to be managed, and although it has allowed some account to be taken of the differences in need across the city, it has not been possible to target our resources very effectively towards geographical areas and local communities in greatest need.

Similarly within Dundee's CHP the delivery of community nursing services is organised and managed centrally at a city wide level. Dundee's community nurses are attached to G.P. practices and their practice populations, and they deliver health care to people in their own homes in line with their treatment needs. Given that G.P. practices in Dundee are not geographically aligned, there is no co-terminosity between practice populations and the local communities in which G.P. surgeries are located. This means that community nurses are delivering services to patients wherever they live in the city and there is little scope within the current organisational arrangements for the targeting of health resources at a community level.

To summarise, there has not been the flexibility within the current organisational arrangements within social work and health to be able respond to changing needs and to organise and target resources at an LCPP or neighbourhood level. The requirements of integration, the new information available to us from our strategic assessment of needs, and our review of service delivery models are now indicating that this is what is required in Dundee.

B Services not Tailored to Address Community/Locality Differences

In addition to the separate social work and health management arrangements, there is also an integrated Community Adult Services Management Team (CASMT) which is made up of senior operational and support service staff from both social work and the Dundee CHP. The Social Work Community Care Management Team is represented on the CASMT, which reports to the Council's Social Work and Health Committee and the Dundee CHP Board. In addition there is a direct line from the CASMT to the Dundee Community Planning Partnership (CPP) for identified aspects of the Dundee Single Outcome Agreement (SOA).

The CASMT has been in operation for several years and was set up to promote a more integrated approach towards the planning and delivery of health and social care services in Dundee. There have been a number of joint initiatives and revised models of working that have been designed and implemented with partners through the CASMT, using the investment of Scottish Government monies (for instance the Reshaping Care and Integrated Care Funds) to support these planned developments.

These new developments have included the Enhanced Community Support initiative, which is a primary care led, enhanced community response service for frail older people to support them to remain in their own homes. This initiative includes input from home care teams, as well as social work and community mental health teams. The initial evaluation of the service shows a reduction in the number of people admitted to hospital, the length of stay and the number of repeat admissions, as well as improved outcomes, for those who have received this enhanced level of community based support.

Another key development has been the establishment of new multi-agency community based service hubs for people with substance misuse issues. These community hubs are improving access to a range of specialist and generic services being provided from a number of key locations across the city. In the past those who are now receiving services from the one hub, had to access them in the separate facilities used as access points by the different agencies providing each specialist service.

The delivery of community rehabilitation services is also being integrated to strengthen the interface between hospital and community rehabilitation nursing services, social work occupational therapy and home care enablement services, the Community Equipment Store and the third sector. The aim is to develop an integrated model of community rehabilitation and enablement, with

single integrated policy statements and agreed criteria for equipment, aids and adaptations.

Within the current organisational arrangements there have nevertheless been limits to the progress of integration. This is both in terms of the constraints that currently exist on the use of our combined core resources, and the flexibility that is now required to allow for the deployment of these resources at a community level, in response to changing needs and priorities.

We recognise that our current organisational arrangements and decision making processes need to be replaced with a new integrated, locality based organisational and service delivery framework, with aligned management and staffing structures. Within such a framework the need for resources at a local community and neighbourhood level can be more effectively assessed, prioritised and targeted. This will then mean that resources will be in the 'right' place to allow services to be more fully and effectively integrated around individuals, carers and their families within their own local communities.

C Reliance on Unpaid Carers

As described earlier, there is a significant level of 'unpaid' care and support provided by family and friends for many people in Dundee who have health conditions and/or are frail due to older age. The provision of such unpaid care can avoid the need for more formal health and social care services, and is frequently delivered as part of packages of care and support, alongside services provided by the health and social care sector. 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.

According to the 2011 Census there were 13,072 carers in Dundee at that time, and it is estimated that together they were providing on average 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 forms of social care, which they may have had to fund themselves. The cost of Dundee's home care service is approximately £15 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 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 are high and can require a

significant financial contribution from the individual involved and/or their family, depending on individual circumstances and means, and the type of resource identified.

The benefits of unpaid care for those who receive it are not just those that are 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. As such the total resource that is unpaid care helps to support many people to remain at home, minimises the demand for health and social care services and maximises the use of all the resources available for care and support in Dundee. In this way unpaid care plays an essential role in supporting the continued functioning of the health and social care system here, as it does in other parts of the country.

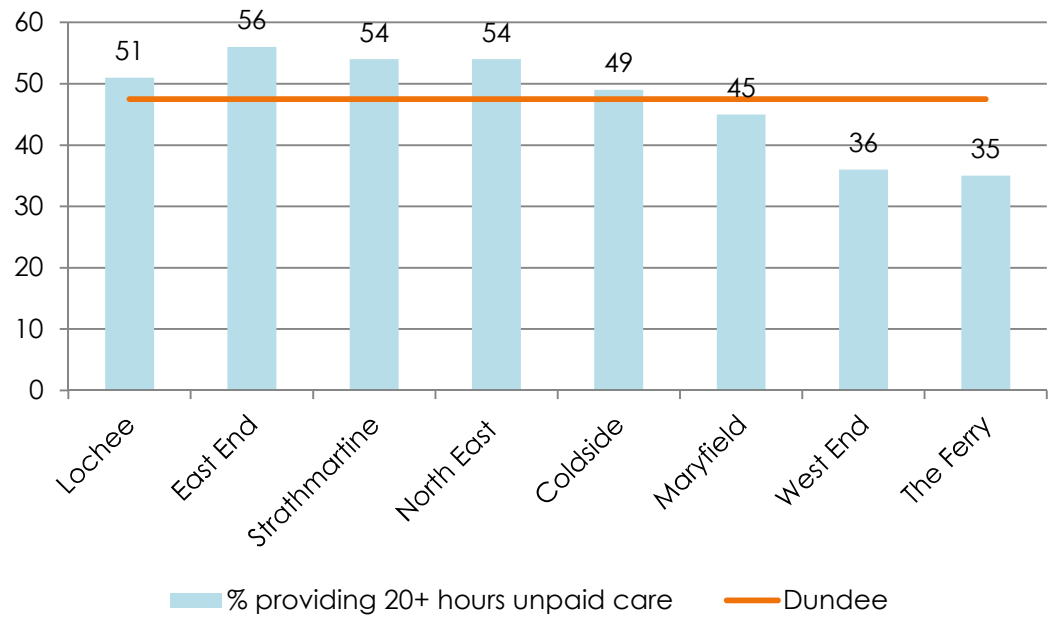
It is clear therefore that we must ensure unpaid carers are appropriately supported to carry out the valuable role they play in the provision of care and support in the city. This includes the improvement of support to those who are already providing unpaid care, as well as those who in the future will become new carers. With the rising number of older people, it is anticipated that the number of upaid carers in Dundee will grow, and we know that there will be a need to 'scale up' the level of carer support accordingly.

The strategic needs assessment and analysis of unpaid care provision in Dundee has shown us that there are some key risks that we need to carefully assess and minimise. Firstly the projected decrease in the 50-64 age group may present some risk to the level of unpaid care available in the city in the years to come, particularly if people in the younger age groups do not take on this role within families.

Secondly the increase in the number of people experiencing health conditions at a younger age, especially in the most deprived LCPP areas and neighbourhoods, may mean that there will be fewer people with the capacity to take on the responsibilities of an unpaid carer for a relative of friend.

Chart 15 shows the differences between LCPP areas in the level of unpaid care provided by identifying the percentage of upaid carers in each LCPP area who deliver in excess of 20 hours unpaid care each week.

Chart 15: % of Carers in each LCPP who provide over 20 hrs of unpaid care



Source: Scotland Census 2011

These figures indicate a clear correlation between the percentage of carers who are providing over 20 hours of unpaid care and those LCPPs areas with the greatest levels of deprivation. The LCPP area with the highest proportion of unpaid carers providing over 20 hours of care is the East End (56%), one of the most deprived, and this compares with 35% in The Ferry LCPP, one of the most affluent.

If the rate of unpaid care was to decrease in Dundee as a result of social or demographic change and/or increased morbidities in the 50-64 age group, we would expect to see an increase in dependence on health and social care services. Such an increase would be likely to have a negative impact, for instance, on the balance of planned/unplanned hospital admissions and bed day usage and lead to an increase in demand for more institutional forms of health and social care.

The impact of such change would be greatest in areas of high deprivation, where health and social inequalities and vulnerabilities are at their highest, and there is least resilience in the community resources available to respond to any increases in need and demand.

It is clear therefore that unpaid carers as individuals, and collectively as a total resource, are one of Dundee's most valuable assets. It is a priority for us to ensure that they are provided with the support they

require, to allow them to continue to deliver the best quality care and support they can, to those whose rely on them for their care and wellbeing.

D Support is not Sufficiently Individualised

As described, the planning and delivery of services at a city wide level for care groups, as 'communities of interest', has had certain key advantages, in that it has allowed priority to be given to the specialised needs of the people in the main disability care groups.

This approach has resulted in multiple points of access to services and issues regarding the integration and coordination of service delivery. Those who have had experience of using the services delivered in this way report having "to tell their story" on a number of occasions to different professionals at different times, and a lack of a holistic approach to assessing, planning and delivering services to meet their health and social care needs.

It is accepted that co-location does not of itself lead to a more integrated approach being taken to the delivery of services. But the experience gained locally through the community hubs and other service developments confirms that improved access and service coordination can be achieved for service users and carers by bringing professionals to work together on the one site.

Alongside such developments there has been a growing emphasis on the need for more integrated and personalised approaches to working with people who need services, and their carers, in the identification of individual outcomes and planning their care and support. There has been an increased drive towards professionals adopting more co-productive approaches to their working relationships with people and their carers, that is relationships within which those who need services are actively supported to play a central role in identifying the outcomes they wish for themselves and the ways in which these outcomes are to be achieved. At the same time it has been recognised that all of the different professionals involved with each individual and carer must work together in practice to achieve more integrated and holistic assessment, care and treatment planning, and improved outcomes for those who require health and social care services.

Progress has been made locally in the development within social work of an Outcomes Focused Assessment Framework, and training has been provided to social work and social care staff, to help them make the conceptual shifts in their approach which is supporting practice change. This training is now also been rolled out to community nursing

and other community health professionals, as well as housing staff and relevant independent and third sector organisations providing services as part of the health and social care system in Dundee.

Within social work further work is required to help staff to integrate this approach into front line practice and ensure that the required 'outcome focused conversations' take place at the earliest point of contact with services possible. This is 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. These conversations need to focus on what matters to a person 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.

For health and other agencies a shift is being made from the more traditional 'medical model' and service led approach to the delivery of treatment and services, to a more integrated and holistic approach to improving quality of life and outcomes. In relation to the provision of mental health and substance misuse services, there is also a growing focus on the adoption of recovery based approaches to the delivery of treatment and support services.

Such 'asset' and recovery based approaches are currently being integrated into professional development activities for health and social care staff, and are being reflected in the new 'My Life' information portal and in the design of new support systems, for example, Social Work's new I.T. system.

We recognise that work is still required to streamline systems, pathways and processes across health and social care to reduce the level of current duplication in activities across agencies and to create the right conditions for a more fully integrated and outcomes focused approach to the planning and delivery of services for those who need them.

The personalisation of services has been further promoted by the introduction of the Social Care (Self-directed Support)(Scotland) 2013 legislation. This legislation emphasises the need for services users and carers to have a greater say in the planning and management of their support and care, if they so wish. To progress the implementation of self-directed support, and promote a co-productive approach to the delivery of packages of care and support in line with individual choice, a staff training strategy has been developed and is currently being delivered for social work and social care staff, as well as a number of housing staff in Dundee.

Despite the work undertaken to date, there has not been a significant increase in the uptake in Dundee, as compared with other authorities, of the options designed to afford the opportunity for people to plan and self-manage their own care and supports.

We realise that the services and supports currently available in Dundee are not sufficiently individualised. We are committed to realising over the coming years the transformational change required to embed service user empowerment and choice at the heart of individual care planning in Dundee.

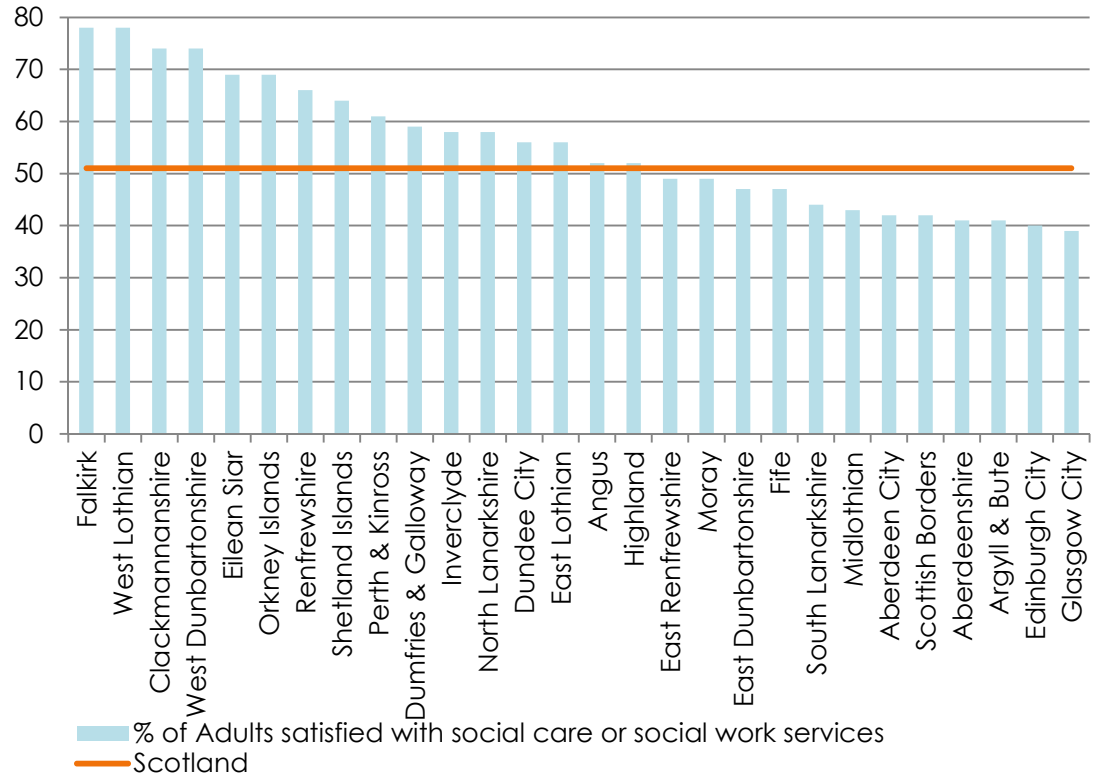
E People Report Variable Experiences of Care and Health

We know through a number of different mechanisms providing feedback from the people who receive our services (including the complaints received by social work and NHS Tayside about community health services) that for the most part the quality of our services for adults in Dundee is of an acceptable and sometimes good standard; it is also at times of the very highest quality. We also know however there are other times when it does not meet service or practice standards, including those set by external regulatory and inspection bodies, or the expectations of the people of Dundee.

The following graph shows satisfaction levels with social work services, by local authorities in Scotland, reported in the Scottish Health Survey for the year 2014-15. Although the number of survey responses may be relatively small, and information is not available for all local authorities, the following Chart 16 does provide some helpful indication of Dundee's performance relative to other local authorities in Scotland.

Chart 16 shows that 56% of the adults who responded were satisfied with social work services in Dundee, a figure that is higher than the Scottish average of 51%, and significantly higher than the other three cities in Scotland. Nevertheless Dundee performs poorly when compared with Falkirk and West Lothian, which showed satisfaction levels more than 20% higher.

Chart 16: % Adults satisfied with social care or social work services 2014-15



Source : Improvement Service 2015

Dundee City Council also conducts an annual Citizen Survey, which showed in 2014 that 98% of respondents were satisfied with local health services and social work services; with 99% saying it was easy to access local health and social work services in the city.

It is recognised that such surveys have their limitations, as there may be disproportionate representation of positive views, due to the potential bias which the reliance on self-reporting can bring to such feedback mechanisms. It is also clear that those whose views are being sought do not always have a good understanding of the nature and quality of care they can reasonably expect to receive, or the outcomes that alternative service delivery arrangements or models of service might offer, if made available.

From the growing body of collective professional knowledge and experience that has accrued, and the learning from the strategic needs assessment and self-evaluation activities that are being undertaken in Dundee, we know that the outcomes for many people who live in areas of deprivation are poor. We are committed to working with all partners, to change the way in which resources are used, and services organised and delivered, so that the impact of deprivation can be reduced and outcomes improved for individuals,

carers and families living in deprived neighbourhood areas across the city.

5.1.3 Analysis for Change: Fiscal Constraints

Health and social care services in Scotland are being delivered within an increasingly challenging financial environment, partly driven by current UK fiscal policy and partly due to increasing levels of demand. The effect of the UK government's aim to reduce overall public sector spending continues to have a significant impact on the funding of local authorities and the NHS.

The impact of the 2016/17 finance settlement for local government in Scotland has resulted in local authorities having to consider unprecedented levels of savings. Locally, Dundee City Council is facing a funding reduction of 4.3% in 2016/17; this amounts to a total of £23 million savings required, with further considerable savings anticipated in 2017/18 and beyond. While NHS services have been relatively protected as a spending priority by UK and Scottish Governments, the extent of financial pressures within the health system also provides considerable challenges. Within NHS Tayside, while an uplift of 1.7% in funding to Health Boards has been provided within the finance settlement, average savings of 5% per annum over the period of the Plan are anticipated to bring expenditure in line with budgeted resources.

At this time of fiscal constraint, demand for health and social care services is increasing and this is particularly acute locally due to the scale of need in Dundee, given the high levels of deprivation and health inequalities which exist and resultant high prevalence of multi-morbidity.

Chart 17 shows the estimated spend required to meet this increasing demand in Dundee across a significant number of care group services, should these broadly continue to be provided in the same way as they are currently against the estimated budgeted resources available over the period of this Plan.

Chart 17: Service Groupings – Estimated Service Demand v Available Resources

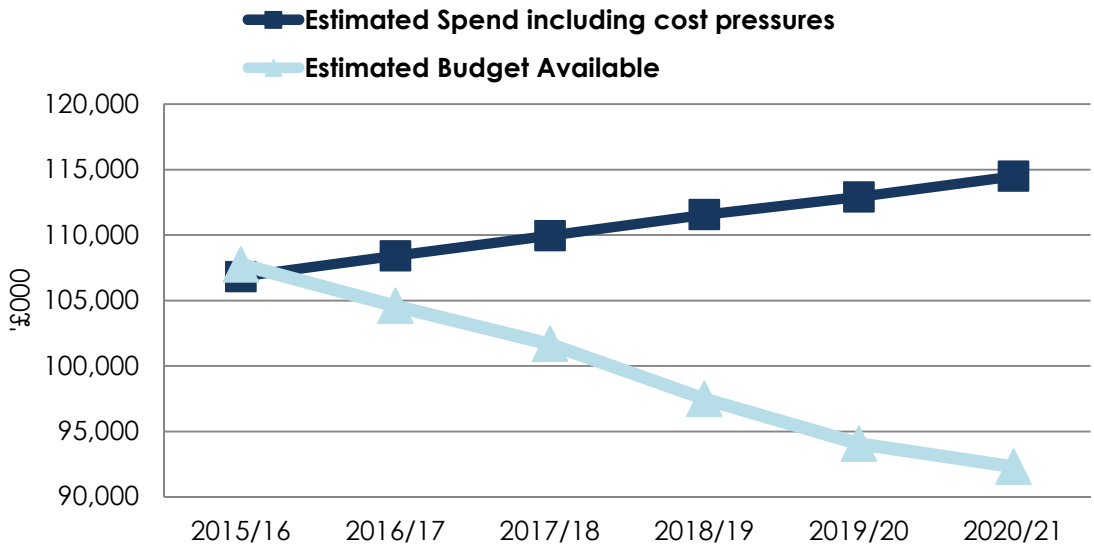
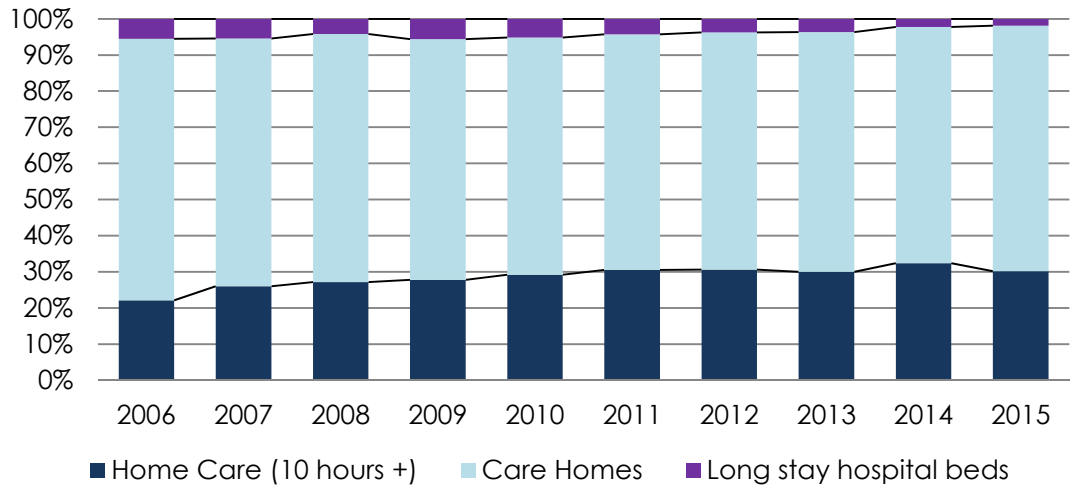


Chart 17 clearly illustrates that if nothing changes there will be a significant financial deficit which will affect the level of services available to those in need.

A comparison of the range of costs of existing models of care and support highlights the need to shift from higher end, higher cost service provision, such as unscheduled hospital care to services which support individuals at home i.e. to shift the balance of care. It is estimated that the cost of Delayed Discharges from Hospital across the Tayside area is around £3m per annum. The cost of a patient accessing a hospital bed on an unscheduled basis is around £454 per night. A nursing home placement costs £609 per week with a residential care home placement costing £525 per week. However the cost of providing an intensive home care package can be around £300 per week (cost of 20 hours of home care), considerably less than these alternatives. If provided at an early stage, such a package of care can support people to remain in their homes longer, reducing the need for (and cost of) more institutional forms of care.

Chart 18 shows that over the last 10 years there has been a positive change to 'shift the balance of care' from just over 20% in 2006 to 30% in 2015. What this means is that instead of being admitted into a care home or a long stay hospital bed, many people are now being supported to remain in their own homes, with a package of home care of at least 10 hours per week. This highlights progress has been made, however more needs to be done.

Chart 18: Balance of Care for Dundee 2006 to 2015 (age 65 and over)

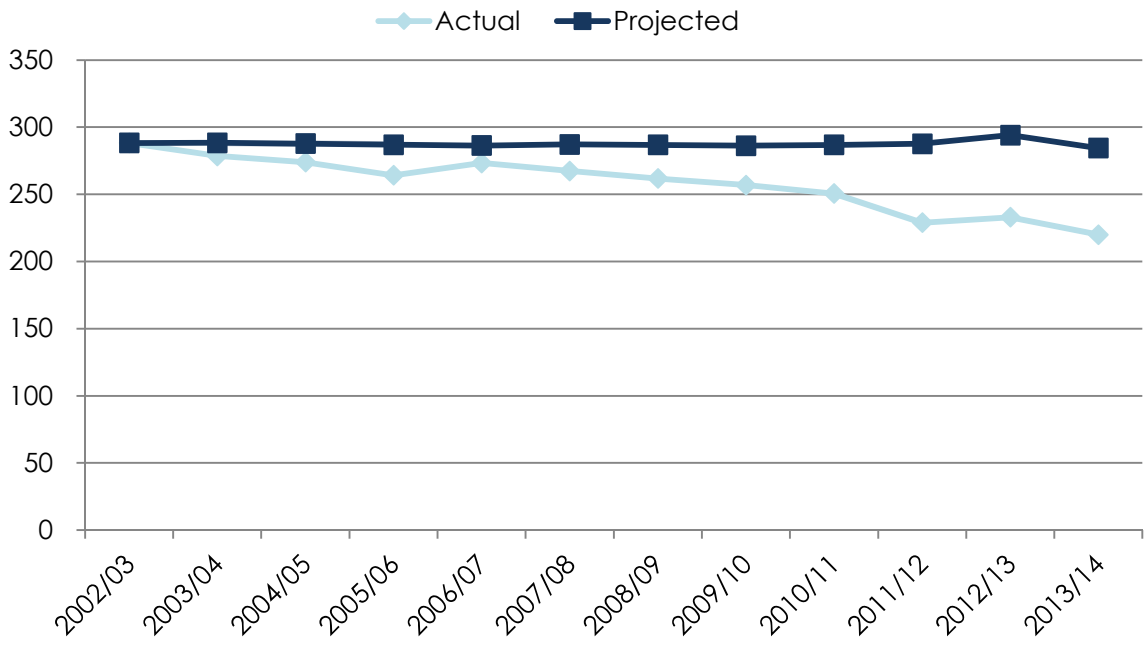


Source: Health and Social Care dataset, Social Care survey, Scottish Government

There is already a body of information available for the over 65s age group which has been drawn on to demonstrate the positive effects of integrated approaches, such as Reshaping Care for Older People and the Integrated Care Fund. This suggests that where we have redesigned services and integrated them fully, demand against expectation has reduced.

Chart 19 shows the projected and actual bed day usage for people age 65+ in Dundee. The projected figures were calculated by applying the annual population change to the baseline year at 2002/03. The difference between the actual and the projected is a reflection of changes (other than population change) which have occurred in the period.

Chart 19: Trend in emergency bed day usage for people aged 65+, actual and predicted 2002-2014 in Dundee



This reduction in projected activity to actual activity can in part be attributed to the work achieved to date towards integrating and improving services, especially that related to shifting the balance of care for older people, and developments through the Reshaping Care for Older People Programme and the Integrated Care Fund. Not only have a number of these developments contributed to preventing people being admitted to hospital on an unscheduled basis, for those in hospital these developments have contributed to improvements in processes which ensure that once ready to be discharged from hospital, services and supports are available sooner to care for people in their own homes. Without these interventions already in place, the projected level of activity would have been unsustainable to health and social care services in Dundee.

We can conclude from this analysis that over the period of the Plan, funding available to meet the increasing health and social care needs of the population will be insufficient should we continue to provide services in the same way. We have demonstrated within this section that there is strong evidence to suggest that further integrating services can contribute to mitigating the impact of these fiscal constraints and growth in demand. The Partnership has made good progress to date, however with an unprecedented reduction in available financial resources over a short period of time, more needs to be done to narrow the gap between resources available and demand.

5.2 What Needs to Change

The analysis above builds a compelling Case for Change which will only be achieved if strategic shifts in the way services are prioritised, accessed, organised and delivered, take place. This will involve a process of investment towards some areas of service and disinvestment from others, with resources deployed towards a more preventative and integrated community based approach.

Taking account of our vision, our strategic needs assessment, the Case for Change, the views of our citizens and partners and our desired outcomes, eight priority areas have been defined to underpin the delivery of this Plan. These are:

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

Under each of these eight priorities there are a range of strategic shifts that have been identified as follows:

Health Inequalities

- Shifting resources to invest in health inequalities
- Prioritising resources towards implementation of the actions arising from the Dundee Alcohol and Drug Partnership Review
- Shifting resources to improve access to training and employment

Early Intervention/Prevention

- Investing in or redirecting existing resources to scale up well evidenced, early intervention and prevention approaches
- Investing in and expanding the Enhanced Community Support model to include adults with long term conditions
- Investing in integrated locality based enablement and rehabilitation models of support
- Investing in locality pharmacy to promote community health advice and better medication management
- Working with and investing in third sector organisations to develop services that take a recovery or rehabilitative approach

Person Centred Care and Support

- Restructuring our financial planning to support the further development of self directed support
- Remodelling care at home services to provide models of support which increase the range and flexibility of available options
- Remodelling and investing in the development of short break options for adults and older people

Carers

- Investing more in the health and wellbeing of carers

Localities and Engaging with Communities

- Investing in an infrastructure to support the development of locality planning
- Allocating resources to implement locality plans

Building Capacity

- Investing in third sector and community developments that build community capacity
- Supporting the development of a community transport strategy and investing in community models of transport

Models of Support/Pathways of Care

- Investing in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community
- Redesign models of non-acute hospital based services and re-invest in community based services
- Remodelling local authority residential care to provide more targeted and specialist resources
- Remodel General Practice in line with G.P. cluster model, the changes to the GMS contract and the opportunities afforded through integration
- Investing in the transformation of community nursing services to deliver the Tayside District Nursing vision and model, improving outcomes for adults and older people
- Remodelling and investing in the development of, and increase in, accommodation with support
- Remodelling and investing in the development of day opportunities for adults and older people
- Investing in and expanding the range of telehealth and telecare supports

Managing our Resources Effectively

- Investing in workforce development to support the integration and development of new models of care and improve outcomes for people
- Investing in co-located, integrated models of care and support aligned to localities

In addition to the above, our expectation will be that the implementation of the key strategic shifts will flow into and from specific care group strategies, primary and acute care strategies and other organisational strategies. The financial assumptions made against the strategic shifts detailed above take into account the financial modelling against each of these strategic frameworks. This will include programmes of investment and disinvestment prioritised into programmes of actions.

A locality approach will provide the overarching framework for the development and implementation of the Plan, including the allocation of resources to achieve the strategic shifts against the priorities identified in the Plan.

5.3 Working in Localities

5.3.1 Locality Model

The concept of localities is embedded within the Plan and will be based on Dundee's 54 neighbourhood areas, and eight localities, as well as four service provision areas. This model will support locality engagement, planning, decision making and accountability. It will be the level at which universal, preventative and health improvement services will be delivered.

Dundee has a strong ethos of working in partnership with its communities and the people it supports. There are eight LCPP areas with established communication and development plans, and regular meetings between community representatives and the statutory services. To resource and maintain a meaningful engagement process, the LCPP areas are deemed the 'localities' for the purpose of the Plan. These eight localities will form the basis of the framework for locality decision making and planning.

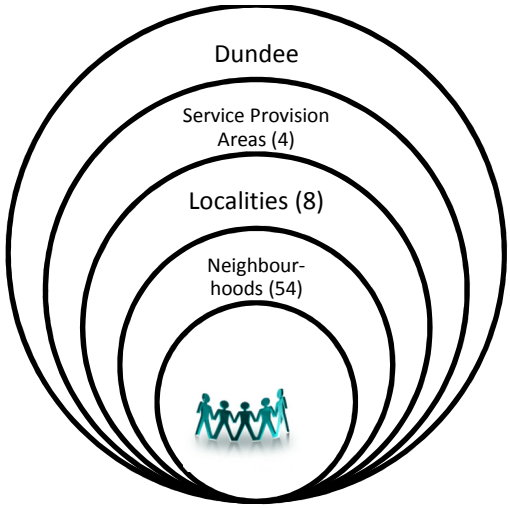
The eight localities consist of 54 natural neighbourhoods. Unlike rural areas, where a sense of community can be linked to a whole village or small town, the nature of Dundee's communities can mean that the natural neighbourhoods that sit within the LCPP areas often have differing demographic, health and socio-economic profiles, as shown through the strategic needs assessment work undertaken.

The concept of locality working for Dundee is further defined within models of service delivery. Large volume services such as home care services have structured models of service delivered in geographical areas. By linking defined staff groups/teams to a locality, the teams develop a better understanding of the local communities and their people, target the resources according to need and make links to local resources. Currently services work across locality boundaries, with smaller services delivered on a city wide basis. To make the most efficient use of resources, there will be four service delivery areas which will work closely to paired LCPP localities.

This concept of dividing the city into four service areas will facilitate the first step towards a sustainable model of locality within the city, which is suitable for service delivery. It will allow targeted multi-agency services

and specialist services to be aligned to meet the needs of service users and patients with specific or complex care needs. This will also support a manageable communication framework for professionals and service providers. The different levels of locality working can be shown below in Figure 2.

Figure 2



In developing the locality model, a three step approach will be taken:

- Identify and clarify health and social care need and variation across natural neighbourhoods
- Co-produce eight locality plans with the LCPPs which address specific health and social care need and target resources
- Redesign assessment and service delivery models to align with the four service areas.

5.3.2 Profiling Localities

The Dundee CPP has developed a range of LCPP locality profiles and this will be enhanced through the development of locality health and social care information. We will draw on the information gathered at both an individual and neighbourhood level to identify and understand specific needs within and between neighbouring communities. In addition, work is progressing independently across the city on the development of care group specific strategies which will describe how supports will be delivered at a locality level. The Plan will therefore draw on individual and collective views and community data.

This information will support a targeted process of resource allocation, as well as the development of community capacity and preventative services and will help determine the priorities for further service development. This information has already led to the targeted

development of community based resources and health improvement initiatives. In addition, work is progressing to develop a pathway which allows G.P.'s to access the community capacity and health improvement initiatives at an early point of contact with patients who need services (e.g. Social Prescribing/House of Care Model).

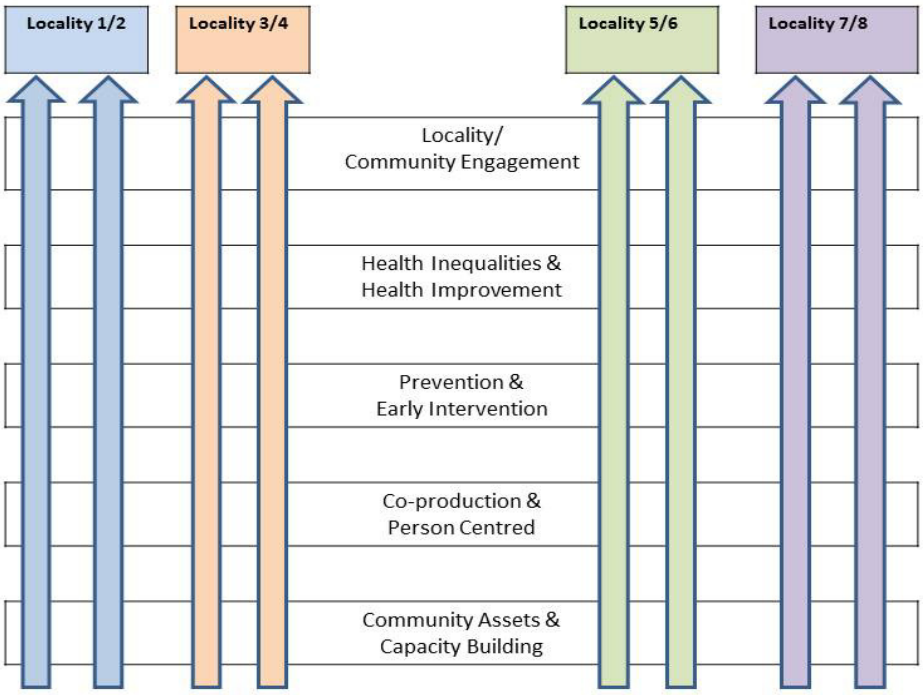
5.3.3 Locality Engagement

An engagement programme with localities will commence during the period of this Plan to co-produce eight health and social care locality plans. It is anticipated that tests of change will be progressed following this process. Many services provided through the third sector have grown from the identification of specific needs or support groups within a neighbourhood. The result is a greater focus on the identification of community need and increased community capacity. While it is anticipated that there will be common approaches across each locality (as described in Figure 2) the level of intervention and the model of community led initiatives may vary across both localities and natural communities.

5.3.4 Phased Development of Locality Based Assessment and Service Delivery

There will be two phases to the development of locality based assessment and service delivery models. Phase one will focus on those who have a longterm condition either as a result of ill health or older age and who are most likely to receive their ongoing care and support through services accessed through their G.P. Practice. Phase two will develop care pathways for adults who access more specialist services. Both these phases will take into account the modelling around G.P. Practices and the recognition that for most G.P.s, patients will be drawn from the whole of the city, rather than a geographical area.

Figure 3



Phase 1

To implement phase 1, we have introduced the Enhanced Community Support model (referred to earlier in the Case for Change Section of this Plan). The Enhanced Community Support (ECS) is a locality model of working based on the clustering of G.P. practices and the alignment of medicine for the Elderly Consultants. It facilitates the continuity of care for older people through regular team meetings held in the G.P. Practice involving health and social work professionals aligned to the G.P. clusters. A locality cluster nurse role was developed to support the case work associated with the patients involved and to ensure communication across the wider team. Through this work, older people and carers at risk of unplanned care are identified and offered appropriate assessments, interventions and reviews. This work will be extended to provide a response to adults under the age of 65 years who have multiple long term conditions.

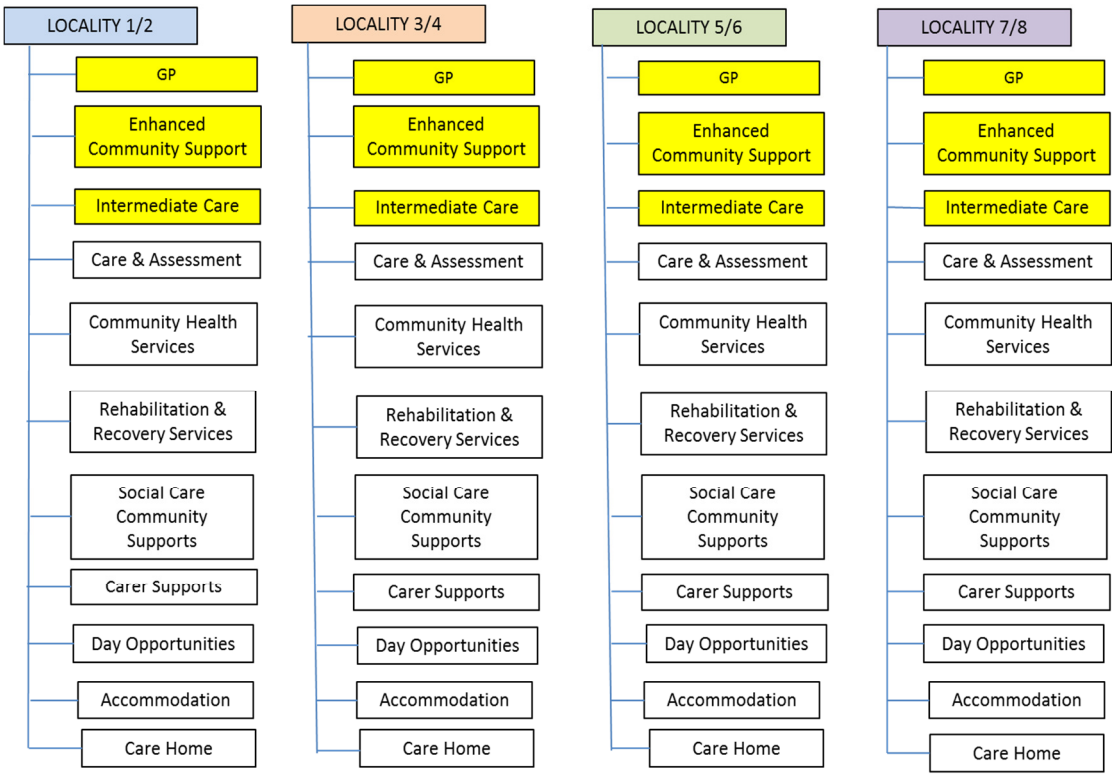
As this model develops, G.P. Practices and other professionals will be the direct referrers to an assessment and service delivery 'hub'. This hub will be both virtual, in that it will provide a point of access to services delivered within the locality and/or service area, and building based, which includes a range of integrated and co-located services. This 'hub' model will facilitate:

- access to care and assessment services
- carers' assessment and supports
- community nursing
- enablement and rehabilitation services
- social care
- accommodation with care
- a range of community based care and support services including services from the statutory, third and independent sectors.

Through time, each of these services will be modelled to demonstrate an alignment with each geographical service area.

As the model develops we would anticipate that the teams aligned to the 'hubs' will become co-located within the localities they serve and that the referral pathways are redesigned to facilitate self referrals and referral by a wide range of organisations. As individuals will be known to the locality teams it is anticipated that this model will support earlier discharge from hospital and prevent inappropriate admissions to hospital and care homes. This is represented within Figure 4.

Figure 4



Phase 2

Phase two of the change to locality working will follow the redesign of specialist adult services, with a focus on the alignment of community based services to localities.

5.3.5 Alignment of Staff to Localities

Throughout the move to locality working we will continue to review the roles and responsibilities within the workforce in order to provide a more integrated approach. This will be reflected through the organisational development and workforce plans developed by the IJB.

5.3.6 Provision of Small Scale and Specialist Services

For those service users whose needs require either a specialist response or whose numbers are small, it is an anticipated that the planning of these services will require a care group or service function focus. In some instances these services will continue to be delivered city wide in the short to medium term. For other services, such as palliative care, they will remain a Regional provision. The modelling of these specialist and regional services will however demonstrate an understanding of local needs.

6.0 STRATEGIC PRIORITIES

In this section we provide more details regarding each of the eight strategic priorities identified in this Plan, together with the strategic shifts which have been identified against them. We explain the aim of each priority, the extent to which we believe we are currently delivering on these and the actions we will need to take to further progress each of these strategic priorities and shifts.

Strategic Priority 1 - Health Inequalities

Why is it a priority?

As detailed in the Case for Change section of this Plan, Dundee has a high level of deprivation with a widening gap between our richest and poorest communities. There is a high prevalence of ill health and reduced life expectancy, and in the case of substance misuse, drug-related death, which is unevenly distributed across the city. The population is also ageing.

In achieving this priority our aim is to:

- Improve the outcomes for individuals and communities and reduce inequalities
- Increase the opportunities for access to employment, education and training.

To address this priority we need to:

- Narrow the health inequalities gap by focusing on areas where the effects are worst.
- Support initiatives that improve employment and training opportunities.
- Develop approaches that positively impact on the health and wellbeing of citizens and communities.
- Support approaches that will help combat the negative impact of welfare reform.

Our current actions:

- Fairness Commission established for the City.
- Developed and tested an Equally Well approach.
- Employment Support Service provision established in the City and subject to review.

- Developed an Autism Academy with Dundee & Angus College and Education partners.
- Action plan developed to mitigate negative effects of Welfare Reform.
- Tested the co-location of welfare rights staff within G.P. surgeries and health centres with a plan in place for implementation
- Services in place to support people to stay at and/or return to work (Working Health Services and Fit for Work Services).
- Provided health checks and support, with ongoing support to improve health, to those living in Dundee's most deprived areas and those from specific groups who have higher risk of ill health.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Health Inequalities	Shift resources to invest in health inequalities.	Develop a health inequalities framework that directs the current resources towards the interventions and actions that are most likely to deliver improvement.	2016 – 2019	Full programme – additional resources
		Extend the range of public information and improve information channels.	2016 -2019	2016 - £50,000 (Integrated Care Fund - ICF) 2017- £500,000 (ICF)
		Identify areas where the take up of health initiatives are low and support approaches to improve access and take up.	2016 – 2019	
		Develop innovative partnerships that seek to reduce health inequalities.	2016 – 2019	
		Enhance support to improve mental wellbeing in those who live in areas which experience greater health inequalities.	2016 – 2019	

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Enhance the skills staff across the Partnership to adopt a social prescribing approach to support individuals. Build capacity within communities to tackle health inequalities. Make better use of community resources such as libraries and community pharmacies to promote health and wellbeing, including a social prescribing role, as a point of contact with people.	2016 – 2019 2016 – 2019 2016 - 2019	
	Prioritise resources towards implementation of the Dundee Partnership Alcohol and Drug Strategy.	Assess the impact of recent budget announcements and take action to review and address any shortfalls. Improve access to alcohol screening and brief interventions in non specialist services working with groups at increased risk.	2016 - 2021	Redirect resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Review and further develop the hub model of substance use provision with local communities to improve access to specialist substance use services and local recovery networks.		
	Shift resources to improve access to training and employment.	Secure the provision of education/training in partnership with local further education institutions and through employment focused social enterprises. Amend the approach to employment support in line with the findings of the Dundee Partnership Employability Review.	2016 - 2021	Within existing resources

Strategic Priority 2 - Early Intervention/Prevention

Why is it a priority?

Our understanding of our local health inequalities identifies that we need to establish positive health behaviours and life style choices as early as possible to reduce the risk of poor health. Investment in early intervention and prevention approaches avoids costly and complex interventions at a later stage by achieving and maintaining an optimum level of health and wellbeing.

Our aim for this priority is to take a preventative and anticipatory approach to health care needs and assist people to manage their heath as independently as possible.

To address this priority we need to:

- Consolidate and scale up programmes and initiatives which have evidenced positive outcomes.
- Work with local communities to design preventative approaches which make best use of community resources and assets to meet local needs
- Shift the culture so that every contact is recognised as an opportunity to proactively connect people to services and resources.

Our current actions:

- Have established Health and Wellbeing networks in each of the eight locality areas.
- Maintaining the Keep Well program – targeted health checks for those in the most disadvantaged areas.
- Worked in partnership with the Scottish Recovery Network (SRN) to develop the 'Making Recovery Real' initiative.
- Commissioned research to clarify our local understanding of prevention.
- Delivered alcohol screening and brief interventions in primary care and the Emergency Department at Ninewells Hospital.
- Developed a hub model with open access to specialist substance use services from health, social care, third sector and police in a local pharmacy hub and a specialist substance use site. Developed an Enhanced Community Support model for older people and are monitoring the impact of this.
- Remodelled Medicine for the Elderly services to have consultants community facing.
- Enablement services are well established, have strong links with community rehabilitation services and include medication reviews

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Early Intervention/ Prevention	Invest in or redirect existing resources to scale up well evidenced, early intervention and prevention approaches.	Implement the outcomes of commissioned research on prevention.	2016 – 17	Within existing resources
		Continue to evaluate current approaches to early intervention and prevention and invest models which increase capacity.	2016 – 2018	Within existing resources
		Provide access to validated information and materials that support individuals' to manage their own health and wellbeing.	2016 – 2018	Within existing resources
		Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self care, and avoid longer term ill health.	2016 – 2021	Within existing resources
		Prioritise and invest in models of support that help to support life style changes which improve health.	2016 – 2018	Within existing resources
		Continue to develop and increase the capacity of volunteers.	2016 – 2018	Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Continue to develop and increase the capacity and early intervention of money advice services to support prevention.	2016 – 2017	£50,000 (ICF)
		Develop shared training programmes for frontline staff to support awareness and understanding of sensory impairment including signposting; sensory health checks and support.	2016 – 2017	£10,000 (Sensory Impairment Strategy Funding)
		Provide sexual and reproductive health services for young people and vulnerable adults that ensure rapid access to services.	2016 - 2021	Within existing resources
	Invest in and expand the Enhanced Community Support model to include adults with long term conditions.	Secure permanent funding and expand the Enhanced Community Support Multidisciplinary Team for each G.P. Cluster. To include • Advanced Nurse Practitioners • Community Nursing • Allied Health Professionals • Care and Assessment Staff • Locality Pharmacy Team • Social Care Resource	April 2016 – April 2018	£1,212,000 (ICF)

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
	Invest in integrated locality based enablement and rehabilitation models of support.	Invest in locality pharmacy support to enhance community support and enablement services.	2016 – 2018	£29,000 (ICF)
		Co-locate the Community Rehabilitation Team with enablement services and develop an integrated approach to rehabilitation.	2016 – 2017	Within existing resources.
		Develop a single referral community rehabilitation pathway across social care, occupational therapy, community rehabilitation and enablement services	2016 - 2017	Within existing resources.
	Invest in locality Pharmacy to promote community health advice and better medication management	Invest in pharmacy services to care homes to promote medication review.	2016 – 2017	To be determined
		Develop and implement models to support people to manage their medicines as independently as possible by introducing social care worker administration of medicines.	2016 – 2018	
		Develop medicines management processes that optimise the most efficient routes and minimise waste.	2016 - 2018	

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
	Work with and invest in third sector organisations to develop services that take a recovery or rehabilitative approach.	Develop a programme of co-designed activities over the next 18 months/2 years to support recovery in line with the 'Making Recovery Real' initiative.	2016 -2018	Within existing resources

Strategic Priority 3 – Person Centred Care and Support

Why is it a priority?

Public expectation of service delivery has changed. People do not want to be the passive recipients of services and have things done to them. They want services designed and delivered in partnership with them and in ways that respect their strengths and their individual circumstances. In addition, there are constraints on public finances. Taking the changing public expectations and the financial constraints together means that the current models of service delivery are no longer sustainable and a different partnership with the public is necessary to allow us to focus on the quality and safety of care for people in our hospitals and communities.

Our aim for this priority is that we provide health, care and support to the highest standards of quality and safety, with the person at the centre of all decisions.

To address this priority we need to:

- Involve citizens in decisions about their social care and support needs.
- Equip individuals and communities with the resources and supports they require to make informed choices.
- Undertake assessment in a multidisciplinary way and at home, wherever possible.
- Ensure people feel safe and are protected.

Our current actions:

- Established service provider forums which promote and share good practice.
- Reviewed and developed advocacy services.
- Range of multi-disciplinary, cross sector events held to develop and promote individualised models of support.
- Developed a framework for the introduction of self-directed support.
- Outcome focused assessment framework, tools and support plans reviewed.
- Developed an electronic directory of services (My Life; My Choices portal.)
- Cross sector Adult Support & Protection training undertaken.

Our proposed actions:

- Implement the recommendations within the Adult Support and Protection Committee Biennial Report (2014 -2016) when published.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Person Centred Care and Support	Restructure our financial planning to support the further development of self directed support.	Bridge the change from the current profile of financial resource allocation to free up finances for individual self directed packages of support.	2016 – 2021	£108,000 (Self Directed Support Funding)
		Support the development of new support options through the introduction of a development fund.	2016 – 2021	To be determined
		Sustain and continue to review staff and organisational development programmes to embed person centred practice.	2016 – 2019	Within existing resources
		Review and develop public information and information channels.	2016 – 2017	Within existing resources
		Simplify our processes and systems to make access to care and support easier.	2016 – 2018	Within existing resources
		Support third and independent sector organisations to achieve the Healthy Organisation Award.	2016 – 2021	To be determined

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Review advocacy models of support in collaboration with local advocacy organisations.	2016 - 2018	Within existing resources
	Remodel care at home services to increase the range and flexibility of available options and support people to remain at home.	Invest in the workforce to develop integrated roles, improve quality and increase capacity.	2016 -2018	£48,000 (ICF)
		Commission internal and external services on a locality basis.	2016 - 2021	Within existing resources
		Increase the balance of care towards care at home services over the period of the plan.	2016 – 2021	Within existing resources
		Work with the Macmillan Local Authority Partnership to develop models of community supports for people living with Cancer.	2016 - 2019	£1 million (over 3 years) (MacMillan)
	Remodel and invest in the development of short break options for adults and older people.	Test a Public Social partnership model of short break provision for adults with Mental Health needs and their carers.	2016 – 2017	£48,000 (Shared Care Scotland Funding)

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Develop a range of short break options for adults with a Learning Disability and/or Autism in collaboration with third sector / independent providers.	2016 - 2018	Within Existing Resources

Strategic Priority 4 – Carers

Why is it a priority?

The majority of care and support provided in the city is provided by unpaid carers. Without a successful partnership with unpaid carers, we would not be able to provide for the needs of our citizens nor succeed with this strategy. We recognise therefore, that we must attend to the wellbeing of carers.

Our aim for this priority is that we recognise the role of family and unpaid carers and support them by providing a range of respite and therapeutic options to support carers in their role.

To address this priority we need to:

- Assess the range and complexity of wellbeing issues for carers.
- Develop or support initiatives which provide opportunities for carers to support each other.
- Improve the emotional and physical well being of carers
- Support carers to combine work, social, leisure and training opportunities with their caring role.

Our current actions:

- Developed multi-agency, locally based approaches to engagement.
- Held a Carers Conference and Carers Consultation event.
- Funded a range of carers' representative organisations.
- Developed carers assessment which is more outcomes focused.
- Commissioned a range of supports for carers including young adult carers.
- Developed a range of training for carers.
- Completed research into the preferred models of respite care.
- Developed a Public Social Partnership for Mental Health Short Breaks.
- Tested new approaches to short breaks including brokerage.
- Improved access to information about supports available to carers and included carers' information on the My Life, My Choices Portal.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Carers	Invest more in the health and wellbeing of carers.	Develop a Strategic Commissioning Statement for carers with input/ involvement from carers' groups and carers' partnerships and implement this.	2016-2017	Within existing resources
		Prepare for and implement the Carers legislation when enacted.	2017 – 2020	To be determined
		Embed and increase carers' health checks within primary care giving consideration to the impact on service provision and ongoing support.	2016 – 2018	Within existing resources
		Support carers to work collectively to develop local community resources.	2016 – 2018	Within existing resources
		Scope out Social Enterprise initiatives as part of a framework of carer supports.	2016 – 2018	Within existing resources
		Review and improve systems to simplify the routes to support, including access to self directed support for carers.	2016 – 2018	Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Review current models of respite support and remodel in line with findings.	2016 – 2018	Within existing resources
		Identify and address the barriers carers experience when accessing leisure and social activities.	2016 – 2018	Within existing resources
		Co-locate activities to allow carers and those they care for to pursue their interests and activities in the same place at the same time.	2016 - 2018	Within existing resources

Strategic Priority 5 - Localities and Engaging with Communities

Why is it a priority?

Integration is about more than developing a partnership between statutory agencies and the independent sectors. It is about local decision making, clear accountability, and good communication with those it affects. Without creating the conditions which will sustain the dialogue, the strategy will not develop. We recognise that arrangements have to be put into place to gain a collective public and professional view on what needs to be made available and on ways to improve locality service delivery.

Our aim of this priority is to develop better links within local communities to make local resources known and more accessible and inclusive.

To address this priority we need to:

- Embed engagement in the future shaping of integrated health and social care.
- Promote initiatives that build on community views for change and provide resources to support this.
- Develop locality based approaches to the planning and delivery of health and social care services.

Our current actions:

- Worked with partners and communities to plan and scope the new community Hubs in Coldside and Menzieshill.
- Put in place a range of initiatives to support engagement with individuals, communities and communities of interest, to contribute to the development of care group Strategic and Commissioning Statements.
- Carried out a range of consultation events.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Localities and Engaging with Communities	Invest in an infrastructure to support the development of locality planning.	In partnership with Communities services and the third sector, agree a staffing model which supports the engagement and development of community plans and commission the delivery of this.	2016 - 2021	£219,000 (ICF)
	Allocate resources to implement locality plans.	Provide a Community Fund for the implementation of the eight locality plans. Further develop inclusive communication initiatives which resonate across all care groups, young and old. Work with current community facilities to develop a range of leisure and social activities including drop in centres for those with additional support needs.	2016 – 2021 2016 – 2021 2016 – 2021	To be determined Within existing resources To be determined

Strategic Priority 6 - Building Capacity

Why is it a priority?

The level of demand against the current resource framework would indicate that current models of service delivery are not financially sustainable. We recognise therefore, that we have to rethink how people, communities and services can work together more effectively and efficiently to coproduce improved outcomes for people. This means that we will have to work even more collaboratively than we do now, in particular with citizens in their own communities.

In achieving this priority we aim to develop a range of activities and opportunities for networking, socialisation and participation.

To address this priority we need to:

- Work more collaboratively with individual citizens, communities, housing organisations, third sector, independent sector and statutory organisations.
- Identify tests of change which build community capacity and recognise the necessary timescales for initiatives to produce results.
- Identify local opportunities to support individuals to build social connections which help build personal resilience.

Our current actions:

- Developed a co-productive approach to recovery by increasing citizen/service user involvement in how our local services are conceived, planned and delivered.
- Provided a Community Fund for the development of local community projects managed through the third sector.
- Developed the Reshaping Care Team within the third sector to support the development of community projects.
- Mapped local community resources for older people and included these in the Celebrate Age Network Directory of Services.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Building Capacity	Invest in third sector and community developments that build community capacity.	Use a co-productive approach to promote opportunities that support recovery closer to where individuals live.	2016 – 2018	Within existing resources
		Build on current engagement methods to identify community need and initiatives.	2016 – 2018	Within existing resources
		Provide staff development programmes which support a co-production approach.	2016- 2017	Within existing resources
		Support change programmes which build community capacity development into whole system change.	2016 – 2021	Within existing resources
		Identify the barriers in accessing opportunities that can promote and sustain recovery and explore ways of reducing/removing these barriers.	2016 – 2018	Within existing resources
		Evaluate current community capacity programmes and using existing resources invest in those projects which indicate positive outcomes (Thirds Sector Small	2016 – 2018	£130,000 (ICF)

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Grants Fund). Refresh the Community Capacity Building Strategy and review the current level of the Community Capacity Fund to reflect predicted use. Further develop community health resources to maintain people living in their own neighbourhoods. Support health and social care staff to identify community resources and to sign post/support individuals to access these resources.	 2016 – 2018 2016 – 2018 2016 - 2018	 £83,000 (ICF) Within existing resources Within existing resources
	Supporting the development of a community transport strategy and investing in community models of transport.	Work in partnership with the statutory agencies, communities and third sector to agree a community transport strategy and fund a test of change.	2016 - 2018	£50,000 (ICF)

Strategic Priority 7 - Models of Support, Pathways of Care

Why is it priority

We know that people want to live as independently as possible and would prefer to be supported at home or in a homely setting. The current models of service delivery will not meet the anticipated increase in demand. With both an ageing population and high levels of deprivation, support should be anticipatory, planned and there should be continuity of care.

We know the hospital environment is not the best place to provide long term care when needs can be better met in the community. For people entering hospital their care pathway should be planned, with discharge planning commencing at the point of admission. People should be supported to die at home where this is their wish. The public report that they cannot easily access services, response times are inconsistent, and when they enter services they do not always work in an integrated way.

In achieving this priority we aim to:

- Expand the level of health and care support provided and give greater choice
- Make these supports more flexible and provide it at home or as close to home as possible
- Develop a range of accommodation and housing choices to meet increasing and changing needs
- Continue to develop partnerships between the statutory, third and independent sectors to progress new models of care and support.

To address this priority we need to:

- Identify and redesign pathways to be integrated so that people receive the right care, at the right time, in the right place, from the right people.
- Further develop pathways so that people experience a smooth, timely transition between services (for example between secondary to primary care.)
- Co-locate services around integrated pathways, develop corresponding single points of access, shared information and systems.
- Deliver support close to home making full use of technological advances.
- Support and enable people to establish and maintain their own recovery and wellbeing.

Our current actions:

- Developing advanced practitioner role - both nursing and AHP
- Redesigned interface between hospital and community services to improve discharge pathways.
- Worked with housing providers to create improved housing solutions within local communities.
- Worked with housing providers to improve housing solutions for people with complex needs.
- Revised the criteria for adaptation and equipment and redesigned the systems for distributing these.
- Entered into the second Macmillan Local Authority Partnership in Scotland to work with people living with cancer.
- Redesigned the Hospital to Home Pathway (along with IRISS.)
- Commenced a test of change of the rehabilitation pathway via Mackinnon Centre back to community.
- Developed "step down" provision as an alternative to remaining in a hospital environment.
- Increase availability of sites for blue badges collection.
- Tested a nutrition project to identify under-nutrition and address eating concerns.
- Established a Mental Health Network with a focus on recovery.
- Developed and tested a locality hub model to access care and treatment for substance misuse in City Centre and Stobswell.
- Developed new arrangements for Crisis Response and home treatment in the mental health service.
- Developed new arrangements for diagnosis and treatment for adults with an autistic spectrum disorder but no associated learning disability
- Improved access to psychological therapies from primary care including web based cognitive behaviour therapy.
- Investing in and expanding the range of telehealth and telecare supports.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Models of Support, Pathways of Care	Invest in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community.	Support more people to be assessed at home rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change.	2016 – 2017	£126,000 (Delayed Discharge Funding)
		Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways.	2017 – 2018	To be determined
		Extend the range of supports for adults transitioning from hospital back to the community.	2016 - 2018	£104,000 (ICF)
		Lead a review, with partners, of the current Learning Disability acute liaison service and develop a future model.	2016 - 2017	Within existing resources
		Increase our investment in intermediate forms of care such as Step Down accommodation and support.	2016 – 2018	£15,000 (Delayed Discharge Funding)

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Invest in resources which support assessment for 24 hour care taking place at home or home like settings	2016 –2018	To be determined
		Redesign services to ensure rapid access to palliative services.	2016 –2018	Within existing resources
		Review patient pathways between Carseview Hospital and the community.	2016 – 2018	Within existing resources
	Redesign models of non-acute hospital based services and reinvest in community based services.	Collocate Medicine for the Elderly (MfE) and Psychiatry of Old Age (POA) services.	2016 –2018	Within existing resources
		Redesign non-acute services for older people (MfE/POA) and develop more community supports.	2016 –2018	Within existing resources
		Redesign Stroke patient services	2016 –2018	Within existing resources
		Redesign the Tayside Neurological Rehabilitation services.	2016 –2018	Within existing resources
		Utilise the Mental Health Innovation Fund to support redesign in Adult Mental Health Services.	2016 –2018	To be determined

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Contribute to the outcome of the Steps to Better Healthcare review of Learning Disability in-patient services and increase the provision of community health supports whilst reducing the bed base.	2016 - 2018	Within existing resources
	Remodel local authority residential care to provide more targeted and specialist resources.	Review the current models of residential care for older people in line with future of residential care (Scottish Government 2013).	2016 - 2018	Within existing resources
	Remodel General Practice in line with the G.P. cluster model, the changes to the GMS contract and the opportunities afforded through integration.	Remodel and further develop multidisciplinary team approach with General Practice at the centre. Address local challenges relating to General Practice boundaries and changing workforce and remodel in partnership with G.P.'s. Test improved and more efficient models of service delivery in partnership with General Practice, focusing initially on longterm conditions and older people.	2016 – 2017 2016 – 2018 2016 – 2018	To be determined

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Support new models of General Practice care and Out of Hours urgent care in line with Sir Lewis Ritchie's 2015 review. Develop the" House of Care" model for care and support planning, ensuring this links with partners approaches to person centred care, for those with a long term condition.	2016 – 2019 2016 - 2019	
	Invest in the transformation of community nursing services to deliver the Tayside District Nursing vision and model, improving outcomes for adults and older people.	Develop a flexible workforce to ensure the safe and effective delivery of a quality community nursing service over 24 hours/7 days a week Build workforce capability and capacity to deliver models of care which promote health, self-management and address inequalities. Implement the recommendations from the National Review of District Nursing and NHS Tayside Transforming District Nursing Programme.	2016 - 2018 2016 - 2018 2016 - 2018	To be determined To be determined To be determined

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Review the roles and responsibilities of the Community Learning Disability Nursing team within the context of a whole system e.g. medical / Psychiatry / Nursing and AHP services.	2016 - 2018	Within existing resources
	Remodel and invest in the development of and increase in, accommodation with support.	Disinvest in residential forms of care for older people and increase investment in accommodation with support. Remodel Housing Support services to ensure equity of access based on need. Implement the proposals for accommodation with care for adults in line with the Strategic Housing Investment Plan.	2016 – 2018 2016 – 2018 2016 - 2021	Within existing resources Within existing resources Within existing resources
	Remodel and invest in the development of day opportunities for adults and older people.	Shift the balance of building based to non-building based day opportunities. Continue to increase opportunities for adults with a Learning Disability and/or Autism to receive more personalised support in leisure, recreational and social activities, including in the evening and at	2016 – 2017 2016 – 2018	Within existing resources Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		weekends. Increase the use of volunteers to support adults and older people in their lifestyle choices.	 2016 - 2018	 Within existing resources
	Invest in and expand the range of telehealth and telecare supports.	Develop a Strategic Commissioning Statement for technological care and implement actions alongside partnership agencies. Increase the range of technological supports.	2016- 2017 2016 - 2017	Within existing resources Utilising available national development resources.

Strategic Priority 8 - Managing our Resources Effectively

Why is it a priority?

We have indicated the Case for Change section of the Plan that we expect to experience resource pressures as a result of increasing demand and fiscal constraint. It is essential therefore that we use all our resources (finance, workforce, accommodation, services) effectively and efficiently while ensuring that we maintain high quality care. To do this we need to set out a common vision, communicate this vision, work to it and evaluate our progress against it. We recognise that to do this we will have to bring together our resources and skills, draw on evidence of best practice and apply innovative approaches.

In achieving this priority we aim to:

- Develop an engaged, flexible workforce
- Make effective use of partnership resources
- Meet agreed standards

To address this priority we need to:

- Define integration resources (finance, workforce, accommodation, services) and make best use of these.
- Continue to make resource decisions transparently.
- Address issues of demand and capacity.
- Collectively develop commissioning intentions and communicate these through a market shaping strategy and procurement arrangements.
- Take an integrated approach to workforce development.
- Redesign systems to support integration, including the monitoring and review of progress and performance, making full use of technology.

Our current actions:

- Invested in cross sector management and leadership learning opportunities.
- Held a joint social care recruitment event with third and independent sector social care providers, which included developing a shared shortlisting process, shared application form and shared interview format.
- Undertaken a health and social care integration financial Due Diligence process.
- Have a number of co-located teams.
- Established an integrated community learning disability service.

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Managing our Resources Effectively	Invest in workforce development to support the integration and development of new models of care and improve outcomes for people.	Develop a shared induction and training programme for health and social care staff across the range of social care providers.	2016 - 2017	£18,000 (ICF)
		Develop an integrated workforce plan and associated development strategy and resource workforce development programmes.	2016 – 2017	Within existing resources
		Develop Learning Networks spanning all sectors to support the workforce to establish models of best practice in key areas such as Care at Home.	2016 - 2018	Within existing resources
	Invest in co-located, integrated models of care and support aligned to localities.	Extend the co- location of teams with common purpose and broaden the definition of integration to include all sectors (health, social work, third sector, independent sector).	2016 – 2019	Within existing resources
		Regroup our assets so that services can be delivered on the basis of collocated teams/community 'hubs'.	2016 - 2021	Within existing resources
		Develop integrated Financial Frameworks and associated financial reporting.	2016-2017	Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Further develop the Strategic Financial Planning process to support devolved decision making.	2016 -2017	Within existing resources
		Agree a prioritisation framework for the allocation of resources which improves decision making and meets strategic objectives.	2016 – 2017	Within existing resources
		Develop partnership working, skills and knowledge to improve strategic commissioning processes.	2016 -2017	Within existing resources
		Streamline and improve systems for the financial and performance monitoring of contracted services.	2016 – 2017	Within existing resources
		Further develop a Dundee Partnership Market Shaping Strategy.	2016 - 2017	Within existing resources
		Review existing community services to reduce duplication, increase efficiencies and reinvest in new or remodelled initiatives and services.	2016 - 2019	Within existing resources

7.0 IMPLEMENTATION OF THE PLAN AT A CARE GROUP LEVEL

Strategic planning and commissioning at a care group level is currently directed by the care group Strategic Planning Groups (SPG). In Dundee we currently have the following SPGs:

- Older People (including Older People with Dementia)
- Learning Disability and/or Autism
- Physical Disabilities
- Sensory Impairment
- Mental Health and Wellbeing
- Carers
- Homelessness
- Dundee Alcohol and Drug Partnership

The SPGs have a multidisciplinary membership, including health, social work, third and independent sectors, service users and carers. The SPGs are in the process of preparing Strategic and Commissioning Statements (the Statements) which set out the strategic direction for the next five years.

Each of these Statements will have an accompanying needs assessment describing the specific health and social care needs experienced by each of the care groups, both at a service level and a locality level. The needs assessments build on the demographic profiling of the city and demonstrate many of the same characteristics shown in the Case for Change Section of this Plan, with adults and older people experiencing the same levels of deprivation and poor health alongside their more specific needs. The ongoing work by the SPGs has influenced and helped shape the priorities and actions contained within this Plan.

In developing these Statements, each of the SPGs will draw on the national policies relevant to the care group involved and any relevant national policies and outcomes. While there are specific drivers for change associated with each care group, there will be common themes identified as pressures, including:

- An increase in demand for community services
- An increase in the number of people with complex needs seeking support
- Increasing pressure on hospital inpatient services from unscheduled admissions and delays in discharging to home
- Requirement for more housing options, both with and without support
- More flexible services to meet variable need across extended days and overnight
- More personalised supports

- Support for carers

To address these strategic pressures, the Statements will describe the redesign and remodelling of current services and the commissioning intentions for the period of the Plan. The developing Statements will reflect the strategic priorities and shifts reflected in this Plan. In addition, the care group SPGs will hold devolved responsibility for the delivery of those actions relevant for each care group contained within this Plan.

As many of the actions detailed in the Plan reflect the work across all community health and social care services, the care group Statements will provide the detailed information and financial costings for the strategic changes which are to take place during the next five years. This progression of the actions will be reflected through the Outcomes and Performance Framework and ongoing reporting related to the Plan.

It is anticipated that these care group Statements will be prepared and published during the financial year 2016 – 2017.

8.0 FINANCIAL FRAMEWORK

8.1 Financial Planning Assumptions

In order to be deliverable and effective, it is essential that the Plan is underpinned by a robust Financial Plan. This financial plan has been developed through adopting a number of high level planning assumptions which are consistent with both NHS Tayside and Dundee City Council's medium term financial planning assumptions. These include anticipated levels of government funding, future cost pressures and resultant potential efficiency targets. Given the Scottish Government has provided both the local authority and NHS with a one year funding settlement for 2016/17 only, any future financial planning assumptions beyond this are subject to change and will be reviewed.

Anticipated increases in demand for services over the planning period, as described earlier in this Plan will also put pressure on financial resources if services continue to be delivered in the same way. The potential effect of this has been costed across service user groupings and is set out and described in chart 17 under the Fiscal Constraints section.

8.2 Estimated Financial Resources

Work is currently being undertaken to refine and finalise the level of resources which fall within the scope of the Plan. Given the scale of the financial challenges facing both Dundee City Council and NHS Tayside, current budgeted resources will be subject to an assumed level of savings as we move into the period of the Plan. The estimate of the current financial resources and the source of funding are noted in the Table 3 below. An amount to be included as the 'large hospital set aside' has yet to be finalised however will be shown in the final version of the Plan.

The estimate of financial resources available also includes specific 'short term' funding streams provided by the Scottish Government and channelled through the IJB to support the development of creativity and tests of change in service delivery (such as the Integrated Care Fund and targeted initiatives such as Delayed Discharge funding). In addition, the recent Scottish Government finance settlement includes additional funding of £250m nationally to be transferred to Health and Social Care Partnerships to ensure better outcomes in social care. The specific resources to be allocated to the Partnership are yet to be finalised. These resources are critical in supporting the service shifts set out in the Plan to achieve the priority outcomes. The financial plan takes cognisance of when these are anticipated to end, and

the requirement for financial sustainability through shifts in resources to those services which target priority areas.

Establishing the formal Health and Social Care Partnership provides the opportunity to access other resources which can be deployed more widely across the Partnership to assist in meeting the strategic priorities and enhance the level of available funding. For example, the Partnership will be in a position to access and deploy funding for Technology Enabled Care, and in partnership with Macmillan Cancer Support, also access funding of £1m over three years to develop the Macmillan Local Authority Partnership cancer care service.

Table 4

Description	Funding Source	Estimated Current Value (2015/16 Resources)
Former Community Care Resources	Dundee City Council	£78m
Former Dundee CHP Resources	NHS Tayside	£42m
Short Term Partnership Funds (eg Integrated Care Fund, Delayed Discharge Funding)	Partnership	£6m
Former Mental Health & Learning Disability Resources	NHS Tayside	£13m
Other Former NHST Resources	NHS Tayside	£3m
General Medical Services	NHS Tayside	£24m
Other Family Health Services	NHS Tayside	£20m
G.P. Prescribing	NHS Tayside	£33m
Large Hospital Resources	NHS Tayside	£tbc
Allocation of Additional Scottish Government Funding for Health & Social Care	Scottish Government	£tbc
Total Resources *Note all figures are provisional	NHS Tayside	£219m

8.3 Care Group Commissioning Intentions – Financial Implications

Financial frameworks have been developed for each of the identified care groups based on current and estimated future resources, and set against demographic and other service pressures. The outcome of this highlights a gap between the availability of resources and anticipated resource requirements across the range of care groups should there be no or limited change to service delivery models.

In order to close that gap while ensuring a focus on achieving the strategic shifts to the priority areas as set out in the Plan, the care group SPGs will work through developing a number of interventions over the period of the plan. These interventions fall within the following four themes:

- Policy Changes – interventions which will require changes in current policy eg review of eligibility criteria to access services
- Models of Support – reviewing and remodelling the way in which services are currently delivered
- Maximising Resources – ensuring the most effective use is being made of current available resources
- Early Intervention & Prevention – shifting services away from high end, costly unscheduled care to more preventative services.

In considering the interventions under these themes, SPGs will ensure consistency with the intentions, priorities and anticipated outcomes of the Plan.

8.4 Financial Implications of Achieving the Strategic Shifts

The financial implications of achieving the strategic shifts are set out within each of the priority areas in section 6 of this plan. All of these shifts will be affected by flexibly utilising the financial resources delegated to the IJB to fulfil its functions.

In the short to medium term, the main vehicle for facilitating the desired changes will be through the application of short term transitional funding streams with the Integrated Care Fund providing most of this resource. In addition, the IJB will deploy available resources as part of the additional specific Scottish Government funding for health and social care to focus on the agreed priority areas. Furthermore, many of the shifts in resources will be achieved through using existing core budgets in a different way.

A range of tests of change in the way services are delivered have been developed over recent years through the application of Reshaping Care for Older People funding and more recently, through the Integrated Care Fund. As we move through the period of the Plan, those tests of change assessed as making a positive contribution to improved outcomes for individuals, many of which are reflected in this Plan, will be scaled up, as appropriate, to become embedded within the way in which services are provided. In doing so, they will shift from short term funding arrangements to form part of core funding and investment arrangements.

The early investment in these priority areas will provide the conditions over the medium to longer term to enable more substantial shifts away from high cost areas, such as unscheduled hospital care and care homes, to community based services. Plan updates will highlight the scale and pace of the resource shifts achieved, and planned for, over the remainder of the planning period and beyond.

9.0 COMMISSIONING

Strategic commissioning will help us to realise our vision for Dundee through the way in which we design, develop and deliver improved and effective services that meet the needs of our changing population.

In developing this Plan we have already adopted a strategic commissioning approach in order to:

- Analyse and understand the evolving needs of our communities, so that we can shape the key strategic priorities that we are committed to deliver against
- Plan design and deliver appropriate services to meet the needs of our communities and secure value for money

We now need to complete the cycle for services in scope for the IJB by:

- Commissioning or directing in-house service provision and the wider health and social care market to deliver services in line with these priorities
- Reviewing and validating these to ensure they consistently meet the priority areas

The impact of commissioning services in line with the priorities will see a health and social care service landscape which reflects:

- More individualised packages of care where individuals will manage and control how their care needs are met
- More investment in services which focus on early intervention and prevention
- A wider range of supports available to carers to support their health and wellbeing
- More tests of change in the delivery of services across more of the communities we serve in order to increase the community capacity and resilience of these communities
- A roll out of services designed to meet the specific needs of local areas which focus on tackling health inequalities across more areas of the city
- A strategic shift in designing and delivering services on a locality basis
- Relatively less reliance of residential based forms of care in relation to the overall population needs, and relatively more reliance on housing with care, and home based care services

- A wider range of housing support options for individuals to help sustain them in their own homes, maintain independent living and reduce homelessness
- More accommodation with support for individuals with particular needs
- More services which provide access to training and employment
- More integrated service provision
- A greater range of telehealth and telecare supports
- A range of services which support the implementation of the Dundee Alcohol and Drugs Partnership Strategy

The Outcomes and Performance Framework described in Section 11 will be used to assess the extent to which the changes in range, focus and shape of services within the Commissioning Strategy meet the expected outcomes and priorities. As part of the commissioning cycle, this will be a continual process, and commissioning intentions will be refined to respond to service areas which are not delivering intended outcomes, and to changes in demand and need.

10.0 WORKFORCE AND ORGANISATIONAL DEVELOPMENT

The vision for our integrated workforce is one that embraces partnership with our citizens to realise their aspirations and full potential. We will support our workforce to gain a greater understanding of individual and community needs. This will enable more locally informed responses and greater participation and engagement with the people in Dundee to improve their outcomes. Workforce development will focus on local solutions that are underpinned by a greater emphasis on self-directed, preventative and anticipatory approaches to support and care.

An understanding of the operating context of our population in Dundee is crucial to any future workforce planning and development. As the demographic profile and complexity of needs and expectations change, the increase in the demand for our health and social care services will be significant. This will present challenges and opportunities, particularly in the direct care sector in terms of labour supply. We will therefore recruit our future workforce from a wider range of backgrounds and communities to reflect the diversity of our population.

The Partnership will ensure that the workforce have the necessary skills, knowledge and confidence to provide people in Dundee with the highest quality of services. We will build on the excellent examples of integrated practice that already exist to explore more varied approaches to increase multi-sector and multi disciplinary learning and organisational development, by sharing good practice for example , induction, supervision and professional development.

We will develop new career progression routes that support flexible and responsive ways of working and the new roles that will emerge as the integration of health and social care services progress in the next five years.

The complexity of the health and social care integration requires effective, collaborative and visible leadership at all levels to drive the changes ahead to realise outcomes for the citizens of Dundee. The leadership role is crucial to promoting and sustaining a culture of collaboration and co-production underpinned by a shared vision and values.

Further details are in our Workforce and Organisational Development Strategy.

11.0 MEASURING IMPROVEMENT AND ENSURING SUCCESS

If we deliver on these priorities we believe we will be working to achieve the National Outcomes for Health and Social Care set out in Section 4 of this Plan.

We recognise that to measure our progress in achieving the National Outcomes, it will be essential to have in place an appropriate performance framework. It is the plan to put in place an Outcomes and Performance Framework (the Framework) for the Partnership that will allow us to carry out this task systematically and robustly.

The Framework will detail the range of performance indicators which are required to measure progress in achieving agreed outcomes. It will include, in particular, those which track our performance in progressing the actions linked to the eight priorities identified in this Plan, and the related shifts in the use of health and social care resources that we are seeking to achieve.

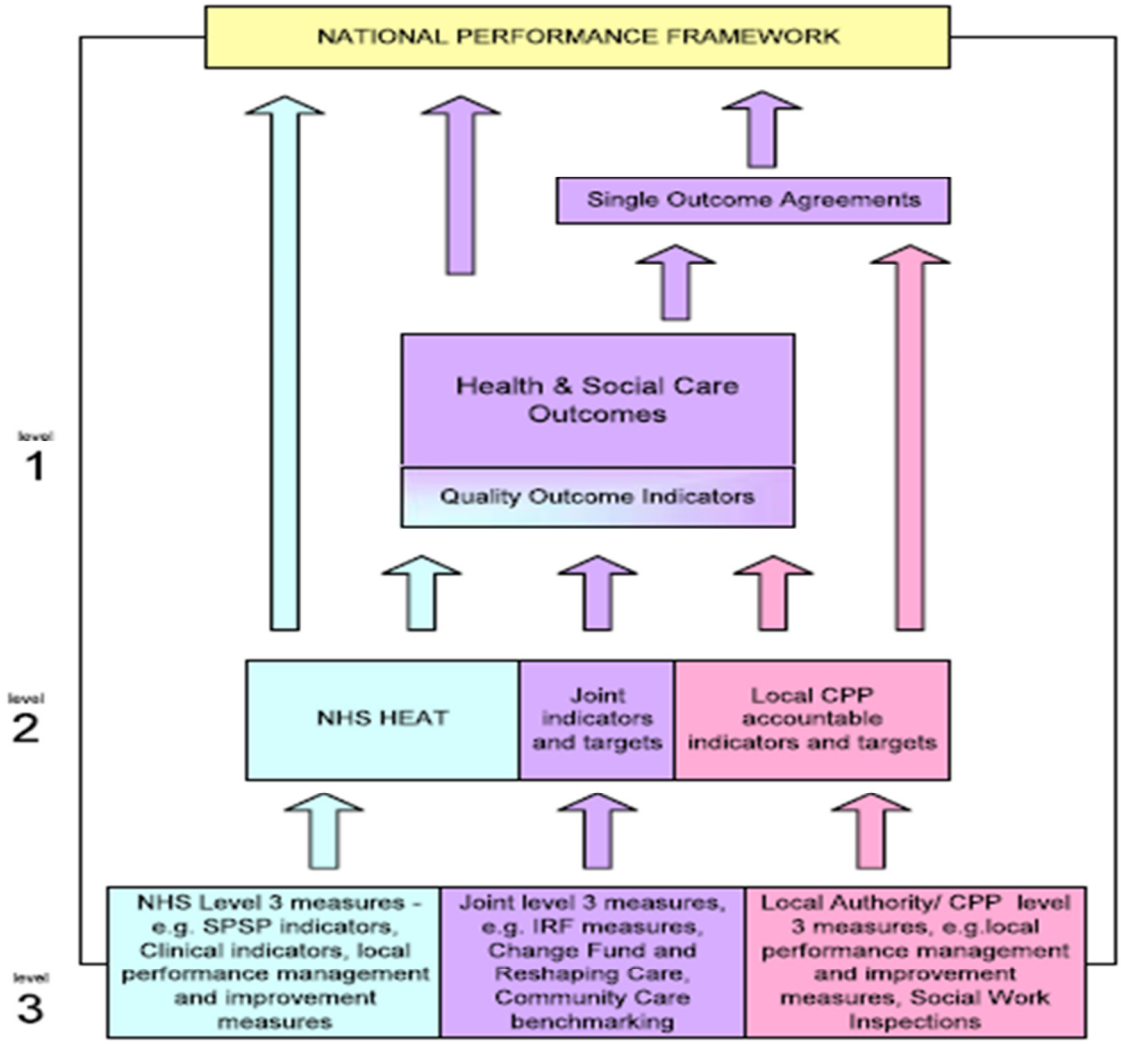
We recognise that the active collection and use of data, along with local intelligence, will help us to monitor the development of our health and social care services. As our Strategic Needs Assessment has demonstrated, the data gathered and analysed helps us to profile and better understand both geographical communities and communities of interest, and strengthens the evidence base for such decisions as to how we allocate our resources. The collation of other forms of data will provide management information that will help us to improve our governance, business processes, front line practice and quality of services delivered.

The overall aim of the Partnership is ensure that we are making a positive difference to the lives of the people of Dundee. We believe that an effective Outcomes and Performance Framework, that allows us to demonstrate continuous progress towards achieving our vision and planned outcomes for those who need health and social care services, is one of the keys to the success of integration in Dundee.

11.1 National Performance Framework

The Framework currently in development for the Partnership will link directly to the National Performance Framework. The National Framework is a tiered model which supports the delivery of an outcomes-based approach to performance, and it enables partners to jointly drive and track progress towards the delivery of agreed outcomes through better integration. The National Framework is shown in diagrammatic form below, together with a description of the three levels of reporting specified.

Figure 5: The National Performance Framework



a) Level 1

High level outcomes used to drive health and social care quality. These are now represented by the nine National Health and Wellbeing Outcomes and the core suite of 23 statutory integration indicators referred to in Section 4 of this Plan.

b) Level 2

Publicly accountable indicators and targets for Health Boards, Community Planning Partnerships and Health and Social Care Partnerships/Integration Authorities used to drive short to medium term improvement and agreed to impact significantly and positively on the Level 1 outcomes.

c) Level 3

Extensive range of indicators/measures used for local improvement and performance management, including core sets of specific

indicators for national programmes. This will also include information from self-evaluation and external scrutiny activity.

11.2 National Health and Wellbeing Outcomes and Indicators

As detailed at Section 4.2 of this report, the Scottish Government has developed nine National Health and Wellbeing Outcomes which the Partnership, and other Integration Authorities, are required to deliver and report against. These National Outcomes are referred to as 'Health and Social Care Outcomes' in the National Performance Framework shown above.

The Scottish Government has also specified a core suite of twenty three quantitative and qualitative indicators to support the assessment of performance against the nine National Outcomes (referred to in the National Performance Framework above as Quality Outcome Indicators).

The data required to measure performance against these quantitative indicators is to be collected by Integration Authorities through their core data gathering, recording and reporting systems. Information to assess progress against the qualitative indicators will be gathered through the Scottish Health and Care Experience Survey to be carried out bi-annually at a national level. Integration Authorities will be required to make arrangements to conduct such a survey locally on alternate years.

The Scottish Health and Care Experience Survey is a postal survey and is the successor to the G.P. and Local NHS Services Patient Experience survey. It asks about people's experiences of their G.P. practice, out-of-hours services, and their outcomes from NHS treatments. It now also covers areas of care and support provided by local authorities and other organisations to support the delivery of the National Outcomes for health and social care.

11.3 National Performance Reporting Requirements

Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states that each Integration Authority must prepare a performance report for the 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 during any given reporting year. There is a requirement for each Integration Authority to publish this report, to a prescribed form and content, within four months beginning with the end of the reporting year. For future performance reports there is a requirement to provide a comparison between the reporting year and the preceding five reporting years (or, where there have been fewer than five preceding reporting years, all preceding reporting years).

The required form and content of this Performance Report includes an assessment of each Integration Authority's performance in relation to the following:

- progress against the national health and wellbeing outcomes
- the carrying out of the integration functions in accordance with the integration delivery principles
- the planning and carrying out of functions in localities
- best value in planning and carrying out integration functions
- financial planning and performance
- the Authority's actions in response to any scrutiny and inspection of services
- actions taken to review the Plan

Each Integration Authority is required to provide a description of the extent to which the arrangements set out in the Plan, and the expenditure allocated in the financial statement, have achieved or contributed to achieving, the National Health and Wellbeing Outcomes. Detailed information about performance against the key National Indicators and measures will be required, to help inform each Authority's local assessment of progress against the National Outcomes.

More detailed information regarding the requirements for the Annual Performance Report will be included in the Framework, when finalised.

11.4 Dundee Outcomes and Performance Framework

The Framework being developed for the Partnership in Dundee is the framework within which all performance improvement and outcome reporting will be organised and managed. It will draw together and reflect the sum of the health and social care data that is currently gathered for local and national performance reporting purposes, as well as incorporate the new data reporting requirements for integration.

In essence the Framework will aggregate and integrate into one composite dataset all of the datasets that are currently in use for performance reporting across the health and social care services that are delegated to the Partnership. As an integrated dataset it will record data regarding performance at all three levels described in the National Performance Framework.

The following are examples of the data which will require to be collated and reported at each of the three levels of our local Framework:

a) Level 1 – High Level Outcomes

- National Health and Social Care Outcomes and Statutory Indicators
- Single Outcome Agreement (SOA) Indicators

b) Level 2 – Publicly Accountable Indicators and Targets

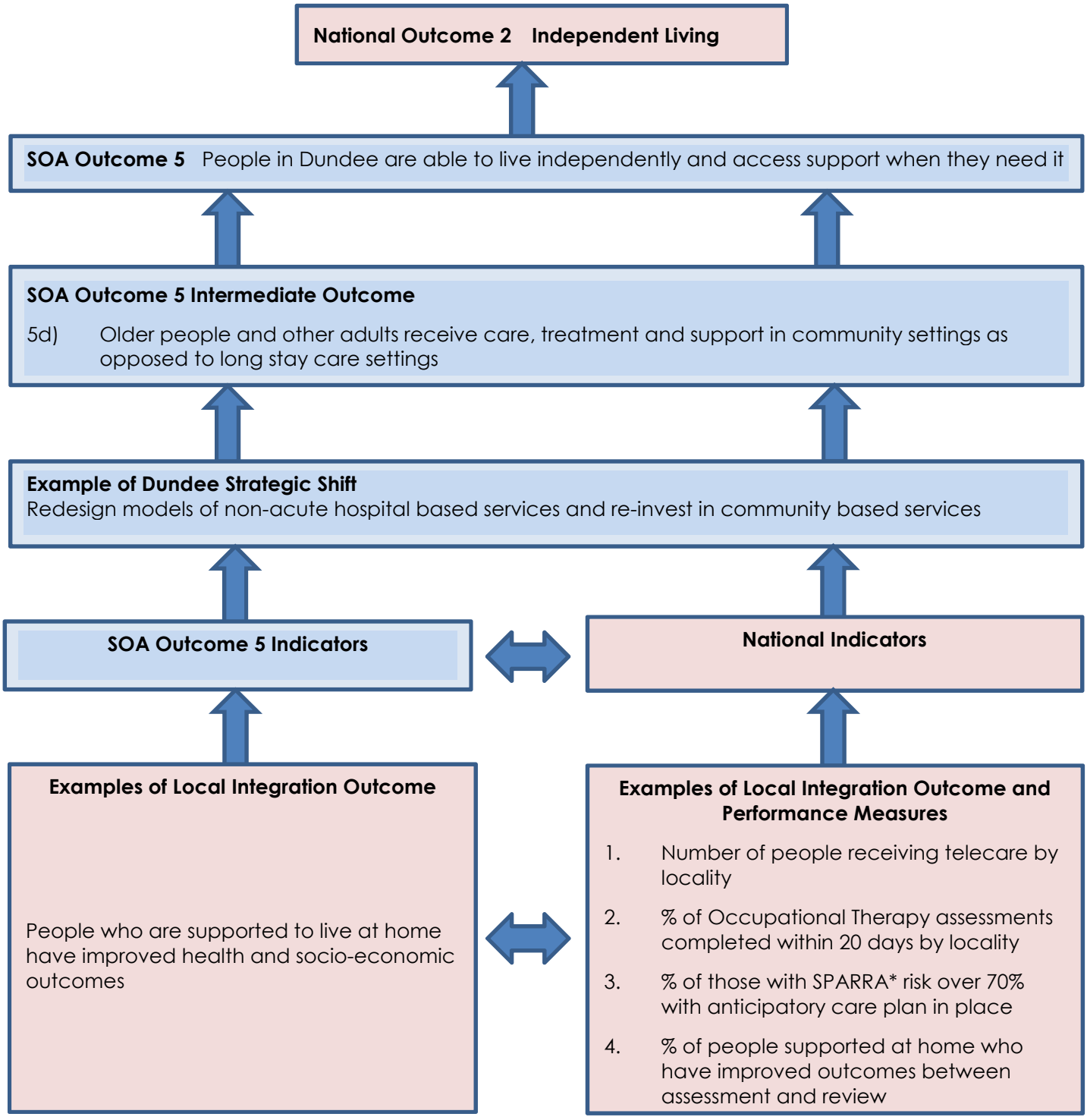
- Social Care indicators
- Heat targets
- Performance at locality level
- Balance of care (between institutional and community based care)

c) Level 3 – Indicators and Measures for Local Improvement and Performance Management

- Performance indicators for Clinical, Care and Professional Governance
- Change Fund and Integrated Care Fund measures
- Finance reporting
- Internal and external inspection and audit reports

There is a requirement in particular, to ensure that the measures agreed to track our performance in progressing the actions linked to the eight priorities identified in this Plan, and the related strategic shifts in the use of health and social care resources, are actively built into the Framework. The following diagram shows how this will work in practice, and expands on the example shown in Table 3 above. This details the links between Outcome 5, National Outcome 2 and their related indicators, and one of the key strategic shifts identified as being required to support the achievement of these outcomes. Figure 5 also includes a possible local integration outcome, together with measures, designed to monitor progress against this particular strategic shift.

Figure 6: Local strategic shifts and outcomes within integrated framework



*SPARRA is the Scottish Patients at Risk of Readmission and Admission is a risk prediction tool which predicts an individual's risk of being admitted to hospital as an emergency inpatient within the next year.

In line with this approach there will be a suite a such local integration outcomes and measures, which will be aligned with existing reporting requirements within an integrated outcomes and performance framework. A report bringing forward the proposed structure of the Framework is being presented for approval by the IJB.

11.5 Annual Performance Report

In accordance with the reporting requirements placed upon all Integration Authorities, an Annual Performance Report will be produced for the Partnership. Locally this will be supported by four quarterly performance reports, which will compare data with any previous quarters for that financial year, and also the same quarter during the previous year.

Before presentation to the IJB for discussion and approval the annual and quarterly performance reports will be discussed by the relevant Senior Management Teams and the Integrated Strategic Planning Group. Following consideration of the content of these performance reports, improvement Actions will be identified and agreed with lead officers, and incorporated into relevant action plans.

Dundee's Strategic Needs Assessment highlighted the level of variation in health and social inequalities between and within LCPP areas across the city and showed the value of examining need on a smaller geographical scale. For this reason the data presented in Performance Reports for the IJB will, where possible, report on data at whole population, care group, LCPP and neighbourhood levels.

11.6 Local Reporting Arrangements

We recognise that it is important to ensure that the performance indicators used locally to show progress against agreed targets and outcomes are 'fit for purpose' and that these are kept under active review. The Performance Framework will reflect all of the Partnership's reporting requirements and identify lead officers who are responsible for each dataset and associated work streams.

The performance data required will initially be submitted using the Council's Corporate Performance Management Tool (called Covalent). Lead officers will be required to update at agreed intervals relevant data, along with narrative and position statements, that relate to the progress of key actions against strategic priorities and 'directions of travel'. They will be able to view the data in dashboard format, as well as analyse the data longitudinally, and this will assist with service planning and improvement actions. Data from Covalent will then be extracted and used to prepare the Quarterly and Annual Performance Reports.

11.7 Improving Access to and Quality of Data

We know that robust information systems will ensure good evidence is available to underpin the process of performance monitoring and management, as well as local strategic planning and decision making.

Work is ongoing currently to improve the level of information that is available to our Partnership, to link data relating to the same person that is currently held separately by agencies, and to strengthen our capacity to use such linked data. This will help us to integrate service delivery, improve performance management and better inform our joint strategic planning.

The Social Work Information Team is currently working with the Scottish Government and the NHS Information Services Division (ISD) in Scotland to develop a linked, individual level, longitudinal social care dataset for the Dundee Partnership. The Health and Social Care Data Integration and Intelligence Project (HSCDIIP) is responsible for leading on this development through a phased programme of work with our Partnership.

One of the aims is to make it possible to track pathways and 'flows' through services and identify resource usage and duplication. This information can be used to direct the targeting of resources towards key points in the pathway, in support of earlier intervention and prevention, and to relieve 'pressure points' where additional resources are required to improve flow and the quality of services for the people who are receiving them.

It is also planned that further work will be taken forward in Dundee to access linked data from ISD's Integrated Resource Framework (IRF). The IRF dataset can provide non-identifiable cost data for people who have used health and/or social care services during a given reporting period. Detailed analysis can then be undertaken at LCPP and, where possible, neighbourhood level, to identify patterns in resource usage, and variations in health and social inequalities, across and within communities. Such information will be used for strategic planning purposes, helping to determine where resources are currently being used, and where any strategic shifts should be made, in line with agreed priorities.

We recognise as a Partnership the contribution good quality intelligence and data can make to improving the quality of services and supporting our performance management and strategic planning activities. Through these and other areas of development, we are actively seeking to strengthen our access to information and our capacity to make best use of it. The establishment of an effective Performance Framework for our Partnership is one of the first important steps in helping us to achieve this.

11.8 Governance Arrangements

The steps we have described to allow us to measure improvement and ensure success will be underpinned by our core governance arrangements.

The four strands of these arrangements are:

- Our national and local performance frameworks
- Our financial due diligence requirements
- Our clinical and professional care governance arrangements, which will include the regulatory requirements of appropriate professional bodies
- Our participation and engagement activities as outlined in our Participation and Engagement strategy.

The IJB will seek assurances that recommendations presented to them by the Chief Officer have been scrutinised against these four key strands prior to decisions being made relating to the work of the Partnership.

12.0 LEADING AND SUPPORTING CHANGE

Organisational and cultural change on a scale required to fully meet the requirements of integration will not be easy. The right leadership style and philosophy, one which generates commitment to a shared purpose developed through collaboration, is most likely to be the one which delivers large scale changes.

The priorities, as outlined in this Plan, give our workforce and partners a clear sense of focus. The strategic shifts required outline where the focus of the key changes need to happen.

The involvement of our wide strategic partnerships in the development of this Plan means that we are confident that the delivery of the Plan will be seen as a shared goal, with practical experience and expertise visible and incorporated into the ambition of the strategy.

Those who are directly responsible for ensuring that this Plan happens will be supported to lead on and influence the process of the changes required. This will include harnessing the 'hearts and minds' of staff and partners at all levels, creating a culture of permissions and encouragement to develop tests of change, and supporting service improvement through learning from the experiences of those who have used our services.

12.1 Leadership Development

Supporting staff and partners to develop as strong, confident and competent leaders is crucial to the success of integration. The implementation of the Workforce and Organisational Development Strategy will lay out how we will provide ongoing opportunities to support staff and partners to help them recognise their leadership strengths and use these to lead more collaboratively and effectively in supporting integrated care.

12.2 Community Engagement

Dundee is recognised as having a well established model of engagement at community levels through the work of the LCPPs. Our intention will be to work closely with the current LCPPs to build on and enhance our understanding of the wishes and needs of local communities. As we progress this development of community led co-production and co-design, we would anticipate the development of local engagement arrangements which involve key staff from the Partnership, build meaningful opportunities for service redesign and support the development of a continuing dialogue.

In addition, the implementation of our Participation and Engagement strategy will support all stages of development and will 'sense check' our intentions and progress.

13.0 WHAT HAPPENS NEXT

Thank you for taking the time to read this Plan.

What Do You Think?

The Partnership want your views on the Plan, in order to ensure that it best supports what services should look like in the future so that they can be more personalised and responsive to the needs of people in Dundee.

The suite of consultation materials consist of the following:

Document 1: The Draft Strategic and Commissioning Plan
Document 2: The Housing Contribution Statement
Document 3: The Draft Interim Equality Outcomes

These three documents make up the main consultation materials to be looked at and should be considered in relation to the specific consultations questions asked.

In addition to the above, there are the following Companion Documents which contain supplementary information that will support the implementation of the Plan.

Companion Document 1: The Strategic Needs Assessment
Companion Document 2: The Interim Participation and Engagement Strategy
Companion Document 3: The Draft Workforce and Organisational Development Strategy
Companion Document 4: Integrated Equality Impact Assessment

The four Companion Documents are only available on request to minimize unnecessary distribution due to their volume. If you would like to be sent any of these documents electronically then please contact:

dundeehsci@dundeecity.gov.uk

The Consultation is now open and will run from 27 January 2016 until 17 February 2016.

You can access an electronic version of the consultation information from the home page of Dundee City Council, or NHS Tayside using the following link:

http://consult.dundeecity.gov.uk/limesurvey/index.php/628745/lang-en

This allows you to complete the consultation process and return your views online.

This phase of consultation will lead to the preparation of the final Plan in March 2016. The published Plan will be available from April 2016.

Once the Plan is approved its implementation and review will be supported by an ongoing programme of engagement.

APPENDIX – Glossary of Terms

Phrase	Definition
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.
Asset-Based Approach	Mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.
Care Package	A term used to describe all the different types of care that make up the total care received by an individual. For example, they may receive support from Community Alarms or a mobile warden, and have home care. All these services together make up the 'care package'.
Care Pathway	The route followed by the service user into, through and out of NHS and social care services.
Care Plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible to the individual in whatever form is suitable to them.

Phrase	**Definition**
Carer	Someone who spends a significant proportion of their time providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Change Fund	As part of the Reshaping Care for Older People initiative, short-term funding was provided to NHS Boards and local authorities to refocus health and social care of Older People towards prevention and early intervention. The Fund ceased to be allocated from April 2015, with some services sustained as part of mainstream health and social care services.
Co-location	Co-located services are those that are established physically and organisationally as part of an integrated service. Co-location can be a key enabler in the development of integrated working.
Community Capacity	Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.
Community Planning	Community Planning is a process by which public agencies work in partnership with communities, the independent and third sector to plan and deliver better services. The partnership process has been in place for 10 years and is led by a Board of representatives from the Dundee City Council, NHS Tayside, Job Centre Plus, Dundee and Angus college, Scottish Enterprise, Skills Development Scotland, Scottish Fire and Rescue, Police Scotland, Tayside Partnership for Transport, and the third and independent sectors.
Co-production	Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where

Phrase	Definition
	activities are co-produced in this way, both services and neighbourhoods become far more effective. There is a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators, including service users and the community taking over some of the work done by practitioners.
Emergency admissions	Unplanned admissions to hospital inpatient services.
Enablement	Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.
Equality Impact Assessment (EQIA)	EQIA is a strategic process to be considered when planning a new, or redesigning an existing, policy, function or service.
Home Care or Care at Home	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 and are accountable for dealing with routine aspects of a care plan or service.
Hub	Area where principal community-based services will be concentrated. Likely to cross several locality and neighbourhood areas.
Independent sector	The independent sector encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and home care providers as well as consultancy and research work.

Phrase	**Definition**
Integration Joint Board (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.
Locality	Local defined area within each neighbourhood.
Long-Term Conditions	Longterm conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support, medication and other therapies. Longterm conditions become more prevalent with age.
Morbidity	The incidence or prevalence of a disease or of all diseases in a population.
Mortality	The death rate, which reflects the number of deaths per unit of population in any specific region, age group, disease, or other classification, usually expressed as deaths per 1000, 10,000, or 100,000.
Multi-disciplinary Team (MDT)	A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.
Multi-morbidity	Multi-morbidity is the presence of two or more longterm health conditions.
Neighbourhoods	Defined communities within Dundee City.
Occupational Therapy	Occupational Therapy gives people the tools and skills to promote health, wellbeing and independence through participation in activities or occupation. Occupational Therapists will analyse the patient's physical, psychological,

Phrase	Definition
	social, cognitive and environmental needs, and provide rehabilitation, or develop new strategies to enable patients to continue to do the activities they need or want to do.
Organisational Development Plan/Strategy	Deliberately planned, organisation-wide effort to increase an organisation's effectiveness and/or efficiency and/or to enable the organisation to achieve its strategic goals.
Personalisation	Personalisation is a means of giving service users more control over the services and support they receive, and includes self directed support, asset management and co-production.
Physiotherapist	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible.
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by G.P. practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and Allied Health Professionals.
Psychology	Psychology is the scientific study of human thought and behaviour. Clinical psychologists help a wide range of people of all ages with all sorts of problems, such as emotional or mental health problems, and people with difficulties with their thinking, such as problems with memory or perception after a head injury, a learning disability or dementia.

Phrase	**Definition**
Secondary Care	Medical care provided by a specialist or facility. Referral would be made by a primary care physician that requires more specialised knowledge, skill, or equipment.
Self Directed Support	The support individuals and families have after making an informed choice on how their Individual Budget is used to meet the outcomes they have agreed. There are four options that Partnerships have a duty to offer: • the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support. • the supported person chooses their support and the local authority makes arrangements for the support on behalf of the supported person. • the local authority selects the appropriate support and makes arrangements for its provision by the local authority. • a mix of options 1, 2 and 3 for specific aspects of a person's support.
Self-Management	A service user and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more longterm conditions. It encourages people to take decisions and make choices that improve their health, wellbeing and health-related behaviours.
Shifting the Balance of Care	Changes at different levels across health and care systems intended to bring about better health outcomes for people.
Single Outcome Agreement (SOA)	The Single Outcome Agreement is an agreement between the Community Planning Partnership and the Scottish Government. Those using the agreed Community Planning Partnership identify priorities to be addressed and outcomes to be achieved. The SOA also includes an Action Plan to show how

Phrase	Definition
	performance targets and Performance Indicators measure progress.
Speech and Language Therapy	Speech and Language Therapists assess, treat and help to prevent speech, language and swallowing difficulties.
Strategic Commissioning)	The term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.
Telecare/Telecare	Telecare and telehealth is technology that can be used to help service users live safely and independently in their home.
Third Sector	The generic term for those involved in Health and Social Care Partnerships comprising non-governmental and non-profitmaking organisations or associations, including charities, voluntary organisations, community groups, tenants and residents groups, faith groups, housing associations, most co-operatives and social enterprises (provided profits are retained for the benefit of the members or community served), and most sports organisations.