



HEALTH AND SOCIAL CARE STRATEGIC AND COMMISSIONING PLAN

2016 - 2021

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FOREWORD

The Public Bodies (Joint Working)(Scotland) Act 2014 (the Act) requires NHS Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. The main purpose of integration is to use the available resources to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex and who require support from both health and social care at the same time.

We recognise the important role communication has to play in this process and the benefits of engaging with those who use services, their families, carers and the public, to involve them in the planning, development, delivery and continuous improvement of services. In order to support the Dundee Health and Social Care Partnership (the Partnership) we have developed this five year Strategic and Commissioning Plan (the Plan) to help us plan and deliver services for both current need and the needs of people in the future.

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

We want to make a difference to the lives of those who need our support. Our collective ambition is to achieve the best outcomes for families and communities, so people are at the heart of everything we do. Our communities are unique and their sense of place defines our work.

Doug Cross

Chair, Dundee Integration Joint Board

Ken Lynn

Vice Chair, Dundee Integration Joint Board

1.0 INTRODUCTION AND BACKGROUND INFORMATION

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

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

We know that while integrated care is often talked about it is not always delivered. The integration of health and social care across Scotland offers an unprecedented opportunity for us to develop and implement different ways of working at a local level to achieve shared goals, better experiences and better outcomes for the citizens of Dundee.

In a time of rising demand for services, growing public expectation and increasing financial constraint, it is essential that we make sure social care, primary care, community health and acute hospital services work well together and with other partners in a truly integrated way. Our values - professional and honest, listening and learning, being open and transparent and respecting and caring - sum up how we have approached this Plan.

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

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

The Plan has been developed with and through our localities, clinicians, professionals, the wider workforce and the population of Dundee. We know that any Plan that is not fully grounded in its local context is more likely to fail and we will ensure this is recognised through planning for localities.

Co-production with people living in local neighbourhoods across the city has been at the heart of this process, and our future conversations with those who use our services, their carers, families and local communities, will continue to guide our approach to integration. This will also allow the strengths and assets of local communities to be fully utilised to help improve the health and wellbeing of local people.

This Plan reflects the context within which we operate and is shaped around our vision.

Our Vision

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

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

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

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

1.1 Policy Context

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

This is in line with the Scottish Government's key goal to:

..focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.

Scotland Performs, Scottish Government Reporting Framework, December 2015

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

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

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

1.2 Strategic Commissioning

A strategic commissioning approach has been adopted in the development of this Plan. This approach is defined as follows:

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

Joint Improvement Team Advice Note, February 2014

1.3 Dundee Strategic and Commissioning Plan

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

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

We are aware of our use at times of formal language and professional jargon throughout the Plan. However some of the terminology we have used is relatively new, and some of the concepts we are referring to are complex and not easy to convey in plain language. We have noted in the text, where we can, the meaning of some of the terminology we have used, and appended is a Glossary of Terms section for further information. It is also our intention to produce other more accessible versions of this Plan. We hope that this will support access to the Plan for all those who need and wish to understand its contents.

1.4 Services the Strategic and Commissioning Plan Covers

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

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

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

1.4.1 Social Care Services to be Delegated

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

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

1.4.2 Community Health Services to be Delegated

Each Health Board must also delegate all adult primary and community health services, along with a proportion of hospital sector provision.

Health services which must be delegated to the IJB are:

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

1.4.3 Acute Hospital Care Services to be Delegated

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

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

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

1.4.4 Hosted Services

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

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

- Highly specialised or complex health services requiring specialist knowledge and expertise to provide quality of care
- Area wide services which are delivered from within a single site or location and are managed by a dedicated team of staff
- Small discrete services that would be very difficult to disaggregate out to be managed at a single IJB level
- Functions or services undergoing major change or transition where the delegation to a number of IJBs may disrupt the transformational change programme

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

The following services are currently planned and delivered across Tayside and will be hosted by Dundee IJB on behalf of other Tayside IJBs:

- Tayside Sexual and Reproductive Health Service
- Tayside Specialist Palliative Care Service
- Homeopathy
- The Centre for Brain Injury Rehabilitation (CBIR)
- Eating Disorders Service
- Nutrition and Dietetic Service
- The Medical Advisory Service
- Tayside Health Arts Trust
- Keep Well
- Psychology
- Psychotherapy
- The Corner

1.4.5 Housing Contribution Statement

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

The requirement to develop a local Housing Contribution Statement (HCS) is a statutory requirement under Section 53 of the Public Bodies (Joint Working) (Scotland) Act, 2014.

The Statement was implemented in 2015 through the introduction of the Scottish Government's HCS statutory Housing Advice Note (2015) which applies to Integration Authorities, Health Boards, and Local Authorities. The Advice Note outlines the significant contribution of the Housing Sector to the national health and social care integration agenda.

As a supporting document, Dundee's HCS outlines the contribution of the local Housing Sector to achieving the outcomes identified in this Strategic and Commissioning Plan for Dundee. The Local Housing Strategy is the primary strategic document for the provision of housing, housing support, and homelessness services in the city and is embedded in the city's Community Planning Partnership framework. Dundee's HCS, therefore, primarily reflects the health and social care housing related priorities that are outlined in the city's current Local Housing Strategy and its associated strategic housing documents.

The link to the Dundee HCS is included in the Document Links section of the Plan at Appendix 2.

2.0 WHO WE ARE

2.1 Integration Joint Board

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

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

The key functions of the IJB are to:

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

2.2 Dundee Health and Social Care Partnership

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

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

2.3 Links to Other Partnerships

There are well established partnership mechanisms currently in place in Dundee which involve the Council, NHS Tayside, Police Scotland, and a range of other key partners, in the planning, co-ordination and delivery of services. Joint working and the effective co-ordination of services across all of the key strategic partnerships is recognised as being essential to the integration of service delivery for individuals, carers, their families and communities across Dundee.

2.3.1 Partnership with NHS Tayside (Acute Services)

While the delegation of health services to the Dundee Health and Social Care Partnership does not include the majority of services within the NHS acute sector, there can be no doubt that the partnership with the acute sector will continue to be critical to the effective functioning of health and social care services in Dundee.

Whilst there is a continuing need for strong links to be maintained between primary care and hospital based services, there is also a need for a more widely integrated partnership approach to be developed, which strengthens the links and pathways between those services in the acute sector and those that are part of the new, fully integrated community based Dundee Health and Social Care Partnership.

This partnership approach is essential if we are to be successful in reducing avoidable admissions to, and length of stay, in hospital, and supporting more people to remain in their own homes for longer.

The Scottish Government has recently published 'A National Clinical Strategy for Scotland'. This Strategy emphasises the central importance of the role of people using services, their carers, and their community in the provision of support, as this approach allows people and communities to manage their own health. The Scottish Government recognises that:

A system that seeks to build on this, rather than supply alternatives, is likely to improve population health and wellbeing, as well as the individual experience and outcome of illness.

A National Clinical Strategy for Scotland, Scottish Government, February 2016

The vision is for services to be based around supporting people, rather than 'single disease pathways', with a solid foundation of integrated health and social care services based on new models of community-based provision.

The vision for the people of Scotland laid out in the Clinical Strategy and that which underpins the creation of Health and Social Care Partnerships are complementary. In recognising this, we are fully committed to working in partnership with NHS Tayside Acute Services to maximise the benefits of joint planning and the most effective use of collective resources, in our efforts to achieve a shared vision for the people of Dundee.

2.3.2 Partnership with Public Health

Public health services play an essential role in promoting and safeguarding the health of individuals and communities, and are key partners in the promotion of prevention and early intervention in the planning and delivery of health and social care services.

In a recently published Review of Public Health in Scotland (2015) there is a clear recognition of the many challenges faced, in improving and protecting health, reducing health inequalities, and improving and integrating health services and social care in

Scotland. The Scottish Directors of Public Health agree that implementation of the Review will contribute substantially to the effort being made in meeting these challenges at a local level.

Amongst some of the key recommendations contained within the Review, there is emphasis on the planned development of the public health workforce and a structured approach to utilising the wider workforce. This includes developing an enhanced role for public health specialists within Community Planning Partnerships (CPPs) and IJBs.

In the NHS Tayside's Director of Public Health Annual Report (2014/15) details are provided of the encouraging progress that has been made in tackling health inequalities in Tayside, with evidence that a real difference is being made in the lives of some people who are experiencing the greatest inequities. It is the vision that over time the level of health in our poorest communities will move towards the level currently experienced in our more affluent communities.

There are a range of services in Dundee which have a responsibility for key areas of public health, some of which have been delegated to the Health and Social Care Partnership. These include services such as the Tayside Sexual and Reproductive Health Service whose role it is to improve sexual and reproductive health and wellbeing through population wide and targeted interventions. This work is carried out in partnership with a range of key partners in the public health sector.

Amongst the range of services provided are testing and vaccination programmes for people at high risk of blood borne viruses (BBV). These include people who inject drugs and those in prison. There is close liaison with Prison Healthcare to ensure appropriate access to BBV testing and care for the prison population. The service also has a key role in supporting the multi-agency public health programme aimed at reducing teenage pregnancies in Dundee.

It is acknowledged that in order to improve public health and wellbeing there is a need for a shift in resource distribution and a greater targeting of services and programmes towards early intervention and those most in need. It is recognised that without this all partners will face unsustainable challenges in the provision of high quality services, within the limited resources available, to an increasing number of people living in poverty and disadvantage.

In Dundee we will work in partnership with the Public Health Directorate, in line with our agreed priorities and planned shifts, to narrow the health inequalities gap and improve the health and wellbeing outcomes of individuals, families and communities across Dundee.

2.3.3 Community Planning Partnership

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

The CPP holds the lead responsibility for the development and delivery of Dundee's Single Outcome Agreement (SOA) 2013-2017. Through the SOA, the local authority and partners are delivering against the range of agreed national outcomes in a way which reflects local needs and priorities. The link to the Dundee Partnership website and Dundee's SOA is included in the Document Links section of this Plan at Appendix 2.

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

In Dundee there are eight Local Community Planning Partnership Groups (LCPPs) which are well established in each of the eight multi-member wards, bringing together elected members, Council officers, partners in Health, Police and Fire and Rescue Services, and community representatives.

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

2.3.4 Children and Families Partnership

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

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

We recognise the need for there to be strong links between the Children's and Adult Services Partnerships to ensure that appropriate transition arrangements and support plans can be put into place for key groups of vulnerable children and young people as they move into adult services. This includes children and young people with long term health conditions or disabilities, along with those who are care leavers and require a multi-agency network of support to help them move on to independence. As a corporate parent for looked after, and previously looked after, children and young people, the IJB shares responsibility with key partners for ensuring the protection of this vulnerable group of children and young people, and promoting their wellbeing and improved outcomes.

Effective planning and partnership working across our two Partnerships is also essential to ensure that the provision of services is appropriately integrated at the point of delivery for individual families. This is particularly important for families where children and young people are vulnerable or at risk due to their parents' illness, disability or lifestyle (for example, parental substance misuse, mental health issues or learning disability). Responsibility for providing treatment or support to the adults involved will largely rest with Adult Services.

There is a similar imperative for partnership working across Children's and Adult Services for children and young people who have a caring role for a family member. They require support from Adult Services to share the responsibility for carrying out this role, alongside access to the everyday opportunities and experiences available to all children to support their own healthy childhood growth and development.

Kinship carers, as a group, have support needs which Adult Services have a responsibility to meet. Kinship carers are those family members or friends who provide care for 'looked after' children and young people, allowing them to remain within their own family and social networks, and avoiding the need for them to be accommodated in other forms of care, such as foster or residential care. The role of kinship carer is frequently challenging and typically kinship carers are grandparents or other relatives who are older and may have their own health or social support needs. Meeting the health and support needs of kinship carers is a priority, both to ensure the wellbeing of carers themselves and to improve outcomes for the children and young people who depend on their care.

We are committed to working in close partnership with the Children and Families Service to achieve the delivery of such 'seamless' and integrated services for people of all ages in Dundee who require health, social work and social care services.

2.3.5 Community Justice Partnership

Along with Social Work's Children's Services, Criminal Justice Social Work (CJS) in Dundee will be managed as part of the new Children and Families Service.

At the current time Dundee's CJS along with their counterpart services in Angus and Perth & Kinross operate as a Tayside partnership. Together they work to develop standardised approaches and, in appropriate circumstances, the delivery of shared services, within the context of the Tayside Community Justice Authority (CJA). However legislative changes are being introduced through the Community Justice (Scotland) Bill 2015, with a plan for CJAs to be dis-established in 2017, and more localised arrangements developed.

In the Community Justice Bill, the Scottish Government defines community justice as:

The collection of agencies and services in Scotland that individually and in partnership work to manage offenders, prevent offending and reduce re-offending and the harm that it causes, to promote social inclusion, citizenship and desistance.

Community Justice (Scotland) Bill

The Bill outlines a new model designed to ensure that a 'defined set of community justice partners' work together locally to determine, in accordance with local needs, which of the national outcomes for people involved in offending should be prioritised in their local authority area.

The duty to co-operate as partners includes IJBs, as well as local authorities, health boards and other partners such as Police Scotland and Scottish Fire and Rescue Service. These partners have been identified because of their role, individually and collectively, in delivering services which will improve community justice outcomes.

The Government also emphasises that a broader partnership approach is required 'to manage and support people with convictions or a history of offending and assist in their journey to desistance'. Engagement with the Third Sector and other partners is considered to be vital to the planning and delivery of such services.

In preparation for the implementation of the new national model in April 2017, a Community Justice Transition Plan has been put together for Dundee. The plan outlines how the Dundee CPP will work with the Tayside CJA to ensure, where relevant, that existing strategic priorities are retained and that appropriate links are built with and between all local partners and service users and communities in the planning and delivery of services.

In the Transition Plan it is clearly recognised that there is a:

..high degree of synergy between the current priorities of the Tayside CJA, the aims and objectives of the Dundee SOA, the wider priorities of the Dundee Partnership (CPP), the prevention and reducing re-offending frameworks and the broader Protecting People agenda.

Dundee Partnership Community Justice Transition Plan 2015-17

The Plan recognises that there is a shared understanding of the complex set of risk factors which have led to the range of social problems being experienced in Dundee. It also acknowledges that there is a shared recognition of the importance of identifying needs and risks at the earliest opportunity, and delivering proportionate, person centred support.

In this it is clear that there is also a high degree of synergy between the current priorities, aims, approach and planned outcomes of Dundee's Health and Social Care Partnership, and those of the Dundee CJS and the wider Dundee CPP. We recognise the importance of our role as a key community justice partner in providing the supports and services required by those involved in offending, both to improve their outcomes and to reduce the risk for them of re-offending.

This includes in particular those who have a learning disability or require help to address their substance misuse or mental health issues. It also involves ensuring that those most at risk of social exclusion, such as people who are being released from prison, receive the targeted and additional support they require to support their reintegration back into the community.

We will be working closely with Dundee CJS and other members of the Dundee CPP to deliver such integrated supports and services to improve outcomes for those in Dundee who are involved in offending and their families.

2.3.6 Public Protection Partnership

There is a well established framework and partnership in Dundee within which the range of multi-agency supports and interventions to protect people of all ages is planned and co-ordinated.

The Chief Officers of the Council, NHS Tayside and Police Scotland individually and collectively lead, and are accountable for, the development of services in Dundee relating to the following 'Protecting People' groups:

- 1) Adult support and protection
- 2) Child care and protection
- 3) Violence against women and domestic abuse
- 4) Multi-Agency Public Protection Arrangements (MAPPA) for high risk offenders who present a risk of harm to the public
- 5) The prevention/promotion of a recovery focused response to drug and alcohol misuse.

The responsibilities of the Chief Officers Group (COG) include ensuring the effectiveness of each of the Protecting People component Committees/Partnerships. Links to further information regarding the role of each of these Committees are included in the Document Links Section of this Plan at Appendix 2.

Within the Dundee CPP there are strong links between the Protecting People Partnership and the Community Safety Partnership. The Community Safety Partnership has a wider role and responsibility for promoting public safety and co-ordinating multi-agency activity at a community level. These partnership mechanisms together provide a more integrated framework within which the protection of individuals can be addressed, alongside the promotion of improved safety for people living in local communities across the city.

The COG has pursued a public protection policy aimed at greater integration of all of these work streams, with all of the Lead Officers working closely together as a Protecting People Team, and most now being co-located. This has improved the efficiency of

protection planning and interventions, and places protecting people within a holistic framework in Dundee.

The Protecting People functions for which the IJB will have direct responsibility include those which relate to Adult Protection, Violence Against Women (including domestic abuse) and Alcohol and Drug Services. However, whilst these functions are being formally delegated to the Partnership, it is intended that the Child Care and Protection Lead Officer should continue to be co-located with the Protecting People Team, and that the strong partnership working with the MAPPA Lead Officer (who is hosted with Dundee's CJS) should be maintained into the new Partnership arrangements from 1st April 2016.

The protection of people of all ages is one of the most important responsibilities which all Partnerships in Dundee share. As we assume our formal responsibilities as Dundee's Health and Social Care Partnership we will continue to ensure that this is maintained as a key strategic priority. We will also ensure that we prioritise our activity and resources to work with other Partnerships in the city and provide the best possible protection services for the people of Dundee.

3.0 CONVERSATIONS WITH YOU

Each IJB is required to establish a Strategic Planning Group for the purpose of preparing a strategic and commissioning plan. The Dundee Integrated Strategic Planning Group is the formal group which has been established to oversee the development and implementation of this Strategic and Commissioning Plan for Dundee.

The Integrated Strategic Planning Group includes representation from a wide range of stakeholders involved in health and social care service provision in Dundee. There is also service user and carer representation on the group.

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

- The views and contributions from representative care groups and individuals, including specific care groups
- The analysis of information about health and social care needs across the population of Dundee
- Listening to and consideration of issues and concerns raised by local people about current models of service delivery
- Consultation and engagement with a wide range of stakeholders throughout the development of our Integration Scheme, our draft vision and priorities and the final Plan

We want to ensure that we continue to actively engage with as many people as possible throughout the implementation of this Plan, so that we are confident that our participation and engagement processes encourage dialogue and partnership.

3.1 Participation and Engagement

Participation and engagement has been central to the development of this Plan. Our engagement journey started well before the design of the Plan, with a number of different engagement methods and opportunities used to consult with a wide range of stakeholders across the city.

These engagement activities included three large scale stakeholder events, involving our local authority, health, third sector, community planning and independent partners. There was also ongoing engagement activity led by our Care Group Strategic Planning Groups, and specific consultation around the development of our Integration Scheme, as well as the vision and priorities contained within this Plan.

We took our consultation out into our local communities, through our network of community centres and libraries and created opportunities for consultation via our web-based communication channels within the local authority and NHS Tayside, which were open to the general public and others.

We also supported the development of a Public Reference Group, membership of which includes service users representative of our Care Groups. Focus groups were arranged with staff and other stakeholders, to listen to their views and contributions.

The Integrated Strategic Planning Group have taken account of the information and views presented by a wide range of stakeholders when finalising the shape of the Plan. The result has been a Plan which we believe reflects this participation and engagement journey. Our hope is that those who have supported this process will be able to recognise where their contribution has made a difference to the content of the Plan.

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

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

The Participation and Engagement Strategy is a companion document to the Plan. A link to the Strategy is provided in the Document Links section of this Plan at Appendix 2.

3.2 Equality, Diversity and Human Rights

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

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

The IJB seeks to improve the way that decisions taken are assessed in relation to the following:

- Equality and diversity (including gender-based analysis of service provision)
- Fairness and poverty
- Environment
- Corporate risk

This Plan has been subject to an Integrated Impact Assessment (IIA). The IIA seeks to demonstrate that the IJB has considered all the likely impacts of the Plan, and has identified the mitigation required to overcome any potentially negative impacts. This should ensure that the content of the Plan, and more importantly, its impact, does not impact negatively on any people with protected characteristics in Dundee.

This Plan includes a commitment to a gendered analysis of domestic abuse (and all other forms of violence against women). This analysis reflects an understanding that domestic abuse is a cause and consequence of women's inequality. We acknowledge that men and boys also experience violence, and that there is an equal right to protection for all people, regardless of gender.

In addition, the IJB has developed a set of Equality Outcomes which fulfil the general duty of Scottish public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. A link to the Equality Outcomes and Mainstreaming Equalities Framework as a supporting document to this Plan can be found in the Document Links Section at Appendix 2.

3.3 Transparency and Accountability

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

4.0 NATIONAL AND LOCAL OUTCOMES AND INDICATORS

The Scottish Government has developed a national performance framework for helping to improve health and social care services. This framework adopts an outcomes based approach, which allows us to identify the tangible differences that services and supports make to people's lives. This means that we will not just focus on the numbers of people who need services in Dundee, or the type and volume of services provided.

A suite of National Outcomes and Indicators have been developed. These are to be linked to the local outcomes and indicators reflected in each local authority's SOA. In addition new local outcomes and indicators have to be developed to allow the IJB to track performance in implementing the actions contained in this Plan.

The aim is to ensure that each IJB, Health Board and Local Authority, as well as Scottish Ministers and the public, can assess the progress being made to improve outcomes for people locally and in different parts of the country.

4.1 National Outcomes and Indicators

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

Table 1 National Outcomes

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

The nine National Outcomes will be measured using a suite of 23 National Indicators. Electronic links to these National Outcomes and Indicators are available in the Document Links Section of this document at Appendix 2.

4.2 Local Outcomes and Indicators

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

Table 2 Dundee Outcomes

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

The National Outcomes and Indicators will be incorporated, with Dundee's local outcomes and indicators, into a Dundee Health and Social Care Partnership Outcomes and Performance Framework.

This will be the Framework within which all performance improvement and outcome reporting for health and social care services in Dundee will be organised and managed in the future. The Framework will include new local measures which we will use to monitor our progress in achieving the strategic priorities and shifts identified in this Plan, as well as our improvement against the National Outcomes.

There is a complex matrix of relationships which exist between these separate, but inter-related sets of national and local outcomes and indicators. The connections between these (the golden thread, as it is sometimes referred to) is described in greater detail in Section 11 of this Plan.

4.3 Tom's Story

Making a difference to people's lives is at the heart of health and social care integration. Tom's story shows how integration will change the way care and support services in Dundee are delivered and how outcomes can be improved for those who receive our services.

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

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

Link to Tom's Story:

<https://vimeo.com/129774994>



5.0 THE CASE FOR CHANGE

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

5.1 Drivers for Change

Our Case for Change is informed by the current demographic and socio-economic situation in Dundee and is built on a number of key 'drivers for change' that are articulated throughout this Plan. These drivers for change have been grouped into three main driver themes, and our analysis for change is presented under each of these three themed headings.

5.1.1 Population's health and wellbeing

- a) Demographic changes
- b) Deprivation and inequalities
- c) Prevalence of multi-morbidities experienced at a younger age
- d) Prevalence of key morbidities and multi-morbidities
- e) Variation in deprivation and multi-morbidity levels within LCPP areas
- f) Prevalence of morbidities and impact on use of health and social care services
- g) Palliative and end of life care
- h) Levels of risk and need for public protection
- i) Population health and wellbeing summary

5.1.2 Delivery of right support at the right time

- a) Centralised service development and decision making
- b) Services are not tailored to address community/locality differences
- c) Contribution of unpaid carers
- d) Support is not sufficiently individualised
- e) Palliative and end of life care
- f) People report variable experiences of care and health

5.1.3 Fiscal constraints

- a) Increasing demand/reducing resources
- b) High costs/reduced budgets
- c) Sustainability of current models
- d) Balance of care
- e) Effectiveness of current models

5.1.1 Analysis for Change: Population's Health and Wellbeing

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

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

The very detailed work taking place to fully complete the needs assessment process is continuing. A link to the overarching Strategic Needs Assessment reflecting the picture to date is included in the Document Links Section of this Plan at Appendix 2.

a) Demographic Changes

Current Population

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

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

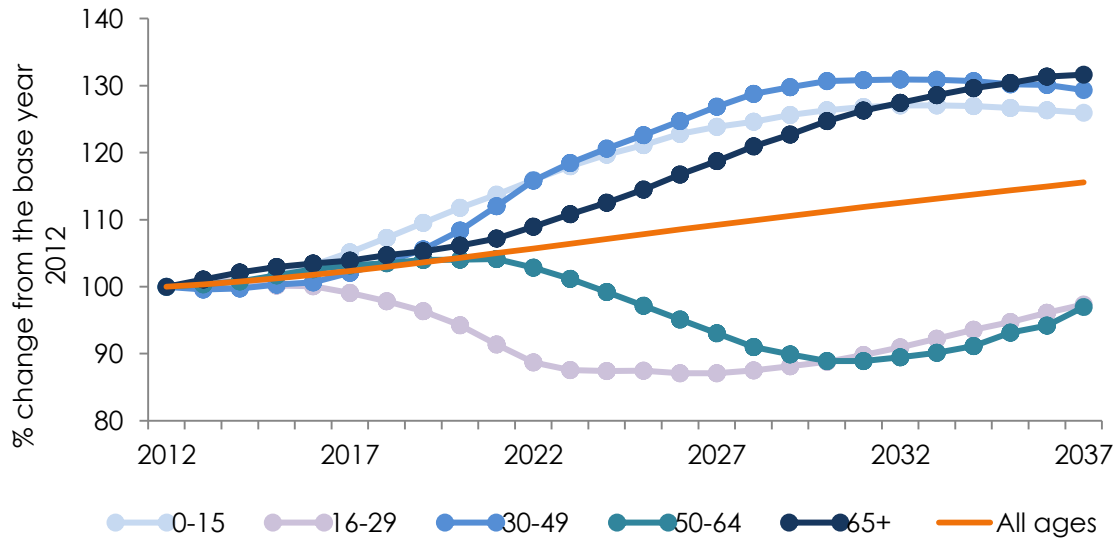
At the same time people aged 60 and over make up 22.5% of the Dundee population. This is smaller than Scotland as a whole, where 24.0% are aged 60 and over.

Projected Population Increase

By 2037 the population of Dundee is projected to be 170,811. This is an increase of 15% when compared to the estimated population in 2014. This growth can be attributed to a combination of in-migration and increased life expectancy.

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

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



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

Ageing Population

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

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

Ethnicity

Dundee's population is predominantly White British (89.4%), with an additional 4.7% of people recorded (in 2011 Census) as White Other. In 2001 this group, which includes those of Irish or Eastern European origin, made up only 2.7% of the Dundee population.

There was also an increase in Dundee in the Asian population from 2.8% in 2001 to 4% in 2011. 1% of the Dundee population are African or Caribbean.

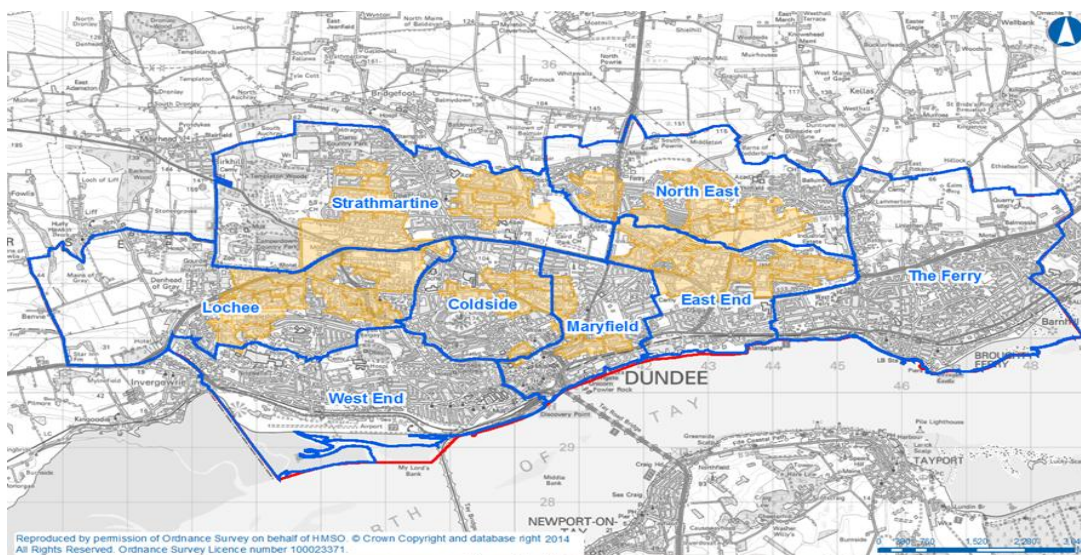
There is generational variation in patterns of ethnicity, and variation across LCPP areas. More detailed information is available in the Strategic Needs Assessment.

b) Deprivation and Inequalities

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

The map in Chart 2 shows those areas in Dundee which are within the 15% most deprived areas in Scotland. Six out of eight of the Dundee Local Community Planning Partnership (LCPP) areas delineated on the map have deprivation levels which are above the Scottish average of 15%, and five have deprivation levels which are above Dundee's average of 29%.

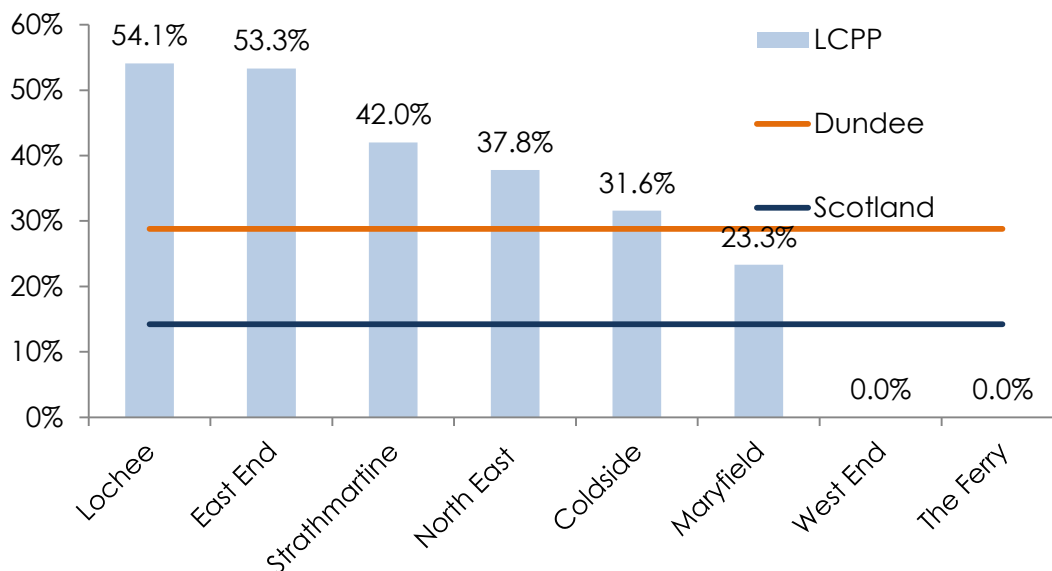
Chart 2: Location in Dundee of datazones within 15% most deprived in Scotland



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

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

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



Source: Scottish Index of Multiple Deprivation 2012, Scottish Government

Life Expectancy

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

Lifestyle Factors related to Deprivation

A significant proportion of the difference in life expectancy between Scotland and the rest of the UK can be accounted for by deaths at a young age from drugs, alcohol, violence and suicide. Substance use disproportionately affects the most vulnerable and socioeconomically deprived in our community and is associated with other aspects of adversity, including mental health problems, crime, domestic violence and child neglect and abuse. Substance use is therefore recognised both at national and local level as a major public health issue and an issue of health equity.

There are other lifestyle factors which have a negative impact on life expectancy and health, and whose prevalence is also deprivation related. Smoking, an unhealthy diet and obesity are all more prevalent in the most deprived communities. People whose lifestyles include all or some of these factors will, in general, have poorer health. Other key social indicators, such as poor sexual health and wellbeing and teenage pregnancy rates are also linked directly to deprivation.

Smoking

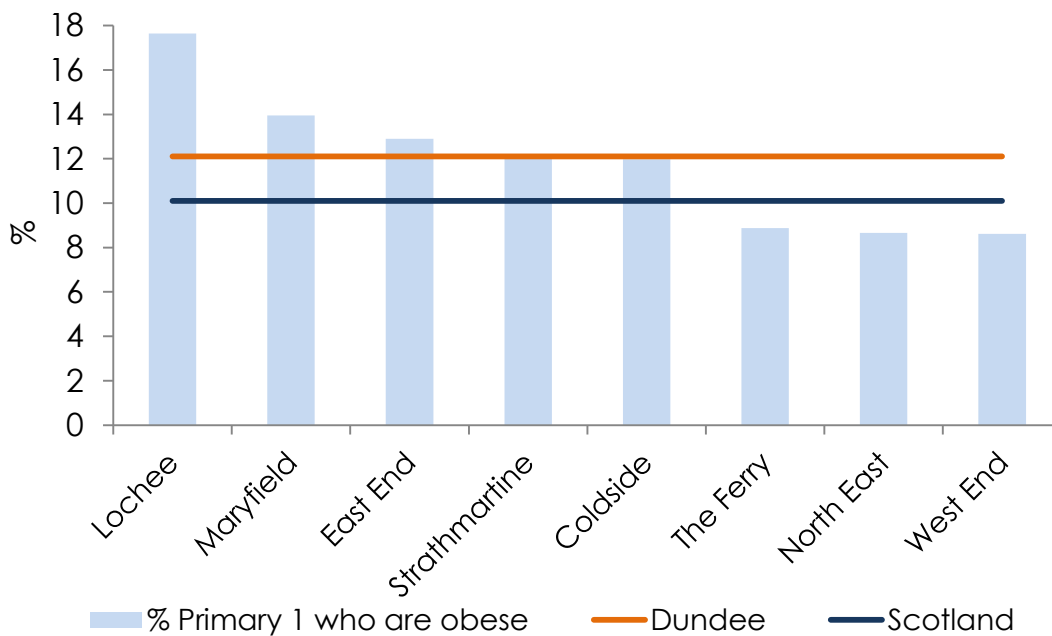
In Dundee a higher percentage of people aged 40+ smoke tobacco compared with Scotland as a whole. The proportion of people aged 16-39 who smoke tobacco in Dundee is similar to that in Scotland as a whole.

Obesity

The figures for the prevalence of adult obesity are only available at Health Board level. These figures show that for people aged 16 years+ with a Body Mass Index (BMI) of 25 or over, Tayside has a higher prevalence than Scotland as a whole. It is reasonable to conclude that the prevalence of obesity is high in Dundee. In 2013/14 (when obesity was one of reported conditions in the Quality Outcome Framework) it was shown as the long term condition with the third highest prevalence for people in Dundee.

Statistics are collated for childhood obesity in Dundee. As shown in Chart 4 there is significant variation in obesity prevalence between LCPP areas for children in Primary 1.

Chart 4: Percentage of children in Primary 1 who are obese by LCPP, 2013/14



Source: ScotPHO profiling, 2013/14

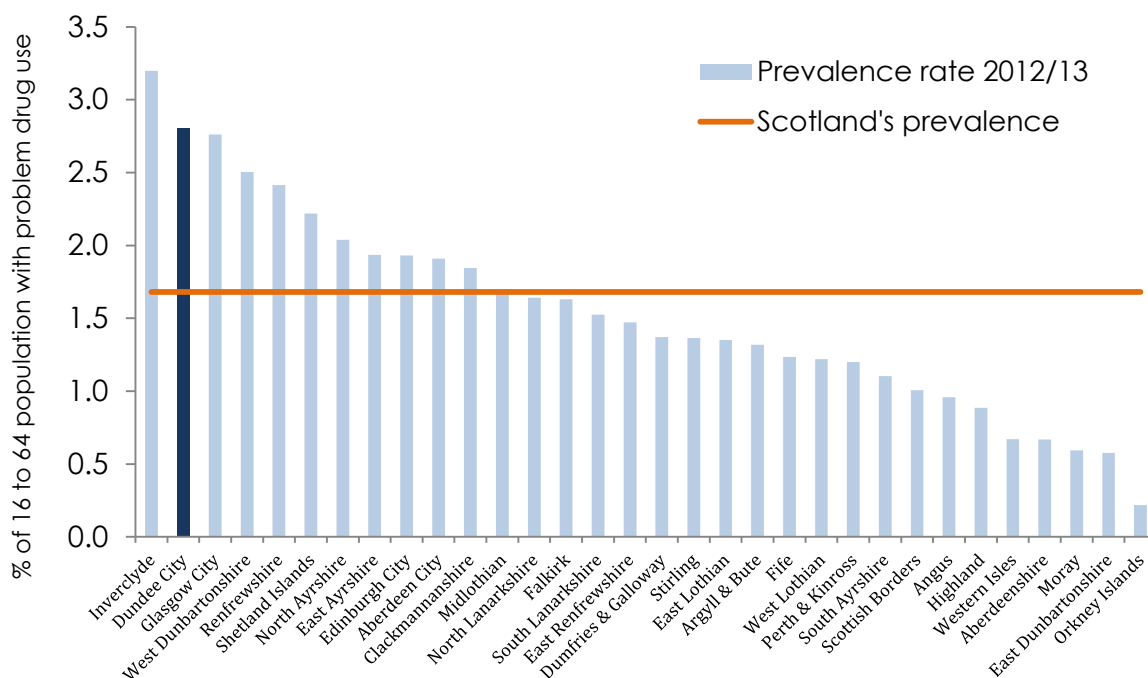
There is a strong link between obesity, Type II diabetes and coronary heart disease (CHD), as well as many other long term conditions. Diabetes and CHD currently have the third and fourth highest prevalence rates in Dundee.

Drug Misuse

The following drug misuse statistics have been included to provide more detailed information regarding the scale of the challenge presenting, and the links with deprivation in Dundee.

Chart 5 shows that Dundee has the second highest prevalence of drug misuse in Scotland. The information is presented as a percentage of the 16-64 population with problem drug use.

Chart 5: Drug prevalence in Scotland



Source: *Estimating the Prevalence of Problem Drug Use in Scotland 2012-13*, ISD Scotland

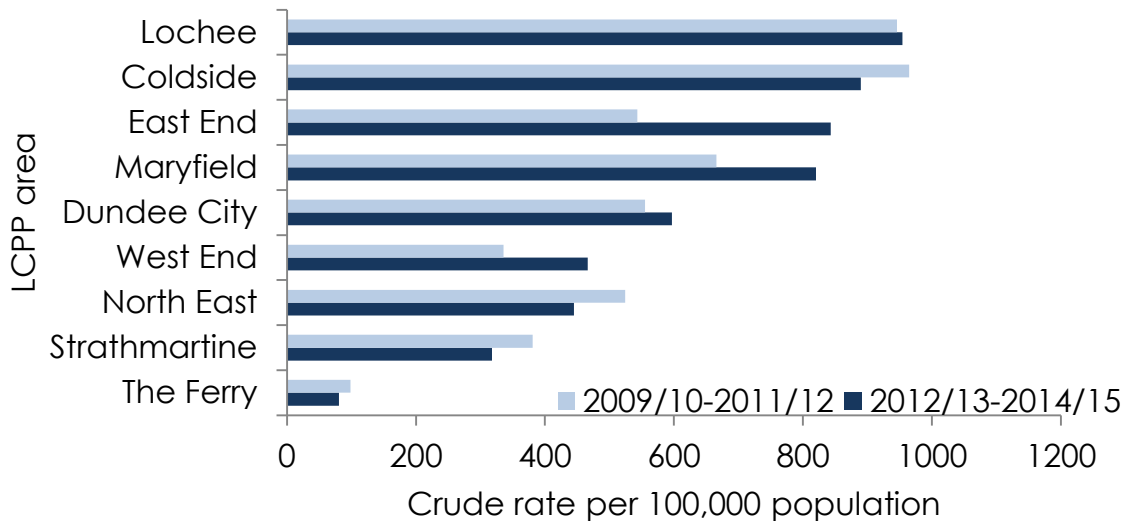
There are an estimated 2900 problem drugs users in Dundee; 1700 are male and 1200 are female. This represents a ratio of 59% males : 41% females, which is significantly different from the average Scotland ratio of 71% males : 29% females. The high proportion of women who are drug users is significant, given the known impact of substance misuse on parenting capacity and the ability to keep children safe.

Figures show that there is significant variation between LCPP areas in the number of drug related attendances at Accident and Emergency (A&E) in Dundee. In 2014/15 the attendance rate was 10 times higher for those living in the most deprived areas in Dundee, compared with the least deprived. 69% of drug related acute hospital episodes involved people who lived in the most deprived areas of the city.

Chart 6 below shows a three year aggregate of drug related hospital discharges in Dundee for the periods 2009/10 and 2014/15. In both time periods the Lochee and Coldside LCPPs had considerably higher rates of drug related hospital discharges.

However, the East End, Maryfield and West End LCPP areas also showed increases between the two periods. The West End is the LCPP area with the largest concentration of the student population in the city and drug misuse by this group may be the factor which accounts for the increase in drug related hospital discharges in the West End.

Chart 6 Dundee City drug related hospital discharges by LCPP area of residence 2009/2010 - 2014/2015



Source: Public Health Department, NHS Tayside

The majority (82%) of drug related hospital episodes in 2014/15 included the use of opioids as a factor in the diagnosis.

As at July 2014, there were 1,232 people in Dundee in receipt of a methadone prescription, with 937 of these being supervised prescriptions.

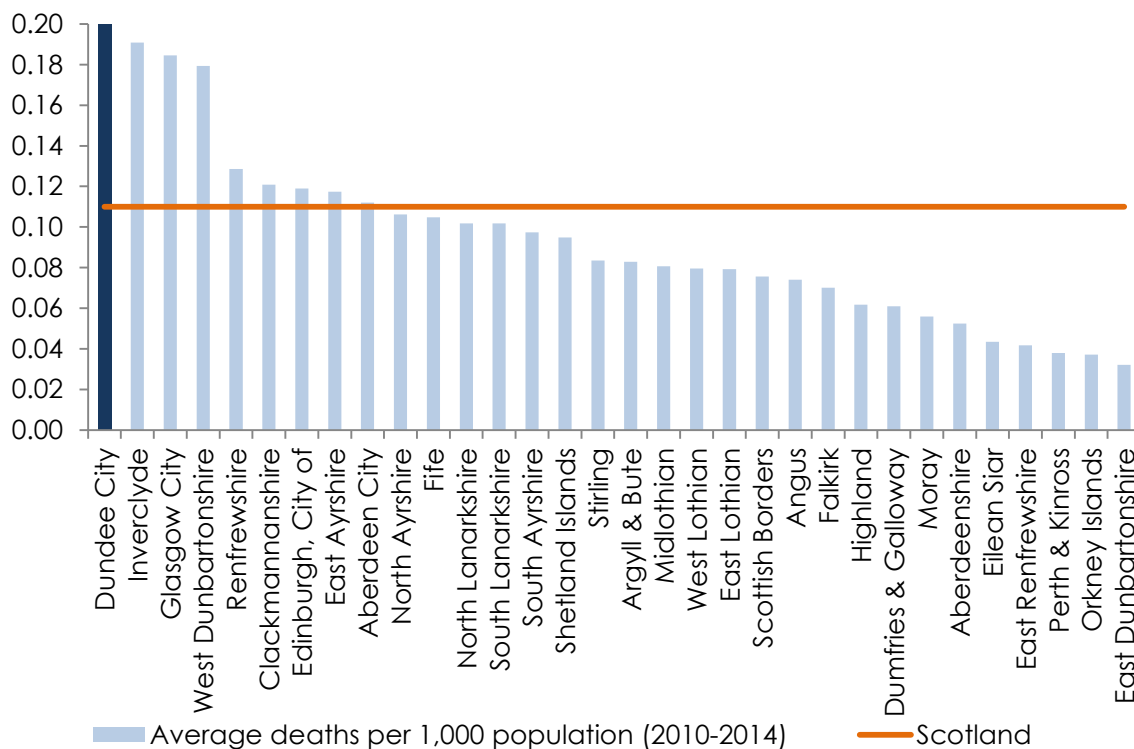
Drug Related Deaths

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

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

Chart 7 below shows Dundee's figures for average drug related deaths, compared with those for all local authorities in Scotland.

Chart 7: Average drug related deaths per 1,000 population (2010 -14)



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

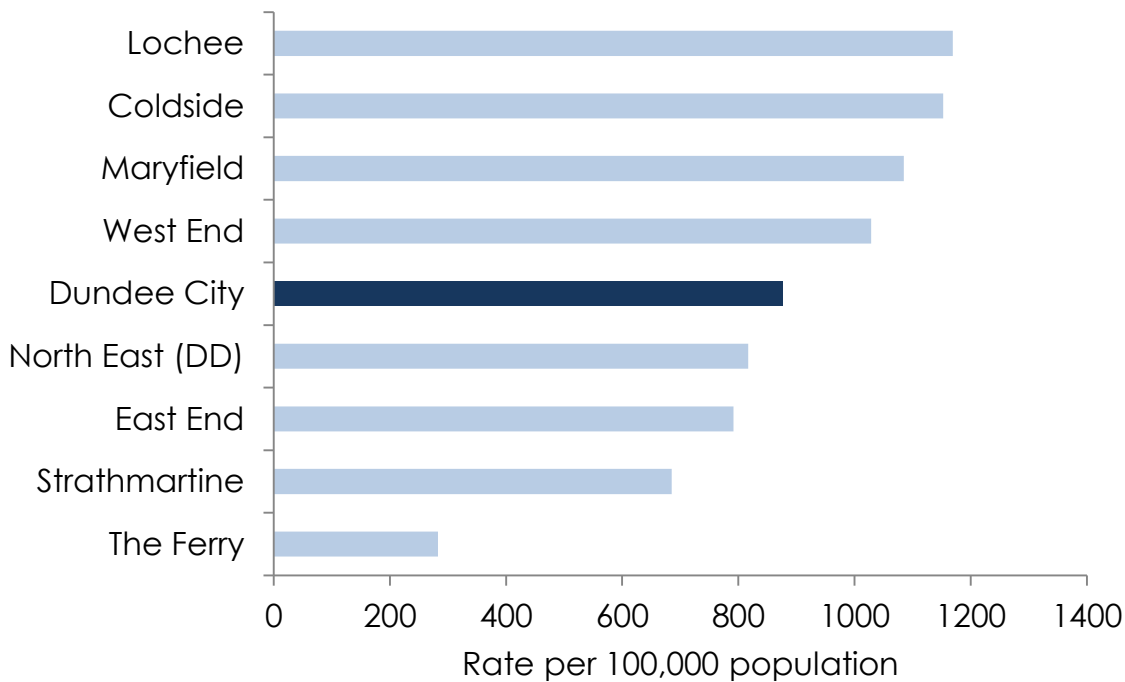
It is significant to note that Glasgow and Inverclyde (as the only two local authorities in Scotland with higher levels of deprivation than Dundee) follow Dundee with the next highest levels of drug related deaths. These figures demonstrate the strong correlation between deprivation and drug misuse, as well as the level of impact drug misuse has on some of our most vulnerable communities in Dundee.

Alcohol Misuse

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

There is similar variation shown across LCPP areas in Dundee for alcohol related Accident and Emergency (A&E) attendance rates in 2014. As shown in Chart 8 these varied from 1,169 per 100,000 in the LCPP area of Lochee to 283 in The Ferry.

Chart 8: Dundee City alcohol related presentation rate to A&E by LCPP area in 2014



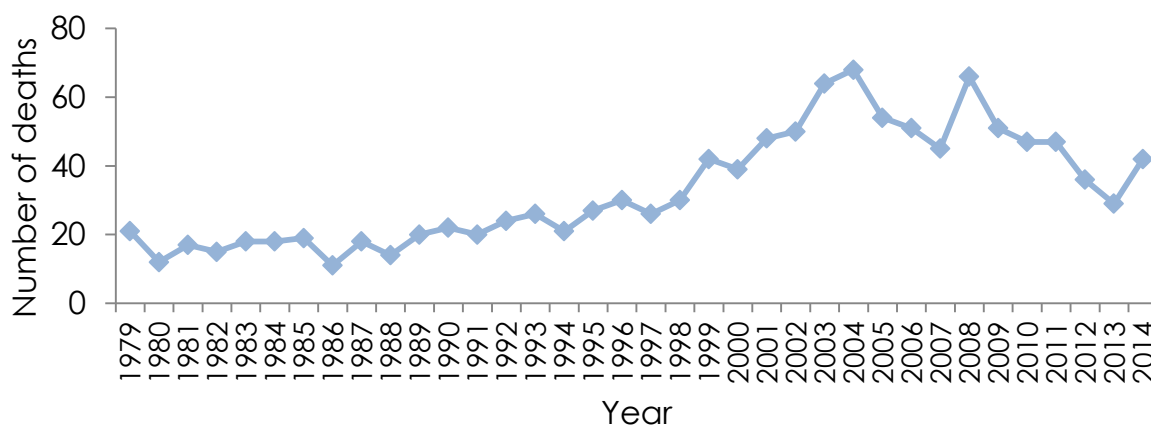
Source: Public Health Department, NHS Tayside

There is a clear deprivation gradient shown in Chart 8 for alcohol related attendances to A&E, with people from the most deprived LCPP areas accounting for four times the rate of presentations compared with those from the most affluent LCPP areas. However, similar to drug related attendances, the West End is showing higher than the Dundee average for alcohol related attendance rates.

Alcohol Related Deaths

Alcohol related deaths have increased over time, peaking at 68 in 2004. Chart 9 illustrates the trend in deaths from alcohol related conditions since 1979. In 2014 there were 42 alcohol related deaths recorded - the first increase since 2008.

Chart 9: Number of alcohol related deaths in Dundee City, 1979-2014



Source: Scottish Government 2015

Substance Misuse Summary

Substance misuse in Dundee has been identified as one of the key priorities to be addressed by the Partnership, due to its negative impact on the health and wellbeing of those who use substances, as well as that of their families and carers, and the wider communities in which they live.

Sexual and Reproductive Health (SRH) and Blood Borne Virus

As with many of the other poor life outcomes for people in Dundee, there is a strong correlation between deprivation and poor sexual health and blood borne virus.

Approximately 1% of the Scottish population live with Hepatitis C (HCV), 80% of whom will go on to develop chronic disease. Prevalence rates are much higher in people who inject drugs (PWIDs) of whom an estimated 34% are infected with HCV. It is estimated that there are approximately 2,400 people with HCV living in Dundee. (Health Protection Scotland, 2015).

New therapies have been developed to improve treatment outcomes, and these have increased cure rates to over 95% of cases, even for those with advanced disease. However, despite considerable success in diagnosing those with HCV, there remains a significant undiagnosed population, posing a risk both to individuals' own health, as well as an ongoing transmission risk to others. It is estimated that for each person with undiagnosed HCV there will be between seven and 30 new infections over a 10 year period.

The overarching aim is to reduce the anticipated burden of HCV liver disease by reducing transmission, identifying infected individuals, and ensuring they can access effective treatment. In Dundee the major challenge is to identify and treat older, former PWIDs, who are at greatest risk of end stage liver disease. There is a need therefore to develop effective strategies for 'case finding', including primary care and in the third sector.

Whilst the prevalence of HIV is relatively low, the burden of disease is unequal, with men who have sex with men (MSM) being at the greatest risk of transmission. However everyone who is sexually active is potentially at risk. There is an active programme of outreach preventative interventions and good access to care and treatment. However approximately 24% of people living with HIV are undiagnosed, and over 50% are diagnosed late or very late, with significant implications for their own health, as well as the risk presented to others. 59% of the diagnosed population in Tayside live in Dundee.

Sexually transmitted infections are most prevalent in the under 25's and among MSM.

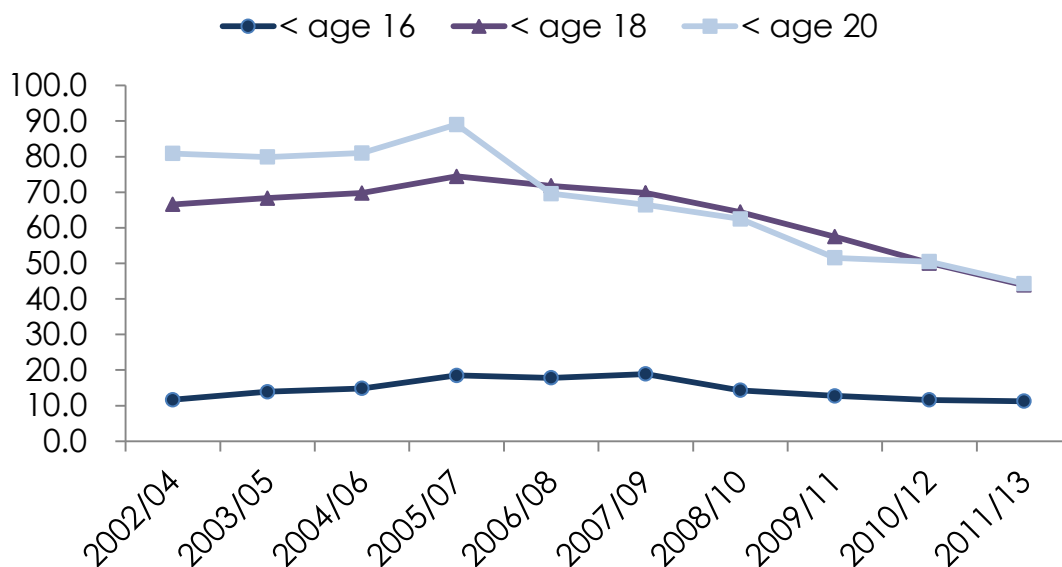
Teenage Pregnancies

The latest teenage pregnancy data (all conceptions for women under the age of 20 years) published by the NHS Information Services Division (ISD) for 2013 show that rates continue to reduce year on year in Dundee. Rates have reduced by almost 50% since 2007 and are now at the lowest levels since records began. From consistently having the highest rate in Scotland, Dundee is now below the national average for teenage

pregnancy in the under 20s. Concerted multi-agency action through evidence-based programmes, coupled with improved access to SRH services, has made a significant contribution to reducing rates in Dundee.

Chart 10 shows the downward trend for the rate of teenage pregnancies in Dundee since 2007. It also shows however that the trend for under 16 year olds does not match with the overall trend. The number of girls under the age of 16 who become pregnant is small and fluctuates year to year, but they are a very vulnerable group who are, due to their young age, the least likely to be prepared for the responsibilities of parenting.

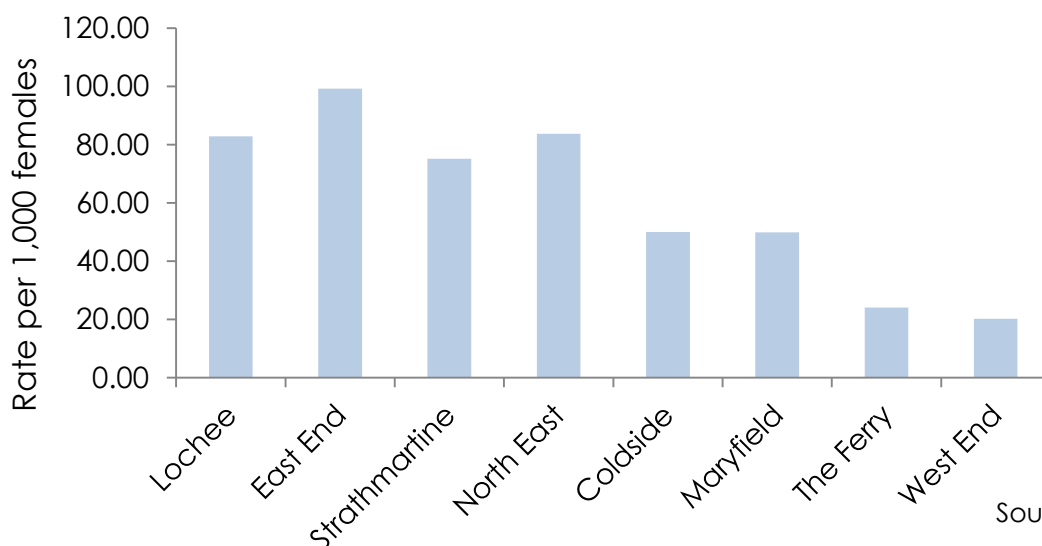
Chart 10 Teenage pregnancies in Dundee, crude rate per 1,000 females (3 year rolling averages)



Source: ScotPho, 2015

Chart 11 provides data on the rates of teenage pregnancies (for females under the age of 20) in Dundee, broken down by LCPP area.

Chart 11: Teenage pregnancy rate per 1,000 females by LCPP, 2010-12



Source: ScotPho, 2015

Chart 11 shows the eight LCPP areas presented in order of deprivation (with highest to the left and lowest to the right). This data shows that there are higher rates of females aged under 20, living in the most deprived LCPP areas who become pregnant, compared with females under 20 living in the most affluent LCPPs. This demonstrates a strong correlation between teenage pregnancy rates and deprivation in Dundee.

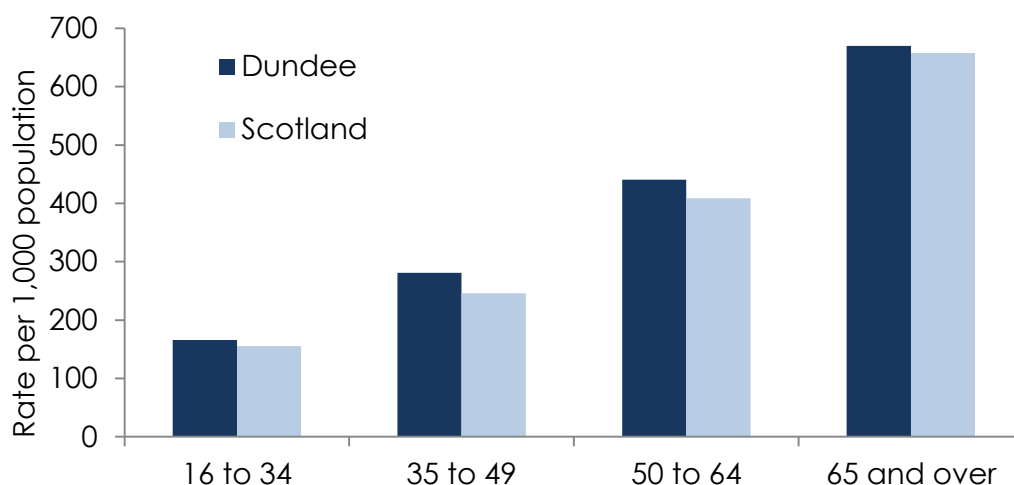
Despite the fact therefore, that the overall rates of teenage pregnancy have fallen in Dundee, there remains significant variation in prevalence across the city and rates amongst our most deprived populations remain high.

c) Prevalence of Multi-Morbidities Experienced at a Younger Age

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

Chart 12 shows the rate of people living in Dundee and Scotland who have one or more health condition. This chart shows that across all age groups the rate of people in Dundee is higher than in Scotland as a whole.

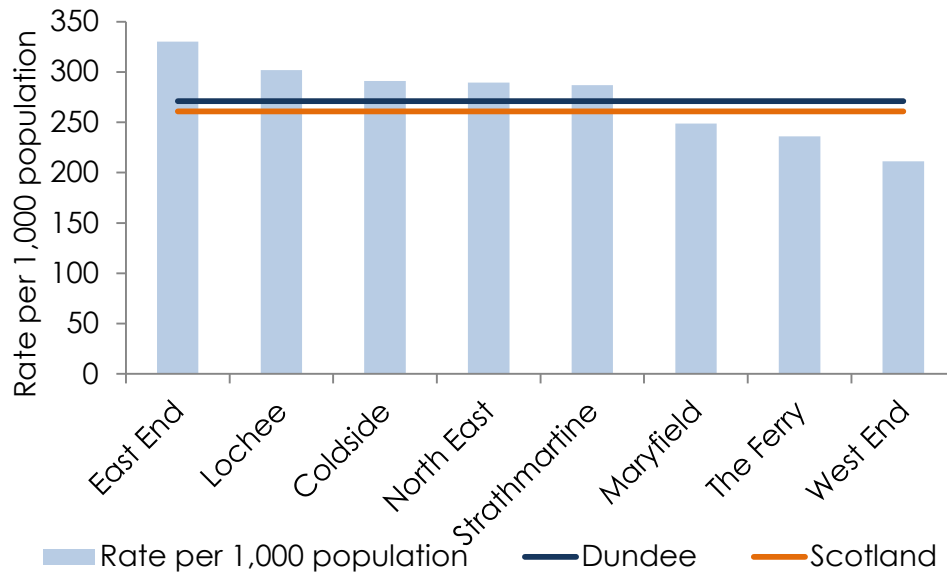
Chart 12: One or more health condition: rate per 1,000 of population (aged 16 and over) in Dundee and Scotland



Source: Scotland Census 2011

There is considerable variation in multi-morbidity rates between LCPPs across the city and not all LCPPs contribute to this trend. Charts 13 and 14 to follow show the rate of people (aged 16-64, and those over 65) with one more or health condition in each LCPP area, as compared with the Dundee and Scotland average rates.

Chart 13: Number of people per 1,000 of population (aged 16 to 64) with one or more health condition by LCPP area, Dundee and Scotland

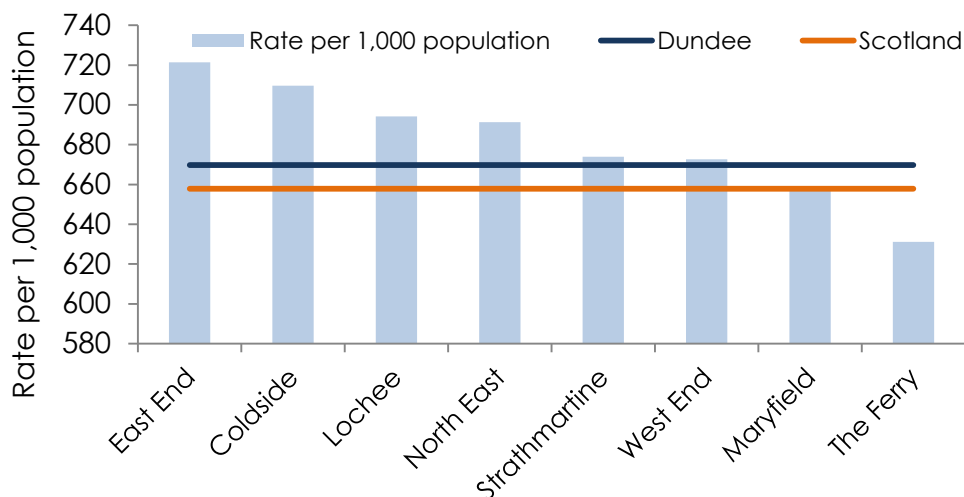


Source: Scotland Census 2011

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

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

Chart 14: Number of people per 1,000 of population (aged 65 and over) with one or more health condition by LCPP area, Dundee and Scotland



Source: Scotland Census 2011

Chart 14 above shows the level of morbidity and multi-morbidity for people **aged 65 and over** in each LCPP in Dundee, compared with the average rates in Dundee and Scotland. Chart 3 identifies the East End and Lochee as the two LCPPs with the highest levels of deprivation in the city. Chart 14 illustrates the correspondingly high levels of associated morbidity and multi-morbidity for the over 65 age group also, in these deprived areas of the city.

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

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

d) Prevalence of Key Morbidities and Multi-Morbidities

There is a direct correlation between deprivation and a range of health conditions and health and social inequalities. Dundee's population ranks in the top five local authorities in Scotland for the prevalence of learning disabilities, physical disabilities, mental health issues and substance misuse. Detailed data and analysis is provided for all care groups in the overarching and individual Care Group Strategic Needs Assessments.

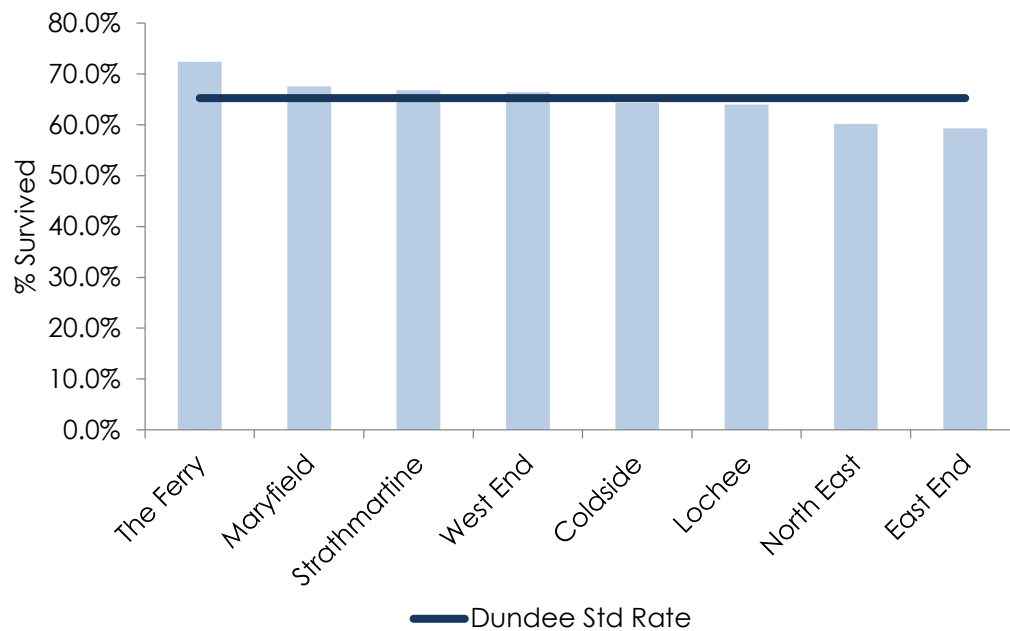
The following is an example of the impact of deprivation on the prevalence of key morbidities and health inequalities in Dundee.

Cancer

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

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

Chart 15: Percentage of people with cancer who survived more than 1 year after diagnosis between 2009 and 2013



Source: NSS ISD 2015

Chart 15 shows clear links between deprivation and cancer survival of more than one year after diagnosis. The Ferry is the LCPP area which has the lowest deprivation and it has the highest rate of people who survived cancer for one or more years following diagnosis. The East End is one of the most deprived areas and has the lowest rate of people who survived cancer for one or more years following diagnosis.

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

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

e) Variation in Deprivation and Multi-Morbidity Levels within LCPP areas

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

Whorterbank and Clement Park/Foggyley neighbourhoods with the Sutherland and Gowrie Park neighbourhoods, all in the same LCPP.

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

f) Prevalence of Morbidities and Impact on Use of Health and Social Care Services

There is a strong correlation between the levels of deprivation in each of the eight LCPP areas, the prevalence of health and social inequalities and the impact on the use of health and social care services in Dundee.

Such variation can be measured by comparing the rate of 'unscheduled care' provided by NHS Tayside for people in Dundee.

Rate of Unscheduled Care in Dundee

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

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

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

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

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

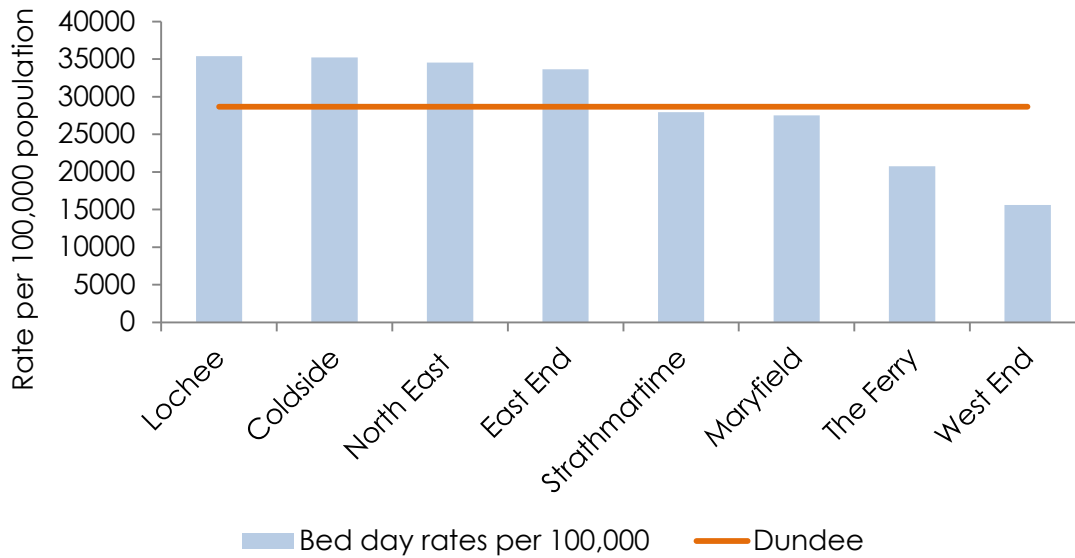
As in other parts of Scotland, the rise in the level of unscheduled care has been one of the biggest pressures on services in Dundee in the last 20 years. However there is a significant difference in the level of unscheduled care in Dundee compared with other areas in Scotland. This is shown in the 'bed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

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

Variation in Unscheduled Care Rates between LCPP Areas

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

Chart 16: Bed day rate per 100,000 of population for emergency admissions to hospital (people aged 16-64)



Source: NSS ISD 2015

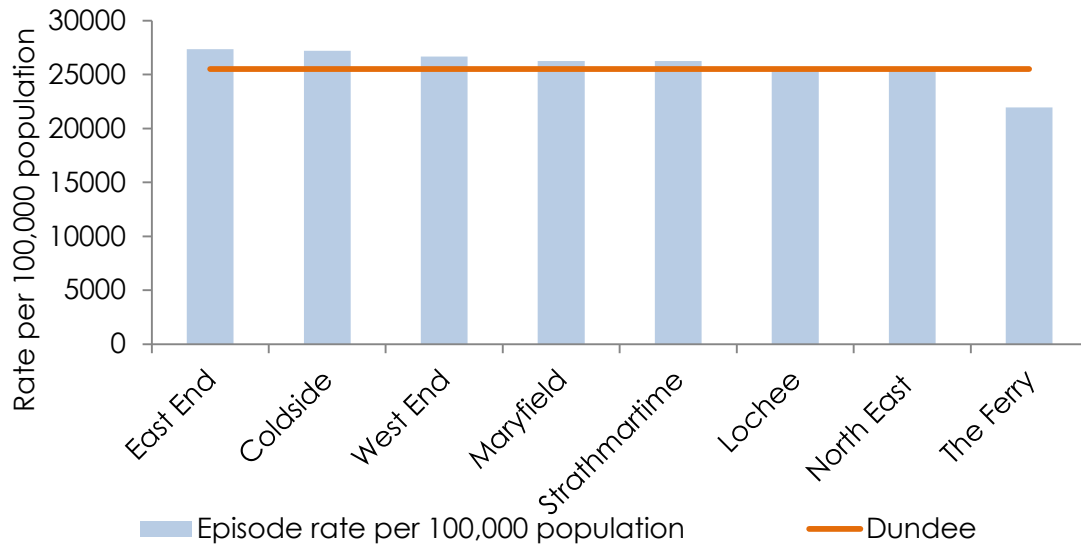
Chart 16 also shows a correlation between bed day rates, the rates of people living in deprivation, and the rates of people with one or more health conditions, when comparing for these three variables across LCPPs.

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

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

Chart 17 shows the bed day rates by LCPP area for people **aged 65 and over** admitted to hospital on an emergency basis. As can be seen, there is significantly less variation overall in bed day rates between LCPPs when compared to the same data for people aged 16-64.

Chart 17: Bed day rate per 100,000 of population for emergency admissions to hospital (people aged 65+)



Source: NSS ISD 2015

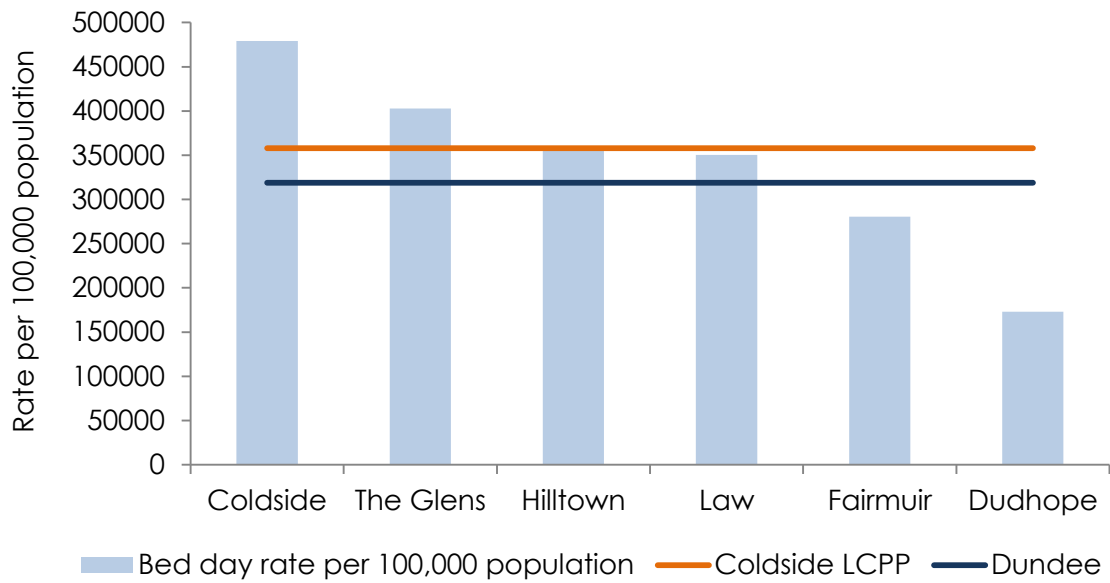
There is a strong correlation between bed day rates and the rate of people aged 65 and over with one or more health conditions for some LCPP areas. East End, Coldside, Strathmartine and The Ferry are LCPP areas that are ranked in the same order for both of these variables. This is a correlation which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

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

Variation in Unscheduled Care Rates within LCPP Areas

There is similar variation **within** each of Dundee's LCPP areas in the use of unscheduled care. The LCPP area with the highest variation in unscheduled care **for over 65's** is Coldside. As shown in Chart 18, there is a neighbourhood within the Coldside LCPP, which is also called Coldside. This neighbourhood has the highest bed day rate per 100,000 of the population for people aged 65+ (479,122 bed days). The neighbourhood in the Coldside LCPP with the lowest bed day rate for those aged 65+ is Dudhope (173,200 bed days).

Chart 18: Number of emergency bed days per 100,000 population for Coldside LCPP neighbourhoods (people aged 65+)



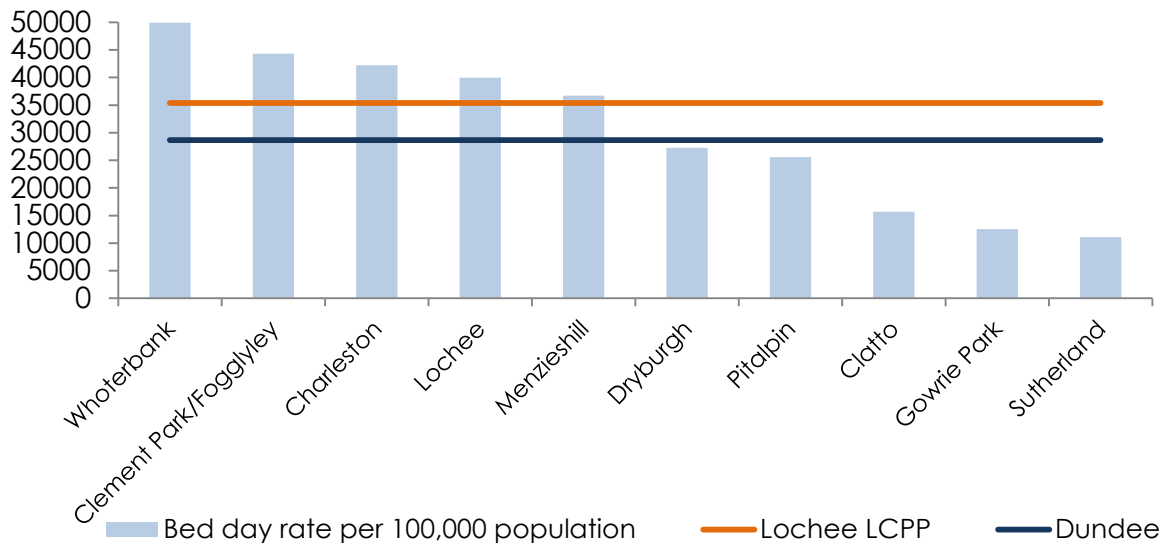
Source: ISD Scotland, unpublished data: emergency admissions and bed days

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

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

Chart 19 below shows this variation across neighbourhoods in the Lochee LCPP.

Chart 19: Number of emergency bed days per 100,000 population in Lochee LCPP neighbourhoods (people under age 65)



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

Whorterbank, Clement Park/Foggyley, Charleston and Lochee are amongst the most deprived areas in the city, whilst Gowrie Park and Sutherland are amongst the least. Chart 19 shows, therefore, that the least deprived neighbourhood areas in the Lochee LCPP have significantly lower levels of unscheduled care usage. It also shows by comparison the high usage of unscheduled care in the less than 65 age group living in five of the 10 neighbourhood areas in the Lochee LCPP.

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

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

This analysis of emergency hospital admission rates alongside emergency bed day rates has been further expanded in the Strategic Needs Assessment.

Community Prescribing Data

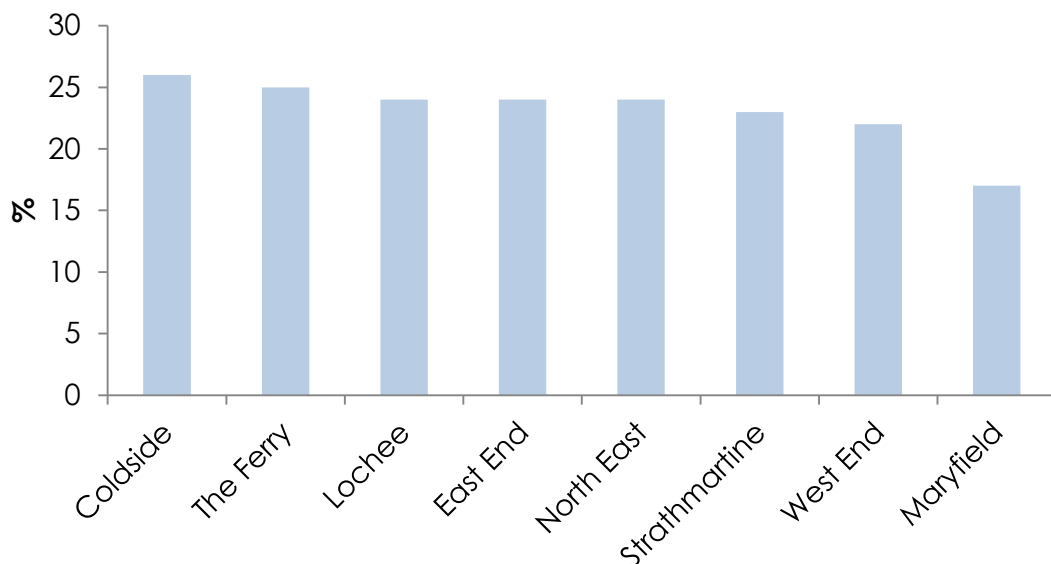
Analysis has been undertaken in relation to data collected by community pharmacies to help us further understand population health need in Dundee. Pharmacy data regarding type of prescription and frequency of use can make it possible to determine morbidity and multi-morbidity prevalence.

The British National Formulary (BNF) chapters with the highest number of prescriptions are similar across LCPP areas. These are:

- Cardiovascular – Cardiovascular drugs
- Central Nervous System – Antidepressants
- Respiratory – Bronchodilators
- Central Nervous System – Opioid Analgesics
- Central Nervous System – Anti-epileptics

Chart 20 shows the % of people who used pharmacies and who were prescribed 5+ distinct BNF chapters and were flagged as high risk.

Chart 20: Percentage of people who used pharmacies and were prescribed 5+ distinct BNF chapters (high risk)



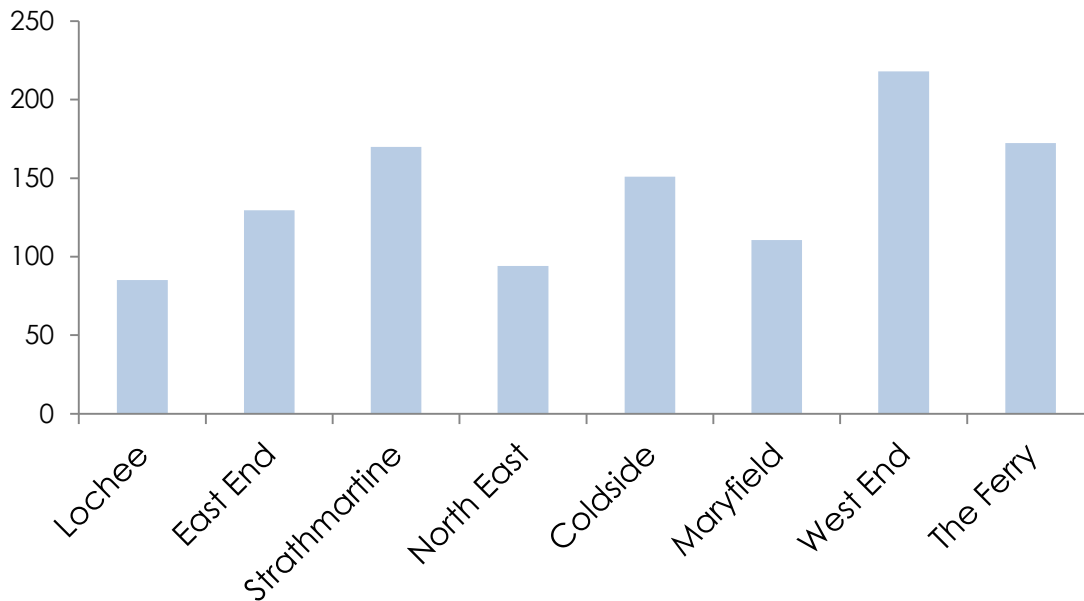
Source: NHS Tayside, 2016

This chart further supports findings which show Coldside as having proportionately higher levels of need based on the prevalence of one or more health condition and rates of unscheduled hospital admissions.

However across all LCPP areas the health needs of people are high. Between 17% and 26% of all prescriptions dispensed were for people who were prescribed five or more distinct BNF chapters and were flagged as high risk.

In addition to prescribing information, pharmacies hold a wealth of additional information which can be used to assess need across the city and between LCPP areas. This includes the number of people registered for a Minor Ailments Service and the number of Methadone Care Plans required.

Chart 21: Rate of people per 1,000, who live in each LCPP and are registered for a minor ailment service within that LCPP



Source: NHS Tayside, 2015

Chart 21 shows the rate of people who live in each LCPP and are registered for a Minor Ailment Service in the LCPP where they live.

The chart is organised in order of deprivation level, with the most deprived LCPP to the left of the chart. Lochee is the most deprived LCPP area and has the lowest rate of people who are registered for this service within their LCPP area. This information should be treated with a degree of caution as people may be registered for a service in another LCPP area. The West End has the highest rate but, as this area covers the city centre pharmacies, people from other LCPP areas may be registered at pharmacies in the city centre.

The Ferry is the area with least deprivation and has the second highest rate of people registered for a Minor Ailments Service within the area where they live.

Our continued assessment of need will further analyse the data collected by pharmacies across the city for additional evidence of key morbidities and multi-morbidities which may have higher prevalence in certain LCPP areas.

g) Palliative and End of Life Care

When a person has a serious illness or is dying, palliative care and end of life care is provided to minimise the impact of suffering and enhance the quality of the person's life. Palliative care includes end of life care, but also extends throughout the illness journey and into survivorship, where this applies.

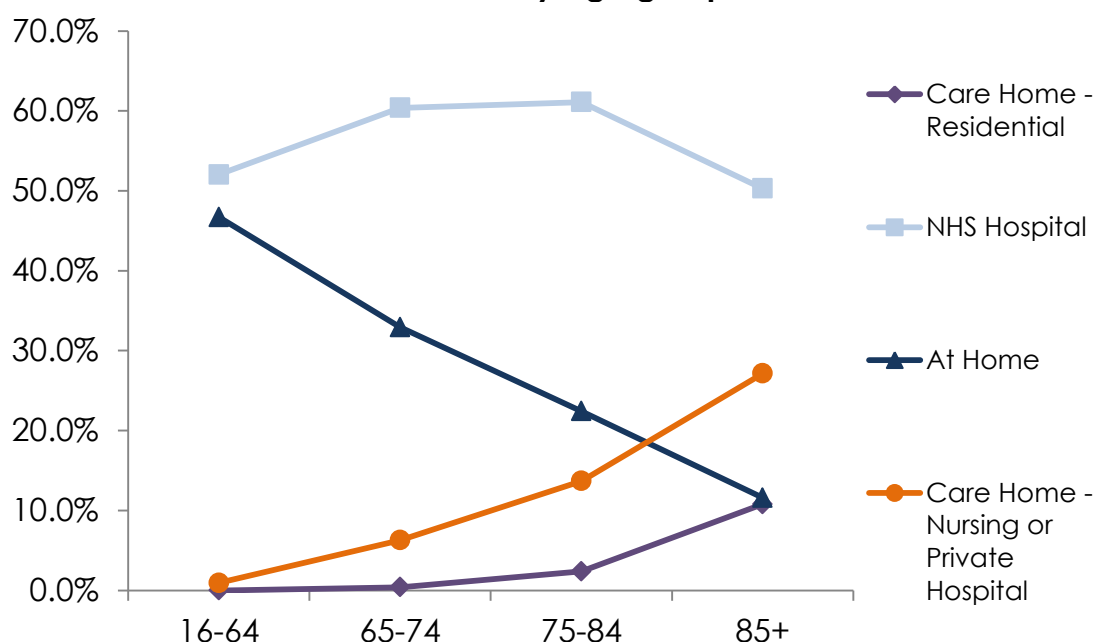
In Scotland around 53,000 people die each year, and this number is rising as the population increases. In March 2013 around 11,800 people were recorded on palliative care registers in General Practice in Scotland. 47% of residents in care homes for older people were also recorded as having an anticipatory care plan at the point at which they died (2013). The number of those who may benefit from access to palliative care is increasing across Scotland.

A recent Scottish study has shown that on a given day in acute hospitals, 10,743 people were admitted. 28.8% (3,093) of these people died within the subsequent year and 9.3% (1,027) died during that admission. This highlights the importance of ensuring high quality palliative care is provided across different settings, and enhancing communication across transitions of care (Scottish Government, 2015).

In Dundee there were 1,579 deaths during the calendar year of 2014. The main cause of death was cancer, and the need for both general and specialist palliative care is rising. A proximal indicator for this is the rising number of referrals to specialist palliative care services in Dundee. Since 2012 there has been a 45% increase in referrals to the palliative care service at Ninewells Hospital. There has also been a 22% increase in admissions to Roxburghe House, alongside an increasing use of day care, clinics and the support provided by Macmillan nursing staff.

When a person dies, the location where they died is recorded. In Scotland, 52.3% of people die in hospital, 30.2% at home and 17.4% in a hospice. Chart 22 shows the location of death for all those who live in Dundee and died in 2014, by age group.

Chart 22 Location at death in Dundee, by age group, 2014



Source: NSS ISD, 2016

Over all age groups in Dundee, 55.7% of people died in an NHS hospital; this is 3.4% higher than the national average. A very small number of people died in other settings; this included a clinic, a prison and a school (four people in total).

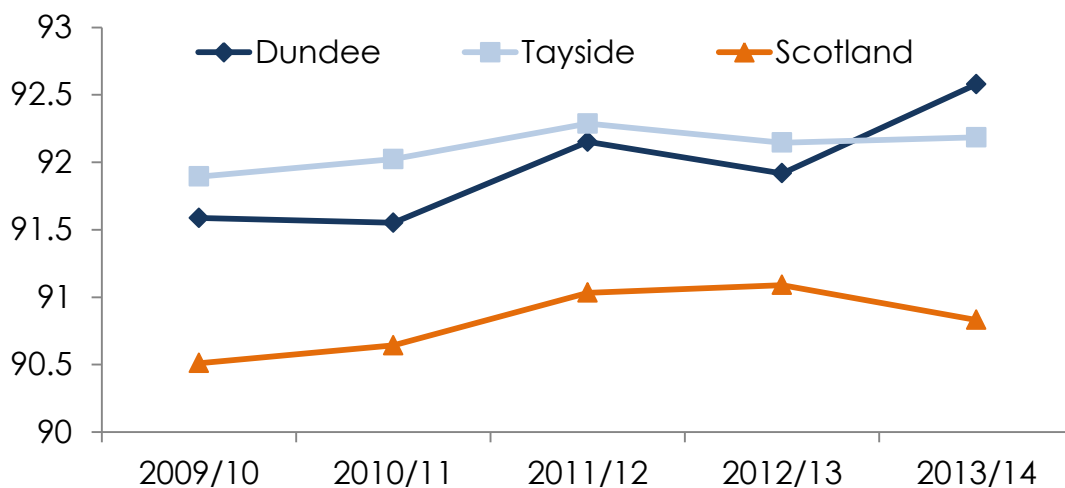
These figures show that the percentage of people dying at home in Dundee dropped significantly with age, with 46.7% of people aged 16-64, and 11.6% of people aged 85+, dying at home.

The percentage of people who died in a residential care home or a nursing home/private hospital increased with age. No people aged 16-64 years died in a care home, and only three people (0.9%) aged 16-64 died in a nursing home/private hospital. The proportion increased considerably with older age, with 10.8% of deaths for people aged 85+ being in a residential care home and 27% in a nursing home/private hospital.

Chart 22 shows that the percentage of people who died in an NHS hospital did not vary considerably across the age groups. However there was an increase by age for those up to the age of 84. 52% of deaths for 16-64 year olds occurred in an NHS hospital, and this increased to 60.4% of the 65-74 age group, and 61.1% of the 75-84 age group. The percentage then decreased for the 85+ age group, as 50.3% of people aged 85+ died in an NHS hospital. This decrease correlates with the increase in deaths in care/nursing homes and private hospitals for the 85+ age group.

There is also data available for the length of time people spent at home, or in another community setting, during the last six months of life. Chart 23 shows figures for the period 2009 – 2014 for the percentage of time people in Dundee spent at home or in a community setting, during their last six months of life.

Chart 23: % of time in the last six months of life spent at home or in community setting, for Dundee, Tayside and Scotland, by LCPP 2009-2014

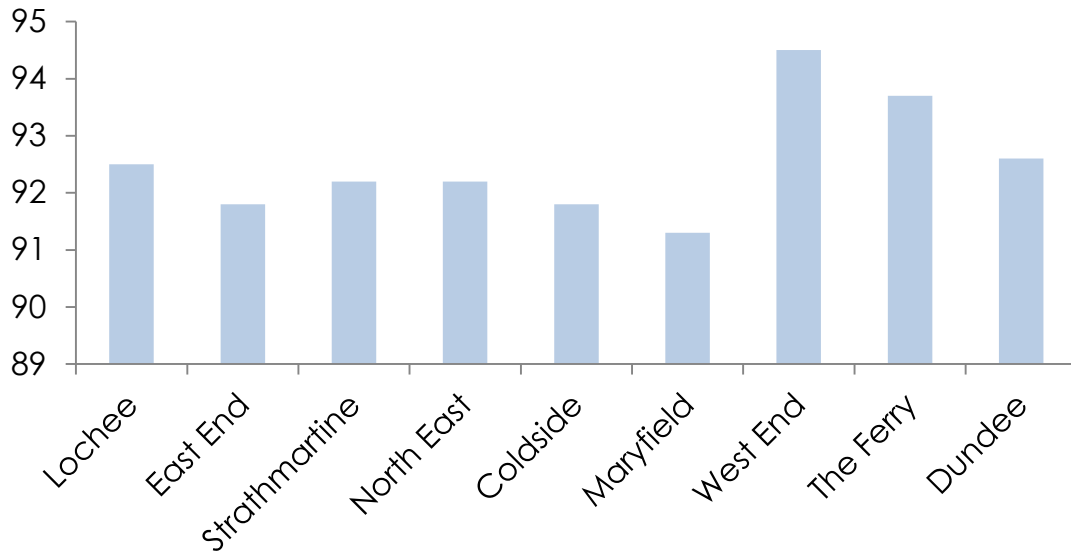


Source: Percentage of End of Life Spent at Home, ISD Scotland

This chart shows that between the years 2009 and 2014 there has been a gradual increase in the amount of time people in Dundee spent at home or in a community setting during the last six months of life. In 2013/14 92.6% of time for people in Dundee was spent at home or in a community setting. This figure is slightly higher than the percentage for Tayside and Scotland as a whole.

The following chart shows the percentage of time spent at home or in a community setting in the last six months of life, for people in Dundee in 2013/14, by LCPP area.

Chart 24: % of people in Dundee who spent their last six months of life at home or community setting, by LCPP, 2013/14



Source: Percentage of End of Life Spent at Home, ISD Scotland

Chart 24 shows that people spent most of their time living at home, or in another community setting, in the months prior to their death. There was slight variation between the most deprived LCPP areas and the most affluent LCPP areas. The West End has the highest percentage of time spent at home or in a community setting by people in the last six months of life, and this is one of the most affluent LCPP areas.

From the information and figures available it is not possible to determine whether the proportion of time people in Dundee spent at home in their last six months of life, or the location of death for those involved, would have accorded with their personal preferences or choice. If this is an indicator against which the performance of health and social care services is to be measured in the future, the information and data gathered will have to be extended to allow this further level of more detailed analysis to take place.

h) Levels of Risk and Need for Public Protection

There is a strong relationship between the levels of deprivation in Dundee, and the levels of risk and abuse being experienced by individuals and families living in many communities across the city.

The responsibility for responding to, and providing protection and supports for those involved, is multi-agency, and requires strong strategic leadership and co-ordination of service delivery. As described in Section 2.3.6 there is a Protecting People governance group and framework in place through which the development and co-ordination of protection services takes place. The following are the key areas in which co-ordinated protection activity is managed in Dundee.

Child Protection

The Protecting People framework includes the arrangements in place to ensure that children at risk of abuse or neglect are appropriately protected.

The responsibility for managing child protection arrangements sits with Children's Services and is not directly 'in scope' for the Dundee Health and Social Care Partnership. However the route to improving outcomes for children and young people is frequently through the provision of services for those adults who are responsible for presenting risk, or who are unable to provide the children involved with the care they require.

This means that there is a need for the targeted involvement of Adult Services from substance misuse, mental health or learning disabilities services (as well as other relevant professionals from across the adult services network) to address the adult treatment and support needs as a component part of each individual Child's Plan.

An area of concern in which there has been a significant increase in awareness, as well as in the level of perceived risk, is child sexual exploitation. Depending on the age of the young people involved, there may be overlaps in the roles of child and adult protection in addressing such risk.

At the same time there are clear responsibilities within Dundee's MAPPA framework, for reducing the risks presented to the wider population by registered sex offenders.

We are aware of the complex nature of child abuse, the poor outcomes for children, if not appropriately protected, and the need for a well co-ordinated multi-agency response. As a new Partnership we recognise that Adult Services have an essential contribution to make to the continuing effort to reduce the number of children and young people in Dundee who experience abuse or neglect and improve their health and wellbeing outcomes.

Adult Support and Protection

The Adult Support and Protection (Scotland) Act 2007 places a duty on the local authority to look into the circumstances of adults at risk and to protect adults who because of a disability, health condition, or age, are less able to protect themselves or their own interests. The Act also gives powers to intervene where an adult is at risk of serious harm, via protection orders, which are applied for through the court.

While Social Work has the lead role, adult protection is a multi-agency responsibility, and a central provision of the Act is the obligation on named statutory agencies to collaborate in adult support and protection activity. Such multi-agency collaboration is evident at various levels in Dundee.

The number of referrals received where an adult protection concern was reported in Dundee has progressively risen over the last five years as follows:

- 125 in 2009/10
- 368 in 2010/11
- 584 in 2011/12
- 562 in 2012/13
- 895 in 2013/14
- 1313 in 2014/15

This increase is in part related to improved awareness by professionals of the protection needs of adults, but it is also a reflection of the impact of deprivation and the resultant social problems in Dundee.

Adult abuse takes many forms but includes physical, psychological and emotional harm, as well as financial harm. Referrals for an adult protection response are also made when self-harm is involved. Depending on the severity of the risk, most referrals result in no formal action.

In 2014/15 82 referrals proceeded to Initial Referral Discussion or Adult Support and Protection Case Conference. Of these financial harm was the type of harm most likely to proceed through to more formal investigation and co-ordination processes (45% of the 82 referrals). Over the three year period 2012 - 2015, there were 44 Case Conferences held in Dundee where one of the concerns related to financial harm.

There are several factors which may increase an individual's potential vulnerability to financial harm. These include living alone and loneliness, increased dependency on external support, and reduced capacity to manage financial affairs.

For older people in particular, potentially increased assets coupled with low cost lifestyles and a lack of awareness of the modern world may make them more susceptible.

(SCIE 2011, p7)

When such factors are considered in the context of the age demographics for Scotland over the next 20 years, we clearly face a national challenge. At a local level the protection of the adult population in Dundee from financial harm, and from the many other forms of adult abuse, is one of the priority areas which the Health and Social Care Partnership, in support of the work of the Adult Support and Protection Committee, will increasingly require to address in the coming years.

Violence Against Women (VAW) and Domestic Abuse

VAW can take many forms. This includes domestic abuse, rape, sexual assault, forced marriage, female genital mutilation and prostitution. Whatever form the abuse takes, it can have an immediate and long-lasting impact on the health, well-being and safety of individuals, families and communities. Those affected by VAW include some of the most vulnerable people in our communities and have a range of complex needs. The Scottish Government is currently re-writing the national VAW strategy (Equally Well) to give this issue greater strategic emphasis.

In 2014/15 there were 1,703 incidents of domestic abuse recorded by Police Scotland per 100,000 population in Dundee. These figures were the highest recorded for any local authority area in Scotland.

The actual number of incidents of domestic abuse recorded by Police Scotland for Dundee City over the past three years is:

- 2,525 in 2012/13
- 2,442 in 2013/14
- 2,525 in 2014/15

Scottish Government Crime & Justice Figures, published 2015

There is a well established framework in Dundee within which multi-agency risk assessment conferences (MARAC) take place to agree multi-agency protection and support plans to improve the safety of people at risk of serious harm from domestic abuse.

Between 1 January and 31 December 2015 the circumstances of 142 people were the subject of MARAC in Dundee. There have to date been a very small number of men (under five in any given year) who are considered through MARAC processes.

The Dundee VAW Partnership is currently updating its strategy and is developing an action plan to strengthen the responses of agencies to violence against women in the city. It is planned to develop the use of multi-agency hubs within local communities, as both access points for services, and bases from which a co-ordinated multi-agency response can be planned and managed.

As a Partnership we recognise the key role many health and social care staff play in protecting those at risk of violence and ensuring that their needs are met. We are fully committed to working with partners to strengthening our multi-agency response and to reducing the prevalence of violence against women in Dundee.

Multi-Agency Public Protection Arrangements (MAPPA) and Supervision of Offenders

Over the last five years crime levels across the city as a whole, in almost all of the major crime groups, have shown a downward trend. This includes reductions in robberies and house break-ins (both of which have reduced by more than one third) as well as violent crime, which fell by 16.8%. At the same time a high proportion of the community (98%) have indicated that they feel increasingly safe and believe that crime is reducing (Dundee Annual Citizens Survey 2012).

We do, however, continue to experience increasingly high levels of domestic violence, high numbers of short term prison sentences of less than twelve months for acquisitive substance misuse related crime, and high levels of drug related deaths, particularly among prison leavers. There also continue to be a small, but significant group of offenders whose behaviour may present a serious risk to members of public, including children, young people and women.

Analysis of the reports provided for Dundee's courts by Criminal Justice Social Work in 2014/15 shows that 66% of reports were for people who lived in SIMD quintile 1, and 86% were for those who lived in either SIMD quintile 1 or 2. These figures show that there is a very strong correlation between the prevalence of deprivation in Dundee and involvement in criminal behaviour.

These figures also show that:

- 80% of court reports produced were for males, with 20% for females
- 78% of the people to whom reports related were unemployed
- just under 20% had committed violent offences; of these, 6% involved domestic violence
- 5% of reports were for people who were homeless, or in homeless accommodation, and 16% were in prison

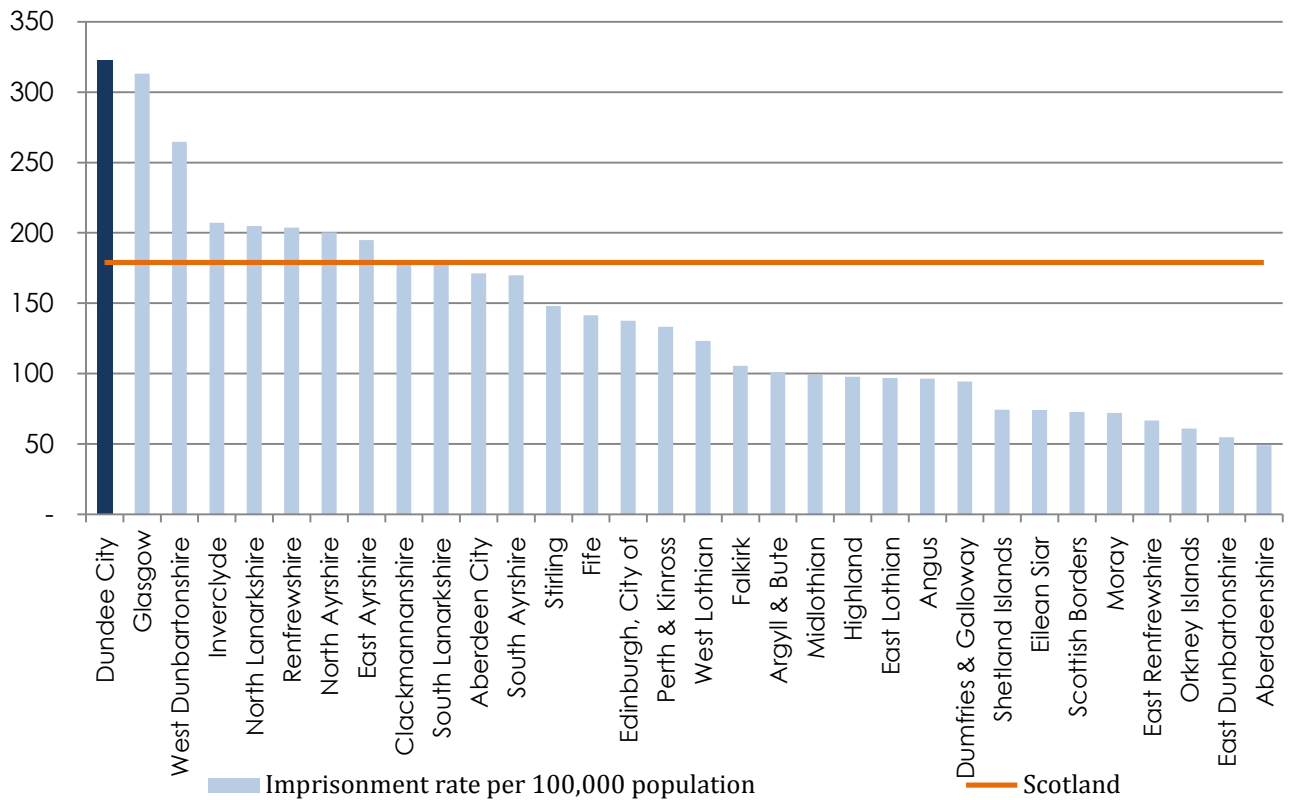
The Management of Offenders etc. (Scotland) Act 2005 introduced a statutory duty on Responsible Authorities i.e. local authorities, Scottish Prison Service, Police and Health to establish joint arrangements for the assessment and management of the risk posed by certain categories of offenders, currently registered sex offenders and restricted patients, who present a risk of harm to the public.

The operation of MAPPA is now well established in Dundee, and the Public Protection Team (PPT) in CJS assess and manage registered sex offenders who are subject to community and post-custodial supervision requirements. At 31 March 2015, 160 offenders were being managed through MAPPA; this represents a significant increase in numbers compared with the same time the previous year.

The PPT also supervises all statutory through care of long-term prisoners serving more than four years, which includes those who have been convicted for violent offences. The Team's role includes the assessment and preparation for release of such offenders while they are in custody, as part of statutory through care arrangements. The total number of people recorded as being subject to through care in prison at 31 March has increased year on year, from 114 in 2011 to 165 in 2015.

As shown in Chart 25, Dundee has the highest imprisonment rate in Scotland, with 322 people per 100,000 of the prison population on 30 June 2013 (compared with the Scotland average of 179 per 100,000).

Chart 25 Prison population at 30 June 2013, per 100,000 population in Scotland



Source : Prison Statistics Scotland 2013-14, Scottish Government

A high percentage of the population in Perth Prison are from Dundee, with many serving short sentences of less than one year. The needs of people who receive a prison sentence, particularly those who are separated from their children, families and communities for significant periods of time, can be considerable. They often require a robust package of services and supports to help them to re-integrate into everyday life, and where it is possible, within their own local communities.

While other forms of offending are reducing, domestic violence and substance misuse are likely to continue to form two of the main priorities for community justice partners, as they move forward.

We are committed as a new public protection partner to contributing to the collective effort, and to using our combined resources, to keep individuals, families and communities as safe as possible. We are also committed to providing the best support possible for those who are at risk/have experienced harm or have been involved in offending, to support them as individuals towards rehabilitation, recovery and improved outcomes.

i) Population Health and Wellbeing Summary

In conclusion the main drivers for change using evidence based population health and wellbeing data in Dundee are:

- the current and projected demographic changes taking place, which may have an impact on the size of the working population and the economy of the city over the next 10 years
- the increase in life expectancy and significant increase in the older people population, in particular the 75+ and 90+ age groups
- the decrease in the number of people aged 50-64, who are the main providers of unpaid care for older family members
- the level of deprivation and the health and social inequalities across Dundee, affecting people of all ages who live in deprived neighbourhoods
- the level of obesity, substance misuse, poor sexual and reproductive health and wellbeing, and teenage pregnancy
- the prevalence of health conditions and multi-morbidities in the older people population, as they live longer, but rely increasingly on health and social care services for care and support
- the higher level of morbidity and multi-morbidities experienced at a younger age by people affected by deprivation and health and social inequalities
- the impact of earlier morbidity and multi-morbidities on people in the 50-64 age group, both in terms of their own care needs, and their capacity to provide unpaid care for older family members
- the variation in the levels of need between LCPP areas, and within LCPPs at a neighbourhood level
- the high level of unscheduled care in the city
- the number of people who die in hospital when it may be their wish to die at home and the need to extend the provision of palliative care to all those who need it
- the level of need for protection and support across all age groups
- the level of violence against women and domestic abuse in the city
- the high number of people from Dundee who receive prison sentences and the level of need for support and services on release

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

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

More detailed information regarding this 'direction of travel' is provided in the 'What Needs to Change' section of this Plan.

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

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

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

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

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

The further drivers for change which have been identified as part of our self-evaluation process are detailed as follows:

a) Centralised Service Development and Decision Making

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

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

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

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

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

b) Services not Tailored to Address Community/Locality Differences

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

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

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

for those who have received this enhanced level of community based support.

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

The delivery of community rehabilitation services is also being integrated to strengthen the interface between hospital and community rehabilitation nursing services, Allied Health Practitioner services, social work occupational therapy and home care enablement services, the Community Equipment Store and the third sector. The aim is to develop an integrated model of community rehabilitation and enablement, with single integrated policy statements and agreed criteria for equipment, aids and adaptations.

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

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

c) Contribution of Unpaid Carers

There is a significant level of 'unpaid' care and support provided by family and friends for many people in Dundee who have health conditions and/or are frail due to older age. The provision of such unpaid care can avoid the need for more formal health and social care services, and is frequently delivered as part of packages of care and support, alongside services provided by the health and social care sector. This is particularly the case for those with very high level care and support needs who are being supported in their own homes or other community settings.

According to the 2011 Census there were 13,072 carers in Dundee at that time, and it is estimated that together they were providing on average 360,000 hours of care each week. If such unpaid care had not been available those requiring support at home may have needed to seek more formal forms of social care, which they may have had to fund themselves. The cost of Dundee's home care service is approximately £15 per hour. Of the total number of carers in Dundee at the time of the 2011 Census, there were 3,909 who were providing more than 50 hours of care each week.

Those who were receiving this level of care from family or friends may otherwise have been unable to continue to live in their own homes, and may have had to move to housing with care or to residential or nursing care, depending on the nature and level of their individual care and support needs. The costs of such provision are high and can require a significant financial contribution from the individual involved and/or their family, depending on individual circumstances and means and the type of resource identified.

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

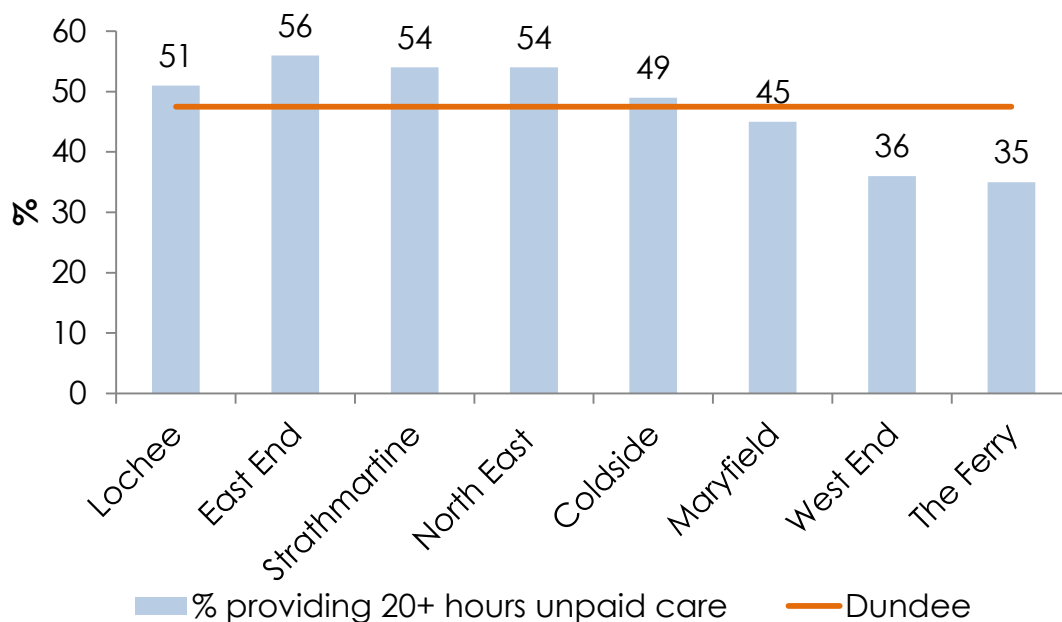
It is clear therefore that we must ensure unpaid carers are appropriately supported to carry out the valuable role they play in the provision of care and support in the city. This includes the improvement of support to those who are already providing unpaid care, as well as those who in the future will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

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

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

Chart 26 shows the differences between LCPP areas in the level of unpaid care provided by identifying the percentage of unpaid carers in each LCPP area who deliver in excess of 20 hours unpaid care each week.

Chart 26: % of carers in each LCPP who provide over 20 hrs of unpaid care



Source: Scotland Census 2011

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

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

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

It is clear that unpaid carers as individuals, and collectively as a total resource, are one of Dundee's most valuable assets. It is a priority for us to ensure that they are provided with the support they require, which will allow them to continue to deliver the best quality care and support they can, to those who rely on them for their care and wellbeing.

d) Support is not Sufficiently Individualised

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

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

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

Alongside such developments there has been a growing emphasis on the need for more integrated and personalised approaches to working with people who need services and their carers, in the identification of individual outcomes and planning their care and support. There has been an increased drive towards professionals adopting more co-productive approaches to their working relationships with people and their carers. That means relationships within which those who need services are actively supported to play a central role in identifying the outcomes they wish for themselves and the ways in which these outcomes are to be achieved.

At the same time it has been recognised that all of the different professionals involved with each individual and carer must work together in practice to achieve more integrated and holistic assessment, care and treatment planning and improved outcomes for those who require health and social care services.

Progress has been made locally in the development within social work of an Outcomes Focused Assessment Framework. Training has been provided to social work and social care staff to help them make the conceptual shifts in their approach which is supporting practice change. This training is now also being rolled out to community nursing and other community health professionals, as well as housing staff and relevant independent and third sector organisations providing services as part of the health and social care system in Dundee.

Further work is required within social care services to help staff to integrate this approach into front line practice and ensure that the required 'outcome focused conversations' take place at the earliest point of contact possible. This is to ensure that service users and their carers are supported to consider the most appropriate options available to them to meet their care and support needs and improve their outcomes. These conversations need to focus on what matters to a person in their own lives, what they can do for themselves, what supports they already have available and how services can complement the personal resources already available to them.

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

Such 'asset' and recovery based approaches are currently being integrated into professional development activities for health and social care staff, and are being reflected in the new 'My Life' information portal and in the design of new support systems.

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

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

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

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

e) Palliative and End of Life Care

Death and dying affects us all at some point in our lives, and the quality of life and supports provided to individuals and their families during periods of life-limiting illness, and at the end of life, is the core business of health and social care services.

In working to avoid premature or avoidable deaths, as well as identify and care for those who are dying, it is the role of health and social care to promote wellbeing throughout each person's life and provide appropriate support to 'end well'. Ending well is important for everyone as individuals, but it is equally important for those who are bereaved and affected by a death. The provision of good quality palliative and end of life care is therefore critical to achieving good health and wellbeing outcomes for people in Dundee.

The Scottish Government's vision for palliative and end of life care is that:

By 2021, everyone in Scotland who needs palliative care will have access to it.

Strategic Framework for Palliative and End of Life Care,
Scottish Government 2015

The definition of the term palliative care is that it is:

..an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

World Health Organisation (WHO) 2014

Palliative and end of life care is not disease or location specific. It is relevant to all types of serious, life-limiting illness (including cancer, organ failure and frailty) and it can be provided at any point of an illness 'journey'. It can also be provided to people in any setting, whether they are living at home, in a hospice, in a care home or a hospital ward.

The data available shows that more than 50% of people die in a hospital setting, highlighting the importance of high quality palliative and end of life care in, and across, different settings. It also means that ensuring effective communication takes place across transitions of care is critical.

While the setting for end of life is important and is highlighted as a specific concern for those with serious illness, it is also important to recognise that this is not usually identified as a primary concern by people themselves. Higher priority is frequently given to such concerns as the need for pain and other symptoms being controlled, dignity being upheld, involvement in decisions being ensured and the provision of information being clear, timely and honest.

People also express a wish for their care to be as holistic and person-centred as possible, and to present the least possible burden on others. Legacy, practical and financial issues are also further highlighted as being of high importance nationally. The provision of good quality information and systems of communication have been identified as areas of priority in the Strategic Framework for Action on Palliative and End of Life Care (Scottish Government, 2015).

For all of these reasons there is a need to undertake further work in Dundee to identify local priorities, decide on the actions required to address these, and agree measures to allow us to track our progress against agreed outcomes and indicators.

In The National Clinical Strategy for Scotland, 2016 the Scottish Government outline their aspiration to strengthen primary care, which will be delivered by:

.. increasingly multidisciplinary teams, with stronger integration (and where possible, co-location) with local authority (social) services, as well as independent and third sector providers.

National Clinical Care Strategy, Scottish Government, 2016

The aim of the expanded health and social care team is to promote and support self-management and independence, person-centred care, and community based services. One of the central aims is also to provide sensitive end of life care in the setting of people's choice. How and where people die is regarded as a significant indicator of the quality of health and social care services provided for those who need them at this critical time.

The principles and practice of integrated health and social care resonate well with a palliative care ethos. We are committed as a Partnership to working with other partners, particularly in the NHS Tayside Acute Sector, to improving the experience of those who have a life-limiting condition and those who are receiving end of life care, in pursuit of the following outcomes:

- People's wellbeing is supported even as their health declines
- People die well
- People are supported through bereavement

Scottish Partnership for Palliative Care, 2015

We recognise that to achieve this we need to build an effective model of multi-agency team working and engagement within localities. There is a need to build further on collaborative working and education between the public and all of the professionals and third parties involved in the delivery of general and specialist palliative care. Such collaboration has a strong foundation in Dundee and Tayside and can be further enhanced through integration. There is an agreement to establish a Managed Care Network for Palliative and End of Life Care in Tayside, linking such partners in Dundee and across Tayside.

We also need to make the best use of our combined knowledge, skills and resources to deliver holistic and integrated treatment, care and support, for those who need it, when they need it, and where possible in the settings of their choice.

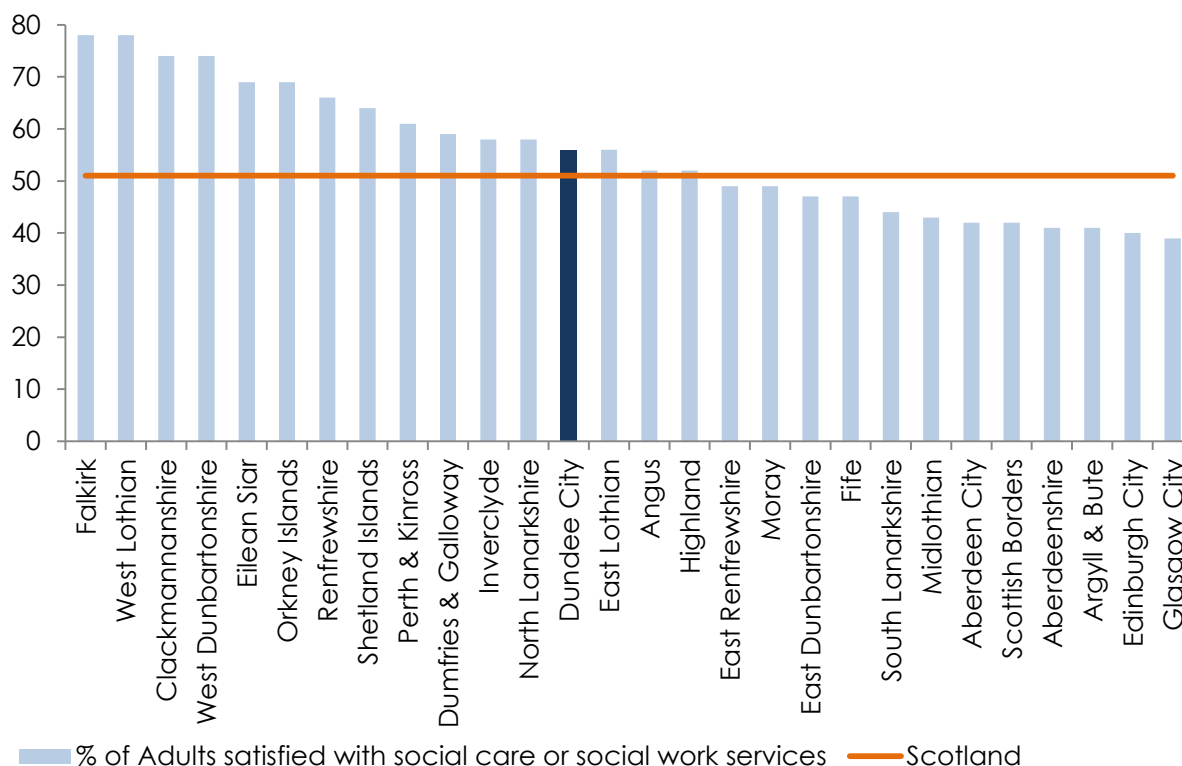
f) People Report Variable Experiences of Care and Health

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

Chart 27 shows satisfaction levels with social work services, by local authorities in Scotland, reported in the Scottish Health Survey for the year 2014-15. Although the number of survey responses may be relatively small, and information is not available for all local authorities, the following chart does provide some helpful indication of Dundee's performance relative to other local authorities in Scotland.

Chart 27 shows that 56% of the adults who responded were satisfied with social work services in Dundee, a figure that is higher than the Scottish average of 51%, and significantly higher than the other three cities in Scotland. Nevertheless Dundee performs poorly when compared with Falkirk and West Lothian, which showed satisfaction levels more than 20% higher.

Chart 27: % Adults satisfied with social care or social work services 2014-15



Source: Improvement Service 2015

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

It is recognised that such surveys have their limitations, as there may be disproportionate representation of positive views, due to the potential bias which the reliance on self-reporting can bring to such feedback. It is also clear that those whose views are being sought do not always have a good understanding of the nature and quality of care they can reasonably expect to receive, or the outcomes that alternative service delivery arrangements or models of service might offer, if made available. The introduction of systematic recording and reporting of individual outcomes should provide a much stronger evidence base for the quality and effectiveness of health and social care services in the future.

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

delivered, so that the impact of deprivation can be reduced and outcomes improved for individuals, carers and families living in deprived neighbourhood areas across the city.

5.1.3 Analysis for Change: Fiscal Constraints

a) Increasing Demand/Reducing Resources

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

The impact of the 2016/17 finance settlement for local government in Scotland has resulted in local authorities having to consider unprecedented levels of savings. Locally, Dundee City Council is facing an overall funding reduction in its funding settlement in 2016/17 to the extent that a total of £23 million savings is required for the year, with further considerable savings anticipated in 2017/18 and beyond.

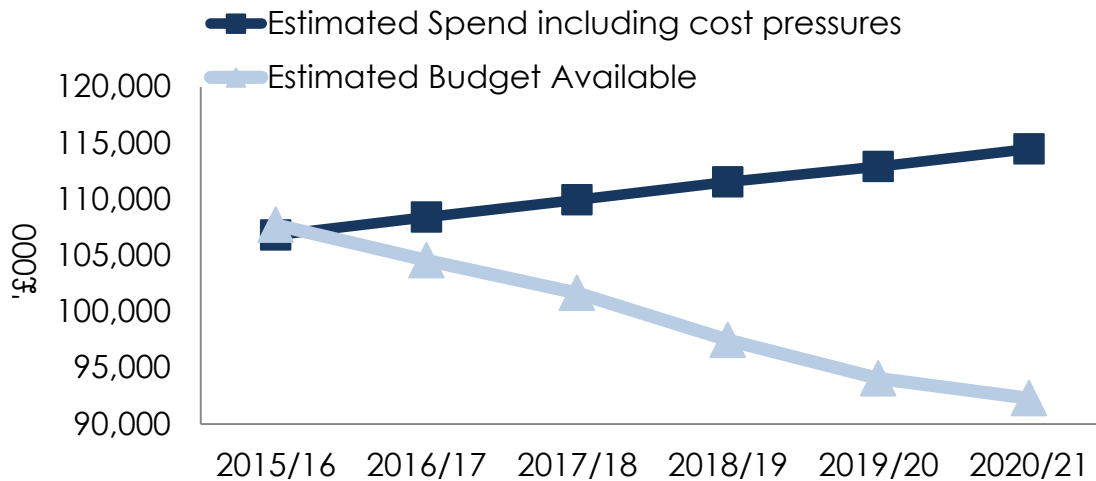
While NHS services have been relatively protected as a spending priority by UK and Scottish Governments, the extent of financial pressures within the health system also provides considerable challenges. Within NHS Tayside, while an uplift of 1.7% in funding to Health Boards has been provided within the finance settlement, average savings of around 5% per annum over the period of the Plan are anticipated in order to bring expenditure in line with budgeted resources.

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

b) High Cost/Reduced Budgets

Chart 28 shows the estimated spend required to meet this increasing demand in Dundee across a significant number of care group services, should these broadly continue to be provided in the same way as they are currently against the estimated budgeted resources available over the period of this Plan.

Chart 28: Service Groupings – Estimated Service Demand v Available Resources



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

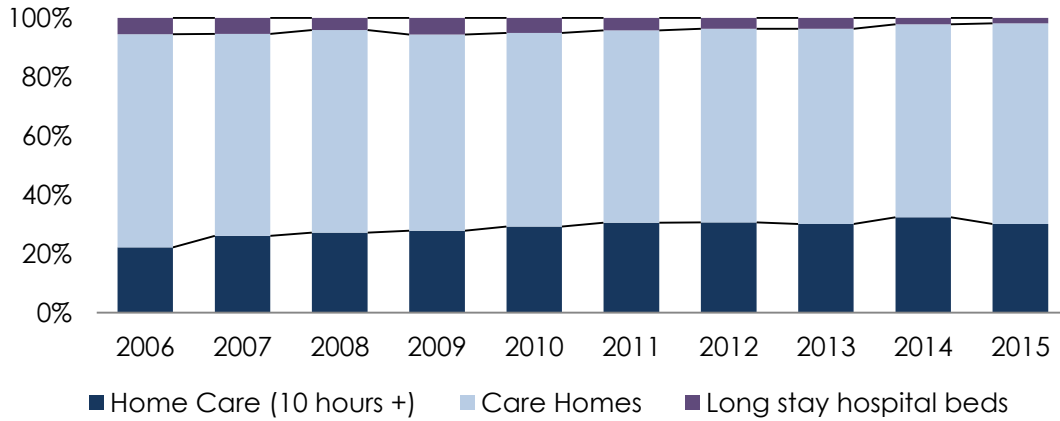
c) Sustainability of Current Models

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

d) Balance of Care

Chart 29 shows that over the last 10 years there has been a positive change to 'shift the balance of care' from just over 20% in 2006 to 30% in 2015. What this means is that instead of being admitted into a care home or a long stay hospital bed, many people are now being supported to remain in their own homes, with a package of home care of at least 10 hours per week. This highlights progress has been made, however more needs to be done.

Chart 29: Balance of care for Dundee (age 65 and over) 2006 to 2015



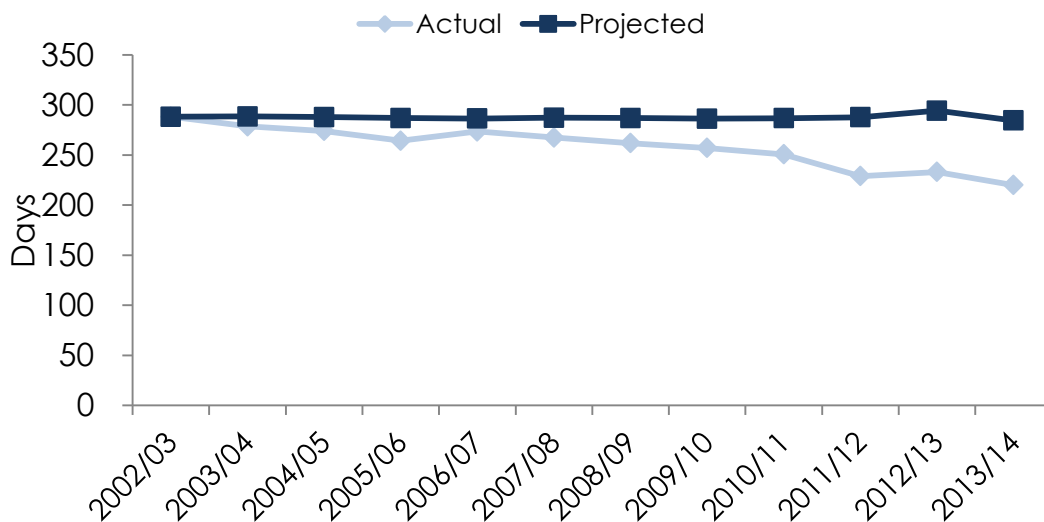
Source: Health and Social Care dataset, Social Care survey, Scottish Government

e) Effectiveness of Current Models

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

Chart 30 shows the projected and actual bed day usage for people age 65+ in Dundee. The projected figures were calculated by applying the annual population change to the baseline year at 2002/03. The difference between the actual and the projected is a reflection of changes (other than population change) which have occurred in the period.

Chart 30: Trend in emergency bed day usage for people aged 65+, actual and predicted 2002-2014 in Dundee



Source: NSS ISD, 2015

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

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

5.2 What Needs to Change

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

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

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

Under each of these eight priorities there are a range of strategic shifts that have been identified. It is recognised that all of these priorities, and their associated strategic shifts, are 'cross cutting' and will impact on each other. For the purposes of clarity, however, the following are the strategic shifts which are most strongly related to each of the eight priorities identified.

5.2.1 Strategic Priorities and Shifts

1. Health Inequalities

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

2 Early Intervention/Prevention

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

3 Person Centred Care and Support

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

4 Carers

- Investing more in the health and wellbeing of carers

5 Localities and Engaging with Communities

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

6 Building Capacity

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

7 Models of Support/Pathways of Care

- Investing in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community
- Redesign models of non-acute hospital based services and re-invest in community based services
- Remodelling local authority residential care to provide more targeted and specialist resources

- Remodel General Practice in line with G.P. cluster model, the changes to the GMS contract and the opportunities afforded through integration
- Investing in the transformation of community nursing services to deliver the Tayside District Nursing vision and model, improving outcomes for adults and older people
- Remodelling and investing in the development of, and increase in, accommodation with support
- Remodelling and investing in the development of day opportunities for adults and older people
- Investing in and expanding the range of telehealth and telecare supports
- Re-model and prioritise mainstream and specialist services to ensure a rapid and effective response to protecting people concerns

8 Managing our Resources Effectively

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

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

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

5.3 Working in Localities

5.3.1 Locality Model

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

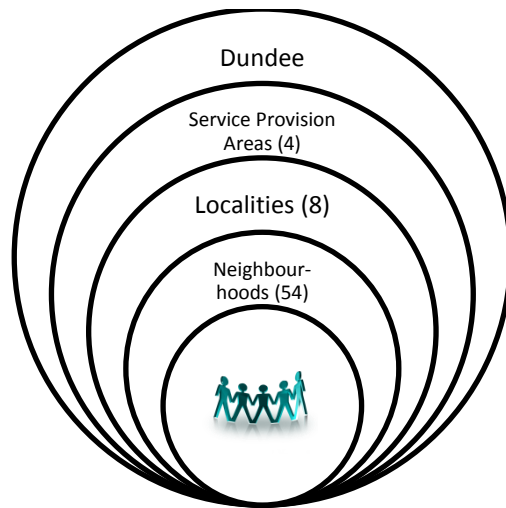
The concept of localities is embedded within the Plan and will be based on Dundee's 54 'natural' neighbourhood areas, and eight localities, as well as four service provision areas. This model will support locality engagement, planning, decision making and accountability. It will be the level at which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

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

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

This concept of dividing the city into four service areas will facilitate the first step towards a sustainable model of locality within the city, which is suitable for service delivery. It will allow targeted multi-agency services and specialist services to be aligned to meet the needs of service users and patients with specific or complex care needs. This will also support a manageable communication framework for professionals and service providers. The different levels of locality working are shown below.

Figure 1



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

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

5.3.2 Profiling Localities

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

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

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

5.3.3 Locality Engagement

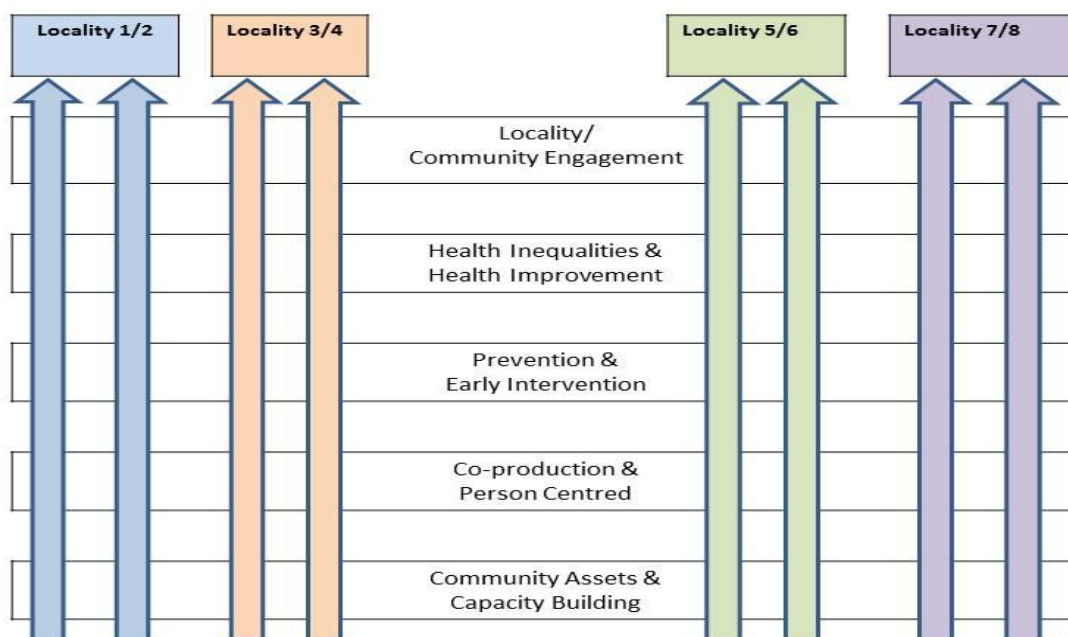
An engagement programme with localities will commence during the period of this Plan to co-produce eight health and social care locality plans. It is anticipated that tests of change will be progressed following this process. Many services provided through the third sector have grown from the identification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

5.3.4 Phased Development of Locality Based Assessment and Service Delivery

There will be two phases to the development of locality based assessment and service delivery models. Phase one will focus on those who have a long term condition, either as a result of ill health or older age, and who are most likely to receive their ongoing care and support through services accessed through their G.P. Practice.

Phase two will develop care pathways for adults who access more specialist services. Both these phases will take into account the modelling around G.P. Practices and the recognition that for most G.P.s, patients will be drawn from the whole of the city, rather than a geographical area.

Figure 2 Locality Framework



Phase 1

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

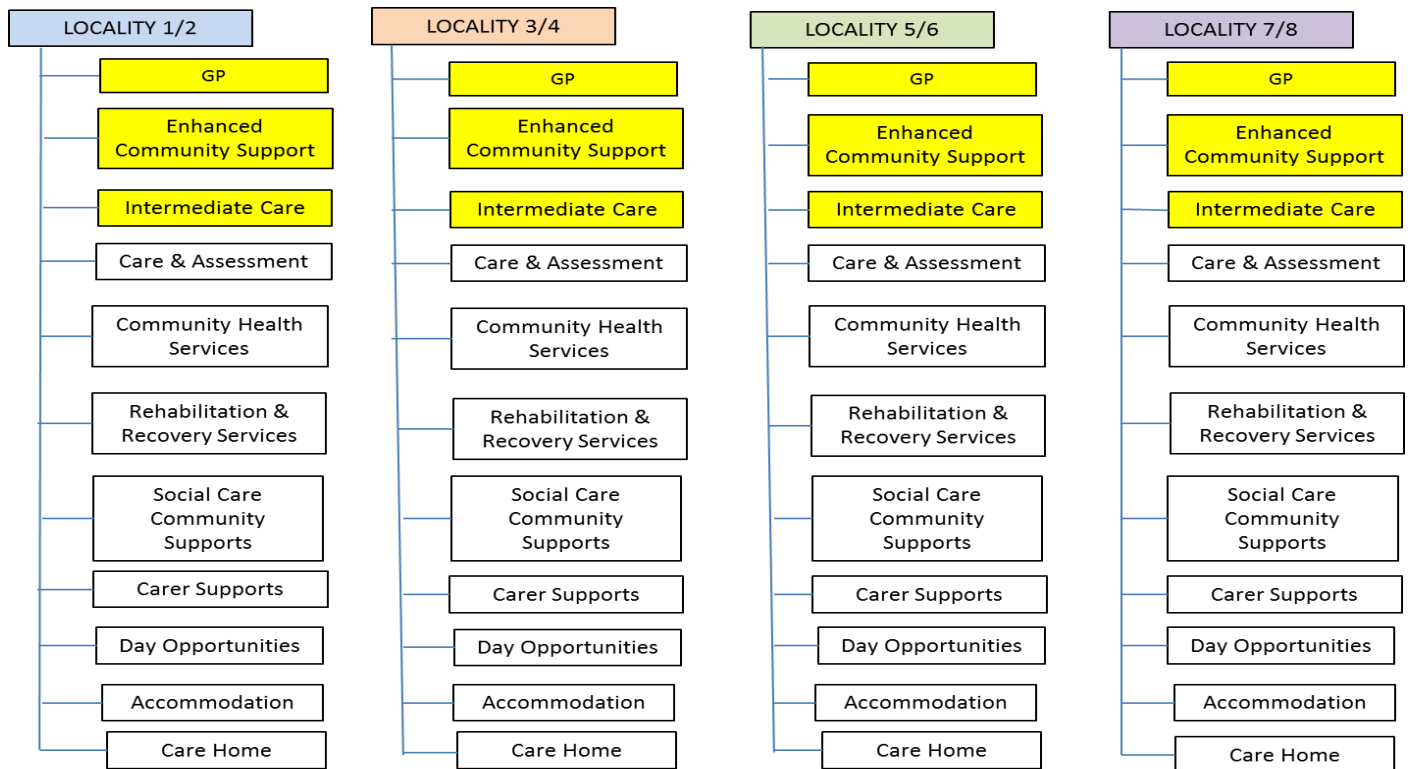
As this model develops, G.P. Practices and other professionals will be the direct referrers to an assessment and service delivery 'hub'. This hub will be both virtual, in that it will provide a point of access to services delivered within the locality and/or service area, and building based, which includes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

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

Through time each of these services will be modelled to demonstrate an alignment with each geographical service area. As the model develops we would anticipate that the teams aligned to the 'hubs' will become co-located within the localities they serve and that the referral pathways will be redesigned to facilitate self referrals and referral by a wide range of organisations. As individuals will be known to the locality teams it is anticipated that this model will support earlier discharge from hospital and prevent inappropriate admissions to hospital and care homes.

This new model of locality structure is represented within Figure 4.

Figure 3 Model Locality Structure



Phase 2

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

5.3.5 Alignment of Staff to Localities

Throughout the move to locality working we will continue to review the roles and responsibilities within the workforce in order to provide a more integrated approach. This will be reflected through the Workforce and Organisational Development Strategy which is a Companion Document to this Plan (link at Appendix 2).

5.3.6 Provision of Small Scale and Specialist Services

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

6.0 STRATEGIC PRIORITIES, SHIFTS AND ACTIONS

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

Strategic Priority 1 – Health Inequalities

Why is it a priority?

Dundee has a high level of deprivation with a widening gap between our richest and poorest communities. There is a high prevalence of ill-health and reduced life expectancy and the population is ageing.

There are a range of health inequality indicators against which Dundee measures poorly compared with other parts of the country. These include levels of substance misuse and mental health issues, as well as smoking and obesity.

We recognise the importance of continuing to support the work of projects which adopt such an empowering and co-productive approach to the development and delivery of services for those most at risk of health and social inequalities in Dundee.

Our aim for this priority is to:

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

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Health Inequalities	Shift resources to invest in health inequalities.	Develop a health inequalities framework that directs the current resources towards the interventions and actions that are most likely to deliver improvement.	2016 – 2019	Full programme of actions from additional resources
		Extend the range of public information and improve information channels.	2016 -2019	2016/17 - £50,000 (Integrated Care Fund – ICF)
		Identify areas where the take up of health initiatives are low and support approaches to improve access and take up.	2016 – 2019	2017/18- £520,000 (ICF)
		Develop innovative partnerships that seek to reduce health inequalities.	2016 – 2019	
		Enhance support to improve mental wellbeing in those who live in areas which experience greater health inequalities.	2016 – 2019	
		Enhance the skills of staff across the Partnership to adopt a social prescribing approach to support individuals.	2016 – 2019	
		Build capacity within communities to tackle health inequalities.	2016 – 2019	

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Make better use of community resources such as libraries and community pharmacies to promote health and wellbeing, including a social prescribing role, as a point of contact with people.	2016 – 2019	
	Prioritise resources towards implementation of the Dundee Partnership Alcohol and Drug Strategy.	<p>Assess the impact of recent budget announcements and take action to review and address any shortfalls.</p> <p>Improve access to alcohol screening and brief interventions in non specialist services working with groups at increased risk.</p> <p>Review and further develop the hub model of substance use provision with local communities to improve access to specialist substance use services and local recovery networks.</p>	2016 – 2021	Redirect resources
	Shift resources to improve access to training and employment.	<p>Secure the provision of education/training in partnership with local further education institutions and through employment focused social enterprises.</p> <p>Amend the approach to employment support in line with the findings of the Dundee Partnership Employability Review.</p>	2016 – 2021	Within existing resources

Strategic Priority 2 – Early Intervention/Prevention

Why is it a priority?

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

There is a recognition of the important contribution made by such services as those provided by The Corner and The Web, through their information, health promotion and support services for young people. The range of contraception, pregnancy testing and sexually transmitted infection (STI) screening services are considered to have played an important role in improving sexual and reproductive health and helping to lower teenage pregnancy rates in Dundee. Although significant progress has been made in reducing the teenage pregnancy rate, there is still further work to be done, particularly in the most deprived communities in the city.

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

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Early Intervention/ Prevention	Invest in or redirect existing resources to scale up well evidenced, early intervention and prevention approaches.	Implement the outcomes of commissioned research on prevention.	2016 – 2017	Within existing resources
		Continue to evaluate current approaches to early intervention and prevention and invest in models which increase capacity.	2016 – 2018	Within existing resources
		Provide access to validated information and materials that support individuals to manage their own health and wellbeing.	2016 – 2018	Within existing resources
		Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self care, and avoid longer term ill health.	2016 – 2021	Within existing resources
		Prioritise and invest in models of support that help to support life style changes which improve health.	2016 – 2018	Within existing resources
		Continue to develop and increase the capacity of volunteers.	2016 – 2018	Within existing resources
		Continue to develop and increase the capacity and early intervention of money advice services to support prevention.	2016 – 2017	£68,000 (ICF)

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Develop shared training programmes for frontline staff to support awareness and understanding of sensory impairment including signposting; sensory health checks and support. Provide sexual and reproductive health services for young people and vulnerable adults that ensure rapid access to services.	2016 – 2017 2016 – 2021	£10,000 (Sensory Impairment Strategy Funding) Within existing resources
	Invest in and expand the Enhanced Community Support model to include adults with long term conditions.	Secure permanent funding and expand the Enhanced Community Support Multi-disciplinary Team for each G.P. Cluster. To include: <ul style="list-style-type: none"> • Advanced Nurse Practitioners • Community Nursing • Allied Health Professionals • Care and Assessment Staff • Locality Pharmacy Team • Social Care Resource 	April 2016 – April 2018	£1,212,000 (ICF)
	Invest in integrated locality based enablement and rehabilitation models of support.	Invest in locality pharmacy support to enhance community support and enablement services. Co-locate the Community Rehabilitation Team with enablement services and develop an integrated approach to	2016 – 2018 2016 – 2017	£132,000 (ICF) Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		rehabilitation. Develop a single referral community rehabilitation pathway across social care, occupational therapy, community rehabilitation and enablement services	2016 – 2017	Within existing resources
	Invest in locality Pharmacy to promote community health advice and better medication management	Invest in pharmacy services to care homes to promote medication review. Develop and implement models to support people to manage their medicines as independently as possible by introducing social care worker administration of medicines. Develop medicines management processes that optimise the most efficient routes and minimise waste.	2016 – 2017 2016 – 2018 2016 – 2018	To be determined 2016/17 - £116,000 2017/18 - £39,000 (ICF) Within existing resources
	Work with and invest in third sector organisations to develop services that take a recovery or rehabilitative approach.	Develop a programme of co-designed activities over the next 18 months/2 years to support recovery in line with the 'Making Recovery Real' initiative.	2016 - 2018	Within existing resources

Strategic Priority 3 – Person Centred Care and Support

Why is it a priority?

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

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

To address this priority we need to:

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

Our current actions:

- Established service provider forums which promote and share good practice.
- Reviewed and developed advocacy services.
- Range of multi-disciplinary, cross sector events held to develop and promote individualised models of support.
- Developed a framework for the introduction of self-directed support.
- Outcome focused assessment framework, tools and support plans reviewed.
- Developed an electronic directory of services (Dundee MyLife website.)

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Person Centred Care and Support	Restructure our financial planning to support the further development of self directed support.	Bridge the change from the current profile of financial resource allocation to free up finances for individual self directed packages of support.	2016 – 2021	£108,000 (Self Directed Support Funding)
		Support the development of new support options through the introduction of a development fund.	2016 – 2021	To be determined
		Sustain and continue to review staff and organisational development programmes to embed person centred practice.	2016 – 2019	Within existing resources
		Review and develop public information and information channels.	2016 – 2017	Within existing resources
		Simplify our processes and systems to make access to care and support easier.	2016 – 2018	Within existing resources
		Support third and independent sector organisations to achieve the Healthy Organisation Award.	2016 – 2021	£46,000 (ICF)
		Further develop systems and processes to ensure standards of quality and safety and best outcomes for individuals are achieved	2016 – 2018	Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		in the provision of services. Review advocacy models of support in collaboration with local advocacy organisations.	2016 – 2018	Within existing resources
	Remodel care at home services to increase the range and flexibility of available options and support people to remain at home.	Invest in the workforce to develop integrated roles, improve quality and increase capacity. Commission internal and external services on a locality basis. Increase the balance of care towards care at home services over the period of the Plan. Work with the Macmillan Local Authority Partnership to develop models of community supports for people living with cancer.	2016 -2018 2016 – 2021 2016 – 2021 2016 – 2019	£53,000 (ICF) Within existing resources Within existing resources £1 million (over 3 years) (Macmillan)
	Remodel and invest in the development of short break options for adults and older people.	Test a Public Social Partnership model of short break provision for adults with Mental Health needs and their carers. Develop a range of short break options for adults with a Learning Disability and/or Autism in collaboration with third sector/independent providers.	2016 – 2017 2016 – 2018	£48,000 (Shared Care Scotland Funding) Within existing resources

Strategic Priority 4 – Carers

Why is it a priority?

The majority of care and support delivered in the city is provided by unpaid carers. We recognise the importance of involving carers as equal partners and 'experts' in the role of caring, and we value their feedback with regard to their experience of health and social care services. Without a successful partnership with unpaid carers, we would not be able to provide for the needs of our citizens nor succeed with this strategy. We know therefore, that we must attend to the wellbeing of carers, and support them to have a life of their own alongside their caring role. One of the challenges is to identify those who are providing care for a family member or friend, as many people do not recognise themselves as a carer. They are not aware of their rights, or how to access support. It is important that we improve the provision of the right information at the right time for those who need it.

This is particularly the case for young carers who as a group have an additional need for support due to the weight of responsibility which comes with a caring role at a young age.

Our aim for this priority is that we improve our identification of those who may need support, recognise the important role of family and unpaid carers, and support them by providing a range of respite and therapeutic options to support them in their caring role.

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

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

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		<p>Identify and address the barriers carers experience when accessing leisure and social activities.</p> <p>Co-locate activities to allow carers and those they care for to pursue their interests and activities in the same place at the same time.</p>	<p>2016 – 2018</p> <p>2016 – 2018</p>	<p>Within existing resources</p> <p>Within existing resources</p>

Strategic Priority 5 – Localities and Engaging with Communities

Why is it a priority?

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

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

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Localities and Engaging with Communities	Invest in an infrastructure to support the development of locality planning.	In partnership with Communities services and the third sector, agree a staffing model which supports the engagement and development of community plans and commission the delivery of this.	2016 – 2021	£223,000 (ICF)
	Allocate resources to implement locality plans.	Provide a Community Fund for the implementation of the eight locality plans.	2016 – 2021	To be determined
		Further develop inclusive communication initiatives which resonate across all care groups, young and old.	2016 – 2021	Within existing resources
		Work with current community facilities to develop a range of leisure and social activities including drop in centres for those with additional support needs.	2016 – 2021	To be determined

Strategic Priority 6 – Building Capacity

Why is it a priority?

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

Our aim for this priority is to develop a range of activities and opportunities for networking, socialisation and participation.

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

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

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		<p>Refresh the Community Capacity Building Strategy and review the current level of the Community Capacity Fund to reflect predicted use.</p> <p>Further develop community health resources to maintain people living in their own neighbourhoods.</p> <p>Support health and social care staff to identify community resources and to sign post/support individuals to access these resources.</p>	<p>2016 – 2018</p> <p>2016 – 2018</p> <p>2016 – 2018</p>	<p>£95,000 (ICF)</p> <p>Within existing resources</p> <p>Within existing resources</p>
	Supporting the development of a community transport strategy and investing in community models of transport.	Work in partnership with the statutory agencies, communities and third sector to agree a community transport strategy and fund a test of change.	2016 – 2018	To be determined

Strategic Priority 7 – Models of Support, Pathways of Care

Why is it a priority?

We know that people want to live as independently as possible and would prefer to be supported at home or in a homely setting. The current models of service delivery will not meet the anticipated increase in demand. Dundee has an ageing population, high levels of deprivation and growing numbers of people living with long term health conditions and complex health needs. In order to meet these challenges support needs to be anticipatory and well planned, and there should be continuity of care.

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

Our aim for this priority is to:

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

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
Models of Support, Pathways of Care	Invest in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community.	Support more people to be assessed at home rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change.	2016 – 2017	£116,000 (Delayed Discharge Funding)
		Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways.	2017 – 2018	To be determined
		Extend the range of supports for adults transitioning from hospital back to the community.	2016 – 2018	£104,000 (ICF)
		Lead a review, with partners, of the current Learning Disability acute liaison service and develop a future model.	2016 – 2017	Within existing resources
		Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults.	2016 – 2018	£10,000 (Delayed Discharge Funding)
		Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired	2016 – 2018	Within existing resources

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

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Contribute to the outcome of the Steps to Better Healthcare review of Learning Disability in-patient services and increase the provision of community health supports whilst reducing the bed base.	2016 – 2018	Within existing resources
	Remodel local authority residential care to provide more targeted and specialist resources.	Review the current models of residential care for older people in line with future of residential care (Scottish Government 2013).	2016 – 2018	Within existing resources
	Remodel General Practice in line with the G.P. cluster model, the changes to the GMS contract and the opportunities afforded through integration.	<p>Remodel and further develop multi-disciplinary team approach with General Practice at the centre.</p> <p>Address local challenges relating to General Practice boundaries and changing workforce and remodel in partnership with G.P.'s.</p> <p>Test improved and more efficient models of service delivery in partnership with General Practice, focusing initially on long-term conditions and older people.</p> <p>Support new models of General Practice care and Out of Hours urgent care in line with Sir Lewis Ritchie's 2015 review.</p>	<p>2016 – 2017</p> <p>2016 – 2018</p> <p>2016 – 2018</p> <p>2016 – 2019</p>	<p>To be determined</p> <p>To be determined</p> <p>To be determined</p> <p>To be determined</p>

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Develop the " House of Care" model for care and support planning, ensuring this links with partners' approaches to person centred care, for those with a long term condition.	2016 – 2019	To be determined
	Invest in the transformation of community nursing services to deliver the Tayside District Nursing vision and model, improving outcomes for adults and older people.	<p>Develop a flexible workforce to ensure the safe and effective delivery of a quality community nursing service over 24 hours/ 7 days a week.</p> <p>Build workforce capability and capacity to deliver models of care which promote health, self-management and address inequalities.</p> <p>Implement the recommendations from the National Review of District Nursing and NHS Tayside Transforming District Nursing Programme.</p> <p>Review the roles and responsibilities of the Community Learning Disability Nursing team within the context of a whole system e.g. medical / Psychiatry / Nursing and AHP services.</p>	<p>2016 – 2018</p> <p>2016 – 2018</p> <p>2016 – 2018</p> <p>2016 – 2018</p>	<p>To be determined</p> <p>To be determined</p> <p>To be determined</p> <p>Within existing resources</p>

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
	Remodel and invest in the development of and increase in, accommodation with support.	<p>Disinvest in residential forms of care for older people and increase investment in accommodation with support.</p> <p>Remodel Housing Support services to ensure equity of access based on need.</p> <p>Implement the proposals for accommodation with care for adults in line with the Strategic Housing Investment Plan.</p>	<p>2016 – 2018</p> <p>2016 – 2018</p> <p>2016 – 2021</p>	<p>Within existing resources</p> <p>Within existing resources</p> <p>Within existing resources</p>
	Remodel and invest in the development of day opportunities for adults and older people.	<p>Shift the balance of building based to non-building based day opportunities.</p> <p>Continue to increase opportunities for adults with a Learning Disability and/or Autism to receive more personalised support in leisure, recreational and social activities, including in the evening and at weekends.</p> <p>Increase the use of volunteers to support adults and older people in their lifestyle choices.</p>	<p>2016 – 2017</p> <p>2016 – 2018</p> <p>2016 – 2018</p>	<p>Within existing resources</p> <p>Within existing resources</p> <p>Within existing resources</p>
	Invest in and expand the range of telehealth and telecare supports.	Develop a Strategic Commissioning Statement for technological care and implement actions alongside partnership agencies.	2016 - 2017	Within existing resources

Strategic Priority	Links to the Strategic Shift	Action	Timescale	Funding (All costs are indicative per annum)
		Increase the range of technological supports.	2016 – 2017	Utilising available national development resources.
	Remodel and prioritise mainstream and specialist services to ensure a rapid and effective response to protecting people concerns	Implement the recommendations within the Adult Support and Protection Committee Biennial Report (2014 -2016) when published. To prevent and eradicate Violence Against Women (including Domestic Abuse) <ul style="list-style-type: none"> • Introduce the Caledonian Programme to work with perpetrators of domestic abuse • Introduce the Safe & Together model for working with families affected by domestic abuse • Deliver awareness sessions on Harmful Practices (including FGM, Forced Marriages and 'honour' based violence) to professionals across the city 	2016 – 2018 2016-18 2016-17 2016-18	Within existing resources Awaiting confirmation of additional resources Within existing resources Within existing resources

Strategic Priority 8 – Managing our Resources Effectively

Why is it a priority?

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

Our aim for this priority is to:

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

To address this priority we need to:

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

Our current actions:

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

Our Proposed Actions

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

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

7.0 IMPLEMENTATION OF THE PLAN AT A CARE GROUP LEVEL

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

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

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

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

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

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

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

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

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

8.0 FINANCIAL FRAMEWORK

8.1 Financial Planning Assumptions

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

Anticipated increases in demand for services over the planning period, as described earlier in this Plan will also put pressure on financial resources if services continue to be delivered in the same way. The potential effect of this has been costed across service user groupings and is set out and described in Chart 28 under the Fiscal Constraints section at section 5.1.3.

8.2 Estimated Financial Resources

Work is currently being undertaken to refine and finalise the level of resources which fall within the scope of the Plan. Given the scale of the financial challenges facing both Dundee City Council and NHS Tayside, current budgeted resources will be subject to an assumed level of savings as we move into the period of the Plan. The current estimate of the financial resources to be delegated to Dundee IJB before the consideration of any savings, and the source of funding, are noted in Table 1 below.

The estimate of financial resources available also includes specific funding streams provided by the Scottish Government and channelled through the IJB to support the development of creativity and tests of change in service delivery (such as the Integrated Care Fund and targeted initiatives such as Delayed Discharge funding). In addition, the recent Scottish Government finance settlement includes additional funding of £250m nationally to be transferred to Health and Social Care Partnerships to ensure better outcomes in social care.

Of this resource, the first £125m is to support additional spend on expanding social care to meet the objectives of integration. The second £125m is to help meet a range of existing costs faced by local authorities in the delivery of high quality health and social care services, including a commitment to ensure that all social care workers in the independent and third sectors are paid the National Living Wage of £8.25 per hour. The total value of this fund for Dundee IJB is £7.65m. These resources are critical in supporting the service shifts set out in the Plan to achieve the priority outcomes on a longer term basis.

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

Table 1

Description	Funding Source	Estimated Current Value (2015/16 Resources)
Former Community Care Resources	Dundee City Council	£78m*
Former Dundee CHP Resources	NHS Tayside	£42m*
Partnership Funds (e.g. Integrated Care Fund, Delayed Discharge Funding)	Partnership	£6m
Former Mental Health & Learning Disability Resources	NHS Tayside	£13m*
Other Former NHST Resources	NHS Tayside	£3m*
General Medical Services	NHS Tayside	£24m*
Other Family Health Services	NHS Tayside	£20m*
G.P. Prescribing	NHS Tayside	£33m*
Large Hospital Resources	NHS Tayside	£21m*
Allocation of Additional Scottish Government Funding for Health & Social Care	Scottish Government	£7.65m (2016/17)
Total Resources *Note all figures are provisional		£247.65m

8.3 Care Group Commissioning Intentions – Financial Implications

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

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

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

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

8.4 Financial Implications of Achieving the Strategic Shifts

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

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

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

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

9.0 COMMISSIONING

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

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

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

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

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

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

- More individualised packages of care where individuals will manage and control how their care needs are met
- More investment in services which focus on early intervention and prevention
- A wider range of supports available to carers to support their health and wellbeing
- More tests of change in the delivery of services across more of the communities we serve in order to increase the community capacity and resilience of these communities
- A roll out of services designed to meet the specific needs of local areas which focus on tackling health inequalities across more areas of the city
- A strategic shift in designing and delivering services on a locality basis
- Relatively less reliance of residential based forms of care in relation to the overall population needs, and relatively more reliance on housing with care, and home based care services
- A wider range of housing support options for individuals to help sustain them in their own homes, maintain independent living and reduce homelessness
- More accommodation with support for individuals with particular needs
- More services which provide access to training and employment
- More integrated service provision
- A greater range of telehealth and telecare supports
- A range of services which support the implementation of the Dundee Alcohol and Drugs Partnership Strategy

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

To deliver on the commitments which are set out in this Plan we need to make sure that there are a variety of providers and creative support options to meet the range of presenting need and demand in Dundee. We also need to ensure that people understand what support is available and be able to make informed choices, by having easy access to information about the quality, flexibility, safety and cost of services.

We intend to develop a Market Facilitation Strategy that will articulate the future shape of our social care market in Dundee. The Market Facilitation Strategy will be relevant for those within the Dundee Health and Social Care Partnership who are responsible for the delivery of social care services, as well as other providers in the independent and third sector. The Strategy will complement and add value to the business planning and development activities of all current and potential providers.

When finalised, the Market Facilitation Strategy will form one of the additional companion documents which will be aligned with, and will accompany this Plan.

10.0 WORKFORCE AND ORGANISATIONAL DEVELOPMENT

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

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

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

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

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

Further details are in our Workforce and Organisational Development Strategy, for which there is a link included in the Document Links Section of this document at Appendix 2.

11.0 MEASURING IMPROVEMENT AND ENSURING SUCCESS

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

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

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

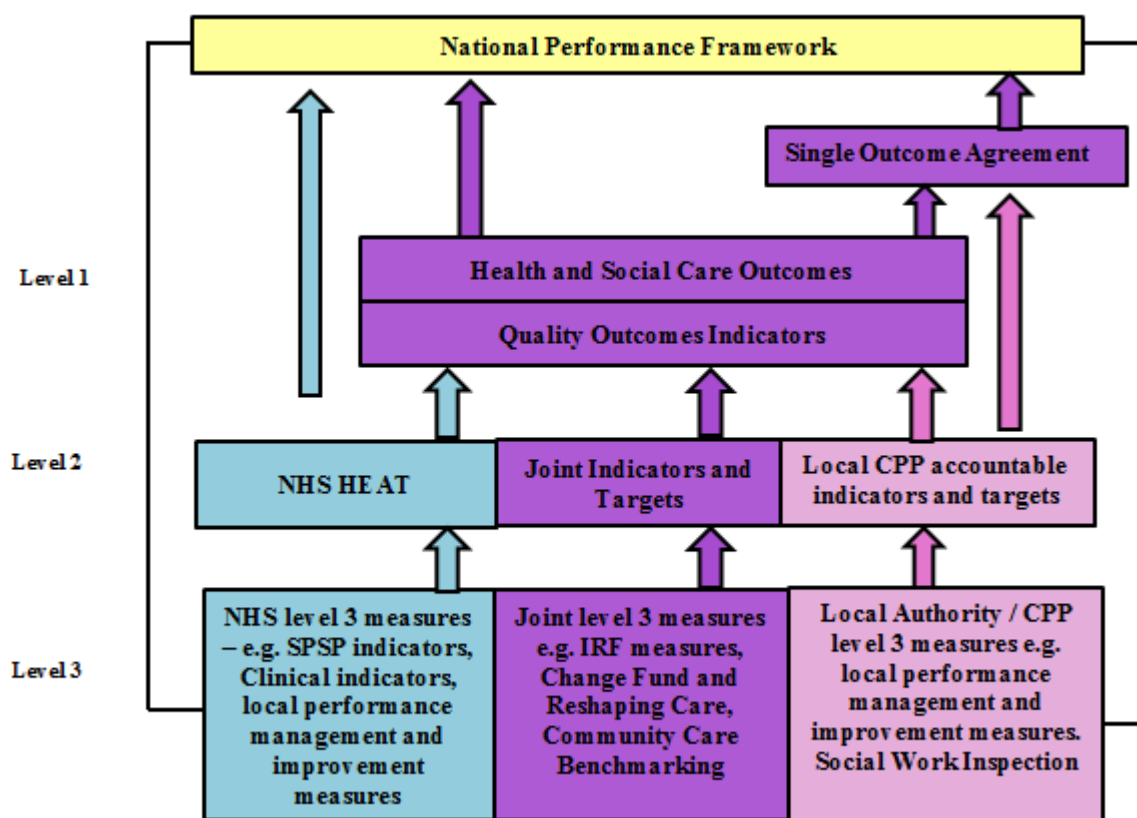
We recognise that the active collection and use of data, along with local intelligence, will help us to monitor the development of our health and social care services. As our Strategic Needs Assessment has demonstrated, the data gathered and analysed helps us to profile and better understand both geographical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

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

11.1 National Performance Framework

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

Figure 4: The National Performance Framework



a) Level 1

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

b) Level 2

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

c) Level 3

Extensive range of indicators/measures used for local improvement and performance management, including core sets of specific indicators for national programmes. This will also include information from self-evaluation and external scrutiny activity.

11.2 National Health and Wellbeing Outcomes and Indicators

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

The Scottish Government has also specified a core suite of 23 quantitative and qualitative indicators to support the assessment of performance against the nine National Outcomes (referred to in the National Performance Framework above as Quality Outcome Indicators).

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

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

11.3 National Performance Reporting Requirements

Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states that each IJB must prepare a performance report for the reporting year.

A performance report is described as a report which sets out an assessment of performance by each IJB in planning and carrying out its integration functions during any given reporting year. There is a requirement for each IJB to publish this report, to a prescribed form and content, within four months beginning with the end of the reporting year. For future performance reports there is a requirement to provide a comparison between the reporting year and the preceding five reporting years (or, where there have been fewer than five preceding reporting years, all preceding reporting years).

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

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

Each IJB is required to provide a description of the extent to which the arrangements set out in the Plan, and the expenditure allocated in the financial statement, have achieved or contributed to achieving, the National Health and Wellbeing Outcomes. Detailed information about performance against the key National Indicators and local measures

will be required, to help inform each IJBs local assessment of progress against the National Outcomes.

More detailed information regarding the requirements for the Annual Performance Report will be included in the Framework developed for the Partnership.

11.4 Dundee Outcomes and Performance Framework

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

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

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

a) Level 1 – High Level Outcomes

- National Health and Social Care Outcomes and Statutory Indicators
- Single Outcome Agreement (SOA) Indicators
- Performance reporting against National Standards e.g. for Clinical, Care and Professional Governance purposes

b) Level 2 – Publicly Accountable Indicators and Targets

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

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

- Local Government Benchmarking Indicators
- Change Fund and Integrated Care Fund measures
- Finance reporting
- Internal and external inspection and audit reports
-

There is a requirement in particular, to ensure that the measures agreed to track our performance in progressing the actions linked to the eight priorities identified in this Plan, and the related strategic shifts in the use of health and social care resources, are actively built into the Framework.

The following diagram provides an example to show how the national and local outcomes and indicators will be used to measure our performance in achieving the strategic shifts we are seeking to make against the strategic priorities identified in this Plan.

As an example, to show the links (golden thread) between the outcomes and performance measures we will use, we have selected the following strategic shift:

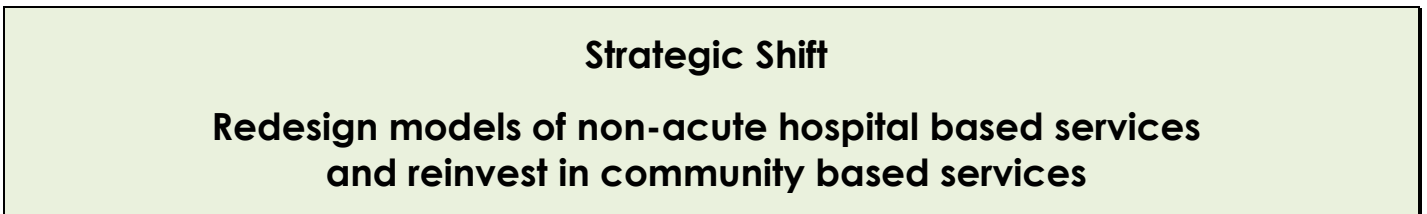
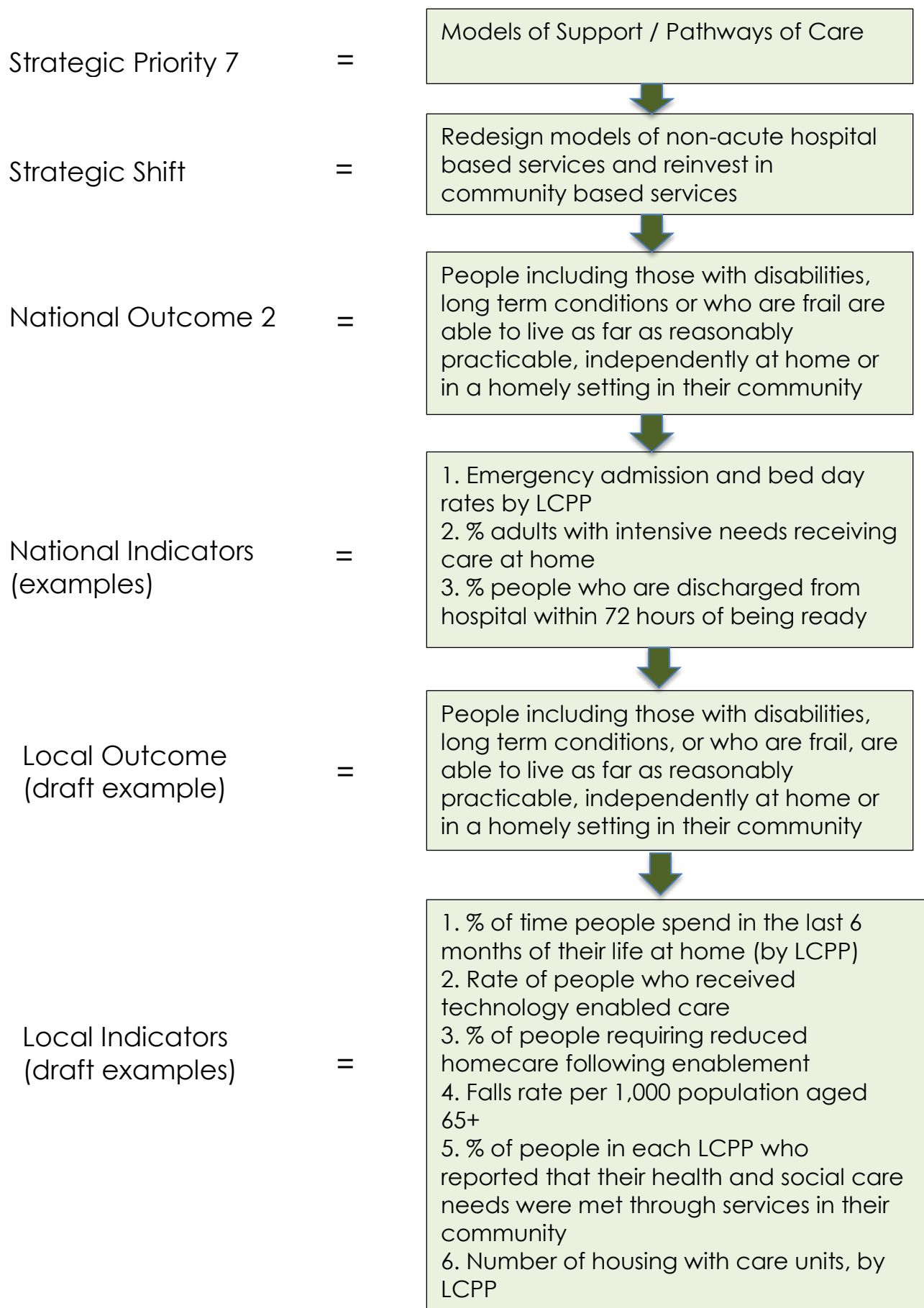


Figure 5 shows the strategic priority to which this particular shift is linked (Number 7: Models of Support/Pathways of Care) as well as the relevant National Outcome and Indicators to which this most directly relates.

Figure 5 also includes a possible local integration outcome and local indicators (shown for illustrative purposes only at this stage) which will allow us to monitor our progress against this particular strategic shift and priority in Dundee. It should be noted that because National Outcome 2 appropriately describes the outcome which we would seek to achieve for 'independent living' here in Dundee, it is shown here for illustrative purposes as an appropriate local outcome also.

This same process will be used to assess our progress in achieving all of the other strategic shifts/priorities identified in this Plan.

Figure 5: Local strategic shifts and outcomes within integrated framework



In line with this approach there will be a suite of such local integration outcomes and measures, which will be aligned with existing reporting requirements within an integrated outcomes and performance framework.

11.5 Annual Performance Report

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

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

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

11.6 Local Reporting Arrangements

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

The performance data required will initially be submitted using the Council's Corporate Performance Management Tool (called Covalent). Lead officers will be required to update, at agreed intervals, relevant data along with narrative and position statements that relate to the progress of key actions against strategic priorities and 'directions of travel'. Data will be used to prepare the quarterly and annual performance reports for the IJB and senior management teams.

11.7 Improving Access to and Quality of Data

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

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

We intend to undertake detailed analysis at LCPP and, where possible, neighbourhood level, to identify patterns in resource usage, and variations in health and social inequalities, across and within communities. Such information will be used to determine where resources are currently being used, and where any strategic shifts should be made in line with agreed priorities.

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

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

11.8 Governance Arrangements

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

The four strands of these arrangements are:

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

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

12.0 LEADING AND SUPPORTING CHANGE

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

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

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

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

12.1 Leadership Development

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

12.2 Community Engagement

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

In addition, the implementation of our Participation and Engagement Strategy (link in Appendix 2) will support all stages of development and will allow us to 'sense check' our intentions and progress.

13.0 SUPPORTING AND COMPANION DOCUMENTS

Thank you for taking the time to read this Plan.

We hope that the Plan helps explain the reasons for the changes that need to be made, the range of actions which we as a Partnership are now committed to taking forward over the life of this Plan, and the approach we will be taking to achieve the improvements we seek in the provision of health and social care services in Dundee.

The following supporting documents accompany the Plan:

Document 1:	Housing Contribution Statement
Document 2:	Equality Outcomes and Mainstreaming Equalities Framework

In addition there is a suite of companion documents which will support the implementation of the Plan. These are:

Companion Document 1:	Strategic Needs Assessment
Companion Document 2:	Participation and Engagement Strategy
Companion Document 3:	Workforce and Organisational Development Strategy
Companion Document 4:	Integrated Equality Impact Assessment
Companion Document 5:	Market Facilitation Strategy

The Dundee Health and Social Care Strategic and Commissioning Plan, the two supporting documents and the first four companion documents will be available from April 2016. The Market Facilitation Strategy is still in development, but will be made available when complete.

You can access an electronic version of the Plan and any of the supporting and companion documents on the home page of Dundee City Council, or NHS Tayside, or by using the following link:

<http://www.dundee.gov.uk/dhscp/ourpublications>

This Plan has been approved by the Dundee IJB and Integrated Strategic Planning Group. Its implementation and review will be supported by an ongoing programme of engagement with service users, carers and families, local communities, staff in the Health and Social Care Partnership, and all relevant stakeholders.

APPENDIX 1 Glossary of Terms

Phrase	Definition
Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include physiotherapists, dieticians, Speech and Language Therapists, psychologists, Occupational Therapists, podiatrists, audiologists, etc.
Asset-Based Approach	Mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.
Care Package	A term used to describe all the different types of care that make up the total care received by an individual. For example, they may receive support from Community Alarms or a mobile warden, and have home care. All these services together make up the 'care package'.
Care Pathway	The route followed by the service user into, through and out of NHS and social care services.
Care Plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible to the individual in whatever form is suitable to them.
Carer	Someone who provides, or intends to provide, unpaid care for another individual (the "cared-for person"). This could be caring for a relative, partner or friend (of any age) who is ill, frail, disabled or has mental health or substance misuse issues.
Change Fund	As part of the Reshaping Care for Older People initiative, short-term funding was provided to NHS Boards and local authorities to refocus health and social care of Older People towards prevention and early intervention. The Fund ceased to be allocated from April 2015, with some services sustained as part of mainstream health and social care services.

Phrase	Definition
Co-location	Co-located services are those that are established physically and organisationally as part of an integrated service. Co-location can be a key enabler in the development of integrated working.
Community Capacity	Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.
Community Planning	Community Planning is a process by which public agencies work in partnership with communities, the independent and third sector to plan and deliver better services. The partnership process has been in place for 10 years and is led by a Board of representatives from Dundee City Council, NHS Tayside, Job Centre Plus, Dundee and Angus college, Scottish Enterprise, Skills Development Scotland, Scottish Fire and Rescue, Police Scotland, Tayside Partnership for Transport, and the third and independent sectors.
Co-production	Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective. There is a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators, including service users and the community taking over some of the work done by practitioners.
Correlation	A statistical measure that indicates the mutual relationship or connection between two things.
Co-terminosity	Areas with similar boundaries.
Emergency admissions	Unplanned admissions to hospital inpatient services.
Enablement	Services for people with poor physical or mental health to help them re-learn skills, or develop new skills, support them to be independent and improve their quality of life. In Dundee enablement is a short term service which is provided for a period of up to a maximum of six weeks.

Phrase	Definition
Equality Impact Assessment (EQIA)	EQIA is a process to be considered when public bodies are planning a new, or redesigning an existing, policy, function or service. EQIA is a way of checking that policies, procedures and practice comply with Equality legislation.
Equally Well	National Action Plan for reducing health inequalities in Scotland published in June 2008.
Fairness Commission	<p>The Fairness Commission brings together members with a wealth of experience from a range of settings including partners in the public, voluntary, community, private and academic sectors. Together the Commission members will:</p> <ul style="list-style-type: none"> • Consider the nature, extent and impact of poverty in Dundee • Identify and investigate the key causes and consequences of poverty along with policy and practical measures to address these • Consider evidence of what has worked elsewhere to combat poverty and inequality • Assess the effectiveness of the efforts to date of Dundee City Council and the broader Dundee CPP through the Fairness Action Plan for Dundee • Seek the views and involvement of those experiencing poverty first hand • Prepare a report for the Dundee CPP and Dundee City Council with recommendations on additional priorities for action to tackle and reduce poverty in the city
End of Life Care	Palliative care provided in the dying phase of life.
Fiscal	Refers to public revenue when used in a financial context.
General Palliative Care	Palliative care provided by health and social care professionals to people living in the community, in care homes and in hospitals. This includes from within communities, families, the voluntary sector and charitable sectors.
Home Care or Care at Home	Help provided directly in the service user's own home. Home carers are people employed to provide direct personal physical, emotional, social or health care and support to service users and are accountable for dealing with routine aspects of a care plan or service.

Phrase	Definition
Hub	Area where principal community-based services will be concentrated. Likely to cross several locality and neighbourhood areas.
Independent sector	The independent sector encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and home care providers as well as consultancy and research work.
Integration Joint Board (IJB)	An Integration Joint Board was established in Dundee to oversee the integrated arrangements and onward service delivery. The Integration Joint Board exercises control over a significant number of functions and a significant amount of resource.
Locality	Locally defined geographical area within a local authority.
Long-Term Conditions	Long-term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support, medication and other therapies. Long-term conditions become more prevalent with age.
Mitigates	Makes something less harmful.
Morbidity	The incidence or prevalence of a disease or of all diseases in a population.
Mortality	The death rate, which reflects the number of deaths per unit of population in any specific region, age group, disease, or other classification, usually expressed as deaths per 1000, 10,000, or 100,000.
Multi-disciplinary Team (MDT)	A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.
Multi-morbidity	Multi-morbidity is the presence of two or more long-term health conditions.

Phrase	Definition
Neighbourhoods	Defined communities within Dundee City. There are 54 neighbourhoods across eight localities (LCCPs) in Dundee.
Occupational Therapy	Occupational Therapy gives people the tools and skills to promote health, wellbeing and independence through participation in activities or occupation. Occupational Therapists will analyse the person's physical, psychological, social, cognitive and environmental needs, and provide rehabilitation, or develop new strategies to enable people to continue to do the activities they need or want to do.
Opioid	The name for a number of chemical substances that act like morphine in the human body.
Organisational Development Plan/Strategy	Deliberately planned, organisation-wide effort to increase an organisation's effectiveness and/or efficiency and/or to enable the organisation to achieve its strategic goals.
Palliative Care	An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and treatment of pain and other problems; physical, psychosocial and spiritual.
Personalisation	Personalisation is a means of giving service users more control over the services and support they receive, and includes self directed support, asset management and co-production.
Physiotherapist	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible.
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by G.P. practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and Allied Health Professionals.

Phrase	Definition
Psychology	Psychology is the scientific study of human thought and behaviour. Clinical psychologists help a wide range of people of all ages with all sorts of problems, such as emotional or mental health problems, and people with difficulties with their thinking, such as problems with memory or perception after a head injury, a learning disability or dementia.
Quintile	One of five equal groups into which a set of things can be divided.
Secondary Care	Medical care provided by a specialist or facility. Referral would be made by a primary care physician (e.g. a G.P.) when more specialised knowledge, skill, or equipment is required.
Self-Directed Support	<p>The support individuals and families have after making an informed choice on how their Individual Budget is used to meet the outcomes they have agreed.</p> <p>There are four options that Partnerships have a duty to offer:</p> <ul style="list-style-type: none"> • the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support. • the supported person chooses their support and the local authority makes arrangements for the support on behalf of the supported person. • the local authority selects the appropriate support and makes arrangements for its provision by the local authority. • a mix of options 1, 2 and 3 for specific aspects of a person's support.
Self-Management	A service user and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long-term conditions. It encourages people to take decisions and make choices that improve their health, wellbeing and health-related behaviours.
Shifting the Balance of Care	Changes at different levels across health and social care systems intended to bring about better health and social outcomes for people. Typically this is to be achieved by providing early diagnosis, care and support, together with a speedier treatment and care planning process, which is tailored more closely to each person's individual's needs and delivered closer to home.

Phrase	Definition
Single Outcome Agreement (SOA)	The Single Outcome Agreement is an agreement between the Community Planning Partnership and the Scottish Government. Those using the agreed Community Planning Partnership identify priorities to be addressed and outcomes to be achieved. The SOA also includes an Action Plan to show how performance targets and Performance Indicators measure progress.
Social Enterprise	Social Enterprises are organisations that trade and operate for social and/or environmental purposes. Their assets are protected to ensure that any benefits accrued are maintained within the community. They meet the conditions of the Sencot Voluntary Code of Practice.
Specialist palliative care services	Services which provide direct and advisory palliative care for people with complex health needs (e.g. need for complex symptom management or psychological support) and support delivery of generalist palliative care.
Speech and Language Therapy	Speech and Language Therapists assess, treat and help to prevent speech, language and swallowing difficulties.
Strategic Commissioning	The term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.
Tests of Change	Small-scale tests which help to determine whether a new idea could result in long term improvement.
Telecare/Telehealth/Digi health	Telecare and telehealth is technology that can be used to help service users live safely and independently in their home. Digi health is the use of digital technology to bring services together.

Phrase	Definition
Third Sector	The generic term for those organisations involved in Health and Social Care Partnerships comprising non-governmental and non-profitmaking organisations or associations, including charities, voluntary organisations, community groups, tenants and residents groups, faith groups, housing associations, most co-operatives and social enterprises (provided profits are retained for the benefit of the members or community served), and most sports organisations.

APPENDIX 2 Document Links

National Legislation and Policy	
National Health Service and Community Care Act 1990	http://www.legislation.gov.uk/ukpga/1990/19/contents
Local Government in Scotland Act 2003	http://www.legislation.gov.uk/asp/2003/1/contents
Delivering Care Enabling Health 2006	http://www.gov.scot/resource/doc/152499/0041001.pdf
Scotland Performs: National Performance Framework 2007	http://www.gov.scot/About/Performance/scotPerforms
NHS Scotland Better Cancer Care: An Action Plan 2008	http://www.gov.scot/Topics/Health/Services/Cancer
NHS Scotland Living and Dying Well a National Action Plan for Palliative and End of Life Care in Scotland 2008	http://www.gov.scot/resource/doc/239823/0066155.pdf

Appendix 2 – Document Links

The Scottish Government: Improving Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan 2009	http://www.gov.scot/Publications/2009/12/03112054/0
The Health Care Quality Strategy 2010	http://www.gov.scot/resource/doc/311667/0098354.pdf
A National Clinical Strategy for Scotland February 2016	http://www.gov.scot/Resource/0049/00494144.pdf
Caring Together: The Carers Strategy for Scotland 2010 – 2015	http://www.gov.scot/Publications/2010/07/23153304/0
Carers (Scotland) Bill	http://www.scottish.parliament.uk/S4_Bills/Carers%20(Scotland)%20Bill/SPBill61BS042016.pdf
Reshaping Care for Older People (2011)	http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare
NHS Scotland Efficiency and Productivity Framework 2011 – 2015	http://www.gov.scot/Publications/2011/02/11144220/0
Commission on the Future Delivery of Public Services 2011 (Christie Commission)	http://www.gov.scot/About/Review/publicservicescommission
NHS Scotland 20:20 Vision 2011	http://www.gov.scot/Topics/Health/Policy/2020-Vision

Scottish Government Building a Health Service Fit for the Future Volume 2 A guide for the NHS 2005	http://www.gov.scot/Publications/2005/05/23141500/15035
Review of Public Health In Scotland 2015	http://www.gov.scot/Resource/0049/00493925.pdf
Welfare Reform Act 2012	http://www.legislation.gov.uk/ukpga/2012/5/contents/enacted
Mental Health Strategy for Scotland 2012 – 2015	http://www.gov.scot/Publications/2012/08/9714
AHPs as agents of health and social care integration, the National Delivery Plan 2012–2015	http://www.gov.scot/Publications/2012/06/9095
Age, Home and Community: A Strategy for Housing for Scotland's Older People 2012 – 2021	http://www.gov.scot/resource/doc/365373/0124256.pdf x
Equality Act 2010	http://www.legislation.gov.uk/ukpga/2010/15/contents
The Equality Act(Specific Duties) (Scotland) 2012	http://www.gov.scot/Topics/People/Equality/PublicEqualityDuties
Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland 2012	http://www.gov.scot/resource/0039/00396826.pdf x

Appendix 2 – Document Links

Scotland's National Action Plan for Human Rights (SNAP) 2013 – 2017	http://www.scottishhumanrights.com/actionplan/readfullreport
Social Care (Self Directed Support) Act 2013	http://www.legislation.gov.uk/asp/2013/1/contents/enacted
Scotland's National Dementia Strategy 2013 – 2016	http://www.gov.scot/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316
Prescription for Excellence: A Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation 2013	http://www.gov.scot/resource/0043/00434053.pdf
The Keys To Life: Improving Quality of Life for People with Learning Disabilities 2013	http://keystolife.info
The Scottish Strategy for Autism	http://www.gov.scot/Resource/Doc/361926/0122373.pdf
Procurement Reform(Scotland) Act 2014	http://www.legislation.gov.uk/asp/2014/12/contents
National Health and Wellbeing Outcomes	http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

Appendix 2 – Document Links

Public Bodies (Joint Working) (Scotland) Act 2014	http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf
Transforming Urgent and Emergency Care Services in England: Urgent and Emergency Care Review: Sir Bruce Keogh 2013	http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
Management of Offenders etc(Scotland) Act 2005	http://www.legislation.gov.uk/asp/2005/14/contents
Community Justice Bill	http://www.scottish.parliament.uk/S4_Bills/Community%20Justice%20(Scotland)%20Bill/b68s4-introd.pdf
Scottish Partnership for Palliative Care 2015	http://www.palliativecarescotland.org.uk/content/annual-conference-2015/
Strategic Framework for Action on Palliative and End of Life Care 2016-2021, published 2015	http://www.gov.scot/Resource/0049/00491388.pdf
Joint Improvement Team Advice Note February 2014: Strategic Commissioning	http://www.jitscotland.org.uk/wp-content/uploads/2014/08/Strategic-Planning-Joint-Strategic-Commissioning-JIT-Advice-Note-February-2014.pdf

Local Policy	
Dundee City Council Plan 2012 – 2017	https://www.dundee.gov.uk/dundee-city-council/publications/publication_3481.pdf
Single Outcome Agreement for Dundee 2012 – 2017	http://www.dundee.gov.uk/publication/single-outcome-agreement-dundee-2012-2017-194mb-pdf
Dundee Fairness Strategy and Action Plan: A Strategy for Challenging Poverty and Promoting Inclusion in Dundee 2012	http://www.dundee.gov.uk/publication/fairness-strategy-and-action-plan-543kb-pdf
Dundee Alcohol and Drug Partnership Delivery Plan 2012 – 2015	http://www.scottishrecoveryconsortium.org/assets/files/Dundee%20ADP%20Delivery%20Plan.pdf
Dundee Partnership Community Justice Transition Plan 2015-17	http://www.dundeepartnership.co.uk/content/community-safety-partnership-strategies-and-other-documents
Dundee Health and Social Care Integration Scheme 2015	https://www.dundee.gov.uk/sites/default/files/publications/dundeeintegrationsscheme.pdf
Adult Support and Protection (Scotland) Act 2007	http://www.legislation.gov.uk/asp/2007/10/contents
Dundee Health and Social Care Partnership: Care Group Strategies	(Link not yet available)

Appendix 2 – Document Links

Dundee Health and Social Care Partnership: Equality Outcomes and Mainstreaming Equalities Framework 2016-2017	http://www.dundeeecity.gov.uk/dhscp/ourpublications
Dundee Health and Social Care Partnership: Participation and Engagement Strategy	http://www.dundeeecity.gov.uk/dhscp/ourpublications
Dundee Health and Social Care Partnership: Market Facilitation Plan	(Link not yet available)
Dundee Health and Social Care Partnership: Workforce and Organisational Development Strategy	http://www.dundeeecity.gov.uk/dhscp/ourpublications
Dundee Health and Social Care Partnership: Strategic Needs Assessment	http://www.dundeeecity.gov.uk/dhscp/ourpublications
Dundee Health and Social Care Partnership: Hosted Services	(Link not yet available)
Dundee Annual Citizen Survey 2012	http://www.dundeepartnership.co.uk/sites/default/files/Dundee City Council Citizens Draft Survey Report.pdf
Other Useful Documents and Links	
Scotland Census 2011	http://www.scotlandscensus.gov.uk/census-results
National Records of Scotland :Statistics and Data	http://www.nrscotland.gov.uk/statistics-and-data

Appendix 2 – Document Links

Scottish Index of Multiple Deprivation	http://www.gov.scot/Topics/Statistics/SIMD
Information Services Division Scotland	https://data.gov.uk/publisher/isd-scotland
Social Care Institute for Excellence(SCIE) 2011 report 49	http://www.scie.org.uk/publications/reports/report49.asp
Scottish Government Crime and Justice Figures 2015	http://www.gov.scot/Topics/Statistics/Browse/Crime-Justice
World Health Organisation Statistics 2014	http://www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf

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



Get in touch:

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