ITEM No …4……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 15 APRIL 2026**

REPORT ON: **JOINT INSPECTION OF ADULT SERVICES IN THE DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP - FINDINGS AND IMPROVEMENT PLAN**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB13-2026**

1.0 PURPOSE OF REPORT

1.1 To inform the Integration Joint Board of the findings of the Joint Inspection of Adult Services for Dundee Health and Social Care Partnership, published by the Care Inspectorate and Healthcare Improvement Scotland on 10 March 2026, and to outline improvement activity arising from these findings.

2.0 RECOMMENDATIONS

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

2.1 Note the content of the inspection report published by the Care Inspectorate and Healthcare Improvement Scotland (attached as appendix 1).

2.2 Note the summary of inspection findings, including positive gradings, seven areas of strength, two good practice examples and areas for improvement (section 4.4).

2.3 Note that improvement activity relating to the four areas for improvement has already begun, and that future plans will be overseen by the Dundee Mental Health and Wellbeing Strategic Planning and Commissioning Group (section 4.4.5 and appendix 2).

2.4 Instruct the Chief Officer to make arrangements for a further update on the implementation and impact of improvement plans to be provided to the IJB no later than 31 December 2026.

3.0 FINANCIAL IMPLICATIONS

3.1 None

4.0 INSPECTION SCOPE AND PROCESS

4.1 In early August 2025 the Care Inspectorate and Healthcare Improvement Scotland notified the Chief Officer of their intention to undertake a joint inspection of adult service in the Dundee Health and Social Care Partnership under Section 115 of Part 8 of the Public Services Reform (Scotland) Act 2010. The inspection in Dundee was the seventh if the rolling programme of themed inspections currently being undertaken by the scrutiny bodies.

4.2 The joint inspection focused on the key inspection question; *How effectively is the partnership working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults?*

For Dundee, the inspection question was considered through the lens of people living with a mental illness (aged 18 to 65 years) and their unpaid carers. Themed inspections consider how well integration of services is supporting people's experience and outcomes. They do not consider the quality of specialist care for the specific group but rather seek to understand if health and social care integration arrangements are resulting in good outcomes. Through consideration of the experiences and outcomes of people living with a mental illness the scrutiny bodies build a picture of what is happening more broadly in health and social care integration and how well that is supporting experiences and outcomes for the wider population. The inspection scope included functions delegated to the IJB and related services delivered by health and social care partnerships.

4.3 The inspection process commenced mid-August 2025, with evidence gathering / field work phases finishing in late December 2025. Activity undertaken included submission of a position statement by the Partnership, a workforce survey, case file reading, engagement with service users and carers through a survey and variety of meeting formats, and focus groups with members of the workforce, including practitioners, managers and senior leaders.

4.4 INSPECTION FINDINGS

4.4.1 The inspection report for the Dundee Health and Social Care Partnership was published on 10 March 2026 (contained within appendix 1). Overall, ten quality indicators were considered in the inspection process and grades of Good or above were awarded for all aspects:

Key Area	Evaluation
Key performance outcomes	Good[1]
Experiences of people who use our services	Good
Delivery of key processes	Good
Strategic planning, policy, quality and improvement	Very Good[2]
Leadership and direction	Good

Overall, the inspection report reflects very positively on work undertaken over the last ten years within integrated community-based services to strengthen access to mental health and wellbeing supports, with subsequent positive impact on service user outcomes and experiences. Benchmarked against the four Partnership areas inspected through the lens of people living with mental illness, Dundee achieved the highest evaluations.

4.4.2 The joint inspection team identified seven key strengths within the Dundee Health and Social Care Partnership:

- Health and social care partnership leaders demonstrated a clear vision and commitment to improving services and outcomes for people living with a mental illness. There was a positive focus on service transformation which included collaboration with people.

"Leaders demonstrated a clear vision and commitment to improvement. They were aware of the level of service transformation required and worked together to produce good outcomes for people living with a mental illness."

[1] An evaluation of good applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement.
[2] An evaluation of very good will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement.

"The partnership made good progress in engaging people with a mental illness in its strategic work, resulting in meaningful involvement of people with lived experience in shaping both policy and the development of services."

- Most people had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life.

"Relationships with staff were impactfully positive for people, and some people expressed that their lives had been thoroughly transformed for the better."

"People experienced statutory and third sector services working effectively together to meet their agreed personal plan."

- Most carers were supported to continue in their caring role.

"Carers were acknowledged and supported in their caring role. Support came from both dedicated carers' services and services that worked with the person they cared for."

"Early intervention and prevention support for carers was evident through direct access to short break funding, without requiring assessment from statutory services."

- The partnership demonstrated strong collaboration with third and independent sector services to deliver care, support, and therapeutic interventions for people living with a mental illness and carers.

"Service providers were extremely positive about the support they received and had confidence in the partnership's commitment to ethical, collaborative commissioning."

"The partnership demonstrated effective interagency collaboration, where third sector providers could raise concerns and collectively plan support for individuals, ensuring responses were well informed and tailored to people's needs."

- There was an emphasis on early intervention and prevention with the network of peer support workers and community projects to alleviate the precipitating factors of mental illness.

"The partnership established an impressive range of resources that supported people's mental health, with a strong emphasis on early intervention and prevention."

"Almost all people living with a mental illness in Dundee who had been helped by a peer support worker, experienced this as having a very positive impact on their lives."

- The partnership was committed to investing in direct access, community-based initiatives to support an improvement in mental health and wellbeing outcomes.

"Direct access services offered spaces where people could go without demands or conditions being placed on them."

"Hope Point provided an immediate, compassionate response for people experiencing emotional distress and crisis."

- The partnership had robust commissioning and contract monitoring processes that involved providers and people who use services.

"The partnership was successfully delivering ethical, outcome focused commissioning."

"The partnership had clear strategic commissioning intentions which were focused on delivering high-quality, person-led services for people and carers."

4.4.2 Two good practice examples were also selected by the join inspection team:

- Peer Support Network – the report outlines that this approach has delivered clear positive outcomes for people, improving confidence, hope and engagement with services through support grounded in lived experience. The approach is integrated within statutory and third sector services and has helped to strengthen recovery journeys, reduce isolation, enhance people's ability to navigate services and to participate more fully in their communities.

- Hope Point – the report highlights that Hope Point has improved access to timely mental health support by providing a compassionate 24/7 alternative to traditional crisis pathways, helping people receive support earlier and preventing escalation to crisis. The strong partnership model and peer-led approach were found to have resulted in high uptake, positive experiences and nationally recognised improvement in crisis response and emotional wellbeing outcomes.

4.4.3 The joint inspection team also identified four key areas for improvement:

- The partnership should ensure that people and carers understand their rights and options under the Social Care (Self-Directed Support) Scotland Act 2013 and the Carers (Scotland) Act 2016 and that these rights are met.

- Further work was required to strengthen integration for people with multiple health conditions.

- The partnership should progress work to capture, aggregate and analyse personal outcomes data for people and carers.

- Leaders should ensure consistent evaluation as to the effectiveness and impact of strategic improvement and development.

4.4.4 The areas of strength and for improvement contained within the inspection report are very closely aligned to the Partnership's own position statement submitted as part of the inspection process. The production of the position statement was informed by a range of performance management, quality assurance and self-evaluation activity undertaken by the Partnership and by commissioned services. The statement reflected the significant improvements that have been taken forward across services and supports for adults living with a mental illness since 2016 and the hard-work, dedication and expertise of the frontline mental health workforce despite the very challenging circumstances associated with the post pandemic period, including increased demand for health and social care supports and resource and workforce pressures. Close alignment between the position statement and inspection report suggests that local quality assurance and self-evaluation processes are robust and also means that the areas for improvement are recognised within and being progressed via both mental health specific strategic and delivery plans and the HSCP's overall annual delivery plan.

4.4.5 The Health and Social Care Partnership is required to agree with the allocated Care Inspectorate Link Inspector the improvement actions that have been identified the to address the four key areas for improvement. A summary of the identified improvement actions is contained within appendix 2. This includes several actions that were already part of Partnership improvement and delivery plans and that are being progressed by relevant teams and services. Where necessary, additional actions have been agreed and incorporated into relevant plans. The progress of these actions will continue to be monitored via the Dundee Mental Health and

Wellbeing Strategic Planning and Commissioning Group, with an overview of progress being provided to the IJB before the end of 2026.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has been assessed to identify impacts on strategic risk management. No impact has been identified, either in relation to the strategic risks currently contained within the IJB's strategic risk register or the identification of any additional, emerging risks.

7.0 CONSULTATIONS

7.1 The Chief Finance Officer, Heads of Service Health and Community Care, members of the Inspection Preparation Group and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

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

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

9.0 BACKGROUND PAPERS

9.1 None

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Chief Officer

DATE: 12 March 2026

Arlene Mitchell
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APPENDIX 1

Joint inspection of adult services

Integration and outcomes – focus on people living with mental illness

Dundee Health and Social Care Partnership

March 2026

Contents

PART 1 – About Our Inspection

Background

The Care Inspectorate and Healthcare Improvement Scotland share a common aim that the people of Scotland should experience the best quality health and social care. We work together to deliver programmes of scrutiny and assurance activity that look at the quality of integrated health and social care services and how well those services are delivered. We provide assurance that gives people confidence in services. Where we find that improvement is needed, we support services to make positive changes.

Legislative Context

The Public Services Reform (Scotland) Act 2010 places a duty on a range of scrutiny bodies to cooperate and coordinate their activities, and to work together to improve the efficiency, effectiveness, and economy of their scrutiny of public services in Scotland. Healthcare Improvement Scotland and the Care Inspectorate have been working in partnership under the direction of Scottish Ministers to deliver joint inspections of services for adults since 2013.

The Public Bodies (Joint Working) (Scotland) Act 2014 sets the legislative framework for integrating adult health and social care. The aim of integration is to ensure that people and carers have access to good quality health and care services that are delivered seamlessly and contribute to good outcomes. This is particularly important for the increasing numbers of people with multiple, complex, and long-term conditions. The Care Inspectorate and Healthcare Improvement Scotland have joint statutory responsibility to inspect and support improvement in the strategic planning and delivery of health and social care services by integration authorities under Sections 54 and 55 of the Act.

Ministerial Strategic Group Report

In February 2019, following a review of progress with integration, the Ministerial Strategic Group for Health and Community Care made proposals for improvement. In relation to scrutiny activity, the Ministerial Strategic Group proposed that joint inspections should better reflect integration, and specifically, that the Care Inspectorate and Healthcare Improvement Scotland should ensure that:

- strategic inspections were fundamentally focused on what integrated arrangements are achieving in terms of outcomes for people

- joint strategic inspections examined the performance of the whole partnership – the health board, local authority and integration joint board, and the contribution of non-statutory partners to integrated arrangements, individually and as a partnership.

Inspection Focus

In response to the Ministerial Strategic Group recommendations, the Care Inspectorate and Healthcare Improvement Scotland set out our planned approach to joint inspections. Our inspections seek to address the following question:

> "How effectively is the partnership working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults?"

To address the question over the broad spectrum of adult health and social care services, we are conducting a rolling programme of themed inspections. These look at how integration of services positively supports people's experiences and outcomes. These thematic inspections do not consider the quality of specialist care for the specific care group. They are simply a means of identifying groups of people with similar or shared experiences through which to understand if health and social care integration arrangements are resulting in good outcomes. We will examine integration through the lens of different care groups which, taken together, will allow us to build a picture of what is happening more broadly in health and social care integration and how this supports good experiences and outcomes for people.

The inspection in the Dundee Health and Social Care Partnership was the seventh in the series of inspections, and the fourth to consider the inspection question through the lens of people living with a mental illness.

We use the definition of mental illness from the National Mental Health and Wellbeing Strategy, 2023 which is:

"Mental illness is a health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life. If left untreated, mental illnesses can significantly impact daily living, including our ability to work, care for family, and relate and interact with others.

"Mental illness is a term used to cover several conditions, (for example depression, post-traumatic stress disorder, schizophrenia), with different symptoms and impacts for varying lengths of time for each person. Mental illnesses can range from mild through to severe illnesses that can be lifelong."

National issues and context

The Scottish Government's priorities for improvement in mental health services were set out in the Mental Health Strategy 2017-27 and the Mental Health and Wellbeing Strategy 2023.

Health and social care partnerships across the country, including Dundee, were facing several challenges. These challenges affect the planning and provision of the range of health and care services, including mental health services.

Several recent inspections have highlighted that across the country:

- demand for health and social care is increasing
- the health and social care sector face ongoing challenges with recruitment and retention. This puts the capacity, sustainability, and quality of care services at considerable risk.

Developing systems which support staff to work in a more integrated way is another area where there is a national challenge. This includes sharing information across and between agencies. It has been highlighted and addressed in Scotland's Digital Health Care Strategy which was produced by the Scottish Government and COSLA in October 2021.

Explanation of terms used in this report.

When we refer to **people**, we mean adults between 18 and 64 years old who are living with a mental illness.

When we refer to **carers**, we mean the friends and family members who provide care for people and are not paid for providing that care.

When we refer to **the health and social care partnership,** or **the partnership**, or **the Dundee partnership**, we mean Dundee Health and Social Care Partnership which is responsible for planning and delivering health and social care services to adults who live in Dundee.

When we refer to **staff** or **workers**, we mean the people who are employed in health and social care services in Dundee, who may work for the council, the health board, or for third sector or independent sector organisations.

When we refer to **leaders,** or **the leadership team,** we mean the most senior managers who are ultimately responsible for the operation of the health and social care partnership.

There is an explanation of other terms used in this report at Appendix 2.

PART 2 – A Summary of Our Inspection

The Partnership Area

Dundee is Scotland's fourth largest city with a population of 150,390. The city of Dundee is situated on the north coast of the mouth of the Tay Estuary and covers 24 square miles, making Dundee the smallest local authority by area in Scotland. In 2020, there were more women 77,003 (52%) than men 71,817 (48%) with 13.8% of the population aged between 16 and 24. This is due to the high number of students who tend not to remain in the city beyond the end of their studies. Overall, there is a decreasing population in Dundee.

Dundee has the second lowest life expectancy in Scotland. In Dundee life expectancy is 76.7 years, whereas it is 79.1 years in Scotland as a whole. This is primarily associated with a high prevalence of long-term conditions and multi-morbidity. Dundee continues to have one of the highest suicide rates in Scotland, however, in 2024 the number of probable suicide deaths decreased to 25, compared to 30 in 2023. Dundee remains one of the areas in Scotland with the highest prevalence of drug-related deaths and hospital admissions; in 2024, there were 42 such deaths (a reduction from 46 deaths in 2023).

Deprivation in Dundee is high with the SIMD 2020 reported that 36.6% of the population lives in the 20% most deprived data zones (SIMD quintile 1). Overall Dundee is the fifth most deprived local authority area in Scotland. There is a higher rate of unemployment with 11% for Dundee compared to 8.1% for Scotland in 2020.

Dundee has the second highest rate of adults in Scotland who reported that they live with a mental illness, 162 per 1,000 population compared to 131 for Scotland. In 2023/24, 22.9% of Dundee's population had been prescribed medication for anxiety, depression, or psychosis. This equates to the fourth highest of all council areas in Scotland. In the 2022 Census, 24% of people in Dundee who reported living with a mental health condition rated their health as 'bad' or 'very bad'. In 2022, there were 16,844 carers in Dundee, with more than half (51.2%) spending up to 19 hours per week, and 26.4% spending more than 50 hours per week caring.

The population and landscape of Dundee can be separated into various geographical areas – health and social care partnership localities, local community planning partnerships, and neighbourhoods. Dundee Health and Social Care Partnership is one of three partnerships aligned to NHS Tayside. Mental health services are supported through a series of lead partner arrangements with Dundee Health and Social Care Partnership, the lead partner for psychological therapy services and Tayside adult autism consultancy team. Angus and Perth and Kinross Health and Social Care partnerships lead other specialist mental health services. NHS Tayside is responsible for operational delivery of mental health inpatient services, including Carseview Inpatient Centre.

In 2018, NHS Tayside commissioned an independent inquiry into mental health services, following concerns raised by MSPs to the Scottish Government. The *Trust and Respect* Report was published in February 2020, outlining five key cross-cutting themes and five service areas requiring improvement. In response the Whole System Change Programme in Tayside was compiled, along with other improvement programmes, with identified actions, targets, and timescales for service improvement. As one of the health and social care partnerships aligned to NHS Tayside, Dundee played a significant role in implementing the required system changes. An Audit Scotland report of NHS Tayside 2024/25 identified outstanding actions from the change programme making recommendations for improvement.

Governance of services delivered in Dundee are through the integration joint board, supported by the strategic planning advisory group and a range of strategic planning and transformation groups. The planning and delivery of services within the partnership are arranged into four localities. These localities are sub divided into eight local community planning partnership areas.

The local community planning partnerships have differing demographic, socio-economic and health profiles. The map below shows the eight local community planning partnership areas in Dundee. The partnership has profiling data at local community planning partnership level.

Summary of our Inspection Findings

Key Strengths

- Health and social care partnership leaders demonstrated a clear vision and commitment to improving services and outcomes for people living with a mental illness. There was a positive focus on service transformation which included collaboration with people.

- Most people had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life.

- Most carers were supported to continue in their caring role.

- The partnership demonstrated strong collaboration with third and independent sector services to deliver care, support, and therapeutic interventions for people living with a mental illness and carers.

- There was an emphasis on early intervention and prevention with the network of peer support workers and community projects to alleviate the precipitating factors of mental illness.

- The partnership was committed to investing in direct access, community-based initiatives to support an improvement in mental health and wellbeing outcomes.

- The partnership had robust commissioning and contract monitoring processes that involved providers and people who use services.

Priority areas for improvement

- The partnership should ensure that people and carers understand their rights and options under the Social Care (Self-Directed Support) Scotland Act 2013 and the Carers (Scotland) Act 2016 and that these rights are met.

- Further work was required to strengthen integration for people with multiple health conditions.

- The partnership should progress work to capture, aggregate and analyse personal outcomes data for people and carers.

- Leaders should ensure consistent evaluation as to the effectiveness and impact of strategic improvement and development.

Our Inspection methodology (See Appendix 1)

The inspection of Dundee Health and Social Care Partnership took place between August 2025 and December 2025.

- We received 62 completed surveys from people and carers and spoke to 60 people living with a mental illness and 16 carers. Our engagement with people and carers was conducted through 65 individual conversations and three focus groups. The conversations informed us of individual experiences of using health and social care services.

- We reviewed 33 records selected at random from an initial pre-inspection return of 383 records. All cases involved adults aged 18–64 living with a mental illness. Three records were identified by the partnership as demonstrating effective integrated working between health and social work services. Following the record review, we met with 10 multidisciplinary teams (52 staff in total), as well as three people who use services and six carers.

- We conducted a staff survey and received 198 completed surveys from staff, managers and leaders from health, social work and the third and independent sector across the partnership.

- We spoke with 92 members of staff. They were from health, social work, occupational therapy, third sector social care service providers and included frontline staff, service planners, commissioners, and managers.

- We conducted site visits to Carseview Inpatient Centre, Hope Point, and services within the Dundonald Centre and Alloway Centre. We attended the mental health and wellbeing strategic planning and commissioning group and the adverse events management group meeting.

- We reviewed evidence provided by the partnership to understand their intended vision, aims, strategic planning and improvement activities for health and social care services.

Evaluations

The following evaluations have been applied to the key areas inspected. Further information on the six-point scale used to evaluate the key areas can be found in Appendix 3.

Key Quality Indicators Inspected		
Key Area	**Quality Indicator**	**Evaluation**
1 - Key performance outcomes	1.2 People and carers have good health and wellbeing outcomes.	**Good**
2 - Experience of people who use our services	2.1 People and carers have good experiences of integrated and person-centred health and social care.	**Good**
	2.2 People's and carer's experience of prevention and early intervention	
	2.3 People's and carer's experience of information and decision-making in health and social care services	
5 - Delivery of key processes	5.1 Processes are in place to support early intervention and prevention.	**Good**
	5.2 Processes are in place for integrated assessment, planning and delivering health and care.	
	5.4 Involvement of people and carers in making decisions about their health and social care support.	
6 - Strategic planning, policy, quality, and improvement	6.5 Commissioning arrangements	**Very Good**
9 - Leadership and direction	9.3 Leadership of people across the partnership	**Good**
	9.4 Leadership of change and improvement	

PART 3 – What We Found During Our Inspection

Key Area 1 - Key performance outcomes

What key outcomes have integrated services achieved for people living with a mental illness and their carers in Dundee?

Key messages

- The partnership delivered positive health and wellbeing outcomes for most people experiencing mental illness.
- People received effective support that enabled them to look after their health and wellbeing.
- People were empowered to manage their mental health using tools and strategies given by services.
- The partnership did not routinely aggregate, analyse, and use data to monitor people and carer personal outcomes.

Table 1: National health and wellbeing outcomes

Outcome	Inspection Finding
1.	Most people were supported to look after their health and wellbeing as much as possible.
2.	Most people were supported to live as independently as possible.
3.	Most people experiencing care felt they were treated with dignity and respect.
4.	Most people had a better quality of life because of the health and social care services they received.
6.	Most carers were provided with some level of support to look after their health and wellbeing and reduce the negative impact of their caring role.
7.	Most people experiencing mental illness were kept safe from harm.

* Outcome 5 not evaluated due to lack of national data to benchmark against.

Public Health Scotland publishes annual integration performance indicators for every health and social care partnership in Scotland. These indicators help partnerships measure their progress on the national health and wellbeing outcomes set by the Scottish Government (see Appendix 4).

Overall, the partnership's performance on these indicators was positive. It performed above the Scottish average in seven of the nine national indicators. Performance within the local government best value network was also positive. The Dundee Integration Joint Board's Performance and Audit Committee provided regular oversight of national indicators and benchmarking data, offering assurance on performance management arrangements. While this was a good platform, variable use was made of the effective range of outcome monitoring tools available. Recognising the benefits of greater consistency, it had identified this as an area for further improvement and was actively progressing a new model of care incorporating a single, cross service outcome measurement tool. This represented a promising development, though it had not yet been fully implemented.

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

Most people living with a mental illness experienced positive outcomes and were well supported to look after their mental health. People found the range of services provided offered direct access to community support and was highly valuable in helping them to stay well. Increasing the availability of information about these services further enhanced choice and ensured more people accessed the right service to meet their needs.

People were empowered to manage the impact of mental ill health on their daily lives because they were provided with a good range of practical tools and strategies that enabled them to cope more effectively. Psychology and psychotherapy interventions were particularly beneficial. However, not everyone received all the support they needed. Where gaps were identified, this was commonly due to services not being available to meet their full range of needs, or because individuals had a negative experience of the support offered.

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

Services delivered supported most people living with a mental illness to live as independently as possible. Some people described their support as helping them to maximise their wellbeing. People benefitted from being involved in meaningful activities, enjoying friendships and relationships, living where they wanted to and feeling able to make plans for the future. People had positive experiences with staff that supported them to live as independently as possible and to build on their strengths and assets in a way that enhanced their daily lives.

Outcome 3: People who use health and social care services have positive experiences of those services and have their dignity respected.

Most people living with a mental illness found that health and social care staff treated them with kindness, compassion, respect, and dignity. We received recurring feedback from people being particularly positive about services where they felt welcome, accepted, supported, and valued. Almost all third sector and community-based services were perceived positively by those who took part in our engagement sessions. People appreciated services which enhanced their daily lives and helped them mitigate negative impacts of living with a mental illness and improved their sense of wellbeing.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Health and social care services supported most people to maintain or improve their quality of life. Relationships with staff were impactfully positive for people. Some people expressed that their lives had been thoroughly transformed for the better. People experienced a range of good outcomes including, having plans for the future, new long-term relationships, finding and maintaining employment, more and better-quality friendships, obtaining and enjoying their own home, exercising, and living more healthily.

Outcome 6: People who provide 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.

Most carers were supported in their caring role. Support was provided either through services that supported the person they cared for, or through the partnership commissioned services. There was also specialised support for carers experiencing mental health difficulties which was provided by mental health third sector organisations. Dundee Health and Social Care Partnership has continued to make steady progress in supporting carers to maintain their own health and wellbeing. The most recent National Health and Care Experience survey showed that 34% of carers in Dundee were supported to continue in their caring role, performing above the Scottish average of 31%. While this indicated a positive shift from previous years, it also highlighted that more needed done. Carers had the opportunity to access a wide range of community services for support which included a range of advice, holistic therapies, and short breaks.

Outcome 7: People who use health and social care services are safe from harm.

Most people living with a mental illness felt safe in the community. People felt safer living in their own homes because of the support they received and because they knew where to get help if they needed it. This assisted people to remain in their communities for longer which was the favoured outcome for most people.

Evaluation: Good

Key Area 2 - Experience of people and carers

What impact have integrated service approaches had on the lives of people living with a mental illness in Dundee?

Key messages

- Most people and carers experienced person-centred services that supported them to live as independently as possible in their communities.
- Most people benefitted from a range of direct access services that contributed to an improved quality of life for them.
- Most carers were well supported in their caring role.
- Most people and carers felt that workers listened to them and supported them to make choices about their treatment and care and how this was delivered.
- Few people or carers understood their rights or options in relation to self-directed support or to carer support, involvement, and information.

People and carers have good experiences of integrated and person-centred health and social care.

Overall, people had very positive experiences of person-centred health and social care services that made their lives significantly better. In some cases, they identified the impact of those services as "transformational" or "life changing." People particularly valued services that supported them to be independent and built on their strengths. People benefitted from a range of effective tools that helped them manage their own mental health. Services connected people with their local communities, enabling them to grow in confidence and make new friendships, broadening their social networks. They also supported people to be involved with community groups and activities, including volunteering opportunities.

The key feature of services that improved people's lives was that workers consistently treated them with dignity, respect, and kindness. People experienced these services as places where they felt welcome, accepted and "at home." Direct access services offered spaces where people could go without demands or conditions being placed on them. This helped people to feel valued and to value themselves.

Many people identified benefits from involvement with peer support workers, who worked as part of staff teams in several statutory and third sector mental health services. One person who used the service commented:

"I know that they've experienced mental health issues, and that helps them to understand my problems."

People whose needs were complex or who were assessed as being at significant risk were supported by community mental health teams and providers using the partnership risk management framework or 'care programme approach.' There were excellent examples of flexible approaches from services working together to support positive outcomes for individuals. People felt that the different disciplines making up community mental health teams communicated well with each other.

More widely, people experienced statutory and third sector services working effectively together to meet their agreed personal plan. Workers had a strong shared understanding of a person's needs and aspirations. They worked with them to achieve their desired outcomes. People felt workers communicated effectively with each other and supported them in a consistent way. This grew confidence in their care and treatment and made their lives better.

For people with multiple health needs, some services were not so coordinated. We identified the communication between mental and physical health services, substance misuse and mental health, and in-patient and community services as requiring more collaborative working. This made it harder for people to get the help they needed at the right time. A few people said they were not aware of care plans, or how their needs would be met or which services could help them. Some people attended separate meetings to discuss their social care needs and their mental health treatment. This felt repetitive to them, and it meant that not all workers had the same information. However, even where people perceived individual services as disjointed, in most cases they still valued them as having a very positive impact on their lives.

Carers were acknowledged and supported in their caring role. Support came from both dedicated carers' services and services that worked with the person they cared for. This took various forms. For example, workers regularly checking in with them, providing information, advice and providing short breaks, including them in care planning and reviews, and in some cases, treatment sessions. Some services offered specific support to carers of the people they supported, on a one-to-one or group basis.

Occasionally people were less positive about the impact of services. Sometimes, this was because the service did not fully meet their needs. In other cases, it was because people did not feel listened to, or treated with respect, kindness or understanding.

People's and carer's experience of prevention and early intervention

Primary care mental health services were easily accessible. People found this early help critically maintained or improved their mental health and wellbeing. They provided sound pathways to secondary and social care services that provided support on an ongoing basis.

Overall, people were well-supported by link workers based in GP surgeries. Link workers offered flexible, person-centred support and advice that helped people to address the practical and social issues that impacted negatively on their wellbeing.

People were also positive about the help they received from the Patient Assessment and Liaison Mental Health Service (PALMS), which provided direct access support and assessment for people who needed help with mental health issues. One person who used the service said:

"It's like the GP prescribes you a friend."

A few people did not experience a prompt or helpful GP response. This made it harder for them to access the help they needed, limiting opportunities to prevent distress and mental health crisis.

Overall people commented favourably on the wide range of effective direct access services that supported them with their mental health and wellbeing. These included a range of activity based, advocacy, therapeutic and one to one support services. A 24/7 emergency response was available through Hope Point. People could access these services at a time that suited them before they reached the threshold for formal mental health services or whilst they waited for appointments.

The popularity of direct access services meant that they sometimes had to operate a waiting list. However, the partnership was actively investing in ways to raise awareness of available services to help people understand which services would best meet their needs. This was having a positive impact and people were increasingly enabled to identify the services that were right for them.

Most people felt the help they received enabled them to identify and build on their own strengths and ability to help themselves, and to live as independently as possible in their communities. People spoke about holistic support that helped with all aspects of their lives such as support with physical health, learning to cook and understanding how to live a healthier lifestyle. In addition, there was help to manage their home and affairs and support available to take part in activities on a group or individual basis. People credited their support and treatment with enabling them to maintain relationships or remain at work. There was a sense that workers helped them to identify what was important for them, and to build towards a positive future. One person noted:

"The help I'm getting is helping me to believe in myself. I am beginning to think about what I want from my life and how I might get there."

People's and carer's experience of information and decision-making in health and social care services

People already in contact with mental health services usually found it straightforward to access any information they needed from the staff who helped them. Most people were well-informed about their mental illness and treatment and knew where to go for help in relation to other issues such as welfare rights or housing.

People who had not yet accessed mental health services, or who had a less positive relationship with their workers, did not always find it easy to know how to get help or to access services. This included the 24/7 mental health response available via Hope Point.

People who had access to good advice and information felt that this helped them to make meaningful decisions about their treatment and care. Many people were supported to make decisions about how their health and social care services were delivered. There were examples of workers respecting and implementing people's decisions, even if they disagreed with them. Opportunities to make choices about social care and support were further enhanced by the good availability of direct access services.

People were supported to share their views, and those views were respected by staff in health and social care services. They also felt involved in planning and reviewing their treatment and care. One person commented:

"I can say if something isn't for me...I make suggestions and the team do what I want."

Professionals listened and respected their wishes particularly regarding involving family members in discussions about their treatment and support. This was important for them. This was a challenge for carers when the person they supported preferred to limit the information shared. In these situations, carers reported it made their role more difficult. On occasion, carers had to advocate strongly to be heard, and a few felt they were not always treated with respect and consideration. Carers did not always fully understand their rights to self-directed support or to carer support and involvement unless advocacy services or mental health officers supported them.

Choice and control were not always supported using advance statements, having a named person, or using future care plans. A limited number of people had these in place. However, psychological services made regular use of future care plans. This fully ensured that people's views could be considered if their circumstances changed and they were unable to make decisions for themselves and was an exemplar for other services to adopt.

There were options to feed back about some services via Care Opinion and people could contribute to consultations through forums supported by Dundee Volunteer and Voluntary Action. These were valuable feedback approaches appreciated by people and carers.

Evaluation: Good

Good Practice Example: Peer Support Network

Dundee Health and Social Care Partnership has implemented and developed the peer support network within its mental health services over the last five years. Peer support workers, operating in both volunteer and paid roles, have become a key element in effective service delivery.

They are embedded in a range of statutory and third sector services, including: Penumbra, Wellbeing Works, SAMH, the mental health officer team, the Carseview Inpatient Centre and Dundonald Centres, the navigator team at Ninewells Accident and Emergency department, Dundee Volunteer and Voluntary Action (DVVA), Veterans First Point Tayside, and the community mental health teams.

Almost all people living with a mental illness in Dundee who had been helped by a peer support worker, experienced this as having a very positive impact on their lives.

They identified a number of elements that contributed to this positive experience.

- It could be less daunting to talk to someone who was not a professional.
- Peer support workers could understand what you were going through without having to spell everything out.
- It was empowering and hopeful to be helped by someone who had gone through what you were going through and come out the other side.
- Talking to a peer support worker meant that you were less likely to burden your friends and family with your mental health concerns.
- Peer support workers could “hold your hand” as you went through treatment and out for activities.
- Peer support workers could challenge gently without judging.
- Peer support workers could signpost you to other places you could get help and would go with you if you needed it.

Some people with lived experience of mental illness and of using services aspired themselves to become a peer support worker and felt that this might offer them a path to eventual employment within the health and care sector.

The partnership is currently developing a co-produced framework for peer support, led by Dundee Volunteer and Voluntary Action. The framework builds on learning from the past five years, with role mapping and impact evaluation shaping its design. The partnership intends to further embed peer support workers in the rollout of the NHS Tayside mental health model of care in its localities.

Key Area 5 - Delivery of Key Processes

How far is the delivery of integrated processes in the Dundee partnership effective in supporting positive outcomes for people living with a mental illness?

Key messages

- There was a good range of collaborative early intervention and preventative community-based support that put people with lived experience at their centre.
- The multiple points of entry and a 'no wrong door' approach to the care and treatment provided was widely implemented and impactful.
- There were positive processes in place that supported collaborative and joint working which included team co-locations and forums for multi-agency discussions.
- There was a strong network of peer support workers within secondary and community care services supporting the recovery and operational involvement of people with a mental illness.
- There was 24/7 self-referral support available to people which provided a compassionate response for people experiencing distress.
- The ability to identify carers was mixed across staff groups, with a need for improvement particularly for health staff.
- Information was not always available to people about their choices of self-directed support options or carers' rights to adult carers support plan.
- Community services were not always informed of people being discharged from hospital, limiting the ability for coordinated care.

Processes to support early intervention and prevention.

The partnership established an impressive range of resources that supported people's mental health, with a strong emphasis on early intervention and prevention. A notable strength was the breadth of access points available, reflecting a commendable commitment to a 'no wrong door' approach. This included a range of commissioned third sector organisations, alongside some of the partnership's own health and social care services. Together, these services ensured that people could seek help at the point of need, reducing barriers to timely support.

This approach was further strengthened by the widespread availability of distress brief intervention across the partnership. A strong network of locality based, direct access commissioned services meant that people could get support without requiring a referral to statutory services. Crisis services such as 'Hope Point,' which had integrated pathways with Police Scotland and the Scottish Ambulance Service demonstrated the commitment to emergency support for people experiencing distress and crisis. The significance of this work was formally recognised in March 2025 when Hope Point received the Divisional Commander Award at the Policing Partner of the Year Awards.

Primary care played a key role in the partnership's early intervention strategy. Services such as the link workers and patient assessment and liaison mental health service were accessible to individuals not currently engaged with any other mental health provision. Most GPs had completed distress brief intervention training. Importantly, there was no limit on how often people could access these supports, ensuring ongoing responsiveness to need. The health inclusion team was embedded in primary care and provided early and preventative support for homelessness, substance use and/or mental health. This team had strong links with other partnership services and provided physical health assessments along with support for mental health. They signposted and referred on to other services depending on the need of the individual.

Since 2022, the partnership delivered CONNECT, an early intervention in psychosis service, developed collaboratively with Healthcare Improvement Scotland and the lived experience network. Embedded within secondary mental health services, the model featured strong family involvement and assertive outreach. This proved to be a successful approach, with expansion planned to incorporate physical health monitoring and improved support during discharge from hospital.

The Local Fairness Initiative, initially established by the council targeted the Linlathen area due to the level of deprivation. The council along with partners including the Department of Work and Pensions, Social Security Scotland, Scottish Government and the third sector providers formed the Fairer Future Partnership Initiative, a community-led project aimed at improving resilience and wellbeing through targeted multi-agency support and interventions. Although not exclusively focused on mental health services, the work addressed underlying factors associated with poor mental health. This initiative was evaluated internally as providing positive improvements. The community planning partnership has used learning from the initiative to inform plans for the Whole Family Support pilot recently approved by the council. This approach focuses on the east end and north-east of Dundee. These are distinct initiatives supported by community planning partners.

Early intervention and prevention support for carers was evident through mechanisms such as direct access to short break funding of up to £400 annually, without requiring assessment from statutory services. This reflected an ethos of enabling carers to seek barrier free support as citizens of Dundee. Funding was flexible and could be used in any way that helped support their caring role including items to improve the carers wellbeing such as black out blinds to enable better sleep. The partnership also provided an accessible Dundee-wide online portal offering advice and support for carers.

While models such as the 'triangle of care' were in place within acute settings, the partnership recognised that consistent identification of carers within wider health services remained an area for improvement. This was highlighted as a learning and development priority in the Carers Partnership Assurance Report April 2025, though progress had been slower than anticipated.

There was not a dedicated carer advocacy service. This made it difficult for carers to be fully aware of their rights. These include the right to an adult carer support plan, or an emergency plan should they be unable to continue in their caring responsibilities. In some cases, this lack of emergency planning created uncertainty for carers about what would happen if they were suddenly unable to continue in their caring role.

For people living with a mental illness, future and emergency plans were occasionally being captured during assessment, care planning, and review processes, although there was limited evidence of this occurring consistently. Where future plans were documented, they were typically stored on social work systems and not routinely shared across the wider multi-disciplinary team.

Processes are in place for integrated assessment, planning and delivering health and care.

Multi-disciplinary working was a significant strength across the partnership's mental health services. Records we read demonstrated consistently strong collaboration in complex and regulatory situations. Staff made highly effective use of each other's expertise and showed a clear understanding of the contributions made by different disciplines. Discussions with staff reflected a high level of professional trust and a well-embedded culture of collaborative practice.

There was evidence of effective multi-disciplinary practice across assessment, planning, and review processes. All records reviewed contained assessments and reviews. Services were adjusted in response to people achieving planned outcomes, especially within structured risk-management frameworks such as the Care Programme Approach, MAPPA, MARAC, and the local authority's risk-management processes. In all high-risk or highly complex cases, a key worker was clearly identifiable, supporting continuity and oversight.

Less positively, outwith these formal structures reviews were often undertaken separately across sectors. These were not always fully integrated, and multidisciplinary input, particularly between health and social work, was variable This led to duplication of effort and, at times, fragmented decision making. Staff and people who use services reported uncertainty about the designated key worker, which weakened coordination. While strong interpersonal relationships between staff frequently resulted in positive collaboration, this success was reliant on informal and individual efforts rather than on robust, systematic processes.

Community mental health teams were co-located across east and west Dundee. Whilst they were predominantly nursing based, they operated as effective multi-disciplinary teams, with allied health professionals, social work staff, and medical staff collaborating well with one another. Other professional groups, such as psychology services, made use of the shared spaces**,** and staff reported an inclusive "open door" culture that facilitated informal consultation, shared problem solving, and professional dialogue. Both teams maintained weekly multi-disciplinary meetings, open to all staff, and these were regarded as high value forums where diverse

perspectives strengthened decision making and improved the quality of support offered to people.

The partnership established a service offering specialist support for people living with a personality disorder. This service benefitted from dedicated clinical leadership, and a specifically designed model of care with a basis on continuing and responsive supports, peer involvement, and a strong focus on reducing stigma. These developments ensured that people with a personality disorder received, personalised, and appropriate support and treatment.

The Multi Agency Consultation Hub in Dundee was established to deliver a coordinated, multi agency response for people experiencing coexisting mental illness and substance use needs. It demonstrated effective interagency collaboration, where third sector providers could raise concerns and collectively plan support for individuals. The multi-agency consultation hub model demonstrated collaborative partnership working, bringing together a broad range of staff to ensure that responses to care and support issues were well informed having received specialist advice. It ensured that individuals received appropriate support tailored to their needs and enabled third sector providers to continue in their support role.

Trauma informed practice was evident in multi-disciplinary work. There was a trauma steering group and senior leadership trauma champions. The steering group reviewed policies and procedures to ensure tools being used were appropriate and staff were trained in trauma informed approaches. An internal review report on the steering groups progress evidenced a positive shift in awareness of the impact of trauma with plans for the group to implement a complex intervention evaluation analysis to work being undertaken across the partnership.

Waiting times for services were mixed. The partnership acknowledged this variability and demonstrated a proactive and innovative response to addressing delays. For example, the partnership commissioned the service provider Scottish Autism to work collaboratively with Tayside Adult Autism Consultancy Team to provide support to autistic people, including those who self-identified and those awaiting assessment. The embedding of peer support workers enhanced the service model**,** offering lived experience perspectives that added depth and relevance to diagnostic and post diagnostic support. These workers also strengthened internal capacity by providing information, advice, and support to partnership staff. There was further evidence of workforce development, with additional training planned to enable more staff to deliver specialist advice to colleagues.

We saw evidence that social work teams had begun testing an improved triage approach, designed to address presenting needs at the first point of contact wherever possible. The aim was to reduce the time people waited for an assessment and meet needs at point of contact. Initial review of this process was showing promise. Routine audits of referrals demonstrated reflective practice and continuous improvement**.**

There was one permanent consultant psychiatrist in post, with the remaining posts filled on a locum basis. This reflected the national picture. The lack of permanent specialist medical staff reduced consistency in clinical decision-making and meant that people were not always able to see the same consultant for their reviews. This frustrated some people, as did the subsequent variable diagnosis resulting from it. Consequently, staff described some difficulties contacting or liaising with a consultant psychiatrist, which increased pressure on their role. The partnership made attempts to mitigate this risk by offering long term contracts to locums. They introduced open access sessions with psychiatrists when all staff, including those from third sector and independent providers, could attend for advice on issues.

The partnership and NHS Tayside made good progress at Carseview Inpatient Centre with a reduction in both delayed discharge numbers and overall admission rates. However, experiences of hospital discharge processes were variable. Although the discharge hub offered valuable short term, wraparound support for up to two weeks post-discharge, people using services, GPs, and community mental health team staff reported a lack of timely and reliable information about discharge decisions. There were instances where staff were unaware that a person under their care had been discharged, limiting their ability to plan safe transitions. Staff felt welcome when they attended discharge meetings, but were not routinely informed about them, reducing their capacity to contribute effectively.

There was considerable work conducted in Carseview Inpatient Centre to improve the ward experience and peer support workers were available to assist the transition to community after a hospital stay. Commendably, they recently achieved national recognition, receiving three awards for reducing violence and aggression and improving the therapeutic ward environment indicating positive cultural and practice improvements within inpatient care.

The partnership demonstrated a clear commitment to integrated working which could be further improved with some infrastructure changes including staff access to each other's IT systems. Social work staff were able to access health records, contributing to greater collaborative practices. However, the absence of reciprocal access for health staff presented a barrier to fully seamless information-sharing. Practical limitations, such as the lack of printers for social work staff in health settings and the absence of administrative support for multi-agency meetings, created avoidable inefficiencies and diverted valuable practitioner time away from direct work with people. These structural barriers reduced the full potential of what were otherwise strong and well-established multi-disciplinary working arrangements and a commitment to collaboration.

Involvement of people and carers in making decisions about their health and social care support

Most people and carers participated in care planning and review meetings. The meetings were held regularly and the input from people was respected. They engaged meaningfully in setting their goals and work was person centred.

The partnership made good progress in engaging people with a mental illness in its strategic work. The partnership's strong commitment to collaborative practice resulted in meaningful involvement of people with lived experience in shaping both policy and the development of services. There was evidence that co-production enhanced health and care pathways, including autism pathways. People who use services had been involved in the recruitment processes for staff, for example the approach was used for recruitment of a consultant clinical psychologist to progress pathways to support people with personality disorders. Dundee Volunteer and Voluntary Action supported the partnership with the collaborative work by involving people who use services and encouraging participation and feedback.

The partnership had also invested significantly in developing an extensive and well-established network of peer support workers across the city. Embedding these roles within a wide range of settings proved effective as contributions consistently strengthened engagement, enhanced recovery, and provided a valued feedback loop for people in their recovery journey. The support of peer workers encouraged people to participate in making choices with support and treatment deciding what was the most appropriate option for them.

Advocacy support was available through the Dundee Independent Advocacy Service, offering direct access for people with a mental illness. Although there were considerable waiting times, the service operated fast-track arrangements for priority groups, including inpatients, those subject to statutory measures, people in forensic mental health pathways, and individuals assessed as high risk.

The partnership took steps to strengthen involvement of carers, establishing a carers' partnership and developing an involvement framework from August 2024, with a scheduled refresh of the carers' strategy in 2026. However, carer engagement remained challenging, largely due to the demands of caring responsibilities. Despite this, carers who did engage, consistently reported a positive experience of support.

People and carers were not routinely provided with clear advice on self-directed support options and had limited understanding of how services were funded. Many people opted for direct access services, rather than choosing services that might better meet their needs but involved a cost. Commissioning low threshold, direct access services was a principal component of the partnership's strategy. This was actively pursued to give people choice following low uptake of self-directed support and difficulty recruiting personal assistants. However, having direct access to a service should not adversely affect choice of other self-directed support options.

We found staff confidence in discussing self-directed support pathways was limited, despite training opportunities being available to social work practitioners. There did not appear to be a consistent embedded practice of discussing all self-directed support options. These gaps hindered people's ability to exercise genuine choice and control over their support.

Almost all people, whose records we read, had effective responses to concerns about capacity with appropriate processes in place for assessment.

The third and independent sector organisations, psychology services, and the Carseview Inpatient Centre demonstrated a strong commitment to quality by routinely gathering feedback from people and carers about their experiences. Care Opinion and paper-based approaches proved to be highly effective in capturing rich, meaningful feedback. Throughout the inspection period, both the Carseview Inpatient Centre and NHS Tayside psychology services received consistently positive responses, reflecting good levels of satisfaction and confidence in the care provided.

Community mental health teams also employed a range of methods to understand patient outcomes and experiences, including feedback and complaints analysis, mortality and morbidity reviews, supervision discussions, and clinical audits.

Evaluation: Good

Good Practice Example: Improving the response to people experiencing emotional distress.

Hope Point

Hope Point in Dundee was established as a new community wellbeing centre that provided immediate, compassionate support for people experiencing emotional distress. It opened to the public on 31 July 2023 following a period of co-production led by a stakeholder group hosted by Dundee Volunteer and Voluntary Action. The resource was operated by Penumbra Mental Health in partnership with Dundee Health and Social Care Partnership.

The service delivered an immediate, compassionate response, followed by emotional and practical support based on a peer-support model led by individuals with lived and living experience. Hope Point was available as a drop in resource 24/7 and worked through established pathways with Police Scotland, the Scottish Ambulance Service, and the Crisis Resolution Home Treatment team. It offered follow-up care and integrated with Distress Brief Intervention and wider partnership services, providing clinical intervention when necessary.

Over two years, 2,061 people accessed support, with more than 10,000 contacts and 58% taking place out of office hours. The service expanded to support families bereaved by suicide, providing tailored peer support and information. Hope Point gained national recognition in the Scottish Government's Safe Spaces report and received the Policing Partner of the Year Award in 2025.

Key Area 6 – Strategic planning, policy, quality, and improvement

How effectively do commissioning arrangements in the Dundee partnership support positive outcomes for people living with mental illness?

Key messages

- The partnership had clear strategic commissioning intentions which were focused on delivering high-quality person led services for people and carers.
- The partnership commissioned a wide range of direct access low threshold services to support mental wellbeing.
- The partnership had successfully established the mental health and wellbeing strategic and commissioning group and the learning disability and autism strategic and commissioning group. These groups was developing a range of integrated services to improve outcomes for people.
- The partnership demonstrated strong collaboration with third and independent sector services to commission services, deliver care, support, and therapeutic interventions for people living with a mental illness and carers.
- The partnership was successfully delivering ethical, outcome focused commissioning. Service providers reported good productive relationships with the partnership and expressed confidence in the procurement and contract management processes.

Commissioning arrangements

The health and social care partnership had a 10 year strategic commissioning framework for 2023–2033. This clearly outlined the partnership's key strategic priorities which were informed by a comprehensive strategic needs assessment and the views of the public and staff from across the partnership. The priorities aligned well with other strategies and delivery plans relevant to people living with a mental illness and their carers.

The partnership's delivery plan, (October 2024 – March 2026), outlined how the partnership would deliver the priorities set out in the strategic plan. It was a comprehensive document, with a range of service specific delivery and improvement plans that fed into it. Among these, was the Mental Health and Wellbeing Strategic Plan (2019–2024), which specified how the partnership would develop and maintain high quality, integrated services for people living with a mental illness and their carers.

A review of the plan highlighted the key achievements and outstanding areas for improvement. The partnership was in the final stages of developing its new plan for mental health and wellbeing. Dundee Volunteer and Voluntary Action supported the co-production of the plan and facilitated a well-attended consultation event in April 2025 to capture the views of people with lived/living experience and communities. Feedback from the event and wider consultation activities informed the development of the draft mental health and wellbeing strategic plan. This was to be presented to the integration joint board in April 2026.

The strategic planning advisory group was responsible for the ongoing review of the strategic plan, aligning planning structures, and supporting budget co-production. This was effective and allowed the partnership to operationalise its high-level intentions to deliver a wide range of health and social care functions, activities, and services.

Alongside the partnership's plans, NHS Tayside had embarked on implementing its mental health model of care. The partnership was progressing implementation of the common principles of this model. This was in its early stages and had not yet been evaluated.

The partnership established two key planning groups for mental health. These were the mental health and wellbeing strategic planning and commissioning group, and primary care mental health and wellbeing strategic planning group. These groups were subject to the same oversight with a wide membership from the statutory and third sectors and demonstrated a particularly strong integrated and transparent approach to commissioning. A range of trauma informed, early intervention, prevention and recovery initiatives had been developed to support positive mental wellbeing, with a focus on capturing and improving outcomes for people and carers.

The integration joint board provided direction on strategic commissioning plans and the partnership's overall procurement strategy. The partnership had recently reviewed its social care procurement policy to introduce 'SMART' sourcing. The revised policy contained comprehensive procurement guidance with a strong focus on ethical and collaborative commissioning.

The partnership had a social care contracts team, with contracts officers dedicated to particular areas of service, including mental health and wellbeing. This was effective in fostering positive relationships and collaboration. The contracts officers worked with senior representatives from service providers and the partnership to manage and monitor contacts as part of the monitoring and review group.

Most service providers for people living with a mental illness were positive about their relationship with the partnership and had confidence in its commitment to ethical, outcome-focused commissioning. However, some service providers felt challenged because limited funding and lack of cost-of-living uplifts impacted on their ability to deliver the services for which they were commissioned. In addition, most service providers reported that they were supporting people with much higher levels of need than before.

In line with the partnership's Primary Care Mental Health and Wellbeing Strategic Delivery Plan (2024–2027), the primary care mental health multi-disciplinary teams were delivering a range of early intervention and prevention support through distress brief interventions, psychosocial support, and connecting people to community resources.

The partnership had commissioned a wide range of low threshold direct access services in response to the needs of the population across its localities. In a few instances, direct access services offered similar support to services requiring a financial assessment. People sometimes chose free services over those that were chargeable. This meant that some chargeable services were not used to their full capacity whist many direct access services had a waiting list. The partnership recognised this as an issue and was considering how to address it.

The partnership was committed to working collaboratively with the third and independent sectors and funded Dundee Volunteer and Voluntary Action to support the third sector. Among other supports, Dundee Volunteer and Voluntary Action's mental health team facilitated a service provider mental health forum which met six-weekly. Service providers were extremely positive about the support they got from Dundee Volunteer and Voluntary Action.

There were good examples of collaborative working between the partnership and the third sector. These included the development and establishment of Hope Point and a support service for survivors of bereavement by suicide. The partnership had established a service provider collaborative group for learning disability, autism, and mental health, demonstrating an innovative approach to commissioning support for people. The group comprised senior representatives of key service providers and had authority to independently commission services up to a set financial level in response to identified needs. It had the autonomy to decide which service provider would be commissioned to provide the service.

The Carers Partnership, jointly chaired by the partnership and the carers centre, played a pivotal role in strategic planning, monitoring, and service development. They were represented on the mental health and wellbeing strategic planning and commissioning group and contributed meaningfully to the development of the new mental health strategy.

Dundee Volunteer and Voluntary Action were instrumental in operationalising the partnership's commitment to keeping the voices of people with lived experience central to its commissioning activity. It supported the peer support network and employed peer support workers with a remit to ensure that the voices of people living with a mental illness and their carers were heard.

Overall, the partnership demonstrated a commitment to commissioning high quality, integrated services that were outcome focused and placed people at their centre. Progress had been made in implementing the priorities of the strategic commissioning framework, although the partnership was not yet fully able to evaluate the impact of its commissioning activity on outcomes for people living with a mental illness and their carers. The partnership was operating in a period of high demand and high pressure on budgets. The co-production of the new mental health and wellbeing strategy provided an opportunity to address these challenges.

Evaluation: Very Good

Key Area 9 – Leadership and direction

How has leadership in the Dundee partnership contributed to good outcomes for people living with mental illness and their carers?

Key messages

- Senior leaders fostered a collaborative culture with third and independent sector providers and a mature relationship with professional trust was evident.
- Leaders demonstrated a clear vision and commitment to improvement. They were aware of the level of service transformation required and worked together to produce good outcomes for people living with a mental illness.
- The partnership recognised the importance of the workforce, and an integrated workforce plan outlined the risk and challenges aligned to the risk register.
- Leaders promoted early intervention and prevention and a commitment to reducing health inequalities with a whole family approach in disadvantaged communities.
- The partnership lacked robust mechanisms to evaluate and oversee progress on strategic and development plans.

Leadership of people across the partnership

The partnership demonstrated a strong strategic commitment to improving outcomes for people living with a mental illness. There was a positive focus on service transformation, which included collaboration with people with lived experience and the third sector. A joint approach to strategic planning was evident, underpinned by a culture of shared aims and values. Staff were positive about their experiences of integrated working.

Partnership leaders promoted a strong culture of collaborative working and integration. There was robust evidence of leaders involving the third and independent sectors in all aspects of service design and delivery, with an emphasis on early intervention and prevention.

The Mental Health and Wellbeing Strategic Plan was being refreshed using co-production models led by Dundee Volunteer and Voluntary Action. Stakeholder groups had contributed to the design of the plan and other aspects of strategic planning. We saw very positive use of the Dundee Fairness Leadership panel, which comprised people with lived experience who made recommendations to the integration joint board and Dundee City Council. They played a significant part in progressing policies across the city, and their work had been recognised by the Joseph Rowntree Foundation. The group identified mental health and isolation as major challenges for people in Dundee. On their recommendations, work was undertaken to improve signposting of support options.

The partnership experienced challenges in leadership continuity and capacity due to turnover of key posts. Temporary arrangements were in place to maintain stability, but these limited the capacity for strategic development. Recent permanent appointments within the partnership senior management team allowed for leadership continuity and an increased focus on improvement. A new management structure, including mental health, was developed with the aim of strengthening integration, with lead posts held by social work and health staff. This represented a positive development. Integrated and co-located teams alongside integrated planning had provided staff with a solid foundation for collaborative working. However, there were inefficiencies in processes and systems where there was duplication. There was opportunity to streamline these processes which would improve the experience for people who used services and release staff time for other duties.

The revised senior management structure aimed to strengthen links between mental health services and other partnership responsibilities, to provide a cohesive experience for people who used services. Developing a whole-systems approach was recognised by the partnership as an area requiring work. The partnership made significant progress fostering a successful integrated approach aimed at addressing the social determinants of poor mental health, collaborating with community partners, and co-developing with the local community. This approach was positively evaluated by Dundee partnership, with plans to expand the model to other localities.

The partnership developed a comprehensive workforce plan aligned with the Scottish Government's 'five pillars' approach and incorporating staff feedback and audit recommendations. It was aligned with the partnership's strategic risk register and the strategic priority of 'valuing the workforce.' We found appropriate detailed actions had been identified to mitigate challenges and risks. There was evidence of recent actions being successful, with a reduction in staff turnover across the partnership and inpatient services almost eliminating the use of agency nursing. However, recruitment of permanent consultant psychiatrists and clinical psychologists continued to remain a challenge. This created a lack of continuity in treatment and placed additional pressures on teams. This issue reflected a national recruitment difficulty and despite repeated advertising the partnership had not succeeded in filling these posts on a permanent basis.

The Clinical Care and Governance Framework launched in 2025 remained under review. Its effectiveness could not yet be fully assessed. In common with most partnerships, governance reporting was through lines to NHS Tayside, Dundee City Council, and the Integration Joint Board. While this arrangement offered accountability to different organisations it also risked duplication and possible gaps. The partnership was aware of this possibility and had attempted to mitigate by introducing a clearer reporting structure.

The chief social work officer framework effectively supported local authority and social work statutory responsibilities and included a dedicated governance group. The chief social work officer was a member of the integration joint board and provided professional assurance of social work duties and safeguarding practices.

There were limitations in the quality and type of data used for governance reporting. The data submitted for governance consisted mainly of output measurement, which was useful for monitoring activity but did not provide evidence of the impact of services on people's and carers' outcomes. Although there were a range of mechanisms in place to gather outcome data, the partnership recognised the need for a more systemic, consistent approach. This would strengthen its governance dataset and demonstrate the effectiveness of services in meeting people's and carers' outcomes. Further benefits would include robust assessment, monitoring and evaluation of the performance and delivery of strategic and operational improvement plans.

Leadership of change and improvement

Following the publication of The *Trust and Respect* Report (February 2020) a whole system improvement programme was initiated with identified actions, targets, and timescales for service improvement. Dundee Integration Joint Board agreed a strategic commissioning framework with a subsequent partnership delivery plan to implement the required changes. The delivery plan operationalised the commissioning framework with good effect, defining actions and displaying strong alignment to other strategic documents. These documents remained in effect. We were not presented with evidence detailing the progress of the plan; however, documentation provided by the partnership demonstrated work undertaken in line with the actions. To facilitate the changes, staff, people who use services and carers attended workshops on design thinking in collaboration with the V&A Museum Dundee.

The delivery plan benefitted from positive stakeholder engagement with a focus on integration across health and care and third-sector providers. The intention was for progress to be monitored via annual performance reports to the integration joint board. We did not see evidence of a routine evaluation of the delivery plan's implementation. Evidence presented by the partnership showed that some of the identified actions were fulfilled, but more robust assurance and monitoring was lacking. We found there was a lack of structure to self-evaluation or other evaluative approaches across the partnership. It did not have a consistent means of assurance that actions were producing the intended outcomes.

Almost all staff agreed that joint working was supported by appropriate policies and procedures and that senior leaders had a clear strategic vision. However, some staff felt that senior leaders were not sufficiently visible and that management of change could have been done more effectively. While this may have been due to the recent senior leadership changes, it indicated a need for enhanced communication and change management approaches to maintain staff confidence.

We found clear evidence of creativity and innovation in the way the partnership responded to the needs of its population. The development of a whole system approach to mental health services with a shift towards increased co-production and partnership working with independent and third sector providers was clear and embedded. The development of Hope Point crisis response service is notable, demonstrating a commitment from the leadership to multi-agency working, and provides a pathway to access support away from traditional statutory crisis response. The partnership had an early intervention in psychosis service and a community team specialised in working with people who have a personality disorder, further demonstrating a dedication to providing effective services for specific needs. Similarly, the multi-agency consultation hub was an established forum where staff from different agencies could discuss and plan for people they support, who have a dual diagnosis of a mental illness and substance use. Developments such as these and the substantial investment in peer support with the policy of 'no wrong door' communities exemplify a culture of improvement and innovation.

Evaluation: Good

Conclusions

The partnership faced significant challenges with some localities experiencing high levels of deprivation and health and social care inequalities. Dundee has the second highest level in Scotland of the number of adults reporting they lived with a mental illness and one of the highest suicide rates nationally. The *Trust and Respect* Report required NHS Tayside and the partnership to conduct a whole-system re-evaluation of mental health services and implement major improvements while retaining public trust. The partnership was acutely aware of these issues and taken significant steps to address them.

The partnership performed well in key outcomes, with many indicators above the national average. The partnership had developed a solid foundation for improvement and demonstrated a strong collaborative culture with people and third-sector providers. Integration was clearly articulated as a shared responsibility, with strategic planning driving the agenda. Leaders recognised that achieving objectives was not the task of a single agency and allowed others to lead change in key areas.

The partnership displayed a culture of positive risk taking. Strategic and operational risk management processes were strong without being restrictive. This gave people freedom within a structure of support. Staff and service providers were empowered to make decisions reinforcing a culture of trust and accountability.

There was significant investment in early intervention and prevention. This included the development of a comprehensive peer support network and direct access community support services. These initiatives allowed people to access support without statutory referral or assessment, giving choice and control. The creation of the Hope Point service and the interagency crisis response was an example of effective integration achieving successful outcomes for people. However, this strategy has come at the expense of enabling some people's rights, and the partnership needs to further develop the right to choose individual self-directed support options to ensure its statutory obligations, as a minimum, are met.

The partnership's ambitious programme of improvement was not always monitored and evaluated robustly. It did not yet have data to measure the success and impact of the direct access services. While some services used different tools and approaches to identify outcomes the partnership did not routinely aggregate, analyse, or use data to monitor personal outcomes. This limited its strategic ability to determine the impact of health and social care polices. There was limited ability to determine what was working well for people and identify the success of key policies.

The partnership demonstrated resilience and commitment to improvement despite significant challenges. It laid strong foundations for integrated, person-centred care and invested in innovative approaches to prevention and crisis support. A continued focus on rights, governance, monitoring, and evaluation is required to maintain progress and deliver positive outcomes for people living with a mental illness and carers going forward.

Appendix 1: Inspection Methodology

The inspection methodology included the key stages of:

- Information gathering
- Scoping
- Scrutiny
- Reporting.

During these stages, key information was collected and analysed through:

- Discussions with service users and their carers
- Staff survey.
- Submitted evidence from partnership.
- Case file reading.
- Discussions with frontline staff and managers.
- Professional discussions with partnership.

The underpinning Quality Improvement Framework reflects a focus on peoples' and carers' experiences and outcomes.

Quality Improvement Framework and Engagement Framework

Our quality improvement framework describes the Care Inspectorate and Healthcare Improvement Scotland's expectations of the quality of integrated services. The framework is built on the following:

- The National Health and Wellbeing Outcomes Framework. These outcomes are specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe what integrated health and social care should achieve. They aim to improve the quality and consistency of outcomes across Scotland and to enable service users and carers to have a clear understanding of what they can expect.

- The Integration Planning and Delivery Principles. These are also specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe how integrated services should be planned and delivered.

- Health and Social Care Standards. These seek to improve services by ensuring that the people who use them are treated with respect and dignity and that their human rights are respected and promoted. They apply to all health and social care services whether they are delivered by the NHS, Councils or third and independent sector organisations.

The quality improvement framework also takes account of the Ministerial Strategic Group's proposals in relation to collaborative leadership, working with the third and independent sector, strategic planning and commissioning, clinical governance and engaging people, carers and the wider public.

Quality Indicators

We have selected a set number of quality indicators from our full quality improvement framework. The indicators relating to people and carers' outcomes and experiences are central to the framework. Other indicators consider the outcomes and experiences that integrated health and social care achieve.

The framework sets out key factors for each indicator and describes how they can be demonstrated. It also provides quality illustrations of good and weak performance. The indicators that will be inspected against are:

1.2	People and carers have good health and wellbeing outcomes
2.1	People and carers have good experiences of integrated and person-centred health and social care.
2.2	People's and carers' experience of prevention and early intervention
2.3	People's and carers' experience of information and decision-making in health and social care services
5.1	Processes are in place to support early intervention and prevention
5.2	Processes are in place for integrated assessment, planning and delivering health and care
5.4	Involvement of people and carers in making decisions about their health and social care support
6.5	Commissioning arrangements
9.3	Leadership of people across the partnership
9.4	Leadership of change and improvement

Engagement framework

Our engagement framework underpins how the Care Inspectorate and Healthcare Improvement Scotland will undertake and report on engagement with people using services and their carers.

The framework consists of 12 personal "I" statements, which focus on the experience and outcomes of people using services and their carers.

The 12 statements are:

No.	People	Carers
1.	From the point of first seeking support from health and social care services, things have been explained clearly to me, and I have been given the right information at the right time.	From when I first asked for help from health and social care services, things were explained clearly to me and the person I care for. We were given the right information, at the right time and in an understandable format.
2.	The advice, support, treatment, and care that I receive, help me to stay as well as possible for as long as possible.	The person I care for receives the advice, support, treatment, and care that they need, when they need it. This helps them to become and stay as well as possible, for as long as possible.
3.	I am fully involved in planning and reviewing my social care and support and in making meaningful decisions about my healthcare, in a way that makes me feel that my views are important.	I and the person I care for are always fully involved in plans and reviews of the help they receive in a way that makes us feel that our views are important.
4.	Professionals support me to make my own decisions about my health and social care and respect the decisions that I make.	Staff support the person I care for to make their own decisions about their health and social care and always respect the decisions that they make.
5.	My views, about what I need and what matters to me, are valued and respected.	I and, the person I care for, are supported to share our views, about what we need and what matters to us, and our views are always valued and respected.
6.	People working with me treat me with dignity and respect and show me care and kindness.	People from health and care services working with me and the person I care for treat us with dignity, respect our rights, and show us care and kindness.
7.	People working with me focus on what I can do for myself, and the things I can do to improve my own life and wellbeing.	Staff focus on what the person you care for can do for themselves and the things they can or could do to improve their own life and wellbeing.
8.	The health and social care and support I receive, help me to remain in and be part of my community.	The health and social care support the person I care for receives helps them to connect or remain connected with their local community or other social networks.
9.	Health and social care staff understand and acknowledge the role of my family and friends in providing me with care and support. Services work	Health and social care staff understand and acknowledge my role as a carer. Staff work together to ensure, that as far as possible, I am able to provide support at a level that feels right for me.

No.	People	Carers
	together to ensure that as far as possible, my family and friends are able to provide support at a level that feels right for them.	
10.	My carers and I can be involved in how health and care services are planned and delivered in our area, including a chance to say what is and is not working, and how things could be better.	I and the person I care for can easily and meaningfully be involved in how health and care services are planned and delivered in their area. This includes a chance to say what is and is not working, and how things could be better.
11.	I am confident that all the people supporting me work as a team. We all know what the plan is and work together to get the best outcomes for me.	I am confident that all the people supporting the person I care for work as a team. We all know what the plan is and work together to get the best outcomes for the person I care for us.
12.	The health and social care and support I receive has made life better for me.	The health and social care support that the person I support receives makes life better for us.

Appendix 2: Glossary

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act, every carer has a right to a personal plan that identifies what is important to them and how they can be supported to continue caring and look after their own health. This is called an adult carer support plan. (The equivalent for a young carer is called a young carer's statement). Adult carer support plans are required to include plans for how the cared for person's needs will be met in the future, including when the carer is no longer able to provide support.
Advance statement	This is a written statement, drawn up and signed when the person is well, which sets out how they would prefer to be treated (or not treated) if they were to become ill in the future. It must be witnessed and dated.
Alloway Centre	A community mental health facility housing the East Community Mental Health Team (CMHT) for Dundee
Anticipatory care plan	See Future Care Plan
Capacity	Capacity is the maximum amount of care, support, or treatment that day service or individual member of staff can provide.
Care and clinical governance	The process that health and social care services follow to make sure they are providing safe, effective, and person-centred care, support, and treatment.
Care opinion	A UK-wide online platform that allows people to share their experiences of health and social care services. It also allows services to respond to people's posts.
Care programme approach	A multi-agency approach to providing effective co-ordinated care to people with severe and enduring mental illness or learning disability, who have complex health and social care needs.
Carers' centre	Carers' centres are independent charities that provide information and practical support to carers. These are people who, without payment, provide help and support to a relative, friend or neighbour who cannot manage without that help. Carers' centres are sometimes funded by health and social care partnerships to provide support.
Commissioning	Commissioning is the process by which health and social care services are planned, put in place, paid for, and monitored to ensure they are delivering what they are expected to.
Community Mental Health Team (CMHT)	The CMHT is a community-based mental health service. The service includes a range of mental health experts who work together to provide assessment and treatment for people with suspected or diagnosed moderate to severe mental illness/ mental disorder.

Term	Meaning
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.
Compulsory Treatment Orders (CTOs)	Under the Mental Health (Care and Treatment) (Scotland) Act 2003. A compulsory treatment order (CTO) allows for a person to be treated for their mental illness. The CTO may set out several conditions that the person will need to comply with. These conditions will depend on whether the person must stay in hospital or in the community.
Contract Management	Contract management is the process that local councils and the NHS use to ensure that services they purchase from other organisations are of a good standard and are delivering at the expected level.
Coordination	Organising different practitioners or services to work together effectively to meet all a person's needs.
Core suite of integration indicators	These are indicators, published by Public Health Scotland to measure what health and social care integration is delivering.
Crisis response Team (CRT)	Community mental health service providing emergency mental health support
Community link workers	Community Link Workers are practitioners who work within GP practices providing non-medical support with personal, social, emotional, and financial issues.
Day services	Care and support services offered within a building such as a care home or day centre or in the community. They help people who need care and support, company, or friendship. They can also offer the opportunity to participate in a range of activities.
Direct payments	Payments from health and social care partnerships to people who have been assessed as needing social care, who would like to arrange and pay for their own care and support services.
Dundonald Centre	The centre is part of the NHS Tayside and Dundee Health and Social Care Partnership's community mental health services, focusing on recovery and wellbeing through various non-medical interventions and support groups
Dundee Drug and Alcohol Recovery Service	A joint health and social work team that offers support to people with alcohol or drug problems. The service includes addiction workers and addiction nurses who are supported by other professionals including doctors, psychology, and occupational therapists.
DVVA	Dundee Volunteer and Voluntary Action.
Early intervention	Early intervention is about doing something that aims to stop the development of a problem or difficulty that is beginning to emerge before it gets worse.
Eligibility criteria	Eligibility criteria are used by social work to determine whether a person has needs that require a social care service to be provided.

Term	Meaning
Emergency planning	These are plans that set out what will be done to maintain the health and wellbeing of people who need support when their normal support cannot be provided because of some kind of emergency, for example if a carer falls ill.
External service providers	Independent organisations from which the health and social care partnership purchases care to meet the needs of people who need support.
Future care plan	Unique and personal plans that people prepare together with their doctor, nurse, social worker, or care worker about what matters most to them about their future care. This was previously called an anticipatory care plan.
Health and social care integration	Health and social care integration is the Scottish Government's approach to improving care and support for people by making health and social care services work together so that they are seamless from the point of view of the people who use them.
Health and social care partnership	Health and social care partnerships are set up to deliver the integration of health and social care in Scotland. They are made up of integration authorities, local councils, local NHS boards and third and independent sector organisations.
Health promotion	The process of enabling people to improve and increase control over their own health.
Hope Point	A 24/7, walk-in mental health crisis and distress centre that provides immediate, non-clinical support to adults (16+) in the city. Operated by Penumbra Mental Health in partnership with Dundee Health and Social Care Partnership
Lead services	An arrangement whereby one health and social care partnership in a health board area takes responsibility for the planning and delivery of a particular aspect of health care for all the partnerships in the health board area.
I Matters	A tool to improve the experience of staff who work for NHS Scotland and in health and social care partnerships.
Independent sector	Non statutory organisations providing services that may or may not be for profit.
Integrated services	Services that work together in a joined-up way, resulting in a seamless experience for people who use them.
Integration Joint Board (IJB)	A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities. Each partnership is required to have at least two localities.
Low threshold services	Easy access services that people do not have to meet set standards or criteria to access, for example drop-in centres or conversation cafes. Low threshold services are often seen as

Term	Meaning
	a way of stopping people's health and wellbeing getting worse.
MAPPA	Multi agency public protection arrangements
MARAC	Multi-Agency Risk Assessment Conference
Mental Health Officer	A Mental health officer (MHO) is a social worker who has the training, education, experience, and skills to work with people living with a mental illness. Some laws in Scotland require that the local council must appoint an MHO to work with those living with a mental illness. Their duties include: • protecting health, safety, welfare, finances, and property. • safeguarding of rights and freedom. • duties to the court. • public protection in relation to mentally ill offenders.
National health and wellbeing outcomes	Standards set out in Scottish legislation that explain what people should expect to get from health and social care integration.
National Performance Indicators	Measures that are used to evaluate how well organisations are doing in relation to a particular target or objective. For example, the Scottish Government uses national performance indicators to understand how well health and social care partnerships are achieving good health and wellbeing outcomes for people.
Outcomes	The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life.
PALMS	Patient Assessment and Liaison Mental Health Service
Personal assistant	Somebody who is employed by a person with health and social care needs to help them live the best lives they can. People who need care can ask a health and social care partnership for a direct payment so that they can employ a personal assistant.
Person-centred	This means putting the person at the centre of a situation so that their circumstances and wishes are what determines how they are helped.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse.
Primary Care Mental Health Team (PCMHT)	The PCMHT is a nurse led service providing assessment and follow up for people who have common mental health problems. For example, depression, anxiety, and adjustment disorders. PCMHTs are usually staffed by mental health nurses, mental health practitioners, and psychologists, and have strong links with GP surgeries.
Procurement	The process that health and social care partnerships use to enter contracts with services to provide care or support to people.

Term	Meaning
Public Health Scotland	A national organisation with responsibility for protecting and improving the health of the people of Scotland.
Quality indicators	Measures that are used to evaluate how good a process is – how efficient and effective a process is in achieving the results that it should.
Rehabilitation	The process of helping a person to return to good health, or to the best health that they can achieve.
Residential care	Care homes – places where people live and receive 24-hour care.
Respite care	Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting but can also be provided via short breaks for the person and/or their carers.
Single point of access (SPOA)	To help people get support at the right time. A single point of access ensures that people needing health and social care support only need to contact one service. That service will ensure they are matched with the most appropriate response, depending on their needs at the time.
Seamless services	Services that are smooth, consistent, and streamlined, without gaps or delays.
Self-directed support	A way of providing social care that empowers the person to make choices about how they will receive support to meet their desired outcomes.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
Short breaks	Opportunities for people who need care and support and/or their carers to have a break. Its main purpose is to give the carers from the routine of caring.
Short term detention certificates (STDC)	An order made by a psychiatrist with the consent of a mental health officer. A STDC may be granted if a person has a mental disorder, is at risk and/or poses a risk to others, and their decision-making ability is impaired. It allows for a person to be detained in hospital for up to 28 days to provide treatment.
Strategic needs assessment	A process to assess the current and future health, care, and wellbeing needs of the community to inform planning and decision-making.
Supported living	Housing with attached support or care services. Supported living is designed to help people to remain living as independently as possible in the community.
Telecare	Telecare is the use of technology to provide health and social care to people in their own homes. It can include communication systems, alarms and monitoring of health status and symptoms.
Third sector	Organisations providing services that are not private or statutory. The term is often used to refer to voluntary

Term	Meaning
	organisations but can also refer to community organisations or social enterprise organisations
Workforce plan	A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met.

Appendix 3: Six-Point Evaluation Scale

The six-point scale is used when evaluating the quality of performance across quality indicators.

Excellent	Outstanding or sector leading
Very Good	Major strengths
Good	Important strengths, with some areas for improvement
Adequate	Strengths just outweigh weaknesses
Weak	Important weaknesses – priority action required
Unsatisfactory	Major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance which is sector leading and supports experiences and outcomes for people which are of outstandingly high quality. There is a demonstrable track record of innovative, effective practice and/or very high-quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. Whilst opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However, improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes which are as positive as possible.

An evaluation of **adequate** applies where there are some strengths, but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance, which is evaluated as adequate, may be tolerable in circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements must be made by building on strengths whilst addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the service provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

An evaluation of **unsatisfactory** will apply when there are major weaknesses in critical aspects of performance which require immediate remedial action to improve experiences and outcomes for people. It is likely that people's welfare or safety will be compromised by risks which cannot be tolerated. Those accountable for carrying out the necessary actions for improvement must do so as a matter of urgency, to ensure that people are protected, and their wellbeing improves without delay.

Appendix 4: The National Health and Wellbeing Outcomes

- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer.

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

- **Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected.

- **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

- **Outcome 5.** Health and social care services contribute to reducing health inequalities.

- **Outcome 6.** People who provide 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.

- **Outcome 7.** People using health and social care services are safe from harm.

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

- **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.

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Appendix 2

Inspection Improvement Recommendation	Action	Linked to…	Lead	Timescale
1.The partnership should ensure that people and carers understand their rights and options under the Social Care (Self-Directed Support) Scotland Act 2013 and the Carers (Scotland) Act 2016 and that these rights are met.	1.1 Create a simple rights-based information package • Produce plain-English materials explaining SDS options (1–4), ACSPs and emergency planning. • Embed these into all first-contact services.	Dundee Carers Strategy 2026-2032 / Personalisation Delivery Plan	Head of Health and Community Care / Acting Head of Strategic Services	October 2026
	1.2 Standardise staff practice and conversations across services / professions to support early identification and advice/information • Introduce an SDS/Carers Act "minimum practice standard" for social work, health staff, link workers and third sector. • Build short e-learning modules into the partnership's Workforce Plan. • Use opportunities within peer support networks and workforce practice forums to help explain rights in an accessible way.	Dundee Carers Strategy 2026-2032 / Personalisation Delivery Plan	Heads of Health and Community Care / Acting Head of Strategic Services	March 2027
	1.3 Explore options to ensure a collaborative approach that improves access to carer advocacy • Explore models of advocacy provision in place in other partnership areas. • Implement local Advocacy Strategy. • Incorporate advocacy information within rights-based information package.	Dundee Carers Strategy 2026-2032	Locality Manager, Mental Health and Learning Disabilities / Third Sector Partners	December 2026

	1.4 Strengthen routine monitoring and reporting • Add ASCP and SDS uptake indicators to management data sets	DHSCP Delivery Plan	Acting Head of Strategic Services	June 2026
2.Further work was required to strengthen integration for people with multiple health conditions.	2.1 Complete the implementation of the Team Around the Adult multi-agency adults at risk pathway, including the lead professional model.	Protecting People Delivery Plan	Heads of Health and Community Care / Acting Head of Strategic Services	March 2027
	2.2 Develop a coordinated approach to improving the physical health of people experiencing mental illness, including better physical-health monitoring, preventive care and co-produced approaches that consider lived experience of health inequalities.	Draft Dundee Mental Health and Wellbeing Strategic Plan	Mental Health and Wellbeing Strategic Planning Group	March 2027
3.The partnership should progress work to capture, aggregate and analyse personal outcomes data for people and carers.	3.1 Develop a Partnership approach to capturing evidence of the impact of services on outcomes for people. • Capture learning from examples of good practice in outcome measurement from across internal and commissioned services. • Improve systems for extracting and reporting information from contract monitoring processes. • Involve lived experience services and networks.	DHSCP Delivery Plan	Acting Head of Strategic Services	March 2027
	3.2 Implement Care Opinion across all Partnership services.	DHSCP Delivery Plan	Lead Officer, Data, Quality and Intelligence	December 2026

4.Leaders should ensure consistent evaluation as to the effectiveness and impact of strategic improvement and development.	4.1 Develop a Partnership Performance Framework and related reporting arrangements.	DHSCP Delivery Plan	Acting Head of Strategic Services	October 2026
	4.2 Develop a partnership approach to capturing evidence of effectiveness and impact. • Build this into the strategic review of third party commissioned services. • Develop interfaces with internal services to capture self-evaluation outcomes. • Improve oversight and reporting of relevant information of service evaluations	DHSCP Delivery Plan	Acting Head of Strategic Services	March 2027